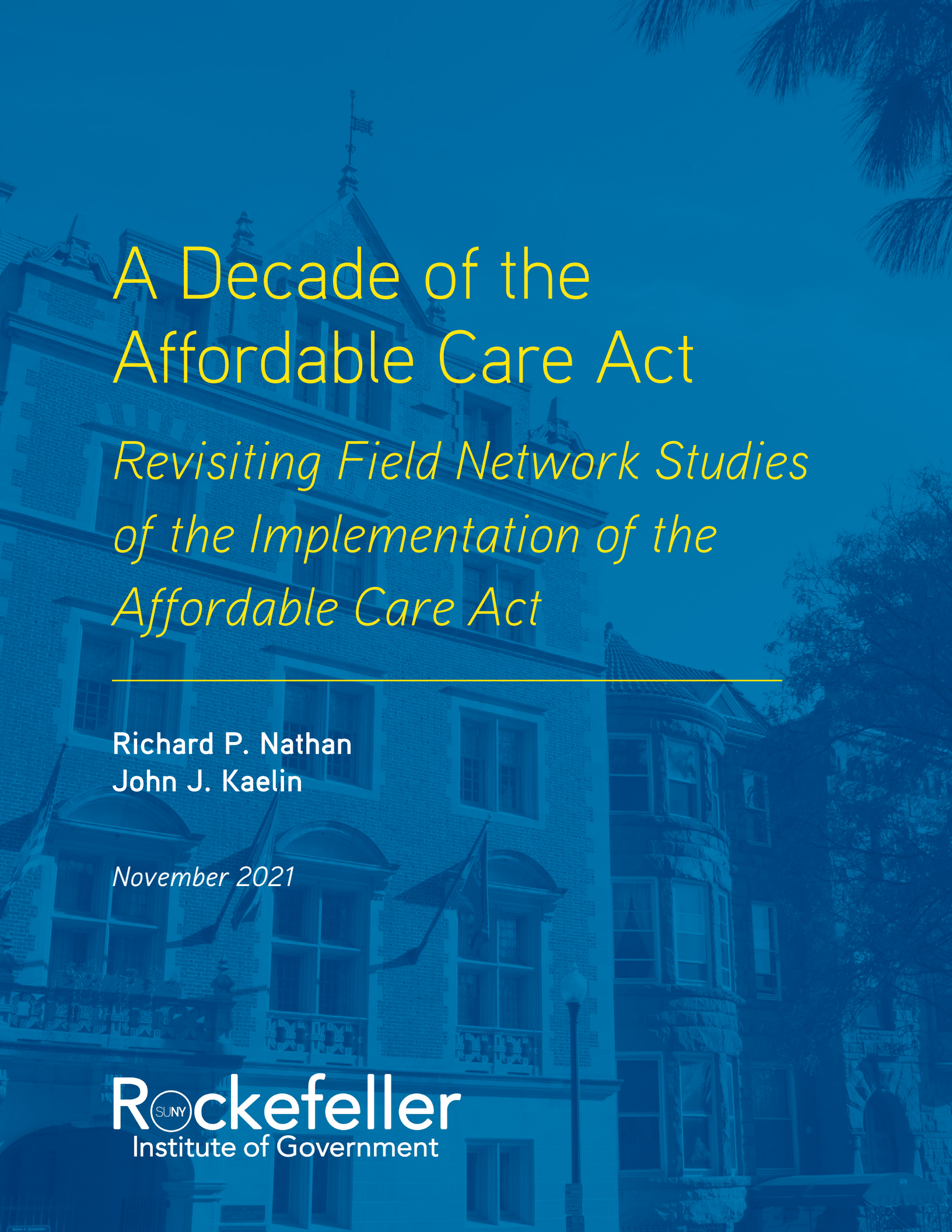

A Decade of the Affordable Care Act

Revisiting Field Network Studies of the Implementation of the Affordable Care Act

Richard P. Nathan
John J. Kaelin

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Rockefeller Institute of Government

ABOUT THE AUTHORS

Richard P. Nathan was the director of the Rockefeller Institute of Government beginning in 1981 and continuing for 20 years. After that, he was a senior fellow working on field studies on the Affordable Care Act.

John J. Kaelin is a fellow at the Rockefeller Institute of Government. He has diverse executive-level experience in the health-care industry spanning government, academia, US-based health insurers, and health systems in the Middle East. He has held senior executive positions in three major health insurers and is currently a senior vice president at Centene Corporation.

In Honor of Richard P. ("Dick") Nathan

Richard P. ("Dick") Nathan passed away on September 12, 2021, in Winter Park, FL. This report represents his final contribution as a senior fellow at the Rockefeller Institute of Government but his tireless work as the director of the Institute for 20 years established the Institute as one of the nation's leading public policy think tanks. He will be greatly missed by his friends and colleagues at the Institute.

Nathan was appointed director of the Institute by the Trustees of the State University of New York in 1989 and oversaw the Institute's research until his retirement in 2009. As noted in a statement from the Institute on his retirement, Nathan led with energy, intelligence, determination, and unquenchable curiosity.[1] Although the Institute was established several years before he was appointed director, "it was Dick who gave the Institute its distinctive mission and methodological style." Following his retirement, Nathan served as a senior fellow at the Institute, focusing his research on healthcare, especially the implementation of the Affordable Care Act.

Nathan dedicated his career to evidence-based policymaking, emphasizing the role of research in finding governmental solutions to society's problems. As a nationally-recognized federalism expert, he inspired generations of scholars to explore the complex relationship between local, state, and federal governments—their distinctive spheres of influence and how they interact.

Having held top positions in the US Office of Management and Budget and the Department of Health, Education and Welfare, Nathan brought his expertise in federalism, social policy, and program implementation to his leadership of the Institute. During his tenure, Institute scholars contributed several influential analyses of federalism, such as cyclical changes in federal-state relations; the growing use of waivers and other executive powers in shaping the federal system; and the use of performance measurement and management.

Nathan wrote and edited several books on the implementation of domestic public programs in the United States and on American federalism. Prior to coming to Albany, he was a professor at Princeton University. He served in the federal government as assistant director of the US Office of Management and Budget, deputy undersecretary for welfare reform of the US Department of Health, Education and Welfare, and director of domestic policy for the National Advisory Commission on Civil Disorders (The Kerner Commission).

The Richard P. Nathan Public Policy Fellowship, created in 2017, is named after him.[2] The one-year fellowship connects experts from a diverse range of backgrounds and research interests with Rockefeller Institute staff and researchers to analyze and address public policy problems.

The obituary for Dr. Nathan was published in the *Albany Times Union* on September 19, 2021 and the *New York Times* on October 3, 2021.[3]

A Decade of the Affordable Care Act

Background

The United States was slowest among advanced industrial democracies to adopt a comprehensive governance system for health care. The debate over whether and how to do this simmered throughout the twentieth century. Under the Patient Protection and Affordable Care Act (ACA), the country produced a typically American policy compromise.

The staff of the *Washington Post* called the ACA "a relatively moderate and incremental document—evolutionary, not revolutionary."[4] It retains private health insurance and produced a proliferation of new state and local administrative entities and arrangements for the provision of care. Now, a decade later, we are in a position to shed light on how this new policy amalgam is working for health-care services and finances.

Unlike the United Kingdom's nationally administered health-care system and bureaucratically centrally controlled European systems, the American system is decentralized. The ACA retained the employer-provided insurance system, Medicare, and Medicaid. To reach those not eligible for health insurance through one of these channels, the ACA relies heavily on health insurance marketplaces, called exchanges, at the state and local levels. These exchanges negotiate with insurers and other providers of service on their participation, purposes, and prices.

There are 512 local-area state-defined exchanges (called rating areas) where consumers can choose among multiple (often as many as 10 or more) income-tested standardized health insurance plans.[5] The ACA's goal is to increase coverage to provide essential health-care services through the operation of competitive state and local health insurance marketplaces. The ACA relies on American bargaining systems for insurance plans (Qualified Health Plans (QHPS)) to constrain prices and enhance efficiency.

In addition to establishing the health insurance exchanges, the ACA implemented a range of other important provisions and regulations. Among many others, these include:

- Subsidies for households participating in the exchanges with incomes between 100 percent and 400 percent of the federal poverty line.
- Expanding Medicaid eligibility to those with incomes up to 133 percent of the federal poverty line.[6]
- A mandate that requires individuals to purchase health insurance or else be subject to paying a penalty fee.[7]
- Prohibiting insurers from denying coverage to those with preexisting medical conditions.

A decade later, national evidence suggests that the ACA has been a success. Between 2009 and 2019, the share of uninsured Americans dropped from 15.2 percent to 9.2 percent.[8] Over 12 million people enroll in ACA plans annually, the number of insurers participating in the marketplace has increased, and premiums have stabilized. However, preliminary exploration of local exchanges reveals disparities across regions.

This piece reviews the key findings from the Rockefeller Institute's research documenting the implementation of the ACA at the state and local levels. It provides an overview at the national level before digging into local data to illustrate the disparities in access, costs, and coverage that still exist across regions. Finally, we outline several questions that could be explored through a reactivated field researcher study.

Lessons Learned From Implementation

Paraphrasing Yogi Berra, if you want to observe something, you have to go out and look at it. Beginning in 2010, the Rockefeller Institute of Government conducted on-the-ground research on the implementation of health insurance coverage under the Affordable Care Act (ACA) enacted in that year. Rockefeller Institute researchers worked with the Fels Institute at the University of Pennsylvania to recruit field researchers to document the implementation in their states.

The Rockefeller Institute published baseline reports on state responses to the law—whether they set up their own exchange, used the federal exchange, did or did not expand Medicaid, and the policy decisions they made as well as the politics involved. These reports are available online.[9]

In 2015, the Rockefeller Institute collaborated with the RAND Corporation and the Brookings Institution to establish the ACA Implementation Research Network.[10] The network of field researchers conducted a seven-state study of the health insurance rollout of the ACA for the assistant secretary of policy evaluation (ASPE) at the US Department of Health and Human Services. Two years later, the Rockefeller Institute collaborated with Brookings (notably Alice Rivlin and Paul Ginsburg) to analyze ACA implementation in five states, including designated local areas in each state. These reports were the subject of a national conference at Brookings[11] in 2017 that highlighted the experiences of five states: California,[12] Florida,[13] Michigan,[14] North Carolina,[15] and Texas.[16]

The ACA field studies have been focused on how and how well major purposes of the new law have been implemented altogether in 40 states.

FOUR BROAD THEMES EMERGED FROM THIS STUDY:

First, health insurance markets are local. While there has been substantial attention on national carriers, their desire to merge, and their withdrawal from selected states or market areas, the field researchers consistently describe substantial differences that exist among the market areas they examined. Insurance markets are local largely because insurers rely on their ability to establish networks of providers to allow them to be priced competitively with other insurers.

If they are unable to negotiate acceptable prices with local hospitals, physicians, and other providers, they are unable to compete. Thus, urban markets are different from rural ones. But urban markets differ as well. San Francisco is remarkably different from Los Angeles, as is Detroit different from Flint, and Miami different from Tampa.

Second, higher-than-expected claims costs have been the source of much of the turmoil in the health insurance marketplaces. In the first two years of the exchanges, insurers had very little information on the utilization experience they might expect from exchange enrollees. Many potential enrollees had not had coverage previously. The effects of the subsidies and the penalties on enrollment were unknown, and the extent and persistence of any pent-up demand for health services was also unknown.

Third, there has been a substantial shift toward narrower insurer networks of providers. During the early 2000s, insurers responded to the backlash against managed care by moving away from relatively narrow panels of hospital and physician providers to broader panels. This was accomplished by offering preferred provider organizations (PPOs) that gave consumers many more provider options than did health maintenance organizations (HMOs). In the initial years of the ACA, many carriers offered PPOs in their exchange plans, field researchers reported. PPOs are inherently less able to negotiate lower prices with health-care providers, because the larger panels undercut the ability of insurers to trade higher patient volume for lower prices from providers.

Fourth, hospital and physician competition is essential to a robust and competitive insurer market. The field researchers report that premiums are higher and the number of insurers are lower in rural areas relative to urban ones. While part of this has to do with population size, it also has to do with the number of hospitals, physician groups, and health systems that are available in rural areas. When insurers had only a single hospital or health system with which to negotiate, insurers paid higher prices, the field researchers noted.[17]

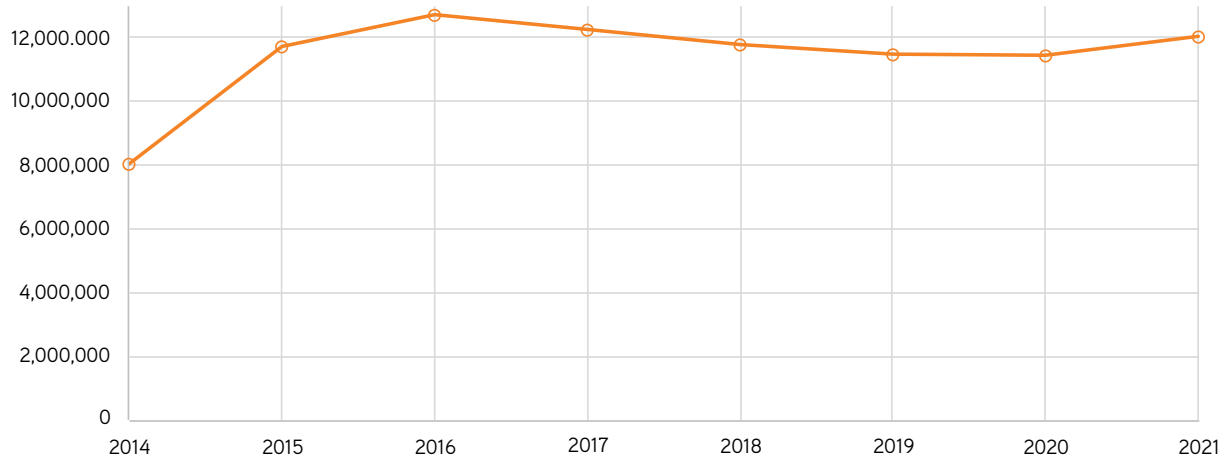
The original network of researchers found that the early years of the ACA were hard going. Some of the original participating insurers pulled out of state and local markets. The choices they offered for Qualified Health Plans were often limited and frequently revised. To add to these shifting sands of program operations, there were constant political glitches and management issues. Opponents tried multiple times to repeal and undercut the law. The national computer system, healthcare.gov, crashed when it was supposed to go into effect causing confusion and delay.

The Current State of the ACA Exchanges: National Level

It takes time to make the kinds of institutional changes necessary to carry out new national programs like the ACA health-care exchanges. Local policymakers must set up the machinery for new laws, arrange financial support, and establish the agencies and offices that run them, develop the day-to-day administrative systems, and adjust policies, procedures, and funding as necessary. Insurance providers need time to understand the newly established market and develop products that meet consumers needs.

A decade after the ACA's passage, the picture has improved. A review of key metrics at the national level suggests that the ACA marketplaces have stabilized and are expanding access to insurance. The number of people obtaining insurance through local exchange marketplaces has been relatively stable since 2015, averaging approximately 12 million people (Figure 1).

FIGURE 1. **Affordable Care Act Exchange Enrollment**



SOURCE: "Marketplace Enrollment, 2013-2012," Kaiser Family Foundation, accessed August 31, 2021, https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Competition Has Increased

One of the initial challenges in the implementation of the exchanges was the lack of competition. Enrollees had a limited number of plans to choose from and lack of competition drove prices higher. This problem has alleviated in recent years.

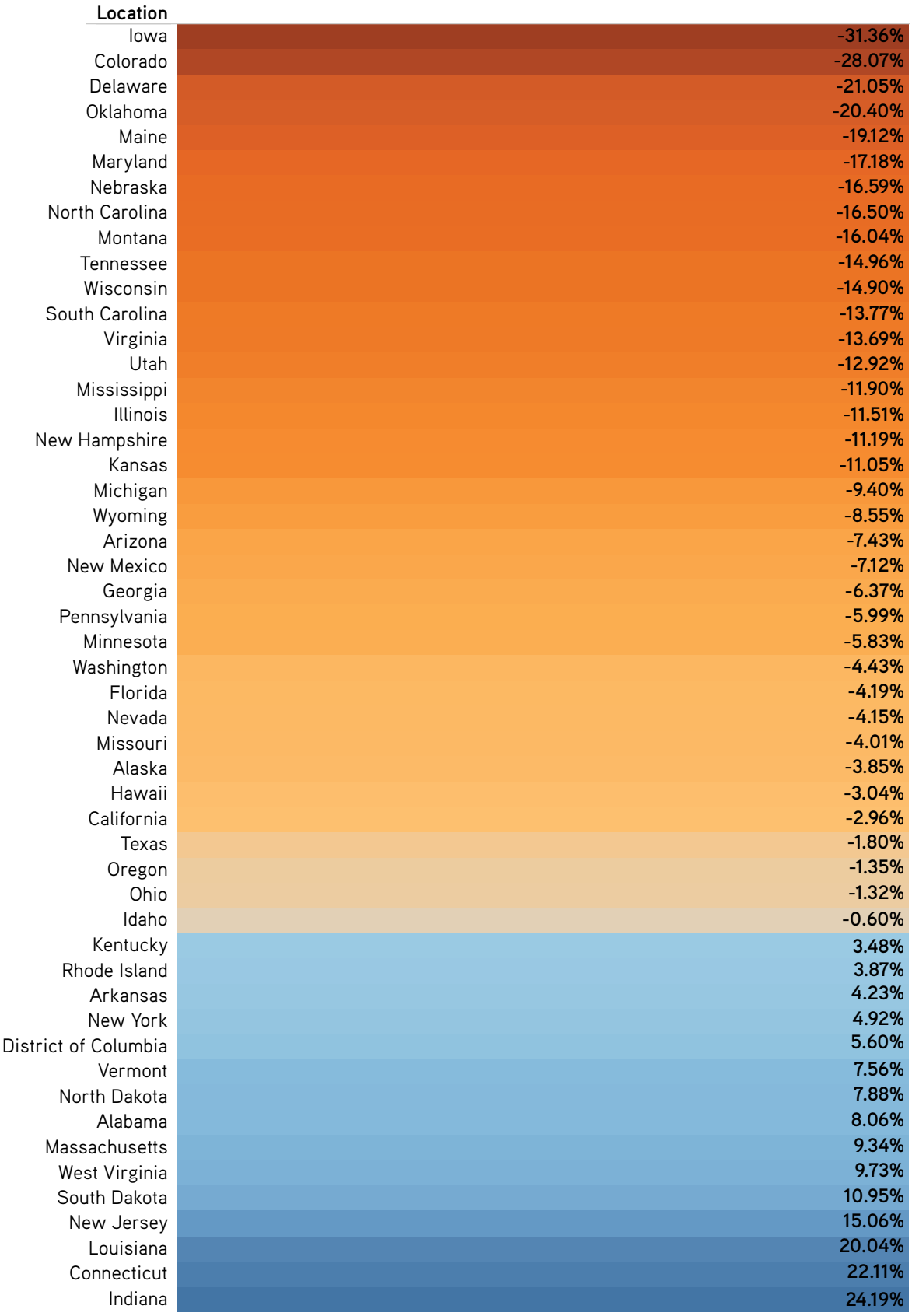
- Healthcare.gov enrollees with access to two or more issuers increased from 71 percent to 96 percent in 2021.
- The average 2021 enrollee had between four and five insurance plans available to choose from compared to between three and four in 2010.
- In 2021, more than three quarters of healthcare.gov enrollees have access to at least three insurers. A total of 37 states have three insurers or more in their marketplaces.
- Counties with one additional insurance issuer in 2019 experienced a 2.5 percent reduction in the benchmark premiums (i.e., second lowest cost silver plan) compared to 2018.
- The number of issuers on healthcare.gov increased from 159 in 2020 to 181 in 2021.
- From 2020 to 2021, the total number of insurers increased in 19 different states. Eight of those states saw multiple insurers enter the marketplace in one year. In the other 32 states and territories, insurer participation remained constant and there were zero states that experienced a decrease in the number of insurers.[18]

FIGURE 2. **Total Number of Insurers in State, 2014-21**

Location	2014	2015	2016	2017	2018	2019	2020	2021
Alabama	2	3	3	1	2	2	2	2
Alaska	2	2	2	1	1	1	2	2
Arizona	8	11	8	2	2	5	5	6
Arkansas	3	3	4	3	3	3	3	3
California	11	10	12	11	11	11	11	11
Colorado	10	10	8	7	7	7	8	8
Connecticut	3	4	4	2	2	2	2	2
Delaware	2	2	2	2	1	1	1	1
District of Columbia	3	3	2	2	2	2	2	2
Florida	8	10	7	5	4	5	7	9
Georgia	5	9	8	5	4	4	6	6
Hawaii	2	2	2	2	2	2	2	2
Idaho	4	5	5	5	4	4	4	5
Illinois	5	8	7	5	4	5	5	8
Indiana	4	8	7	4	2	2	2	3
Iowa	4	4	4	4	1	2	2	3
Kansas	3	3	3	3	3	3	5	6
Kentucky	3	5	7	3	2	2	2	2
Louisiana	4	5	4	3	2	2	3	3
Maine	2	3	3	3	2	3	3	3
Maryland	4	5	5	3	2	2	2	3
Massachusetts	10	10	10	9	7	8	8	8
Michigan	9	13	11	9	7	8	8	8
Minnesota	5	4	4	4	4	4	4	6
Mississippi	2	3	3	2	1	1	2	2
Missouri	3	6	6	4	3	4	7	8
Montana	3	4	3	3	3	3	3	3
Nebraska	4	4	4	2	1	1	2	2
Nevada	4	5	3	3	2	2	3	5
New Hampshire	1	5	5	4	3	3	3	3
New Jersey	3	5	5	2	3	3	3	3
New Mexico	4	5	4	4	4	4	4	5
New York	16	16	15	14	12	12	12	12
North Carolina	2	3	3	2	2	3	4	6
North Dakota	3	3	3	3	2	3	3	3
Ohio	12	15	14	10	8	9	9	9
Oklahoma	4	4	2	1	1	2	3	6
Oregon	11	10	10	6	5	5	5	5
Pennsylvania	7	8	7	5	5	6	7	7
Rhode Island	2	3	3	2	2	2	2	2
South Carolina	3	4	3	1	1	2	4	4
South Dakota	3	3	2	2	2	2	2	2
Tennessee	4	5	4	3	3	5	5	6
Texas	11	14	16	10	8	8	8	10
Utah	6	6	4	3	2	3	5	5
Vermont	2	2	2	2	2	2	2	2
Virginia	5	6	7	8	6	7	8	8
Washington	7	9	8	6	5	5	7	9
West Virginia	1	1	2	2	2	2	2	2
Wisconsin	13	15	16	15	11	12	12	13
Wyoming	2	2	1	1	1	1	1	2

SOURCE: Rockefeller Institute calculations based on data from "Number of Issuers Participating in the Individual Health Insurance Marketplaces," Kaiser Family Foundation, accessed August 31, 2021, https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

FIGURE 3. **Change in Average Benchmark Premiums by State, 2019-21**



Location	
Iowa	-31.36%
Colorado	-28.07%
Delaware	-21.05%
Oklahoma	-20.40%
Maine	-19.12%
Maryland	-17.18%
Nebraska	-16.59%
North Carolina	-16.50%
Montana	-16.04%
Tennessee	-14.96%
Wisconsin	-14.90%
South Carolina	-13.77%
Virginia	-13.69%
Utah	-12.92%
Mississippi	-11.90%
Illinois	-11.51%
New Hampshire	-11.19%
Kansas	-11.05%
Michigan	-9.40%
Wyoming	-8.55%
Arizona	-7.43%
New Mexico	-7.12%
Georgia	-6.37%
Pennsylvania	-5.99%
Minnesota	-5.83%
Washington	-4.43%
Florida	-4.19%
Nevada	-4.15%
Missouri	-4.01%
Alaska	-3.85%
Hawaii	-3.04%
California	-2.96%
Texas	-1.80%
Oregon	-1.35%
Ohio	-1.32%
Idaho	-0.60%
Kentucky	3.48%
Rhode Island	3.87%
Arkansas	4.23%
New York	4.92%
District of Columbia	5.60%
Vermont	7.56%
North Dakota	7.88%
Alabama	8.06%
Massachusetts	9.34%
West Virginia	9.73%
South Dakota	10.95%
New Jersey	15.06%
Louisiana	20.04%
Connecticut	22.11%
Indiana	24.19%

SOURCE: Rockefeller Institute calculations based on data from "Number of Issuers Participating in the Individual Health Insurance Marketplaces," Kaiser Family Foundation, accessed August 31, 2021, https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Premiums Have Decreased Annually Since 2019

- Premiums fell 3 percent between 2020 and 2021 coverage years, after decreasing 4 percent between 2019 and 2021.
- Average benchmark premiums (40 year-old individual silver plans) decreased in 36 of 51 states and territories.

Enrollment Remains Strong

- Over 12 million consumers nationally enrolled during 2021 open enrollment period (OEP), a 5 percent increase from the 2020 OEP.
- The COVID-19 special enrollment period (SEP), along with increased outreach and marketing, has led to significant coverage gains. Between February 15 to July 2021, over 2.5 million people have enrolled in the marketplace via the SEP through healthcare.gov.

The Current State of the ACA Exchanges: Local Level

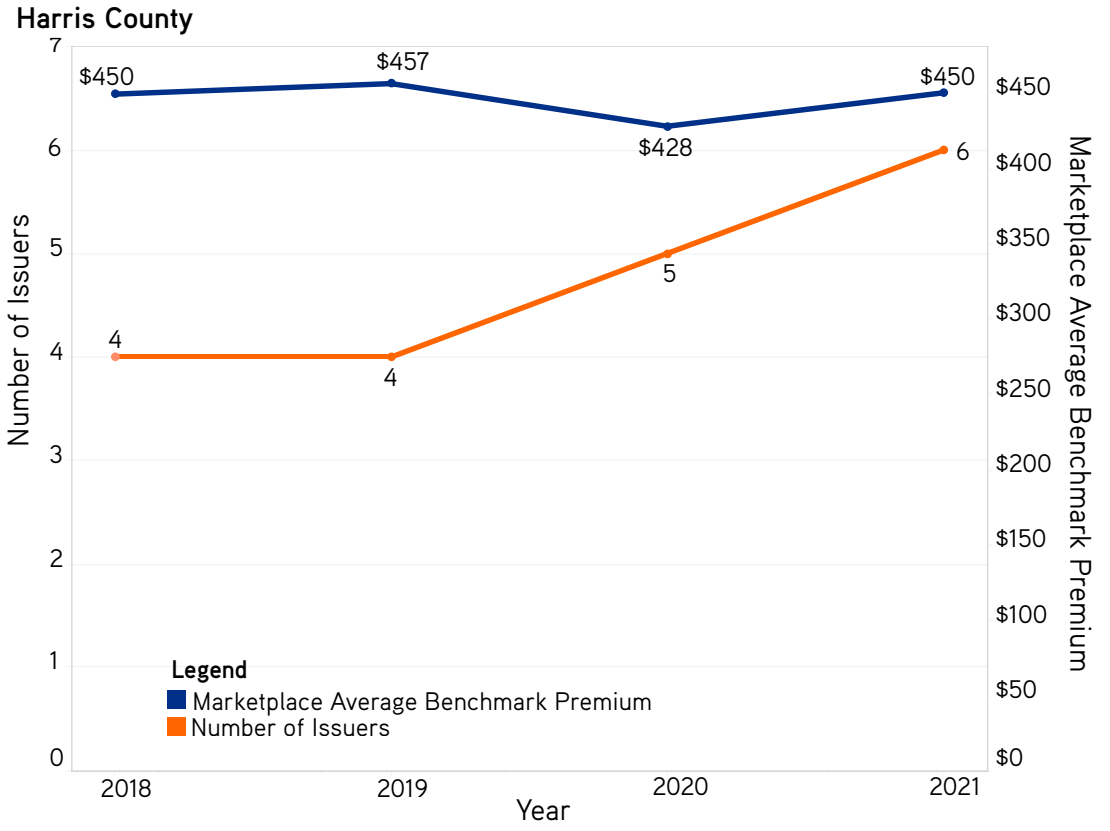
While national trends show greater competition, increased enrollment, and lower costs, an examination of local markets shows the trend is not universal. The Affordable Care Act has had a disparate impact on local markets, including those within the same state where there seems to be a stark difference in premium trends between large, urban centers, and some less densely-populated areas.

Trends from Texas

The three largest cities by population in Texas are Houston, San Antonio, and Dallas, located in Harris County, Bexar County, and Dallas County, respectively. The insurance markets in Harris and Dallas Counties have shown different trends in recent years than Bexar County. Both Houston and Dallas have seen gradual increases in the number of insurers since 2019. Houston (Harris County) has gone from five to nine insurers since 2019 and Dallas has seen an increase from three to six. In 2020, a year where both markets saw a new insurer enter, average premiums dropped between 4 and 5 percent. This decline in prices is in line with national trends. Economic theory suggests that new insurers entering a local marketplace will result in a decline in premiums. The number of insurers increased by 33 percent in both markets in 2021. Despite this new competition, premiums increased by 9 percent in Houston and 5 percent in Dallas. Over the same period, the national average premium fell by 3 percent.

In contrast, the market in San Antonio has seen little change in price over the past four years. Average premiums have remained stable even with an increase in the number of insurers available in 2021.

FIGURE 4. **Total Number of Insurers and Marketplace Average Benchmark Premiums (40 Year-Old Individual Silver Plans) in Harris, Bexar, and Dallas Counties**



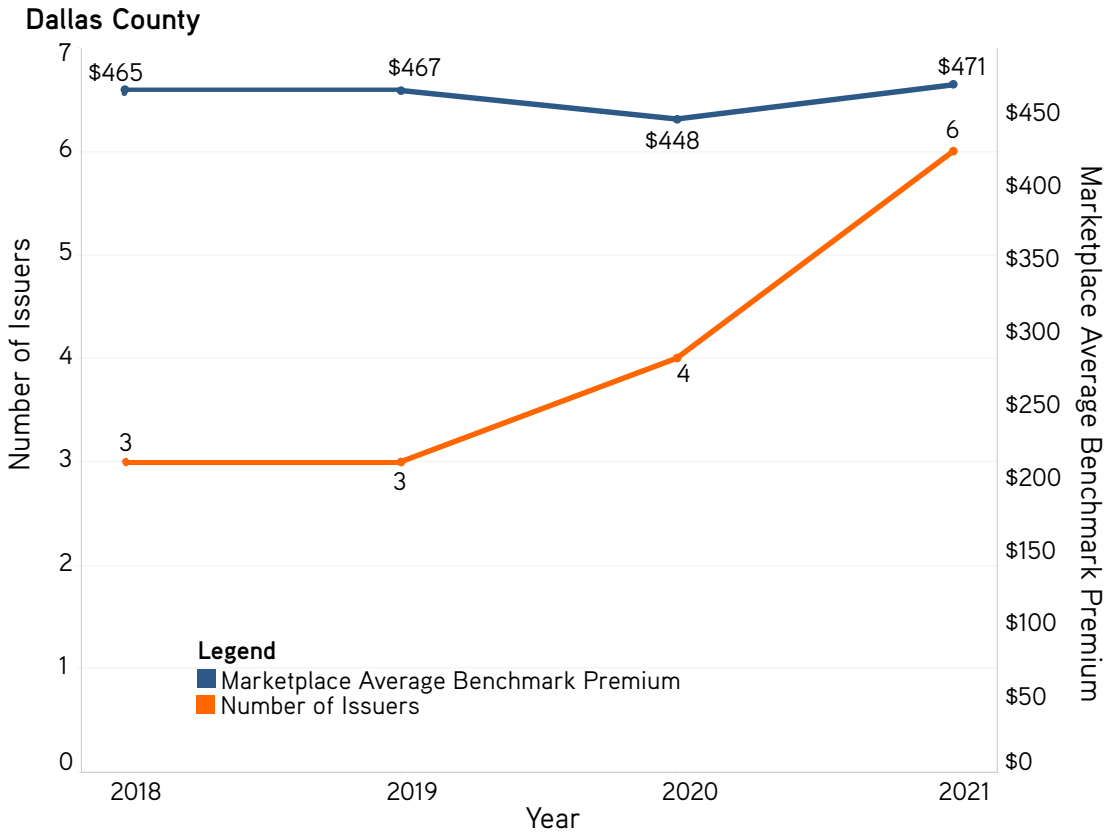
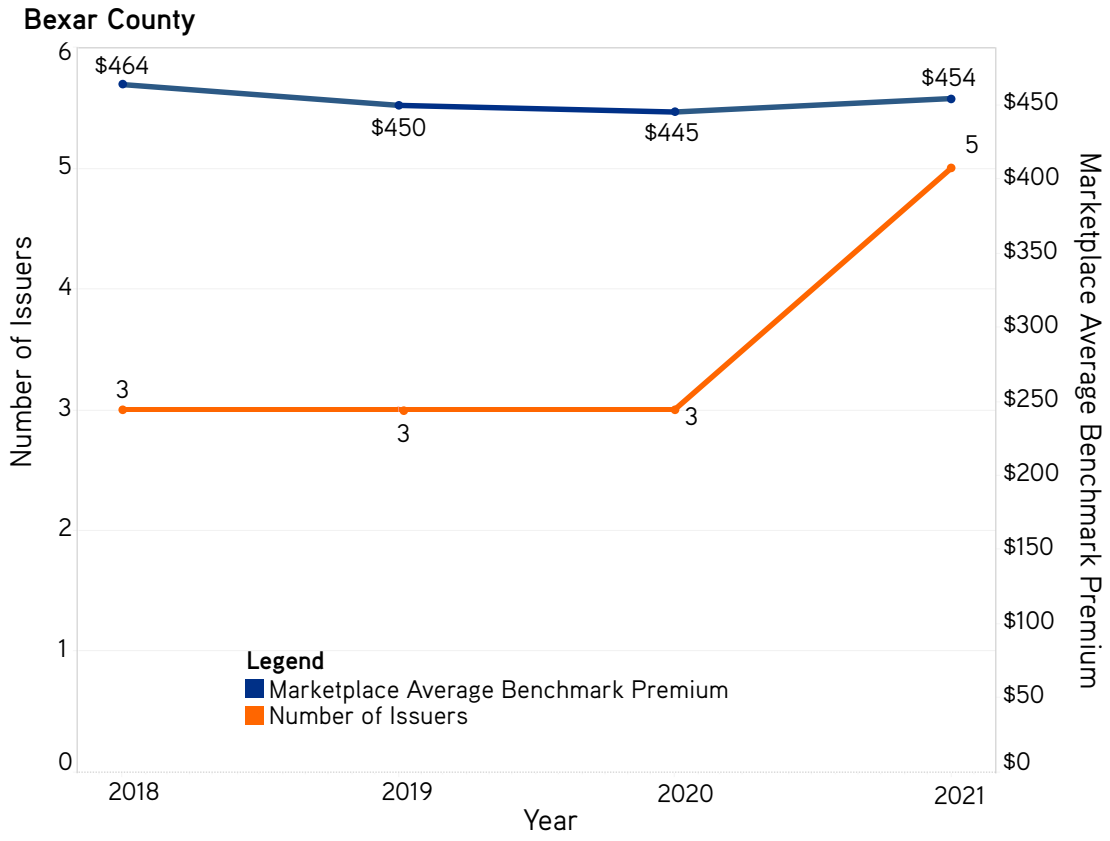
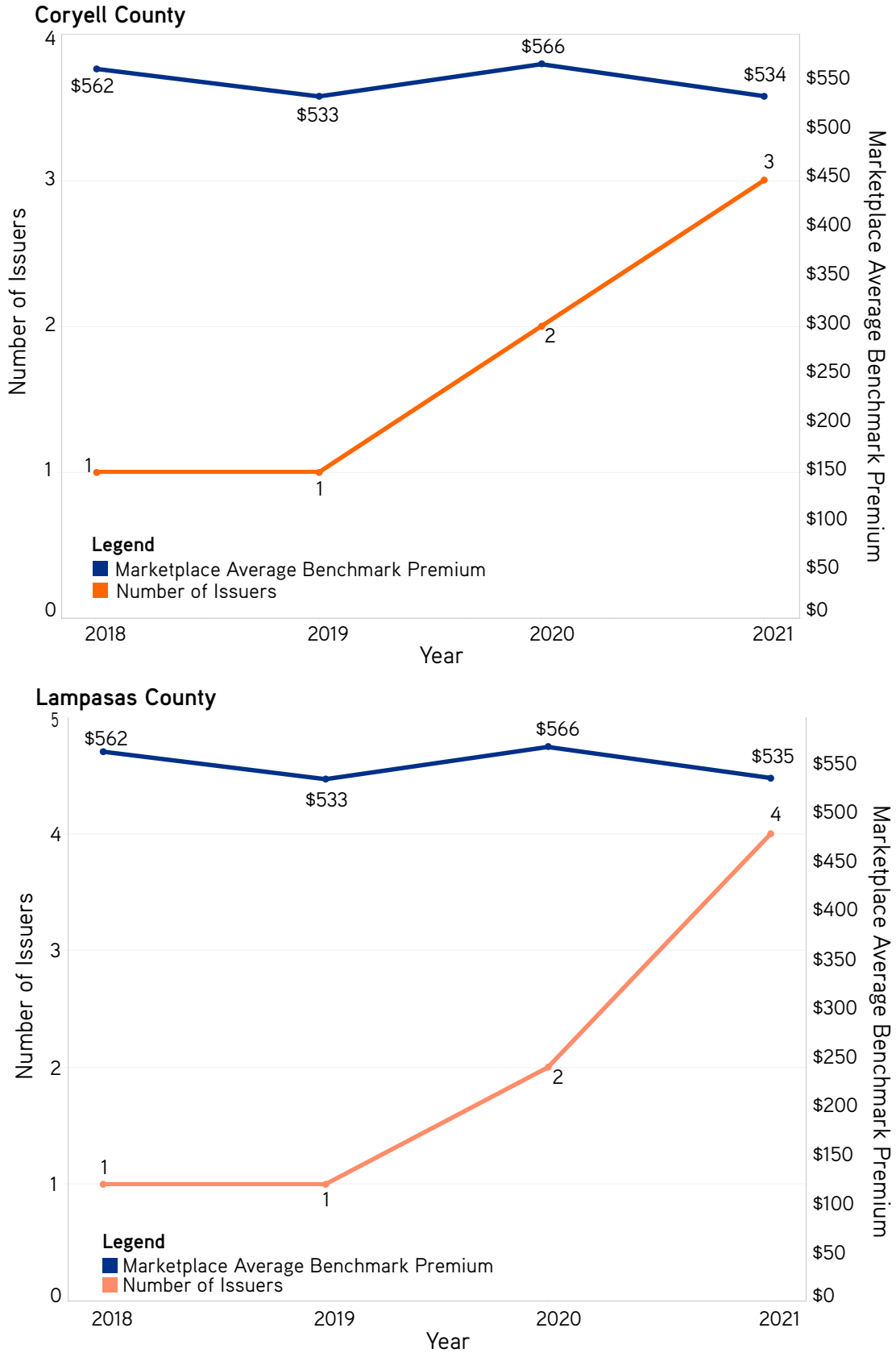


FIGURE 4. **Total Number of Insurers and Marketplace Average Benchmark Premiums (40 Year-Old Individual Silver Plans) in Harris, Bexar, and Dallas Counties, *continued***



SOURCE: Rockefeller Institute calculations based on data from "FFM QHP landscape files: Health and dental datasets for researchers and issuers," Healthcare.gov, accessed August 31, 2021, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/.

FIGURE 5. **Total Number of Insurers and Marketpace Average Benchmark Premiums (40 Year-Old Individual Silver Plans) in Coryell and Lampasas Counties**



SOURCE: Rockefeller Institute calculations based on data from "FFM QHP landscape files: Health and dental datasets for researchers and issuers," Healthcare.gov, accessed August 31, 2021, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/.

Other markets in Texas have seen premiums rise with the introduction of new insurers only to fall again, like Coryell and Lampasa Counties located in Texas's Rating Area 11, to name a few.

A cursory review of the most recent years in several rating areas in Texas raises a number of questions:

- What is it about these local markets that causes premiums' prices to fluctuate in a uniquely different way?
- What explains the deviations from the national trends in Texas?
- Were there market forces or policy trends that resulted in the pricing and insurer shifts seen in 2020?

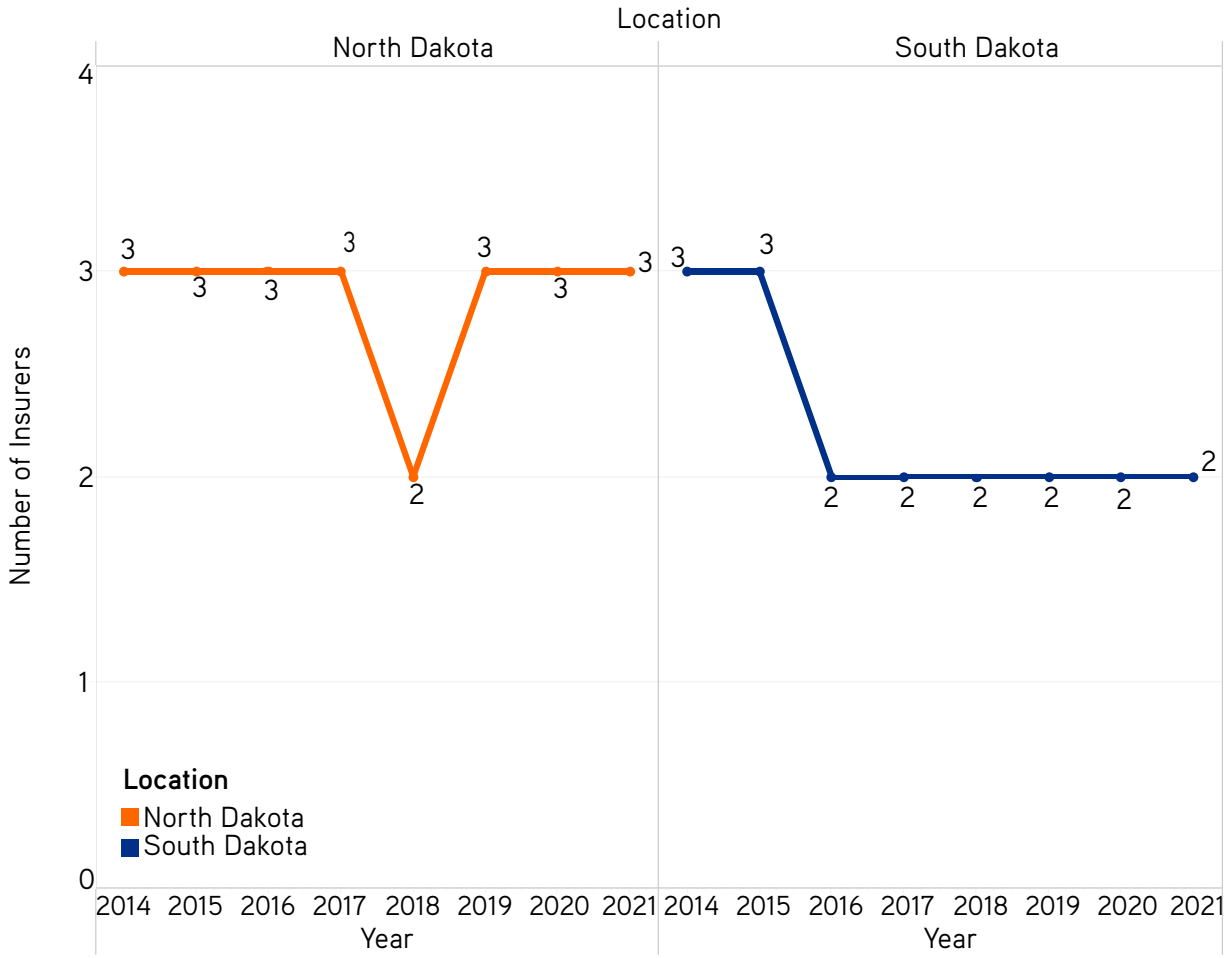
North and South Dakota

An exploration at the local level has also revealed some interesting trends between adjacent states with similar demographic populations. North Dakota and South Dakota are an interesting example. Neither state has seen a new entrant to their insurance markets since 2019, indicating that the market has been relatively stable. We do see divergence in premium trends. In 2014, average premiums were virtually identical at $284 in North Dakota and $286 in South Dakota. Over the past seven years, North Dakota enrollees have seen premiums rise at an average annual rate of 7.6. South Dakotans on average pay 12.3 percent more than the previous year. As a result, the price differential went from $2 in 2014 to $125 in 2021. Also of note is that South Dakota has seen a steady rise annually, whereas North Dakota premiums appear to fluctuate up and down from year to year.

What explains the difference in market reaction and what explains the difference in pricing in two states that are traditionally comparable?

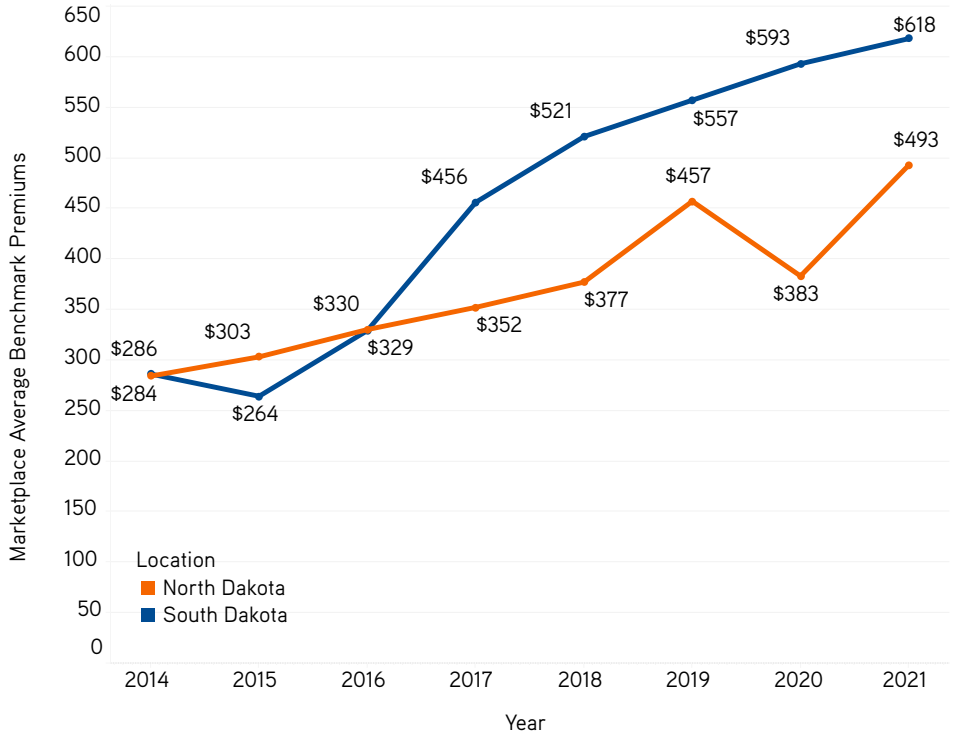
Using data from all 50 states, we ran an ordinary least squares regression to investigate which factors might explain the disparities in premiums across different states' markets. We found that the variables with the most explanatory power for determining prices were the number of insurers, whether a state expanded Medicaid, the percentage of hospitals that are government-run, and demographic variables, such as percentage of the population that is Black or Hispanic. Though North Dakota expanded Medicaid and South Dakota did not, the two states are roughly similar across all other important factors. While Medicaid expansion may account for some of the variability, it does not on its own explain the differing trends and wide gap in premiums between the two states. While a quantitative analysis reveals the disparity, additional qualitative research will be required to better understand the market factors and policies that shape these two markets.

FIGURE 6. **Total Number of Insurers in North Dakota and South Dakota**



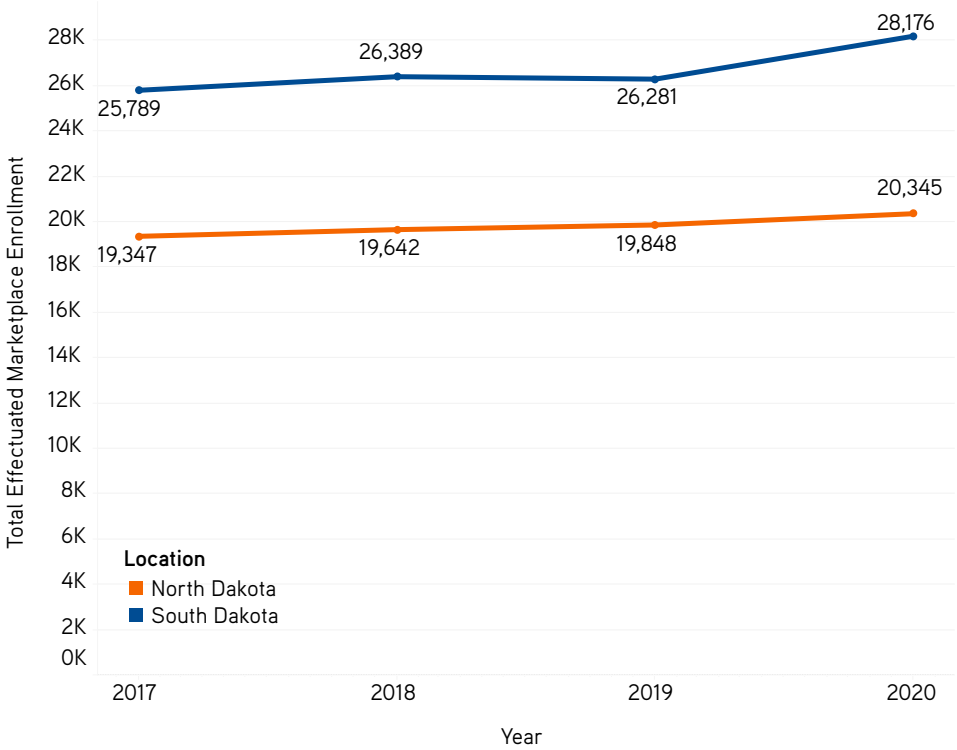
SOURCE: Rockefeller Institute calculations based on data from "Number of Issuers Participating in the Individual Health Insurance Marketplaces," Kaiser Family Foundation, accessed August 31, 2021, https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

FIGURE 7. **Marketplace Average Benchmark Premiums in North Dakota and South Dakota**



SOURCE: Rockefeller Institute calculations based on data from "Number of Issuers Participating in the Individual Health Insurance Marketplaces," Kaiser Family Foundation, accessed August 31, 2021, https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

FIGURE 8. **Total Effectuated Marketplace Enrollment in North Dakota and South Dakota**



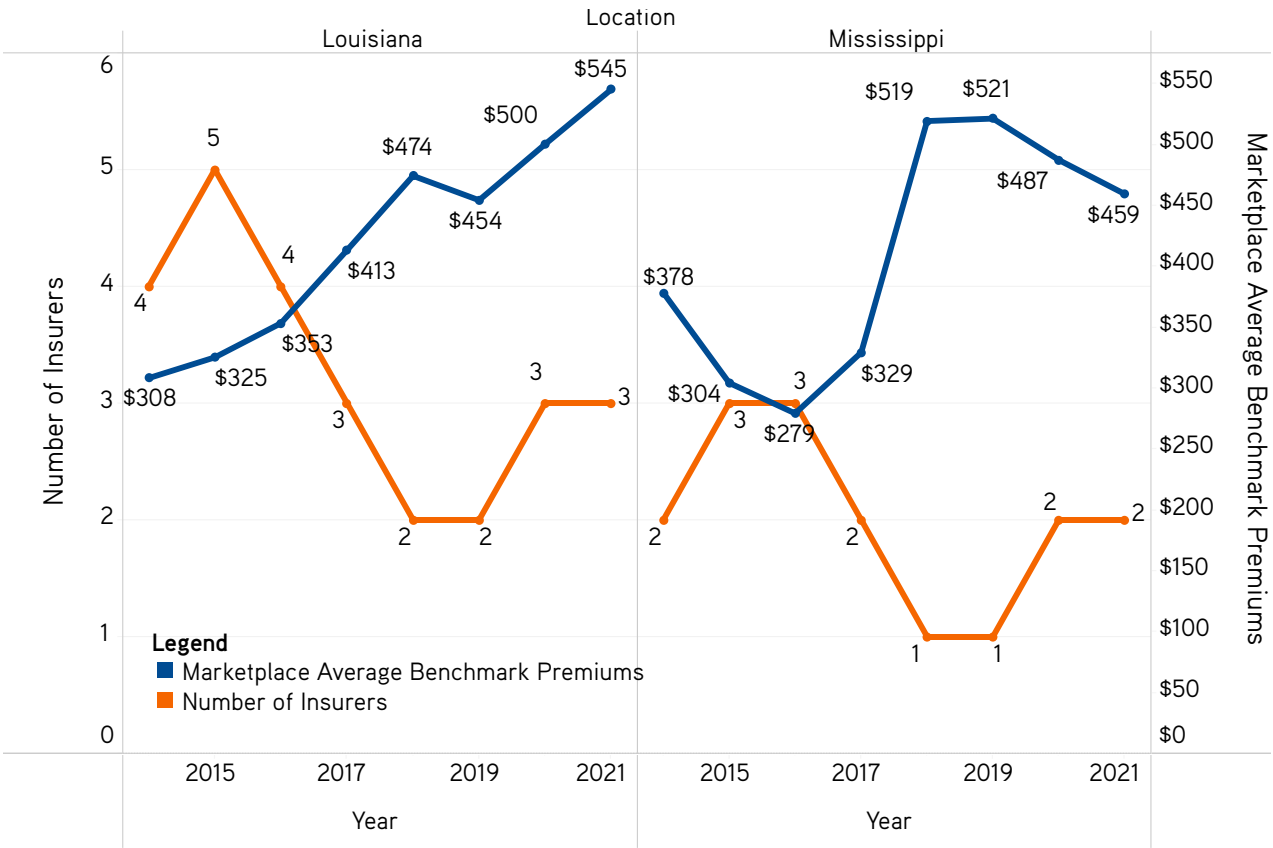
SOURCE: Rockefeller Institute calculations based on data from "Number of Issuers Participating in the Individual Health Insurance Marketplaces," Kaiser Family Foundation, accessed August 31, 2021, https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Other State Comparisons

Similarly, adjacent state markets in the southern United States, like Louisiana and Mississippi, have shown inverse relationships between the number of insurers participating and the average benchmark premiums footed by consumers. Mississippi's insurance market follows the relationship seen throughout the country: premiums decrease when new insurers enter the market or when insurer participation stays constant. Between 2019 and 2021, new insurers entered the market in Mississippi and premiums decreased 12 percent, from $521 to $459 on average. Louisiana tells the opposite story, that when insurer participation increases or stays constant, premiums go up. In the same period, from 2019 to 2021, a new insurer entered the Louisiana marketplace and premiums increased 20 percent, from $454 to $545 on average. What distinguishes one marketplace from another? Why did the markets react differently to new insurer participation?

Questions and case studies like these demonstrate that merely analyzing the available data is insufficient for explaining these dissimilarities and highlight the importance of reconvening the field study research network, whose intimate knowledge of local markets can help find explanations in ways that a strictly data-oriented approach cannot.

FIGURE 9. **Total Number of Insurers and Marketplace Average Benchmark Premiums in Louisiana and Mississippi**



SOURCE: Rockefeller Institute calculations based on data from "Number of Issuers Participating in the Individual Health Insurance Marketplaces," Kaiser Family Foundation, accessed August 31, 2021, https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Revisiting the Field Studies

The data presented in this paper and in other recent articles summarize many positive developments for the ACA Exchanges. Despite these positive trends at the national level, closer examination at the state and local level reveals many unexplained phenomenon. How does increased competition lower prices in some markets but not others? Why do two nearly identical states have such dramatic differences in premiums? Have differences in state and local policies contributed to the relative efficiency of markets? Purely quantitative analysis will not be able to fully explain these discrepancies. It requires analysis performed by experts with local knowledge to fully explain the factors that are contributing to the supply and demands in each market.

More on-the-ground research is needed to understand more fully the factors contributing to the success and learn about how those factors can help shape further policy development. Thus, the authors recommend reactivating the Rockefeller Institute field research team to examine the following questions:

Insurer Market Competition

- To the extent more competition from insurance carriers helped to moderate and even lower premium increases, what variations exist within states that may not have benefitted from increased competition?
- What are the characteristics of the rating areas that have not seen the benefits of competition?
- What are the reasons for insurers entering specific health-care markets (for example, delivery system competition, large membership opportunities)?
- What are the characteristics of the insurers that are expanding in ACA markets (for example, new start-up companies, larger insurers reentering the markets, or insurers who have consistently participated in the ACA)?

Provider Delivery System Makeup

- How does the provider delivery system makeup affect observed premium changes in specific markets?
- Did premiums vary in markets where provider competition was limited and had greater consolidation?
- Was insurer participation impacted by lack of provider competition?

State Actions and Roles

- To what extent did state actions, such as the 1332 waiver, affect insurer participation and was premium growth different in those state than non-1332 states?
- What differences were observed between active state involvement in insurance markets versus more passives state roles? (For example, Florida witnessed premium moderation and more insurer entry, but relies on the federal exchange.)

Impact of the American Rescue Plan Act's (ARPA) Enhanced Tax Credits

- How did the enhanced tax credits for purchasing insurance affect any of the underlying trends identified above?

Consumer Reaction

- The field team will be asked to expand its research to include gathering input from consumers and enrollees on the marketplaces. Areas to explore include how have consumers responded to the trends documented in this report? For example, is enrollment increasing due to premium affordability, more choices of plans, marketing, and broker outreach?
- Despite the gains on premium affordability and more choices, why are many subsidy eligible consumers still choosing not to enroll?

Conclusion: A Call to Action for the Field Research Team

This report documents many positive developments in the ACA marketplaces since the original Rockefeller Institute brief was published in 2017. Broadly speaking and consistent with many recent reports on the ACA, consumers are presented with more choices of plans, moderating premiums, and have benefited from increased competition from insurers entering and expanding in the market. However, our review of the local-based markets illustrates divergent patterns from these national trends. The authors believe additional, locally-based field research should be conducted and add to a better understanding of the ACA markets. Following publication of this report our plan is to reengage the University-based field research team to examine the questions posed above.

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