prices. CMS is nudging physicians to prescribe wisely because it can. Nudging manufacturers to price wisely is more contentious and would require congressional approval. The experiment may have trickle-down effects that slow price growth, but ultimately, controlling Medicare spending will require addressing the underlying pricing problem.

An audio interview with Dr. Schrag is available at NEJM.org

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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The ACA and Risk Pools — Insurer Losses in the Setting of Noncompliant Plans

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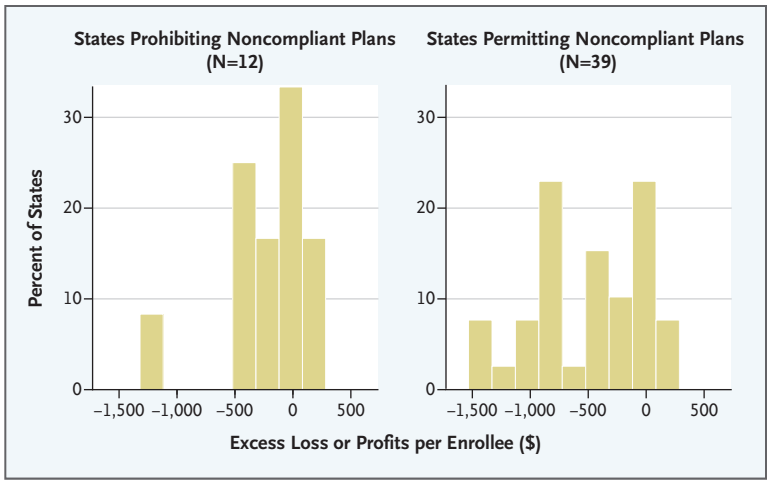
The viability of health insurance exchanges established under the Affordable Care Act (ACA) is in doubt. Many insurers, including the newly created Consumer Operated and Oriented Plans, or CO-OPs, incurred losses in 2014, and some withdrew from the program.[1] Several explanations for those losses have been proposed, including decisions by insurers to set premium prices too low; poorly enforced enrollment rules, including multiple extensions of enrollment deadlines; liberal special enrollment periods; and Congress's stipulation that the risk-corridor program, under which the federal government shares profits and losses with insurers, be budget-neutral. Another important factor was the government's decision to allow noncompliant insurance plans to continue operating, which shrank the ACA's intended insurance risk pools.

To drum up support for the ACA, President Barack Obama famously told Americans, "If you like your health care plan, you can keep it." Although he might originally have been referring only to plans that met the ACA's basic requirements, the administration announced in November 2013 that state insurance commissioners could allow consumers with noncompliant plans to keep them for 2014 — a deadline that was subsequently extended to the end of 2017.

The noncompliant plans, whose existence predated the ACA, did not adhere to several important standards that the law required new plans to meet; such plans were permitted to discriminate on the basis of preexisting conditions, typically provided low levels of coverage, and lacked some of the essential benefits required by the ACA. Because they restricted enrollment to healthier people and offered only limited coverage, these plans could generally have modest premiums and appealed largely to people with low expected medical expenses. In-

Ninety percent of the $2.55 billion in reported losses were claimed by insurers in states that permitted continuation of noncompliant plans, which also reported a substantially larger average loss per enrollee.



Mean Excess Losses or Profits per Enrollee in the 2014 Individual Insurance Market, by State.

Shown are percentages of states (plus the District of Columbia) among those prohibiting versus permitting noncompliant plans that had losses or profits per enrollee under the risk-corridor program (shared risk beyond 3%). There were 228 insurers that offered plans in one or more of the states that permitted noncompliant plans; 91 insurers offered plans in states that did not. If a single insurer offered plans in multiple states, it was counted once in each state. Data are from the Centers for Medicare and Medicaid Services.

surers, however, had priced their exchange plans assuming that noncompliant plans would no longer be allowed and that people formerly enrolled in such plans would be purchasing new insurance on the exchanges. Allowing consumers to keep their noncompliant plans meant that people purchasing plans on the exchanges were on average less healthy than insurers had assumed they would be when setting their premiums.

Granted federal permission to allow ACA-noncompliant plans to continue, insurance commissioners in 39 states did so; commissioners in 11 states plus the District of Columbia did not.[2] Insurers' subsequent filings under the risk-corridor program show the importance of those decisions. That program stipulated that the government would share any profits earned or losses incurred by insurers beyond 3% of their expected claims. In 2014, a total of 53% of insurers filed claims for losses totaling $2.55 billion, whereas only 24% shared profits of $346 million. Because of a provision enacted after the passage of the ACA that required the risk-corridor program to be budget-neutral, it could cover only $346 million, or 14%, of what would have been the government's share of the losses.

Ninety percent of the $2.55 billion in reported losses were claimed by insurers in states that permitted continuation of noncompliant plans. By contrast, profits shared under the program were more evenly split between the two groups of states: 34% were earned by insurers in states with noncompliant plans, and 66% by insurers in states without them. Furthermore, insurers in states with noncompliant plans reported a substantially larger average loss per enrollee: $493 versus $222 (see graph). Because insurers in both groups of states priced their policies under the same set of assumptions, most of this difference could be attributed to a failure to anticipate changes in risk pools resulting from the last-minute decision to allow noncompliant plans to continue operating.

Although insurers had limited experience with the new marketplaces when they set their 2015 premiums in May 2014, by the following year they had substantially more data on the type of consumers purchasing plans on the exchanges. Thus, changes in premiums from 2015 to 2016 may in part reflect adjustments made by insurers to account for the effect of noncompliant plans on risk pools. Premiums for benchmark plans — the silver plan with the second-lowest premium in each state — increased by an average of 12% in states with noncompliant plans, as compared with only 5% in states without them.[3]

This disparity in rate hikes emphasizes the importance of broad participation in the insurance risk pool. In 2014, slightly more than 5% of the population chose to pay a penalty rather than purchase insurance.[4] If the majority of these people were healthier than the average insurance enrollee, their lack of participation in the risk pool would result in higher premiums for people buying insurance on the exchanges and could raise costs for the federal government as well. On the one hand, premium tax credits provided by the government are larger when premiums are higher. On the other hand,

people choosing to pay the penalty instead of purchasing insurance do not collect a tax credit — though some unknown proportion of them (those with incomes exceeding 400% of the federal poverty level) would not have been eligible for one anyway.

Although the ACA's expansion of coverage has substantially reduced the number of uninsured Americans, the sustainability of the new health insurance marketplaces depends on the affordability of insurance for both individual consumers and the government. That affordability, in turn, depends on the policy decisions that determine the structure of the individual marketplaces. It's estimated that at least 20 million Americans who were eligible to purchase insurance on the exchanges in 2015 did not do so.[5] Moreover, with expiration of the reinsurance program in 2016, premiums will almost certainly increase in 2017, which could discourage some people from becoming insured and others from remaining so. Thus, continued efforts to increase and maintain participation are needed — such as greater outreach to people on the entire spectrum of the risk pool, more publicity about and enforcement of the mandate to obtain health insurance, and sparse use of exemptions from the mandate's penalties. The expiration of the grace period for noncompliant plans in December 2017 should also help expand the risk pool.

The effect of allowing ACA-noncompliant plans emphasizes the importance of ensuring near-universal participation in the risk pool and provides a cautionary tale about the unintended consequences of altering a single policy within the interwoven set of ACA reforms.

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A Modern *Ars Moriendi*

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My father the rancher was stoic and taciturn. His cowboy hat and boots were no affectation: the boots protected him from snakebites; the hat shaded his face from the strong sun of the Colorado plains. He loved everything about his 3300-acre ranch — from the stark, flat, expansive landscape to the house whose dining table hosted countless family meals and whose living room welcomed an untold number of friends. Until fairly recently, he had tended his land and cattle with vigor and joy.

One Monday afternoon in the spring of 2015, my sister telephoned to say that Dad's neighbor Rocky had just contacted her. "Dad is alive, but he can't speak or move his right side. Rocky found him lying on the kitchen floor. The ambulance is on its way."

Decisions about his health care loomed, and during the next 4 days I shifted among the roles of daughter, health care proxy, and physician. It was disorienting, difficult . . . and transformative. After 20 years of taking care of patients as an internist, I was now plying my trade with my closest family member. I didn't want him to suffer. I wanted him to have a good death — something akin to the *ars moriendi*.

Latin for "art of dying," the *ars moriendi* is a body of literature that originated in Europe during the 15th century, on the heels of the bubonic plague. Its aim was to provide a practical and spiritual framework for the prepara-