SSN SCHOLARS STRATEGY NETWORK

BASIC FACTS

EVEN IF OBAMACARE IS REPEALED, INSTITUTIONAL CHANGES WILL PERSIST AND LESSONS CAN BE LEARNED

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Republicans in the U.S. House of Representatives have taken the first step toward repealing the Affordable Care Act, known as ObamaCare. The bill that passed the House, called the American Health Care Act, removes regulatory protections and mandates massive reductions of federal financial support for health insurance for millions of Americans. For now, until both houses of Congress act and the President signs a new law, the Affordable Care Act remains. Its inception altered rules, roles, and expectations related to accessing health insurance and regulation of the healthcare system at federal, state, and local levels. Even if there have only been three years of full implementation, experience with ObamaCare shows how complex systems and the organizations that operate within them adapt and change during periods of reform.

Over the course of two years, I talked to leaders and stakeholders in California who had a hand in implementing the law. Their first-hand experience and impressions suggest that the Affordable Care Act encouraged new and existing organizations to work together in profoundly different ways to devise novel models to guide insurance enrollment and coverage expansion. My interviews suggest two conclusions – first, that competition is not always a good thing; and second that ObamaCare's new infrastructure may be hard to unravel because previously separate stakeholders have learned to work together to boost insurance enrollments.

Expanding Access and Infrastructure, while Intermixing Roles

ObamaCare expanded insurance coverage to more Americans. Those with middle incomes not insured by employers, yet earning between 138% and 400% of the federal poverty level, could get tax subsidies to buy private plans through government-run "exchanges." Meanwhile, in states that fully implemented the law, low-income people earning less than 138% of the federal poverty level were eligible to receive public insurance through Medicaid (called Medi-Cal in California). To facilitate Medicaid enrollments, California used both the "Covered California" exchange website and existing administrative arrangements in each of its 58 counties.

Expanding eligibility was not enough to expand insurance coverage. And, although people were required to actually enroll through these new access channels, choosing and enrolling in an insurance plan is not easy. As one agent described, "I get people who are totally new to health insurance that have no idea what's going on." To facilitate enrollment, California took a multipronged approach. It used federally mandated Navigator and Certified Application Counselor programs, and supplemented them with additional efforts unique to the state: the Outreach and Education Grant Program, the Community Outreach Network, and the Enrollment Assistance Program. In total, the state certified over 8,200 county workers, 12,000 insurance agents and 6,400 enrollment assisters to raise awareness of the availability of qualified health plans, distribute fair and impartial information, facilitate enrollment in qualified health plans, and

help potential enrollees in a manner culturally and linguistically appropriate to the needs of the various segments of the state population.

Covered California and over 25,000 enrollment stakeholders made a commitment to a "no wrong door approach," with diverse groups sharing territory and operating together under new rules and expectations. As I learned, the institutional roles and responsibilities of state, market, and civil society stakeholders have become thoroughly intermixed, as government agencies now *run* markets, social workers now *sell* insurance, and insurance agents now seek to *help* the poor.

From Cooperation to Zero-Sum Competition

It was first thought that having as many people and organizations as possible assisting enrollees in an "all hands on deck" effort would best help to meet ObamaCare's goal to expand health insurance coverage. However, enlisting multiple partners under new rules, roles, and responsibilities and using multiple forms of incentives created tensions. Competition in California left some organizations no longer able to participate and reduced overall capacity to assist enrollees. Misperception about capacity led to difficulties after early phases of implementation.

As a Covered California staffer commented, it was presumed that "there was enough (*money and work*) to go around" – and that may have been true at first, when Navigators were awarded competitive grants to fund their education, outreach, and enrollment assistance services and when independent agents and Certified Enrollment Counselors were paid $58 for each exchange and Medi-Cal enrollment. Initial enrollment events featured a mix of navigators, agents, and enrollment counselors from community-based organizations and sometimes county agencies. "At these early events," a certified enrollment counselor recalled, "we shared the workload. If someone was eligible for a private plan on the exchange, we would send them to an agent. The agents would send the Medi-Cal enrollees to us."

But cooperation soon eroded. In later enrollment periods, the Covered California Board approved stricter, performance-based funding guidelines for Navigator grants. Performance was measured against each enrollment, and payments curtailed. And Medi-Cal enrollment payments dwindled. These changes put potential partners at cross purposes. Each organization became territorial out of concern to meet its own enrollment target. As a respondent recalled, "that next year was very numbers driven, so we didn't do as much collaboration." As a state representative put it, "all of a sudden it was every man for himself; 'I've got to meet my goals.'" Zero-sum competition trumped cooperation.

Looking Ahead

If the Affordable Care Act persists, or replacement legislation retains key elements, the newly devised roles and relationships among agents and enrollment assisters will continue to shape the insurance market in California and beyond. Even though Congress may reverse recent insurance coverage gains, much of the revised architecture of the nation's health system – a system that combines employer-sponsored insurance with privately purchased and publically supported insurance – will surely remain. It is therefore incumbent on scholars and policy researchers to glean lessons from what has occurred under the Affordable Care Act, so that future steps to meld diverse parts of the complex U.S. health insurance system can be taken with foresight and on the basis of lessons learned from past successes and failures.