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# Evaluating the “Keep Your Health Plan Fix”

## Implications for the Affordable Care Act Compared to Legislative Alternatives

*Evan Saltzman and Christine Eibner*

### Key findings

- Premium increases are small to moderate.
- ACA-compliant market enrollment declines are modest to substantial.
- The number of uninsured decreases.
- ACA-compliant market enrollees are older and less healthy, while non-ACA-compliant nongroup plans retain and/or attract young and healthy individuals.
- The net cost of the ACA's coverage provisions will increase, particularly under the optional extension plus buy-in proposal.
- None of the proposals will lead to a death spiral or the implosion of the ACA-compliant market.

**SUMMARY** ■ President Obama's promise that Americans could keep their existing health care plan under the Affordable Care Act (ACA) has received increased scrutiny in the wake of millions of Americans having their existing plans canceled. The majority of cancellations have occurred in the individual or nongroup market—where individuals directly purchase health insurance plans from insurers, as opposed to the more prevalent practice of purchasing a plan through an employer group. According to the Kaiser Family Foundation, over 55 percent of nonelderly Americans have plans through an employer, whereas only 5 percent of nonelderly Americans purchase plans in the nongroup market (The Kaiser Commission on Medicaid and the Uninsured, 2013). Many of the existing nongroup plans provide limited

coverage and do not satisfy the minimum coverage provisions of the ACA. As a consequence, insurers are unable to renew a large percentage of existing nongroup plans, precipitating large numbers of plan cancellations.

Amid criticism over consumers in the nongroup market losing their existing health insurance plans, President Obama announced a policy on November 14, 2013, to allow current nongroup enrollees to keep their existing plans, provided their state's health insurance commissioner permits the plans to be offered and their health insurance company decides to renew their plans. Two alternative proposals, one sponsored by Representative Fred Upton (R-MI) and the other put forth by Senator Mary Landrieu (D-LA), are more aggressive in extending non-ACA-compliant nongroup plans than Obama's policy. Passed in the House of Representatives on November 15, 2013, Representative Upton's bill allows anyone to purchase a non-ACA-compliant nongroup plan, not just current enrollees. Senator Landrieu's bill imposes a requirement that insurers continue to offer non-ACA-compliant nongroup plans indefinitely, but limits future enrollment in these plans to current enrollees only.

Broadly speaking, the three reform proposals to allow individuals to keep their existing health plan are closely associated with the following three general categories:

1. Optional extension: Insurers are given the option to extend non-ACA-compliant nongroup plans to current enrollees (e.g., President Obama's policy).
2. Mandatory extension: Insurers are required to extend non-ACA-compliant nongroup plans to current enrollees (e.g., Senator Landrieu's bill).
3. Optional extension plus buy-in: Insurers are given the option to extend non-ACA-compliant nongroup plans to anyone (e.g., Representative Upton's bill).

Although the reform proposals may allow millions of Americans to keep their health plan, critics contend that the ACA-compliant market, which includes the newly created state-based Marketplaces, would be deprived of the young and healthy enrollees it needs for premiums to remain affordable. According to the theory, the failure of the young and healthy to enroll in ACA-compliant plans in 2014 would lead to higher premiums in 2015, if insurers anticipate that lower-risk enrollees will have continued options to avoid enrollment in the ACA-compliant market. In the extreme, opt-out by young and healthy enrollees could lead to a "death spiral," a self-reinforcing cycle of increasing premiums and decreasing enrollment ending with the implosion of the ACA-compliant market.

The likelihood of a death spiral depends, therefore, on the extent to which the three proposed reforms discourage lower-risk individuals from enrolling in ACA-compliant plans and increase accessibility to the non-ACA-compliant market. Of the three proposals, the optional extension proposal places the greatest limit on access to the non-ACA-compliant market by leaving plan renewals to the discretion of the insurer and state insurance regulators, and only allowing current enrollees to retain their plans. The mandatory extension proposal mandates that insurers renew non-ACA-compliant plans owned by current enrollees, increasing the possibility of a death spiral by expanding the pool of lower-risk individuals who can remain in the non-ACA-compliant market. Finally, the optional extension plus buy-in proposal substantially expands access to the non-ACA-compliant market by allowing insurers to sell non-ACA-compliant plans to any enrollees they wish (while maintaining the option to deny coverage to high-risk applicants), potentially depriving the ACA-compliant market of the low-risk enrollees it needs to be sustainable.

In this report, our objective is to quantify how these proposals would affect the ACA-compliant nongroup market and to understand the impact of these changes on health insurance cost and coverage. In particular, we assess how changes to rules regarding plan cancellations will affect premiums and enrollment in the ACA-compliant market, the composition of the ACA-compliant market risk pool, and federal spending. For each reform proposal, we determine whether a death spiral would result. To estimate the potential impact, we use the RAND Comprehensive Assessment of Reform Efforts (COMPARE) model, a microsimulation developed by RAND researchers to predict the effects of health care reform proposals.

Our model results suggest that the key provisions embraced by the proposed legislation will have a modest to moderate impact on the ACA-compliant market, as compared to a case in which all nongroup plans are canceled. Of the three proposal types, optional extension of non-ACA-compliant nongroup plans to current enrollees would lead to the smallest decrease in ACA-compliant market enrollment and the smallest increase in ACA-compliant market premiums. Mandatory extension of non-ACA-compliant nongroup plans to current enrollees would have a slightly more adverse impact on ACA-compliant market enrollment and premiums, but the effects are still relatively small. By contrast, opening non-ACA-compliant plans to anyone would have a far more detrimental effect on the ACA-compliant market, raising premiums by as much as 10 percent and decreasing enrollment by 3.2 million. However, opening non-ACA-compliant nongroup plans to anyone would increase health insurance enrollment overall, relative to other scenarios. For the optional

extension plus buy-in proposal, federal spending on the ACA's coverage provisions would rise by more than \$5 billion (or 6.3 percent) in 2015, while the optional extension and mandatory extension proposals would lead to increases in spending of 0.8 percent and 1.4 percent, respectively. None of the three proposals would lead to a death spiral. As compared to the case in which all nongroup plans are canceled, our key findings with regard to the key provisions of the three proposal categories are as follows:

- Premium increases are small to moderate: ACA-compliant market premiums in 2015 would rise from a low of 1 percent under the optional extension proposal to a high of 10 percent under the optional extension plus buy-in proposal.
- ACA-compliant market enrollment declines are modest to substantial: Under the optional extension proposal, enrollment in the ACA-compliant market would decline by 500,000 (4 percent). The optional extension plus buy-in proposal would lead to a decrease of 3.2 million enrollees (26 percent), the largest of the three proposals.
- The number of uninsured decreases: The optional extension and mandatory extension proposals lead to small decreases in the number of uninsured of 260,000 and 450,000, respectively. Under the optional extension plus buy-in proposal, the number of uninsured would drop by 2.5 million. One important caveat to this seemingly positive outcome is that the non-ACA-compliant plans may have a significantly lower actuarial value than plans offered in the ACA-compliant market and provide more limited coverage.
- ACA-compliant market enrollees are older and less healthy, while non-ACA-compliant nongroup plans retain and/or attract young and healthy individuals: ACA-compliant market enrollees are at least eight years older, on average, than participants in the nongroup market and spend twice as much on medical care.
- The net cost of the ACA's coverage provisions will increase, particularly under the optional extension plus buy-in proposal: Despite declining enrollment in the ACA-compliant market, we find that the amount spent by the federal government on premium tax credits and cost-sharing subsidies actually increases, while revenue from the individual mandate penalty decreases. The optional extension proposal would add \$0.6 billion in net cost in 2015, while the optional extension plus buy-in proposal would increase federal spending by \$5.2 billion.

Hence, the proposals to allow people to “keep their health plan” will have an adverse impact of varying degrees, but will lead to neither a death spiral nor the implosion of the ACA-compliant market. Several key reasons for the sustainability of the ACA-compliant market include:

- Restricting subsidies to the ACA-compliant market: The ACA provides subsidies only to enrollees in the ACA-compliant market through the Marketplace. Therefore, individuals with incomes below 400 percent of the federal poverty level may be foregoing substantial subsidies to remain in the non-ACA-compliant market (or in the case of the optional extension plus buy-in proposal, to remain or enroll in the non-ACA-compliant market).
- Marketplace subsidy structure: The design of the subsidy formula shields subsidized enrollees in the Marketplace from premium shocks. An individual's subsidy is calculated such that the individual's out-of-pocket premium for the second-lowest cost “silver” plan will be limited to a fixed percentage of his or her income. The fixed percentage is set in the ACA on a sliding scale from 2 percent to 9.5 percent, depending on the individual's income level. For individuals whose unsubsidized premium currently exceeds their fixed percentage, a subsequent premium increase will have no bearing on their out-of-pocket premium (i.e., the government will increase the subsidy amount to keep the out-of-pocket premium constant). In some cases, the unsubsidized premium for the second-lowest cost silver plan faced by a young adult could be sufficiently low that it is less than the fixed percentage. These young adults would receive no subsidy and could be vulnerable to small premium increases, but would have their out-of-pocket premium capped.
- Reinsurance: These funding sources are designed to keep premiums reasonable during the first few years of the ACA-compliant market to protect against adverse selection. Reinsurance provides a fixed amount of money (i.e., independent of the number of enrollees) that is used to lower premiums in the ACA-compliant market. If fewer people enroll in the ACA-compliant market than expected, the fixed amount of money will be divided over fewer people, implying that there will be a greater per-capita amount of funds available to help keep premiums in check. Similarly, risk corridors will help insurers offset some of the costs associated with setting premiums too low, although we did not model risk corridors in our analysis.

- Composition of the buy-in population: The main objection to the optional extension plus buy-in proposal is that it will deprive the ACA-compliant market of the young and healthy enrollees it needs. While we found that some individuals who are expected to enroll in the ACA-compliant market may opt to buy a non-ACA-compliant plan instead, the majority of the buy-in population consists of those who would be otherwise uninsured. Many in this population are ineligible for subsidies on the Marketplace because their income is above 400 percent of the federal poverty level or they have access to an “affordable” employer-sponsored insurance offer.

In contrast with most of our findings, the result that the three reform proposals expand coverage—particularly the optional extension plus buy-in proposal—stands out as a seemingly positive outcome of the reform proposals. The individual mandate penalty combined with very low premiums in the non-ACA-compliant market entices those who might be otherwise uninsured to buy a plan in the non-ACA-compliant market. However, a non-ACA-compliant plan may have very high cost-sharing obligations and limit coverage for very basic benefits, such as hospitalization. Thus, a non-ACA-compliant plan could leave enrollees exposed to financial risk and may increase the burden on the rest of the system if enrollees cannot pay for uncovered care. We did not consider or model the repercussions that this potential for uncompensated care would have for premiums elsewhere in the health care system, including the ACA-compliant market.

Many experts have predicted that the optional extension plus buy-in provision would lead to a death spiral in the ACA-compliant market, as the provision would deprive the ACA-compliant market of the young and healthy enrollees that it needs. We find that the ACA’s safeguards, including the subsidy availability, subsidy structure, and reinsurance, will likely prevent the feared death spiral from occurring. In other words, it is because of the ACA’s defense mechanisms that the ACA-compliant market is robust enough to escape a death spiral. Attempts to modify, weaken, or repeal the ACA’s defense provisions or to extend the optional or buy-in programs to subsequent years without robust reinsurance might lead to a very different outcome, and a death spiral might ensue.

As with any model, COMPARE has several key limitations, which are detailed in the fourth section of this report. Most notably, COMPARE is an equilibrium model that is best suited to project the ACA’s impact in 2016 and beyond. By 2016, the majority of the ACA’s major reforms will have been implemented and most consumers will, presumably, have learned of the ACA-compliant market and acquired sufficient information to understand how the offered plans might fit their needs. In this analysis, we assess the expected impact of the “keep your health plan” proposals in 2015, a year during the ACA’s phase-in period when ACA-compliant market enrollment may still be in flux. To the extent that adverse selection is stronger than COMPARE predicts as the ACA is being implemented (i.e., a higher-than-expected proportion of older and sicker individuals enroll in 2014 and 2015), our estimates of the impact of the reform proposals could be understated, particularly for the optional extension plus buy-in proposal. Some of the temporary defense mechanisms, particularly the reinsurance program, may lead to a further underestimate when applied to an equilibrium pool. However, we find no evidence that would change the key qualitative result of our analysis; namely, that the proposals do not lead to a death spiral.

In summary, our analysis found that none of the three reform proposals would result in a death spiral. Comparing the three proposals, we observed that the optional extension proposal has the least disruptive impact on the ACA-compliant market, having a minimal impact on premiums, enrollment, and federal spending. By contrast, the optional extension plus buy-in proposal has the most significant impact of the three proposals on the ACA-compliant market, having a pronounced negative impact on premiums and enrollment while increasing federal spending by more than \$5 billion. The reforms have the beneficial effect of expanding coverage through the non-ACA-compliant market, although this coverage may be inferior to insurance available on the ACA-compliant market. The bottom line of our study is that the proposed reforms to allow people to keep their existing health plans will not result in the unraveling of the ACA-compliant market.

## INTRODUCTION

With the deadline for complying with the ACA's requirements drawing near, many insurance companies issued cancellation notices to millions of policyholders in nongroup plans during October and November of 2013. Many insurers cited the ACA's compliance requirements as the reason for canceling their enrollees' plans. To be ACA compliant, plans must satisfy the minimum coverage provisions of the ACA for policyholders to meet the requirements of the individual mandate. Furthermore, ACA-compliant plans must adhere to the ACA's rating regulations, which prohibit insurers from charging higher prices or denying coverage to individuals with preexisting conditions. Before the "keep your plan fix" was enacted, insurers were permitted to renew non-ACA-compliant plans in 2013 for one year, but could not renew plans starting after January 1, 2014.

The large-scale cancellation of plans put great public pressure on the Obama administration to allow nongroup enrollees to keep their health plans, as the president had promised in several speeches. In response, President Obama proposed a policy in mid-November to allow individuals to keep their health plan. As we describe in detail in the next section, Obama's policy *allows* insurers, with the approval of the state's insurance commissioner, to continue offering existing plans, even if they are not ACA-compliant, to current enrollees only. An alternative proposal offered by Senator Mary Landrieu (D-LA) *requires* that insurers continue to offer existing plans to current enrollees, while a House bill sponsored by Representative Fred Upton (R-MI) *allows anyone* to buy a non-ACA-compliant plan.

Critics of these proposals fear that the young and healthy would opt out of the ACA-compliant market and instead enroll in the non-ACA-compliant market, where premiums for the young and healthy could be lower because they are not subject to the ACA's rating regulations. Plans in the non-ACA-compliant market typically offer limited coverage, more appropriate for a young and healthy individual with minimal health risks. According to the critics' theory, the failure of the young and healthy to enroll in the ACA-compliant market would prompt a "death spiral," a self-reinforcing cycle of premium increases and enrollment declines that may lead to the collapse of the ACA-compliant market. In this report, we investigate the possibility of a death spiral and consider the potential impact of the three proposals on premiums and enrollment in the ACA-compliant market. Moreover, we explore the implications for changes in the ACA-compliant market risk pool, total insurance coverage, and federal government spending. To quantify the impact, we

Many insurers cited the ACA's compliance requirements as the reason for canceling their enrollees' plans.

use the RAND Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model, which was developed by researchers at the RAND Corporation to study the effects of health care reform.

Our report is organized as follows. In the first section, we provide an overview of the three key proposals for allowing current nongroup enrollees to keep their health plan. The second section outlines our quantitative approach, employing the RAND COMPARE model, and how we assessed the impact of the three proposals. Model results are presented in the third section, focusing on the effect of the proposed legislation on ACA-compliant market enrollment, premiums, risk pool composition, and federal government spending. The final two sections discuss limitations of our analysis approach and summarize the main conclusions of our study.

## OVERVIEW OF REFORM PROPOSALS

During the debate over how to address the cancellation of nongroup plans, three main categories of proposals have emerged:

- *Optional Extension:* The optional extension proposal category gives insurers the option of extending non-ACA-compliant plans to current enrollees. President Obama's administrative policy (Centers for Medicare and Medicaid Services, 2013), announced on November 14, 2013, is an example of an optional extension approach. With approval from the health insurance commissioner in the state of issue, insurers under the Obama policy are permitted to renew their plans for current enrollees for plans that were in effect as of October 1, 2013, even if the plans are not ACA compliant. Furthermore, non-ACA-compliant plans can be renewed for one plan year beginning no later than October 1, 2014 (i.e., the plan can be extended into 2015). New customers are not eligible to purchase these extended

plans. Note that for a current enrollee to retain his or her plan, both the state health insurance commissioner and the insurance company must agree that the plan should be offered. Soon after the president's announcement, several states, including Washington, Rhode Island, and Vermont, quickly signaled that they would not allow insurers in their states to offer non-ACA-compliant plans. Of the three proposal types, optional extension of the non-ACA-compliant nongroup market is the least aggressive in restoring plans that were cancelled as a result of the ACA's minimum coverage rules.

- **Mandatory Extension:** In contrast with the optional extension proposal, the mandatory extension proposal requires that insurers continue offering non-ACA-compliant plans to current enrollees. On November 4, 2013, Senator Mary Landrieu (D-LA) introduced the Keep the Affordable Care Act Promise Act legislation that incorporated the idea of mandatory extension (U.S. Senate, 2013). The Senator's bill gives individuals the right to continue any plan that they were enrolled in as of December 31, 2013. Health insurance companies are thus required to continue offering plans (in perpetuity) to individuals who enroll by the end of 2013, unless their health insurance company cancels all plans offered in the individual market. All plans in existence prior to 2014 are exempt from the ACA's minimum coverage requirements.
- **Optional Extension Plus Buy-In:** The final proposal category, optional extension plus buy-in, grants insurers the option of continuing to offer non-ACA-compliant plans and allows anyone to purchase these plans, not simply current enrollees. Sponsored by Representative Fred Upton

(R-MI), the Keep Your Health Plan Act of 2013 authorizes health insurance issuers to continue selling individual health insurance plans that satisfy the minimum essential health insurance coverage requirement under the ACA (U.S. House of Representatives, 2013). Any plan that was in effect as of January 1, 2013, is eligible to be continued into 2014 and will be treated as a "grandfathered health plan." Any individual is allowed to "buy in" to a non-ACA-compliant plan. Insurers can continue to deny coverage to individuals based on preexisting conditions as they have prior to 2014. Representative Upton's bill does not make reference to the role of state health insurance commissioners in the renewal decision and thus is ambiguous as to whether commissioner approval is required for an insurer to continue offering a plan. The House of Representatives approved the bill on November 15, 2013, by a vote of 261 to 157.

Table 1 compares the three proposal types.

## APPROACH

The chief objective of our analysis was to quantify the expected economic impact of the reform proposals on the ACA-compliant market. To this end, we focused our analysis on studying the following six research questions:

### 1. How much will ACA-compliant market premiums be affected?

If those deciding to keep their health plan or buy in to the non-ACA-compliant market are disproportionately young and healthy, then premiums would be

**Table 1. Comparison of Proposal Categories to Restore Canceled Plans**

Provision	Optional Extension	Mandatory Extension	Optional Extension Plus Buy-In
Requires insurers to continue offering?	Optional	Mandatory	Optional
Insurance commissioner approval required?	Yes	No	Unclear <sup>a</sup>
Who can purchase a non-ACA-compliant nongroup plan?	Current enrollees only (No buy-in)	Current enrollees only (No buy-in)	Anyone (Buy-in)
Which proposed legislation falls into this category?	President Obama's policy	Senator Landrieu's bill	Representative Upton's bill

<sup>a</sup> As noted, Representative Upton's bill is unclear as to whether insurance commissioner approval is required for insurers to continue offering a non-ACA-compliant nongroup plan.

expected to rise in the ACA-compliant market. The extent of the premium increase depends on how many of these individuals would have opted into the ACA-compliant market if their plan was cancelled. If the ACA-compliant market is deprived of a significant number of young and healthy individuals who would have otherwise chosen to enroll without the reform proposals, premiums could rise sharply.

## **2. How many individuals will opt out of the ACA-compliant market?**

Most likely, the proposed reforms will reduce enrollment in the ACA-compliant market, as individuals will have the option to remain or buy in to the non-ACA-compliant market. If Marketplace premiums rise due to young and healthy enrollees opting out, enrollment could drop even further. The extent of the enrollment drop, therefore, will depend on how much premiums rise.

## **3. What effect will there be on the total number of uninsured?**

Allowing individuals to enroll in the non-ACA-compliant market could lead to two potential outcomes. First, increasing access to health insurance by allowing individuals to purchase non-ACA-compliant plans could increase health coverage and reduce the total number of uninsured. Consumers may be able to find more affordable options on the non-ACA-compliant market, where many plans are often very limited. Cheaper options combined with the prospect of having to pay the individual mandate penalty could incentivize some who would have otherwise been uninsured to purchase a non-ACA-compliant plan. It is important to note, however, that plans in the non-ACA-compliant market could be very limited and leave enrollees subject to significant financial risk.

If, however, a death spiral were to ensue in the ACA-compliant market, it is possible that the total number of uninsured could increase. For many older and sicker individuals, the non-ACA-compliant market is inaccessible because plans are unaffordable or the insurer will not issue a plan to them (e.g., these individuals could be denied coverage due to a preexisting condition). For a large cohort of individuals, the ACA-compliant market is the only insurance option. Hence, a nonviable ACA-compliant market could leave many without any options for purchasing health insurance. Because of the ACA's subsidy structure and other safeguards, this potential outcome is less likely than the first.

## **4. How do the risk profiles of the ACA-compliant market and the non-ACA-compliant market compare?**

Many experts predict that adverse selection will be exacerbated by the proposed reforms, with younger and healthier individuals choosing to enroll in a non-ACA-compliant plan that is often inaccessible to old and sick individuals (i.e., because insurers are permitted to deny individuals with preexisting conditions and charge exorbitant premiums to high-risk individuals). As a result, the ACA-compliant market might turn into a high-risk pool, with the federal government providing subsidies to older and sicker individuals. Individuals not receiving subsidies in the ACA-compliant market are also more likely to opt out because they would be exposed to premium growth; in contrast, the out-of-pocket premium paid by a subsidized enrollee is capped at a fixed percentage of income according to the ACA's subsidy formula. In our analysis, we investigated the risk pool compositions of the ACA-compliant market and non-ACA-compliant market along three dimensions: age, average medical expenses, and subsidy eligibility.

## **5. What will be the impact on the federal budget?**

It is not immediately clear what the impact of the reform proposals will be on net federal spending. If enrollment in the ACA-compliant market declines substantially, the government would have to subsidize fewer people, causing federal spending to decline. Furthermore, if the total number of uninsured increased due to a death spiral, the federal government may earn more revenue from the individual mandate penalty.

However, the interplay between the ACA's safeguards and the likely phenomenon of young, healthy, and/or unsubsidized individuals remaining in the non-ACA-compliant market (and in the case of the optional extension plus buy-in proposal, drawn to the non-ACA-compliant nongroup market) makes this outcome unlikely. In the Marketplace, premium tax credits are limited to a fixed percentage of a tax unit's income. Because of this structure, the out-of-pocket premium faced by subsidized individuals on the Marketplace will not change as premiums rise and fall, assuming that the unsubsidized premium exceeds the tax unit's fixed percentage. Instead, the federal government will realize the savings with premium decreases and assume the added burden with premium increases. Therefore, young and healthy individuals who pay more than they cost are particularly valuable, serving in effect as a second source of

subsidies for the old and the sick, who cost the system more than they pay. If the young and healthy cohort decides to remain in non-ACA-compliant plans, the government would assume a greater role as a subsidizer and shoulder increased costs. In addition to added subsidy costs, the federal government may also generate less revenue from the individual mandate if fewer individuals are uninsured.

#### **6. Will the ACA-compliant market be viable (i.e., will there be a death spiral)?**

For each reform proposal, we assessed the likelihood of whether a death spiral will occur and lead to the non-viability of the ACA-compliant market. The ACA included several safeguards to preclude this very outcome from occurring. In particular, the exclusive availability of premium tax credits and cost-sharing subsidies in the Marketplace incentivizes consumers to enroll. Furthermore, the ACA's subsidy formula caps a subsidized enrollee's out-of-pocket premium at a fixed percentage of income, making a subsidized enrollee insensitive to premium increases. Finally, temporary measures, such as reinsurance, have the effect of limiting premium increases in the ACA-compliant market during the initial years of the ACA, should adverse selection be strong.

Because 2014 ACA-compliant market premiums have already been set, we focus our analysis on answering the above research questions for 2015. The expected market impacts in 2015 will in large part be determined by the observed risk pool in the ACA-compliant market in 2014. Insurers will be submitting ACA-compliant market rate proposals for 2015 in the first half of 2014, and hence the "keep your health plan" fixes will directly impact 2015 premiums. Our results help to elucidate the expected impact of the potentially higher premiums in 2015 on the ACA-compliant market.

To calculate the expected impact of each proposal, we use the COMPARE microsimulation model, which assesses how firms, insurers, and individuals respond to health care policy changes. A complete technical description of COMPARE can be found in Chapter Two of Eibner, Girosi, Price, et al. (2010) or Appendix D of Eibner, Girosi, Miller, et al. (2011). In this section, we highlight the most pertinent aspects of COMPARE for this analysis and discuss how we adapted the model to assess the impact of the three proposal types.

From a modeling perspective, it is necessary to make methodological choices and assumptions regarding the following three issues:

1. How will individuals decide whether to enroll in a renewed nongroup plan or choose an alternative option (e.g., an ACA-compliant market plan)?
2. Who will be permitted to enroll in a non-ACA-compliant nongroup plan?
3. Which non-ACA-compliant nongroup plan will be offered for renewal by insurers?

COMPARE is specifically designed to predict how non-elderly individuals and families will select a health insurance plan type, including coverage from an employer, Medicaid, the non-ACA-compliant market, the ACA-compliant market, or another source (e.g., Medicare or Tricare). In the model, individuals, families, and firms weigh the costs and benefits of available plans, including economic factors such as plan value, expected out-of-pocket costs, and financial risk associated with the plan. After reviewing their available options, individuals, families, and firms select the option that yields the best value. People may also consider non-economic factors in making their plan decisions, such as the extent of provider networks and any perceived stigma associated with the plan. Stigma associated with enrolling in Medicaid has been well-documented (Stuber and Kronebusch, 2004). COMPARE is less well suited in predicting how changes in non-economic considerations (e.g., difficulty in using the Marketplace website, political bias for or against the ACA, fear of a claim being denied, or desire for consumer protections) will affect plan choice.

Because these factors are not quantifiable and will not be understood until the ACA has been fully implemented, we assumed that individuals consider only economic factors when deciding between a non-ACA-compliant plan and an ACA-compliant plan. Key economic factors that may influence plan selection include community rating and the abolition of denying individuals with preexisting conditions. In the non-ACA-compliant market, insurers can continue to use experience rating, subject to individual state regulations, by screening out less-healthy individuals or charging such individuals higher premiums. COMPARE simulates the underwriting and denial process, accounting for factors such as age, health status, and experience. Age and health status variables come from the Survey of Income and Program Participation (SIPP), a longitudinal survey administered by the U.S. Census Bureau. The SIPP collects an extensive set of information on income sources, work patterns, participation in government programs, and sociodemographic characteristics. As a proxy for experience, we use medical expenditures from the Household Component of the Medical Expenditure Panel Survey (MEPS-HC), a longitudinal

survey administered by the Agency for Healthcare Research and Quality (AHRQ). The MEPS-HC provides comprehensive estimates of health care utilization and expenditures by individuals and families from a diverse set of sociodemographic groups. In reality, insurers do not have perfect prescience in predicting an individual's medical expenditures, so we allowed for imperfect experience rating in the model. By using experience to underwrite premiums in the model, we captured the aggressiveness with which insurers target young and healthy enrollees, who generally have minimal claims. In the optional extension plus buy-in proposal, we assumed that young and healthy nongroup enrollees can reapply for a nongroup plan and are not “stuck in a pool” that must go up proportionately with older and less healthy individuals in their pool.

By contrast, ACA-compliant market regulations prohibit discrimination by health status (except if an individual smokes) and only permit insurers to discriminate by age. (A 64-year-old enrollee can be charged a premium up to three times as high as a 21-year-old enrollee under the ACA, while in many states, the non-ACA-compliant nongroup market does not have any restrictions on the degree of age discrimination.) Consequently, young and healthy individuals will have an economic preference for remaining on a non-ACA-compliant plan. One countermeasure to this potential for adverse selection is the requirement of individuals to enroll in the Marketplace to be granted premium tax credits and cost-sharing subsidies. Hence, the young and healthy individuals who are eligible for subsidies may decide to enroll in the Marketplace to receive financial assistance. In our microsimulation model, we incorporate these economic considerations into an individual's decision in selecting a health insurance plan.

Due to the high degree of volatility in the nongroup market, we have to make one further adjustment to the modeling approach for the optional extension and mandatory extension proposals. Changing circumstances associated with an individual's employment situation or income play a key role in nongroup enrollment volatility. Our analysis of the 2008 SIPP indicates that only 53 percent of individuals enrolled in a nongroup plan in April 2010 were still enrolled in a nongroup plan one year later. Approximately 65 percent of the April 2010 nongroup enrollees who left the nongroup market found plans

in the employer market, while another quarter became uninsured. Hence, the data suggest that roughly one-half of individuals “keep their health plan” each year. Prior to 2014, those exiting the nongroup market due to a new job or falling income would typically be replaced by those entering the nongroup market who became unemployed or experienced a sufficient rise in income to be able to afford a nongroup plan (in any given year, the number entering may not exactly equal the number exiting). Under the optional extension plus buy-in proposal, we would expect these dynamics to continue. However, the optional extension and mandatory extension proposals do not permit those who would normally enter the nongroup market to replace those who would normally exit. We must account for this volatility in our simulation because the underlying demographic input data used for COMPARE are static, not dynamic. Therefore, we assumed that, in the optional extension and mandatory extension proposals, normal volatility due to income declines or obtaining a job will result in one-half of the current nongroup market enrollees deciding not to renew their plans.<sup>1</sup> The remaining half of nongroup enrollees who would be expected to remain on their nongroup plans prior to the ACA are allowed to consider remaining on their current plans or choosing any other plan, including an ACA-compliant market plan.

The second modeling issue was to consider who would be permitted to enroll in a non-ACA-compliant plan. Under the optional extension and the mandatory extension proposals, only current enrollees will be permitted to enroll in their existing nongroup plans. For these two proposals, we removed the non-ACA-compliant nongroup market option from the choice set of individuals who are not currently enrolled in a nongroup plan. By contrast, those not currently enrolled in the nongroup market are permitted to select a non-ACA-compliant plan under the optional extension plus buy-in proposal. In our analysis, we tested the sensitivity of allowing anyone to be enrolled in a non-ACA-compliant plan versus permitting only current enrollees to renew. *Access to the non-ACA-compliant market* is our first sensitivity parameter.

Finally, the third modeling issue we considered was determining how many non-ACA-compliant plans would be authorized for renewal by state health commissioners and

Young and healthy individuals will have an economic preference for remaining on a non-ACA-compliant plan.

subsequently offered for renewal by insurers. There is no historical basis for understanding how insurance commissioners and insurers will respond to the new flexibility to renew non-ACA-compliant plans. Furthermore, the Obama administration's reversal has come only six weeks before those plans would no longer be qualified under the ACA. Given this uncertainty, we turned to sensitivity analysis to place bounds on the range of potential market outcomes. We ran COMPARE assuming that 0 percent, 25 percent, 50 percent, 75 percent, and 100 percent of currently offered nongroup plans, selected randomly for cancellation,<sup>2</sup> would be renewed by the insurance provider. Full cancellation of all nongroup plans corresponds to the 0-percent case, while a renewal of all nongroup plans corresponds to the 100-percent case. In the results section below, we construct a curve showing how each market outcome is affected by the percentage of nongroup plans that are offered by insurers for renewal. Hence, the second sensitivity parameter we used was the *percentage of all currently offered nongroup plans that the insurance companies offer to renew*.

Although our modeling approach focused on bounding the range of potential market outcomes rather than quantifying the exact impact of the three reform proposals, we attempted to make an educated estimate of mapping the reform proposals to the sensitivity cases. Because the mandatory extension proposal requires all insurers to continue offering existing plans to current enrollees, we label the 100-percent case where only current enrollees are granted access to the non-ACA-compliant market as the mandatory extension case. It is possible that some state health insurance commissioners and/or insurers could challenge the mandatory extension requirement, making our approximation rough.

For the optional extension and optional extension plus buy-in proposals, we had to estimate what percentage of non-ACA-compliant nongroup plans would be offered for renewal by insurers. For the optional extension proposal, state health insurance commissioners must approve of non-ACA-compliant plans being offered in their state. Given the very mixed recent reaction to date by states and insurers, we assumed that one-half of the remaining nongroup population (i.e., 50 percent of the 2013 nongroup population) would have their plans renewed by insurers. Hence, the optional extension proposal corresponds to the 50-percent case where only current enrollees are granted access to the non-ACA-compliant market. For the optional extension plus buy-in proposal, we had to allow for the possibility that some current enrollees whose plans are not renewed may be able to buy another nongroup plan. In addition, it is not

clear under the optional extension plus buy-in proposal whether state health insurance commissioners would have to authorize the renewal of non-ACA-compliant plans. We assumed that one-half of the population with cancelled plans would have access to another nongroup plan under the buy-in provision. Consequently, the optional extension plus buy-in proposal corresponds to the 75-percent case, where anyone is allowed to purchase a non-ACA-compliant plan. It is important to stress that these mappings should be considered within the entire context of the sensitivity cases. The subsequent results section presents our simulation results with respect to our two sensitivity parameters: access to the non-ACA-compliant market and percentage of all currently offered nongroup plans that are offered by insurers for renewal.

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## RESULTS

As discussed in the previous section, we quantified how the reform proposals would affect:

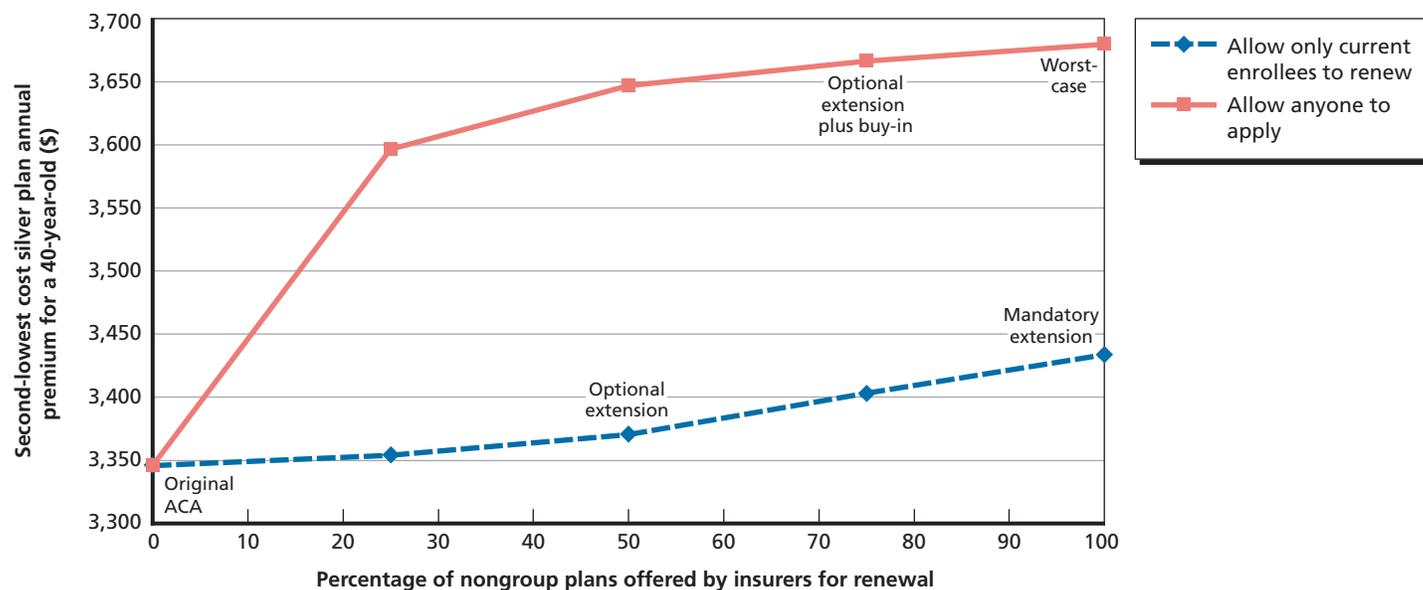
- ACA-compliant market premiums
- ACA-compliant market enrollment
- Uninsurance
- Characteristics of ACA-compliant market and non-ACA-compliant market enrollees
- Federal spending
- ACA-compliant market viability.

In the following six subsections, we present the COMPARE simulation results for each of these five market metrics in turn.

### ACA-Compliant Market Premiums

In Figure 1, we plot the expected impact on 2015 ACA-compliant market premiums of allowing individuals to keep their plans. Our first sensitivity parameter, access to the non-ACA-compliant market, is represented in the legend of Figure 1. The blue curve corresponds to the case where only current enrollees are permitted to renew their non-ACA-compliant plans, while the red curve corresponds to the case where anyone is permitted to purchase a non-ACA-compliant plan. The second sensitivity parameter, the percentage of all currently offered nongroup plans that insurers offer for renewal, is depicted on the x-axis. The optional extension proposal corresponds to the 50-percent case on the blue curve, the mandatory extension proposal corresponds to the 100-percent case on the blue curve,

**Figure 1. Effect on ACA-Compliant Market Premiums in 2015**



NOTE: The figure indicates how silver premiums change for a 40-year-old as compared to the original ACA where 0 percent of nongroup plans are renewed. As described in the text, we assume that 50 percent of nongroup plans will be offered by insurers under the optional extension proposal and 75 percent will be offered under the optional extension plus buy-in proposal. For the mandatory extension proposal, we assume that all nongroup plans will be offered for renewal.

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and the optional extension plus buy-in proposal corresponds to the 75-percent case on the red curve. We represent the original ACA as the 0-percent case, where the blue and red curves intersect, and the 100-percent case on the red curve as the worst-case scenario. Subsequent graphs in this report follow the same formatting conventions, with the market outcome on the y-axis adjusted accordingly.

Because premium tax credits are tied to the second-lowest cost “silver” plan, we report the expected unsubsidized premium paid by a 40-year-old enrollee in 2015 for a silver plan. If all non-ACA-compliant nongroup plans are cancelled, the expected premium will be approximately \$3,350 in 2015. Under the optional extension proposal, under which we assume that 50 percent of non-compliant plans will be renewed, premiums on the ACA-compliant market will increase less than 1 percent, or approximately \$25 for a 40-year-old. The mandatory extension proposal would result in a 2.5-percent increase in unsubsidized premiums, or approximately \$90 for a 40-year-old. If any consumer is allowed to purchase a non-ACA-compliant plan on the nongroup market under the optional extension plus buy-in proposal, unsubsidized premiums will increase 9.6 percent, or approximately \$320 for a 40-year-old. Figure 1 also illustrates how changing the percentage of plans renewed would affect premiums. In the extreme case, premiums could increase 10.0 percent, or \$335 for a 40-year-old, if all plans are renewed and

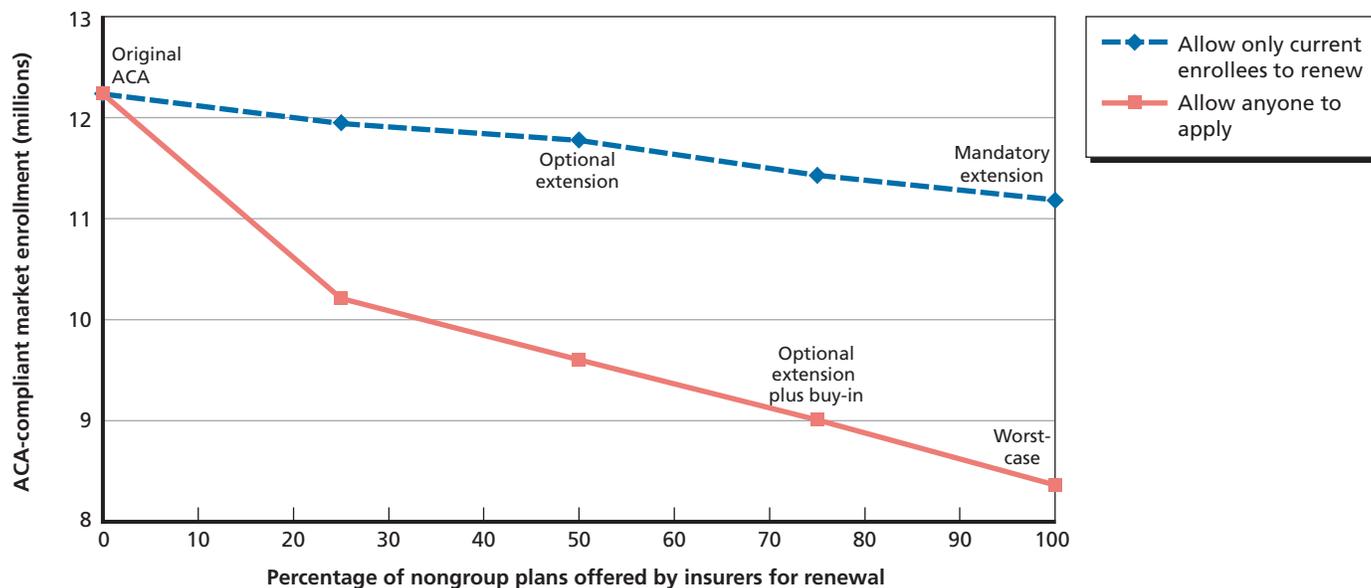
any consumer is permitted to purchase a non-ACA-compliant nongroup plan, as indicated by the label “Worst-Case” in the uppermost right corner of the figure.

Note that the premiums displayed in Figure 1 are unsubsidized. Because of the ACA subsidy structure, most enrollees are unlikely to observe an increase, as the federal government will pick up the tab through subsidy payments. In some instances, however, the unsubsidized premium for the second-lowest cost silver plan faced by a young adult could be sufficiently low that he or she would not be eligible for a subsidy, and hence may bear an increase in premiums.

### ACA-Compliant Market Enrollment

As indicated in Figure 2, all of the proposals would modestly reduce the 2015 projected enrollment in the ACA-compliant market, resulting from the increase in premiums. If all non-ACA-compliant nongroup plans are cancelled, we found that 12.2 million individuals will enroll in the ACA-compliant market. A reduction of approximately one-half million, or 4 percent, would be expected under the optional extension proposal. Under the mandatory extension proposal, there would be a reduction of 1.0 million, or 8.5 percent. Under the optional extension plus buy-in proposal, assuming 75 percent of non-compliant plans are offered by insurers, approximately

**Figure 2. Effect on ACA-Compliant Market Enrollment in 2015**



NOTE: The figure indicates how marketplace enrollment changes with respect to the original ACA where 0 percent of nongroup plans are renewed. As described in the text, we assume that 50 percent of nongroup plans will be offered by insurers under the optional extension proposal and 75 percent will be offered under the optional extension plus buy-in proposal. For the mandatory extension proposal, we assume that all nongroup plans will be offered for renewal.

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3.2 million, or 26.2 percent, would drop their ACA-compliant market plan. If all nongroup plans are renewed and anyone is permitted to apply, enrollment in the ACA-compliant market could fall by 3.9 million, or 31.5 percent.

## Uninsurance

In Figure 3, we illustrate the effect on the total number of uninsured resulting from the proposed reforms. Neither the optional extension nor mandatory extension scenarios have much effect on total coverage. What this result indicates is that few people having their plans cancelled in the non-ACA-compliant market would prefer to go without insurance, particularly given the individual mandate penalty and any potential subsidies to purchase a plan in the Marketplace. However, the optional extension plus buy-in proposal appears to capture a substantial number of people who would otherwise be uninsured. As we investigated further, most of these individuals were uninsured prior to 2014 and do not qualify for subsidies. Although these individuals decide not to pay the premium in the ACA-compliant market, paying a much smaller premium for a more limited plan in the non-ACA-compliant market is more enticing, particularly because a non-compliant plan will exempt the enrollee from the individual mandate penalty. In some cases, the penalty that an individual would occur for going without

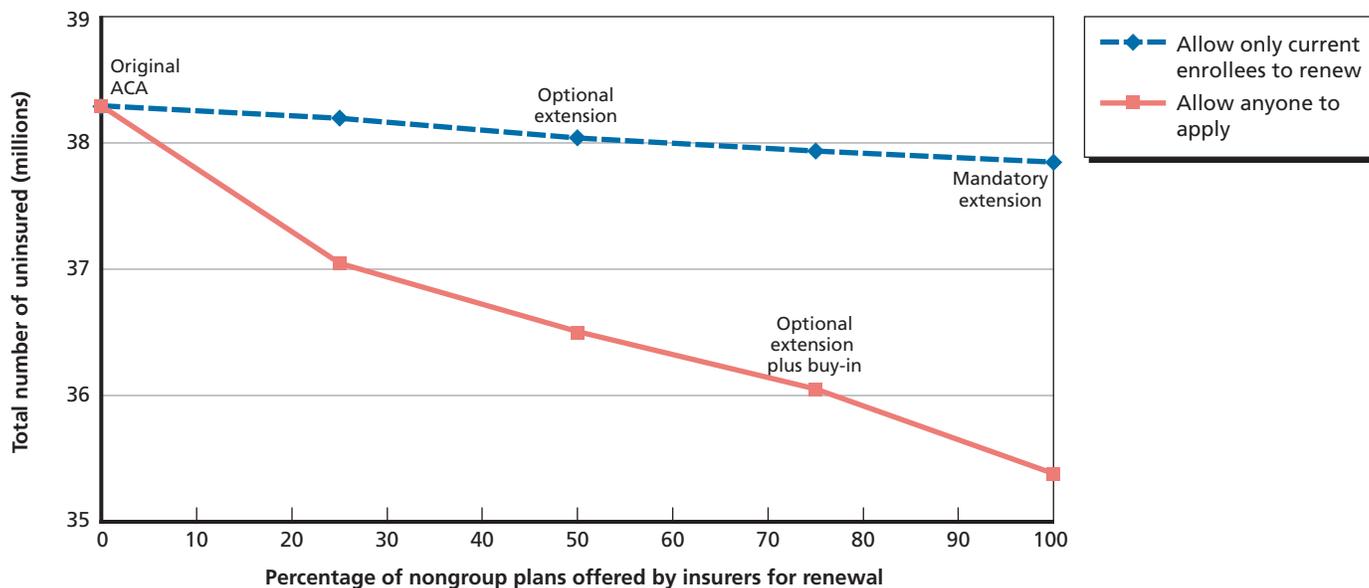
insurance may be close to the cost of one of these non-ACA-compliant plans. It is important to note, however, that the drop in uninsurance is due to the proliferation of very limited non-ACA-compliant plans.

## Characteristics of ACA-Compliant Market and Non-ACA-Compliant Market Enrollees

To better understand why ACA-compliant market premiums increased and enrollment decreased, we analyzed the characteristics of the ACA-compliant market risk pool and the non-ACA-compliant market risk pool. As shown in Table 2, the two risk pools are clearly divergent. While the ACA-compliant market attracts older individuals with a mean age of almost 40, the non-ACA-compliant market acts as a magnet for younger individuals, with an average age below 31. As the percentage of nongroup plans offered for renewal by insurers increases, there is a distinct increase in the average age among ACA-compliant market enrollees. We find that the average age is approximately 39 if all nongroup plans are cancelled; under the optional extension plus buy-in proposal, the average age increases nearly one year to 40.

In addition to being younger, enrollees in non-ACA-compliant plans are also considerably healthier. Table 2 displays the per-capita annual medical expenditures in the two markets.

**Figure 3. Effect on the Number of Uninsured in 2015**



NOTE: The figure indicates how the number of uninsured individuals changes with respect to the original ACA where 0 percent of nongroup plans are renewed. As described in the text, we assume that 50 percent of nongroup plans will be offered by insurers under the optional extension proposal and 75 percent will be offered under the optional extension plus buy-in proposal. For the mandatory extension proposal, we assume that all nongroup plans will be offered for renewal.

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Average annual medical expenditures in the ACA-compliant market are approximately double medical expenditures in the non-ACA-compliant market. Under the optional extension proposal, the average annual medical expenditure in the ACA-compliant market is approximately \$6,900, while only \$3,400 in the non-ACA-compliant market. Under the mandatory extension proposal, the per-capita medical expenditure in the ACA-compliant market rises to \$7,140. Finally, the average medical expenditure increases to \$7,590 in the optional extension plus buy-in proposal.

Finally, Table 2 compares the percentage of the population in each of the two pools that are eligible for subsidies. From the data, it is evident that the ACA-compliant market draws most of the subsidy-eligible population, while the nongroup market acts as a magnet for those ineligible for subsidies. Each of the reform proposal categories tends to deprive the ACA-compliant market of unsubsidized enrollees as compared to the original ACA. Unsubsidized enrollees are important because they help to offset the cost of providing subsidies to lower-income and middle-income individuals.

**Table 2. Age, Spending, and Subsidy Eligibility of Regulated and Non-ACA-Compliant Market Enrollees**

Proposal Category	Mean Age		Mean Annual Per Capita Spending		% Subsidy Eligible	
	ACA-Compliant Market	Non-ACA-Compliant Market	ACA-Compliant Market	Non-ACA-Compliant Market	ACA-Compliant Market	Non-ACA-Compliant Market
Original ACA	39.0	N/A	\$6,730	N/A	71%	N/A
Optional extension	39.2	26.3	\$6,880	\$3,370	74%	15%
Mandatory extension	39.8	26.3	\$7,140	\$2,930	76%	14%
Optional extension plus buy-in	39.9	31.2	\$7,590	\$3,200	88%	18%

Taken together, the data in Table 2 reveal that the non-ACA-compliant market pool is significantly younger, healthier, and higher-income than the ACA-compliant market pool, and the proposals departing further from the original ACA (i.e., the mandatory extension and optional extension plus buy-in proposals) exacerbate the discrepancy. Furthermore, Table 2 helps explain why premiums in the ACA-compliant market increase only slightly across the scenarios considered. While there is a sizable difference between the age and health of ACA-compliant market and non-ACA-compliant market enrollees, the characteristics of the ACA-compliant market pool are affected only marginally by the departure of young and healthy individuals. Among the three proposals, the largest increase in age as compared to the original ACA is less than one year, while the greatest increase in mean annual per capita spending is 6 percent. Therefore, although non-ACA-compliant plans disproportionately enroll the young and healthy, the total number departing from the ACA-compliant market is small enough to have only a marginal effect on the ACA-compliant market. In addition, many of the non-ACA-compliant market enrollees would not necessarily sign up for the ACA-compliant market in the original ACA scenario. Only 49.2 percent and 49.3 percent of non-ACA-compliant market enrollees under the optional extension and mandatory extension proposals, respectively, would decide to enroll in the ACA-compliant market if their

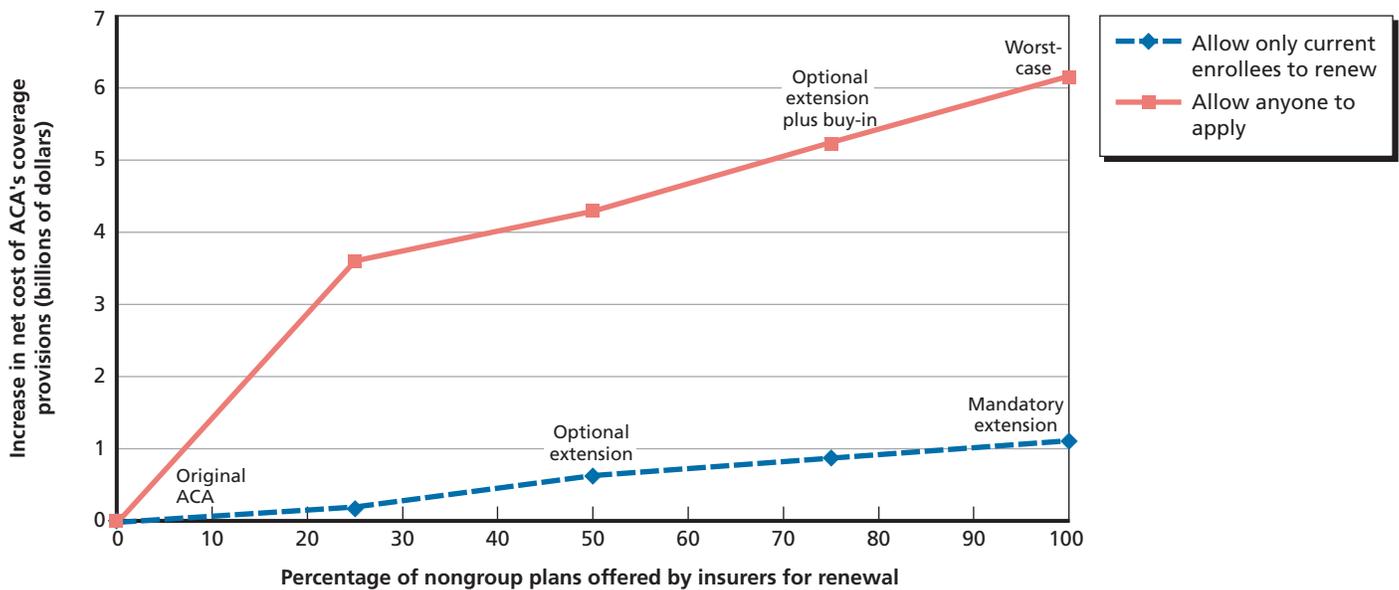
plans were cancelled. Moreover, only 36.5 percent of enrollees in a non-ACA-compliant plan under the optional extension plus buy-in scenario would enroll in the ACA-compliant market if their plans were terminated.

### Federal Spending

It is not particularly intuitive or clear what the implications of the reform proposals will be for federal government subsidy spending on premium tax credits and cost-sharing subsidies. Increased premiums and higher medical spending put upward pressure on federal subsidy outlays, but decreased enrollment may reduce federal spending. Since the reform proposals reduce the number of uninsured, we would expect revenue collected from the individual mandate penalty to decline, increasing the net cost of the ACA's coverage provisions.

Figure 4 reveals that permitting nongroup plan renewals will be a modest drag on the federal budget in two of the three scenarios. The optional extension proposal will add approximately \$0.6 billion in net cost in 2015, approximately 0.8 percent of the Congressional Budget Office's \$83 billion estimate of the net cost of the ACA's coverage provisions in 2015 (Congressional Budget Office, 2013). By contrast, the mandatory extension proposal would add \$1.1 billion, approximately 1.4 percent of the Congressional Budget Office's net cost

**Figure 4. Increase in Net Cost of ACA's Coverage Provisions in 2015**



NOTE: The figure indicates how federal spending changes with respect to the original ACA where 0 percent of nongroup plans are renewed. As described in the text, we assume that 50 percent of nongroup plans will be offered by insurers under the optional extension proposal and 75 percent will be offered under the optional extension plus buy-in proposal. For the mandatory extension proposal, we assume that all nongroup plans will be offered for renewal.

estimate for 2015. The optional extension plus buy-in proposal would be a more significant burden for the government, adding \$5.2 billion in net cost, or 6.3 percent of the Congressional Budget Office's net cost estimate for 2015.

### ACA-Compliant Market Viability

Finally, we assessed the viability of the ACA-compliant market and the possibility of a death spiral occurring. In all of our simulation runs, repeated interactions between individuals through plan selection, firms by offering health insurance, and insurers through premium-setting resulted in a convergent outcome. That is, although we observed premium increases and enrollment declines, the ACA-compliant market did not spiral out of control. Instead, it converged to an equilibrium with higher premiums and lower Marketplace enrollment. Thus, our results indicate that a death spiral will not result from any of the proposed reforms.

### LIMITATIONS

Our simulation results should be interpreted with several caveats and cautions. First, the premiums for 2014 have already been set, and we do not account in our model for insurers attempting to recoup some of their potential 2014 losses as result of the proposed reforms through higher premiums in 2015. However, the White House administrative proposal states, "To protect against the potential impacts this change will have on premiums, [the Department of Health and Human Services] will adjust the temporary risk corridor program which is designed to stabilize premiums as changes are implemented." In our model, we do not account for risk corridors.

Furthermore, COMPARE is designed to predict the equilibrium enrollment in the ACA-compliant market and it is not clear what the take-up or learning rate will be over the next few years as people learn of the Marketplace and determine if it fits their needs. We use the same take-up rate as the Congressional Budget Office (2013), assuming that 2015 enrollment will be roughly 60 percent of the 2016 enrollment when most of the ACA's provisions will be implemented.<sup>3</sup> Unforeseen events, such as the malfunctioning of the Marketplace website and the negative press surrounding the cancellation of nongroup plans, may reduce the take-up rate and possibly exacerbate the potential for adverse selection. Therefore, these events that COMPARE does

not account for could accelerate the increase in premiums and put further strain on the federal budget.

Although COMPARE has been used for state-level analyses, we used the national-level version of COMPARE for this analysis. For several reasons, the effect of the reform proposals is likely to vary widely in each state. First, states have very different age compositions, and a state with an older population (e.g., Maine) may be less robust to an exodus of young and healthy individuals from the ACA-compliant market than a state with a younger population (e.g., Utah). Moreover, a higher-income state with a larger proportion of unsubsidized enrollees might experience a greater impact, as unsubsidized enrollees do not have the subsidy incentive to remain in the ACA-compliant market. Federal government subsidy costs could also balloon in these states because, as noted earlier, unsubsidized enrollees are important to help offset some of the

Unforeseen events . . .  
may reduce the take-up  
rate and possibly  
exacerbate the potential  
for adverse selection.

cost of providing premium tax credits to subsidized enrollees. The impact of the reform proposals may also be greater in states that have particularly lax regulations in the non-ACA-compliant market, such as permitting unrestricted age rating (the ACA limits age rating to a 3:1 ratio in the ACA-compliant market). As a test case, we simulated the Commonwealth of Virginia, one of the highest-income states in the nation with lax regulations in the non-ACA-compliant market. Our results indicate that the impact of the reform proposals would be greater in Virginia, but a death spiral would not ensue. The optional extension plus buy-in proposal would have the most detrimental effect to the ACA-compliant market, causing premiums to rise by 16 percent and enrollment to fall by 29 percent. By comparison, premiums in the national-level model rose by 10 percent, while enrollment dropped by 26 percent.

COMPARE also does not address several other issues that could be prominent in 2015. Starting in 2015, states will have

## Persistent uncertainty due to late-breaking policy changes may cause insurers to drop insurance entirely and exit the ACA- . . . and/or non-ACA-compliant markets.

the option of offering a basic health plan, which would cover individuals earning between 138 percent and 200 percent of the federal poverty level and remove these individuals from the ACA-compliant market pool. Since these individuals receive the larger subsidies and tend to have higher medical expenditures than individuals earning between 200 percent and 400 percent of the federal poverty level (Agency for Healthcare Research and Quality, undated), premiums and federal subsidy spending on the Marketplace could be lower in 2015 in states adopting the basic health plan.

Another limitation of COMPARE is that it does not model the full spectrum of plans available on the nongroup market. The biggest obstacle is the availability of data for the existing nongroup plans. Reliable data to estimate the prevalence of particular actuarial value plans and the extent of coverage they provide are scant. Even if such data existed, it would be nearly impossible to model a multitude of pools with different actuarial values because the model would become computationally intractable. Consequently, it is very difficult to characterize the range of insurance offerings on the non-ACA-compliant market, which may vary greatly by service coverage and actuarial value. In COMPARE, we model the “average” plan using data from America’s Health Insurance Plans (2011). COMPARE premiums for the average plan vary widely by age and health status to the extent that individuals are attracted to renew or buy into very limited plans with low premiums (i.e., a so-called “junk” plan). Unfortunately, there is no reliable data source that indicates how prevalent these junk plans are. By not accurately representing the prevalence of junk plans, COMPARE may underestimate the impact of all three proposed reforms. Our analysis suggests that many of those who would enroll in a junk plan would likely otherwise be uninsured, and hence the

ACA-compliant market would not necessarily be deprived of these individuals due to the reform proposals. As a test case, we did a simulation run in COMPARE where we forced the non-ACA-compliant premiums to be approximately half of what the model suggested they should be based on predicted medical expenditures. Despite the significantly lower premiums, we still did not observe a death spiral. Premiums were 11.5 percent higher than in the original ACA scenario, while enrollment fell by 3.8 million to roughly 8.5 million in 2015.

In addition, our analysis assumes that volatility due to job acquisition or income fluctuations in the nongroup market will remain at historic levels. However, it is plausible that certain individuals may decide to hold onto their plans, particularly if they will be prohibited from reapplying at a later date. In other words, the optional extension and mandatory extension may actually change the behavior of nongroup market enrollees because they remove the possibility of reentry. If fewer people exit the nongroup market, we would expect the impact on the ACA-compliant market to be more substantial. In our analysis, we assessed the impact of changing the volatility assumption on the optional extension scenario. If nongroup market turnover was 25 percent instead of the 50 percent assumed in our analysis, we found that net government spending would increase approximately \$1.1 billion as compared to the original ACA, while ACA-compliant market enrollment would drop roughly 1 million.

Our model may also not adequately reflect the behavior of insurers. Some insurance companies may strategically offer low premiums in 2014 to capture market share. Furthermore, insurers may intentionally restrict provider networks on the Marketplace and encourage higher-income individuals who are ineligible for subsidies to select broader network plans outside of the Marketplace. Early evidence from the Marketplace plans established in 2014 suggests that insurers may already be adopting restricted networks for plans on the Marketplace. Our model computes premiums based on the observed expenditures of individuals using data from the MEPS, with adjustments to account for changes in insurance status. In reality, insurers have limited data regarding their enrollees and have to make assumptions regarding their potential enrollment pool. COMPARE also does not represent all aspects of the underwriting process. However, we do allow insurers to charge premiums to customers in the non-ACA-compliant market based on their health status.

Finally, persistent uncertainty due to late-breaking policy changes may cause insurers to drop insurance entirely and exit the ACA-compliant market and/or non-ACA-compliant

market. The only legislation mandating that insurance companies continue to offer non-ACA-compliant nongroup plans is Senator Landrieu's bill, but the bill also caveats this mandate by allowing an insurance company to drop out of the nongroup market entirely. When compelled to continue offering existing plans, some insurers may demand a higher premium because they are forced to accept risk that they may not want. The ACA contains several provisions that may mollify this impact: (1) risk corridors, which help to offset the costs of underestimating claims; (2) subsidies, which are only available in the ACA-compliant market through the Marketplace and limit the vulnerability of subsidized enrollees to premium increases; and (3) medical loss ratio requirements, which put a floor on the amount that insurers must spend on paying claims and necessitate paying a large rebate if the amount spent on claims falls below 80 percent of the collected premium. The medical loss ratio requirements also place greater importance on increasing market share, and charging a high-risk premium would make an insurer potentially uncompetitive. In conclusion, it is important to consider the aforementioned limitations when interpreting the results of our study.

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## CONCLUSION

In this report, we analyzed how three proposals to allow people to “keep their health plans”—the optional extension, mandatory extension, and optional extension plus buy-in proposals—would impact the ACA-compliant market. Overall, we find the effects of the optional extension and mandatory extension proposals on the ACA-compliant market are relatively small, while the optional extension plus buy-in proposal has a more substantial impact. In particular, this study found the following estimates to our six research questions:

### 1. How much will ACA-compliant market premiums be affected?

The optional extension and mandatory extension proposals result in relatively small ACA-compliant market premium increases of 1 percent and 2.5 percent, respectively. By contrast, the optional extension plus buy-in proposal leads to a more sizable premium increase of nearly 10 percent.

### 2. How many individuals will opt out of the ACA-compliant market?

Consistent with the findings on how premiums are impacted, the decline in ACA-compliant market enroll-

ment is modest for the optional extension and mandatory extension proposals, with enrollment falling by 4 percent and 8.5 percent, respectively. Because of the more substantial premium increase associated with the optional extension plus buy-in proposal, ACA-compliant market enrollment falls approximately 26 percent in that scenario.

### 3. What effect will there be on the total number of uninsured?

The total number of uninsured falls under the three proposals, particularly the optional extension plus buy-in proposal. Almost 2.5 million people gain insurance under the optional extension plus buy-in proposal. Coverage gains are more modest for the other two proposals, as one-quarter of a million individuals obtain health insurance under the optional extension proposal and one-half million individuals find insurance under the mandatory extension proposal. It is important to note, however, that plans in the non-ACA-compliant market may be inferior to plans in the ACA-compliant market and leave enrollees exposed to significant financial risk. We find that coverage expands because premiums for limited coverage in the non-ACA-compliant market are very low and individuals are incentivized to purchase health insurance to avoid the individual mandate penalty. This phenomenon is stronger for the optional extension plus buy-in proposal because those who would otherwise be uninsured have the opportunity to buy into the non-ACA-compliant market.

### 4. How do the risk profiles of the ACA-compliant market and the non-ACA-compliant market compare?

We found that the proposed reforms would segregate the nongroup market. The non-ACA-compliant market would attract enrollees who possessed some or all of the following characteristics: young, healthy, and unsubsidized. In all three scenarios, the average enrollee medical expenditure in the ACA-compliant market was more than double that in the non-ACA-compliant market and ACA-compliant market enrollees were at least eight years older on average than their counterparts in the non-ACA-compliant market. Moreover, enrollees in the ACA-compliant market were predominately subsidized, while those in the non-ACA-compliant market were largely unsubsidized. Thus, the proposals create a higher-risk, subsidized pool of enrollees in the ACA-compliant market and a lower-risk, unsubsidized pool in the non-ACA-compliant market.

# The proposals to allow people to keep their health plans will not have a catastrophic impact on the ACA-compliant market.

## 5. What will be the impact on the federal budget?

All three proposals increase federal spending. Federal subsidy payments will increase because of higher premiums and the departure of young, healthy, and unsubsidized individuals from the ACA-compliant market who would have cost less to insure than they would have paid in premiums. In effect, this departing group acts as a second subsidizer, and the federal government must fill the void. In addition, the decrease in uninsurance causes federal revenue from the individual mandate to decline. We estimated that the optional extension proposal would increase net federal spending by \$600 million and the mandatory extension proposal would expand federal obligations by \$1.1 billion. The optional extension plus buy-in proposal would have a more detrimental impact, increasing federal outlays by \$5.2 billion.

## 6. Will the ACA-compliant market be viable (i.e., will a death spiral occur)?

We did not observe a death spiral in any of the scenarios. The ACA-compliant market appears to be sufficiently robust to the expected premium increases and enrollment declines associated with the proposals. As discussed above, the ACA's safeguards are designed to protect the ACA-compliant market against negative market impacts.

As we noted above, it is difficult to pinpoint the exact impact of the three proposals on the ACA-compliant market. The sensitivity graphs presented in the results section, therefore, allow policymakers to understand the robustness of our assumptions and to consider the best- and worst-case scenarios.

In our analysis, we did not consider the impact of extending the three proposals beyond 2015. Among the three proposed reforms, Senator Landrieu's bill is the only one that allows for the extension of non-ACA-compliant nongroup plans in perpetuity. For several reasons, it is unlikely that continuing to extend non-ACA-compliant plans in perpetuity would have significant impact on the ACA-compliant market, and the non-ACA-compliant market would likely dissolve on its own. As noted earlier, the non-ACA-compliant nongroup market has a very high annual turnover rate of approximately

50 percent, with a large number moving to an employer plan after obtaining a new job. Hence, non-ACA-compliant nongroup plans may be reduced simply through attrition. In addition, a great number of people eventually get sick, and some nongroup market participants in non-ACA-compliant plans may opt for a more secure and comprehensive plan in the ACA-compliant market. With an ever-shrinking pool, insurers continuing to offer existing plans in the nongroup market may decide that it is no longer economically viable to continue offering non-ACA-compliant plans and may want to bolster their ACA-compliant market pools. Finally, the "carrot" of the Marketplace subsidies may eventually entice some nongroup enrollees, particularly those with fluctuating annual income, to enroll in the Marketplace. However, one of the ACA's key safeguards, the reinsurance program, will culminate in 2016. The absence of the reinsurance program may exert additional upward pressure on premiums starting in 2017 if one of the reform proposals is still in effect.

To summarize, the proposals to allow people to keep their health plans will not have a catastrophic impact on the ACA-compliant market. The two key objectives—expanding coverage and reducing health care costs—will not be compromised. Health care costs will rise only slightly under the optional extension proposal to moderately under the optional extension plus buy-in proposal, while total health insurance coverage will actually increase. Therefore, the proposed fixes will not lead to the unraveling and demise of the ACA-compliant market.

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## NOTES

<sup>1</sup> An alternative approach would be to directly include the longitudinal data in the SIPP into COMPARE. However, this approach would be computationally expensive and not necessarily improve the accuracy of the model results.

<sup>2</sup>This assumption will not affect the 0-percent or 100-percent cases, but may affect the other three cases. We may see more bowed curves in the results section than the relatively linear curves produced by the simulation.

<sup>3</sup>Note that the Congressional Budget Office projects enrollment in the Marketplace will be 13 million in 2013, while COMPARE estimates 12.2 million enrollees.

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## REFERENCES

- Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, website, U.S. Department of Health and Human Services, undated. As of August 17, 2013:  
<http://meps.ahrq.gov/mepsweb/>
- America's Health Insurance Plans, 2011 Health Insurance: Overview and Economic Impact in the States, September 2011. As of November 25, 2013:  
<http://www.ahip.org/State-Data-2011/>
- Centers for Medicare and Medicaid Services, letter to U.S. insurance commissioners from Gary Cohen, Director of the Center for Consumer Information and Insurance Oversight, Washington, D.C.: Department of Health and Human Services, November 14, 2013. As of November 23, 2013:  
<http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>
- Congressional Budget Office, "Effects of Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline," Washington, D.C., May 14, 2013. As of November 19, 2013:  
<http://www.cbo.gov/publication/44190>
- Eibner, Christine, Federico Girosi, Amalia Miller, Amado Cordova, Elizabeth A. McGlynn, Nicholas M. Pace, Carter C. Price, Raffaele Vardavas, and Carole Roan Gresenz, *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA)*, Santa Monica, Calif.: RAND Corporation, TR-971-DOL, 2011. As of January 3, 2014:  
[http://www.rand.org/pubs/technical\\_reports/TR971.html](http://www.rand.org/pubs/technical_reports/TR971.html)
- Eibner, Christine, Federico Girosi, Carter C. Price, Amado Cordova, Peter S. Hussey, Alice Beckman, and Elizabeth A. McGlynn, *Establishing State Health Insurance Exchanges: Implications for Health Insurance Enrollment, Spending, and Small Businesses*, Santa Monica, Calif.: RAND Corporation, TR-825-DOL, 2010. As of January 3, 2014:  
[http://www.rand.org/pubs/technical\\_reports/TR825.html](http://www.rand.org/pubs/technical_reports/TR825.html)
- The Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer—Key Facts About Health Insurance on the Eve of Coverage Expansions*, Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, October 2013. As of December 14, 2013:  
<http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-on-the-eve-of-coverage-expansions/>
- Stuber, Jennifer, and Karl Kronebusch, "Stigma and Other Determinants of Participation in TANF and Medicaid," *Journal of Policy Analysis and Management*, Vol. 23, No. 3, 2004, pp. 509–530.
- U.S. Census Bureau, Survey of Income and Program Participation (SIPP), website, June 6, 2012. As of August 17, 2013:  
<http://www.census.gov/sipp/>
- U.S. House of Representatives, 113th Congress, House Resolution 3350—Keep Your Health Plan Act of 2013, Washington, D.C.: U.S. Government Printing Office, 2013. As of January 3, 2014:  
<http://beta.congress.gov/113/bills/hr3350/BILLS-113hr3350rfs.pdf>
- U.S. Senate, 113th Congress, Senate Resolution 1642—Keeping the Affordable Care Act Promise Act, Washington, D.C.: U.S. Government Printing Office, 2013. As of November 19, 2013:  
<http://beta.congress.gov/bill/113th-congress/senate-bill/1642>

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## About This Report

President Obama's promise that Americans could keep their existing health care plans under the Affordable Care Act (ACA) has received increased scrutiny in the wake of millions of Americans having their plans cancelled. These cancellations primarily occurred in the individual or nongroup market, where individuals purchase health care plans directly from an insurer instead of through an employer. Many such plans do not meet the minimum coverage requirements of the ACA, leading insurers to send plan-cancellation notices to their enrollees.

This report describes a comparative analysis of three proposals to remedy the situation: one by the White House, another by Senator Mary Landrieu (D-LA), and a third by Representative Fred Upton (R-MI). The proposals are evaluated based on their potential impact on the ACA-compliant market and the cost and coverage of health insurance. The possibility of each proposal causing a "death spiral," in which rising premiums and decreasing enrollment undermine the viability of the ACA-compliant market, is also addressed.

The authors find that the three proposals vary from slight to moderate impact on ACA premiums, enrollment, and federal spending, but none of them would result in the unraveling of the ACA-compliant market.

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