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Landrieu-Manchin Bill Would Raise Premiums and Threaten Viability of Insurance Marketplaces

Administration Policy Poses Much Less Risk

By Sarah Lueck

The Obama Administration announced last week that, for current enrollees, insurance companies may extend into 2015 any health plans they offer in the individual or small-group market that do not comply with health reform's standards and consumer protections. Congress, however, may consider proposals that go further — including a bill sponsored by Senators Mary Landrieu and Joe Manchin (S. 1642) — that risk unraveling key components of the Affordable Care Act (ACA) by causing premiums to rise significantly in the new health insurance marketplaces (also known as exchanges) and undercutting the law's reforms to the individual health insurance market. This would place the viability of the marketplaces at risk. If the marketplaces unravel, millions of uninsured people expected to gain coverage under health reform will lose access to coverage.

In general, both the Administration's new policy and recent House and Senate proposals would prompt larger numbers of healthier-than-average people to remain in non-ACA-compliant individual-market plans outside the marketplaces; that, in turn, would cause the pool of people in the marketplace plans to be sicker, on average, than it otherwise would be. This "adverse selection" would produce higher premiums in the marketplaces, particularly for 2015. Depending on how many healthier people remained outside the marketplaces, the more far-reaching proposals — including the Landrieu-Manchin bill and the bill the House passed on November 15 — could trigger sticker shock when the 2015 premiums for marketplace plans are announced next October, just a few weeks before the congressional mid-term elections.

In contrast to the Administration's new policy, the Landrieu-Manchin bill would *require* insurers to continue existing individual-market plans for current enrollees and do so *in perpetuity,* not just for a year or two. That would likely cause substantially higher marketplace premiums on an ongoing basis and thus weaken the marketplaces' chances of survival.

The problems posed by the bill that House Energy and Commerce Committee Chairman Fred Upton introduced, which the House passed last week, are even more severe. That measure would allow insurers to offer non-ACA-compliant plans to *new* as well as current enrollees, through 2014.[1]

[1] For an analysis of the adverse effects of the House-passed Upton bill, see Sarah Lueck, "House Bill to Expand 'Grandfathering' of Individual-Market Plans Would Raise Premiums in Health Insurance Exchanges and Undermine

While the Upton and Landrieu-Manchin bills differ, both would substantially enlarge the risk of adverse selection and higher premiums compared to the Administration's policy. They would therefore be much more likely to threaten the long-term viability of the marketplaces and the ACA's major insurance-market reforms that start in 2014. While not without risks of its own, the Administration's new policy would be significantly less dangerous.

Moreover, if the Senate passes the Landrieu-Manchin bill or some other legislation, it will have to go to conference with the deeply problematic House bill. The result could be a final bill that causes greater adverse selection than whatever the Senate had passed and poses more serious risk to the viability of the marketplaces, which lie at the heart of the Affordable Care Act and its coverage expansions.

One other issue with the Landrieu-Manchin bill deserves attention: its *mandate* that insurers continue to offer current policies is likely to be unworkable. The only exemptions from the requirement would occur when an enrollee no longer pays premiums or when an insurer cancels all coverage in the individual market and ceases operations as a health insurance issuer. As a result, the requirement appears to require insurers to extend policies even when this is at odds with state requirements related to financial solvency as well as other existing standards. It is also unclear how this provision of the Landrieu-Manchin bill would be enforced if insurers fail to comply. In short, the Landrieu-Manchin bill's requirement that insurers extend existing plans whether they want to or not isn't likely to be feasible.

Background: The Impact of Extending Non-ACA-Compliant Insurance

The ACA already permits people to remain in "grandfathered" individual-market plans that do not comply with ACA standards as long as they were enrolled in such plans when the ACA was enacted in 2010 and the plans have not changed significantly since then. Proposals to permit more people with non-ACA-compliant plans to keep them must define which plans may continue, who may enroll, which ACA requirements would not apply to the plans, and how long the plans could remain in effect. In general, the approaches that would be most damaging — particularly in driving up premiums in the new marketplaces — are those that maximize the number of people and plans in the non-ACA-compliant individual market, include the broadest exemptions from ACA standards, and allow non-ACA-compliant plans to continue far into the future.

The more sweeping a proposal is in these areas, the more likely it would prompt a large number of healthier people to enroll or stay enrolled in non-ACA-compliant plans outside of the marketplaces, making the pool of people in marketplace plans sicker and more costly to cover than under current law. The result would be higher premiums for marketplace coverage in 2015 and beyond (and possibly in 2014 as well). Premium announcements for 2015 are expected next October, just before the 2014 elections.

Market Reforms," Center on Budget and Policy Priorities, November 12, 2013, http://www.cbpp.org/cms/index.cfm?fa=view&id=4050.

Many Recent Plan Cancellations Not Required Under Health Reform

Amid the controversy over the non-renewal or cancellation notices that various health insurers have issued, it's important to note that in many cases the Affordable Care Act did *not* require the insurance companies to terminate these plans at the end of 2013. Many insurers made business decisions to take such actions.*

In some cases, insurers chose not to renew grandfathered plans they could have continued. In others, insurers could have continued people's 2013 coverage until various points in 2014 (when a person would have to join a new, ACA-compliant plan) but decided to end the old coverage to coincide with the open enrollment period for ACA-compliant plans.

In addition, while some states required insurers to discontinue pre-ACA individual-market plans at the end of 2013 and to offer new plans in 2014 that comply with the new standards, insurers in most states had the option of "early renewal" of individual-market plans, which would have permitted the plans to continue covering current enrollees until the end of 2014.** Some insurers chose not to take advantage of this option and instead sent enrollees non-renewal notices.

* Sabrina Corlette and Kevin Lucia, "Policy Cancellations – Another Tempest in a Teapot?" Center for Health Insurance Reforms, Georgetown University Health Policy Institute, October 28, 2013.

** Christine Monahan and Sabrina Corlette, "The Affordable Care Act's Early Renewal Loophole: What's at Stake and What States are Doing to Close It," The Commonwealth Fund Blog, August 22, 2013.

The most harmful proposal is the House-passed Upton bill. It would allow insurers to continue to offer, through 2014, any non-ACA-compliant plans in effect in the individual market as of January 1, 2013. By grandfathering these plans, the bill would exempt them from many ACA reforms — permitting them, for example, to charge people more based on their health status and gender and to continue to have major gaps in coverage. The most problematic element of the House bill is that it would allow insurers to enroll new individuals in these plans throughout 2014. That would open the door to active "cherry picking" by some insurers, which could market their non-ACA-compliant plans to healthier, younger people who otherwise would have enrolled in marketplace plans for 2014. Such a practice would further drive up premiums in the marketplaces.

Moreover, while the House bill would extend the availability of non-ACA-compliant plans only through 2014, there would be pressure next summer and fall to then extend these plans — whose enrollment could have grown significantly if insurers promote them to young, healthy individuals — through 2015 or (more likely) permanently. That would permanently raise premiums in marketplace plans, further discouraging healthy people from enrolling and seriously threatening the marketplaces' viability.

Landrieu-Manchin Bill Would Raise Premiums and "Grandfather" More Non-Compliant Plans Forever

The Landrieu-Manchin bill would also be highly problematic, but for somewhat different reasons. It would *require* all insurers in the individual market to continue offering their current plans to individuals who are enrolled in such plans as of December 31, 2013, and to do so on a *permanent* basis. Insurers would have to allow individuals to renew these plans for as long as an enrollee

wanted (unless the enrollee stopped paying the premiums or the insurer canceled all coverage in the individual market and ceased operations as a health insurance issuer). The bill also would deem any coverage that people had as of December 31, 2013 as grandfathered, meaning the plans would not have to meet various ACA requirements that otherwise apply in 2014 to individual-market plans (such as the requirement not to vary premiums by health status or gender).

Meanwhile, the plans available through the new insurance marketplaces *would* have to comply with all of the standards and consumer protections that take effect under the ACA in 2014, creating two markets with disparate rules. The people most interested in remaining in grandfathered plans would be a younger and healthier group — and hence less costly to cover — than those who would enroll in the new marketplace plans. This would cause the pool of people buying coverage in the marketplaces to be less healthy than it would otherwise be, pushing up premiums for marketplace coverage. This dynamic, known as adverse selection, occurs when healthier and less-healthy people separate into different insurance pools.

Adverse selection is dangerous for insurance markets. For example, in California, a small-business pool known as PacAdvantage operated from 1993 to 2006 but ultimately failed — and ceased operation — because of serious adverse selection. PacAdvantage tended to attract people with high medical costs, in part because insurers operating within it were not permitted to charge higher premiums to small firms with less-healthy workers, while insurers in the outside small-group market *could* do so. Sicker people consequently concentrated in plans offered through PacAdvantage, while small businesses with healthier workers continued to buy coverage in the outside small-group market, where they could get coverage more cheaply because of their healthier enrollee pool. As a result, PacAdvantage premiums climbed ever higher compared to the outside insurance market, making the PacAdvantage marketplace less and less attractive to small firms with healthier workers. Eventually, the pool was shut down because PacAdvantage was not viable. Similar efforts in other states have also failed because of adverse selection.[2]

The Administration's new policy and the Upton bill differ from the Landrieu-Manchin bill in that they leave it up to states and insurers to decide whether non-ACA-compliant plans may continue. Some states have already indicated they will not take up the Administration policy. Under the Landrieu bill, however, states and insurers would have no discretion. All individuals enrolled in plans as of the end of December would have to be given the choice of staying enrolled in that coverage. This would expand the number of healthy people who could remain outside the marketplaces in non-ACA-compliant plans compared to current law.

The Landrieu-Manchin bill also allows individuals *not* enrolled in these non-ACA-compliant plans to enroll in them through December 31, 2013. (Some insurers might also be able to rapidly develop additional plans that don't meet the ACA standards and put them on the market between enactment of the bill and December 31). This element of the Landrieu-Manchin bill would further increase the risk of adverse selection by opening the door (even if only slightly) to active cherry-picking by insurers that could move quickly to enroll new people who are healthy while turning away people

[2] Sarah Lueck, "States Should Structure Insurance Exchanges to Minimize Adverse Selection," Center on Budget and Policy Priorities, August 7, 2010, http://www.cbpp.org/cms/?fa=view&id=3267.

Another Senate Approach: The Udall-Shaheen Bill

A bill introduced by Senators Mark Udall and Jeanne Shaheen (S. 1699) would allow people enrolled in individual-market plans as of September 30, 2013 to remain in those plans through the end of 2015. Like Landrieu-Manchin, it *requires* insurers to continue these plans, but it differs from Landrieu-Manchin in other respects and would be less harmful for the insurance marketplaces, for several reasons.

First, in contrast to the other bills (and to the new Administration policy), the Udall-Shaheen proposal would not exempt existing plans from all of the ACA's 2014 standards. It would exempt them from the ACA's benefit requirements but apply other ACA insurance reforms. For example, the non-ACA-compliant plans (like marketplace plans) would be prohibited from charging higher premiums due to health conditions or gender. Udall-Shaheen also wouldn't permit new enrollment; people could only stay with plans in which they were enrolled as of September 30, 2013. And those plans could continue only through 2015, rather than permanently, as under Landrieu-Manchin.

In addition, while Udall-Shaheen would allow people to remain enrolled through 2015 in plans that lack essential benefits or the ACA's limits on out-of-pocket costs, enrollees still would be part of the same risk pool as people covered by the marketplace plans. This would be the case because the pre-ACA plans would be subject to the ACA's rules for setting premium rates, which require each insurer to treat all enrollees in its individual-market plans — whether the plans are offered inside or outside the marketplaces — as part of the same pool.

Also, the non-compliant plans would participate in the ACA's risk-mitigation programs that reduce incentives for insurers to cherry-pick healthier enrollees and compensate insurers that disproportionately enroll high-cost people. The Udall-Shaheen bill thus would not pose as great a risk of adverse selection as the Landrieu-Manchin and House bills would.

It is not clear, however, whether it is feasible for insurers to quickly modify existing plans to comply with some but not all of the ACA requirements, as Udall-Shaheen provides. Moreover, it is unclear how Udall-Shaheen's *requirement* that insurers continue pre-ACA plans would be enforced and made feasible.

who would cost more.[3] The Landrieu-Manchin bill wouldn't allow additional new enrollees after 2013, however, which is one of the most harmful features of the Upton bill.

Finally, as noted, Landrieu-Manchin would require insurers to make these non-ACA-compliant plans available permanently. If the requirement proved workable, it would result in many more healthier-than-average individuals remaining in such plans, potentially indefinitely. Even *allowing* insurers to continue in such plans permanently would raise premiums in marketplace plans for years beyond 2015, even as two transition mechanisms designed to stabilize the individual market while the ACA's market reforms take effect — "reinsurance payments" to individual-market plans that

[3] Under the Landrieu-Manchin bill, insurers that can market these plans to new customers prior to December 31, 2013, generally would also be able to reject any new applicant whom they didn't wish to cover or to charge particular applicants substantially more based on pre-existing health conditions.

enroll high-cost people and "risk corridor payments" to marketplace plans experiencing higher-than-expected costs — cease after 2016. (Notably, while the ACA's "risk adjustment" mechanism is permanent, it does not apply to plans extended under Landrieu-Manchin because they are deemed to be grandfathered and thus are exempt.)

Individuals who suffer illness and badly need the benefits of the ACA's reforms could move to the marketplaces during the next annual open enrollment period in order to get more comprehensive benefits and better protection against high out-of-pocket costs. But if substantial numbers of people switch from non-ACA-compliant plans to marketplace plans only when they expect to need costly health care, that will further drive up premium costs for everyone in the marketplaces.

The ACA is designed to make the individual health insurance market much more accessible, especially to people with health problems. That and other important ACA reforms are viable, however, only if healthier people who cost less to cover are part of the same risk pool as less healthy people. The Landrieu-Manchin bill would threaten to unravel the balance among healthier and less healthy people that the ACA was carefully designed to achieve by siphoning off many people who otherwise would join ACA-compliant plans.

Moreover, the people pulled from the market of ACA-compliant plans would remain in the old, dysfunctional system; their insurance plans often would have important gaps, and they could face very high out-of-pocket costs if they needed substantial medical services.[4]

Thus, the concern that the National Association of Insurance Commissioners (NAIC) has raised about the new Administration policy — that it "continues different rules for different policies and threatens to undermine the new market, and may lead to higher premiums and market disruptions in 2014 and beyond" — would be much greater under the Landrieu-Manchin bill.[5]

Administration Policy, While Flawed, Is More Reasonable and Less Damaging

The Administration announced last week that it will permit health insurers to extend health plan coverage in effect on October 1, 2013 through 2014 and into 2015. This transitional policy will apply for coverage available to individuals as well as small businesses. Extended plans won't have to comply with many of the ACA's 2014 reforms: they can continue to charge people higher premiums based on factors such as health status and gender, charge far higher premiums to people who are older, and fail to cover the essential health benefits that ACA-compliant plans (including

[4] Landrieu-Manchin does require individual-market insurers to provide plan enrollees with annual notices that identify the ways in which the plan doesn't meet these standards and also explain that the enrollee has the right to buy a plan through the marketplace. This is similar to the consumer-notice provisions reflected in the new policy the Obama Administration announced on November 14.

[5] National Association of Insurance Commissioners, "NAIC Statement on President Obama's Announcement Regarding One Year Extension for Existing Plans," November 14, 2013, http://naic.org/Releases/2013_docs/naic_president_obama_one_year_extension_existing_plans.htm. The American Academy of Actuaries has also raised concerns about the Administration policy; see "Implications of changing ACA rules regarding insurance cancellations in the individual and small group health insurance markets," November 14, 2013, http://www.actuary.org/files/Academy_Letter_Implications_of_ChangingACARules_RegardingInsuranceCancellations_131114.pdf.

those available through the marketplaces) must provide. Insurers that decide to extend their 2013 plans under the Administration's new policy must notify affected enrollees of the ACA market reforms that will *not* be available under the plan, as well as their right to enroll in a marketplace plan, possibly with financial assistance.

By allowing current individual and small-group enrollees to remain in plans that meet a weaker set of standards and consumer protections, the new Administration policy will likely raise premiums for marketplace plans in 2015. Insurers may push for adjustments for 2014 premiums as well, although it appears increasingly unlikely that there is time for such adjustments.

Despite its flaws, the Administration's policy has strong advantages over the Landrieu-Manchin and House bills.

- It doesn't allow *new* people to enroll in non-ACA-compliant plans, as the House bill would.
- It leaves the decision of whether to extend the non-compliant plans to insurers and states. This means that fewer people will remain in such plans, and less adverse selection will result, than if the policy required insurers to offer them, as under Landrieu-Manchin.
- It extends the non-compliant plans through 2015, rather than permanently, as under Landrieu-Manchin.
- It is an administrative action and thus doesn't require legislative action that could open up the ACA to even more harmful statutory changes that could push marketplace premiums up markedly, undercut the ACA's insurance-market reforms, and threaten the long-term viability of the new marketplaces, without which millions of Americans will remain uninsured.

Table 1

Proposals to Extend Health Insurance That Doesn't Meet Health Reform Standards

	Administration Policy	Upton H.R. 3350	Landrieu-Manchin S. 1642	Udall-Shaheen S. 1699
Which plans does it exempt?	Those in effect on Oct. 1, 2013	Those in effect on Jan. 1, 2013	Those in effect on Dec. 31, 2013	Those in effect on Sept. 30, 2013
Can these plans accept new enrollees?	No	Yes	Yes, through Dec. 31, 2013	No
How long can non-compliant plans continue?	Through 2014 and into 2015	Through 2014	Permanently	Through Dec. 31, 2015
Are the plans exempt from the ACA's major 2014 standards?	Yes	Yes	Yes	Only the Essential Health Benefits Package. (Plans are *not* exempt from market and rating reforms.)
Can insurers choose *not* to continue offering the plans?	Yes	Yes	No	No
Does the exemption apply to the individual and small-group markets?	Yes	Individual only	Individual only	Individual only

Source: CBPP analysis