

# United States Senate

WASHINGTON, DC 20510

July 19, 2017

Dear Colleague:

As the Senate continues to consider the best path forward to fix the damage caused by Obamacare, we write to draw your attention to important analyses that we obtained recently from the Department of Health and Human Services (HHS).

The first analysis is titled “Premium reconciliation and pre-ACA deep dive.” According to HHS, the analysis was done by McKinsey & Company at HHS’s request and provided to HHS on May 10, 2017.<sup>1</sup> McKinsey analyzed how particular Obamacare mandates affected insurance markets and contributed to increases in insurance premiums. This analysis, prepared by independent and nonpartisan experts, reviewed real market data and is the most granular examination we have seen on the drivers of the premium increases that so many Americans have faced because of Obamacare.

The McKinsey findings are significant. McKinsey examined the factors that contributed to premium increases from 2013 to 2017 across a sample of four states – Georgia, Pennsylvania, Ohio, and Tennessee.<sup>2</sup> McKinsey found that Obamacare mandates related to pre-existing conditions, including guaranteed issue (the requirement that insurers issue plans to any applicant) and community rating (the requirement that insurers charge the same premium to individuals regardless of health status, use of services, etc.), were the chief drivers of premium increases in the markets analyzed. The analysis shows that these mandates, along with other risk factors, have been responsible for 41 percent to 76 percent of the premium increases in the markets analyzed. In Tennessee, for example, these factors were responsible for 73 percent to 76 percent of the 314 percent average monthly premium increase of \$327.

The second analysis is titled “Estimating the Effects of the Consumer Freedom Amendment on the Individual Market,” dated July 15, 2017.<sup>3</sup> This analysis examines the cost of premiums under the Consumer Freedom Amendment. The results are remarkable. If, under a

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<sup>1</sup> After Senator Johnson’s staff asked HHS staff for an updated version of a 2013 Milliman report on the predicted impact of Obamacare insurance rules on premiums (available here: <http://www.iss4all.com/MillimanACAPremiumReport4252013.pdf>), staff of the HHS Office of the Assistant Secretary for Legislation (ASL) volunteered that HHS engaged in “conversations” with McKinsey about the same issue. Senator Johnson requested documentation of those discussions, and HHS eventually produced this McKinsey analysis. HHS ASL staff informed Senator Johnson’s staff that the McKinsey analysis was produced to HHS on May 10, 2017. HHS ASL staff also informed Senator Johnson’s staff that HHS had removed all HHS and McKinsey markings from the document before producing it to Senator Johnson.

<sup>2</sup> To conduct its analysis, McKinsey used a 2013 baseline of the weighted average of the top five most popular plans for a 40-year-old male in these states. It then compared those premiums to the 2017 premium of the lowest price Obamacare silver plan for the same individual in these states and assessed which factors contributed to higher premiums.

<sup>3</sup> HHS sent this analysis to Senator Lee’s staff on July 15, 2017 after he requested additional information on how various iterations of a Consumer Freedom Amendment might affect the cost of premiums in the individual market.

Consumer Freedom Amendment, insurers were to offer Obamacare-compliant plans and non-Obamacare compliant plans there would be a significant decrease in premiums.<sup>4</sup>

Under Obamacare, individual market monthly premiums would rise to an enrollment weighted average of \$845 per month by 2024, according to the analysis. If a Consumer Freedom Amendment with two risk pools is included, by 2024 premiums for Obamacare-compliant plans for a 40-year-old are estimated to be as much as 30 percent lower than the enrollment weighted average. Premiums for non-Obamacare compliant plans are estimated to be as much as 77 percent lower. The report also shows that the single risk pool version of a Consumer Freedom Amendment, which was included in the latest version of the Better Care Reconciliation Act, would lower premiums. However, premiums for non-Obamacare compliant plans in the single risk pool version for a 40-year-old would potentially cost \$600 more by 2024 on an annualized basis compared to a two risk pools version.

We are sending these analyses to you to inform our current debate. We hope you find them useful and informative.

Sincerely,



Ron Johnson



Mike Lee

Enclosures:

Premium reconciliation and pre-ACA deep dive

Estimating the Effects of the Consumer Freedom Amendment on the Individual Market

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<sup>4</sup> This analysis does not take into consideration every change that the latest version of the Better Care Reconciliation Act proposes to make. However, it assumes that all states have adopted changes to allow insurance providers in all markets to offer non-Obamacare compliant plans and have a 5:1 age band in both the Obamacare-compliant and non-Obamacare compliant plans. Additionally, in both the single risk pool and two risk pools analysis, the report considers a scenario where consumers have a high price sensitivity and the federal government provides an additional \$10 billion each year to the market compared to a scenario where consumers have a low price sensitivity and there is no additional federal funding.

# Premium reconciliation and pre-ACA deep dive

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PRELIMINARY DRAFT

CONFIDENTIAL AND FHE-DECISIONAL

# Requested questions for discussion

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Two analyses were requested to examine the following:

1. What portion of the increase in premium is attributable to the effects of guaranteed issue and community rating?
2. For the states that have a high percentage of pre-ACA plans (IA/MS/SD), how do they compare to states that have terminated pre-ACA plans, and what is the financial performance of QHP vs non-QHP plans?

# Topic 1

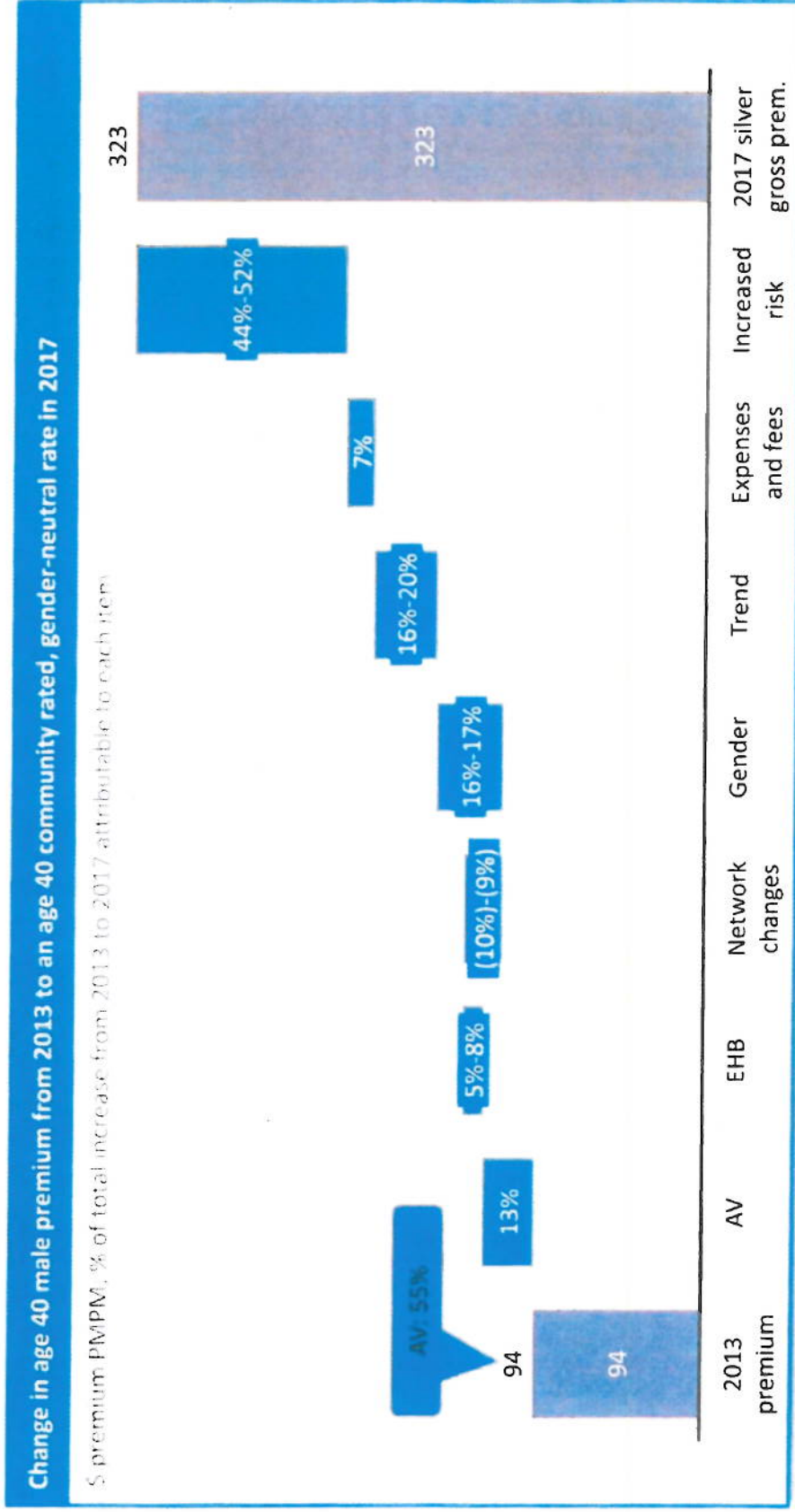
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# Method for determining premium reconciliation

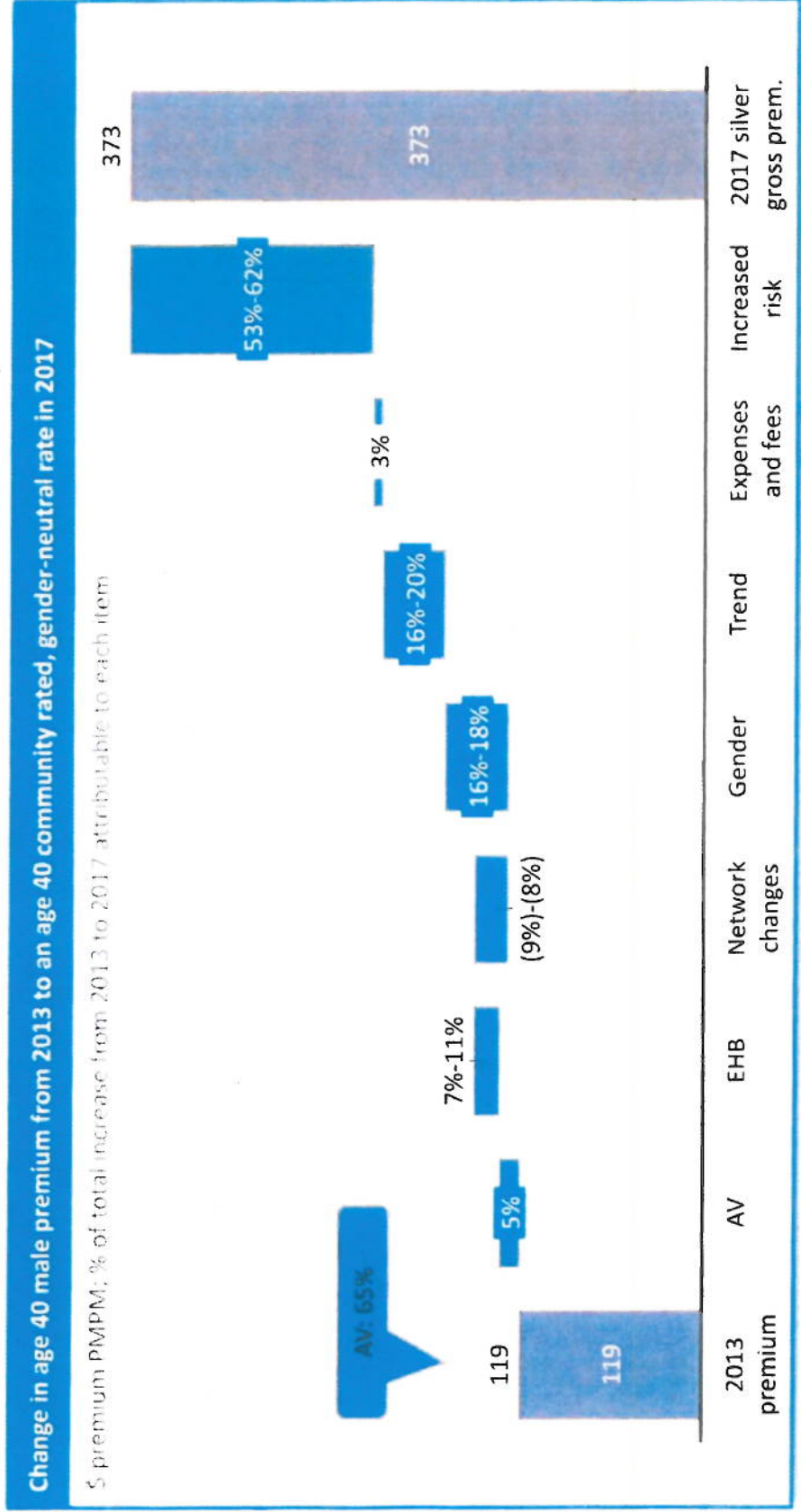
Note: You would have to believe ALL elements of the respective methodology descriptions detailed here are true for the example outcomes that follow to hold

Category	Description	Source
2013 premium	Weighted average premium of top five most popular plans in each rating area for a 40 year old male, aggregated to state-level weighted by QHP-eligible population	2013 eHealth data
AV	Weighted average actuarial value of the top five most popular plans in each rating area, aggregated to state-level weighted by QHP-eligible population	2013 eHealth data
EHB	Weighted average reduction in claims based on top five most popular plans in the largest rating area in the state measured by coverage of maternity, mental health, substance abuse, and non-generic drugs	2013 eHealth data; Truven
Network changes	Change in premium due to narrowing of networks and increase of managed plans, measured by prevalence of such plans multiplied by associated savings, based on county level data aggregated to state-level weighted by QHP-eligible population	Exchange Network Database
Gender	Change in premium due to the removal of gender rating for a 40 year old based on Truven claims	Truven; 2017 QHP enrollment report
Trend	2013 to 2017 medical trend applied to claim costs ranging from 5.5-6.5% compounded annually	Public carrier financial reports
Expense and fees	Change in PMPM expense (SG&A and TL&F) from 2013 to 2017, assuming SG&A is a fixed cost PMPM and TL&F is a variable cost as a percent of premium	Supplemental Health Care Exhibits; MLR Reports
Increased risk	Residual increased risk after all of the above items have been accounted for. This would include items such as guaranteed issue, community rating, consumer response to mandates, subsidies, effectiveness of SEP rules, and other disruptions (not exhaustive)	<i>Remaining difference in premium to reconcile to 2017 premium</i>
2017 premium	2017 age 40 lowest price silver plan, based on county level data aggregated to state-level weighted by QHP-eligible population	Public exchange premiums

# Premium reconciliation: median premium state example (1/2)

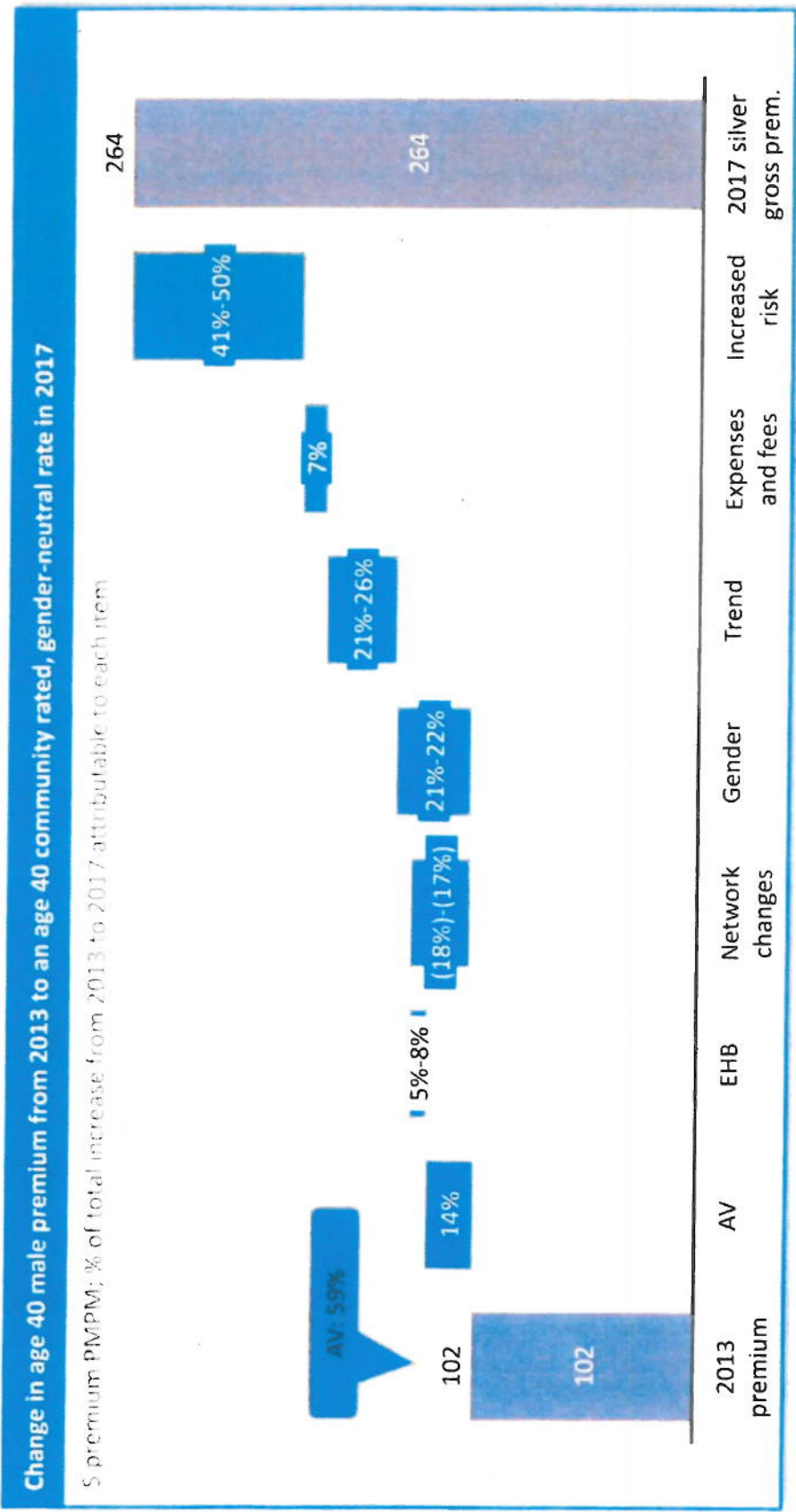


# Premium reconciliation: median premium state example (2/2)





# Premium reconciliation: low premium state example



# Premium reconciliation: high premium state example

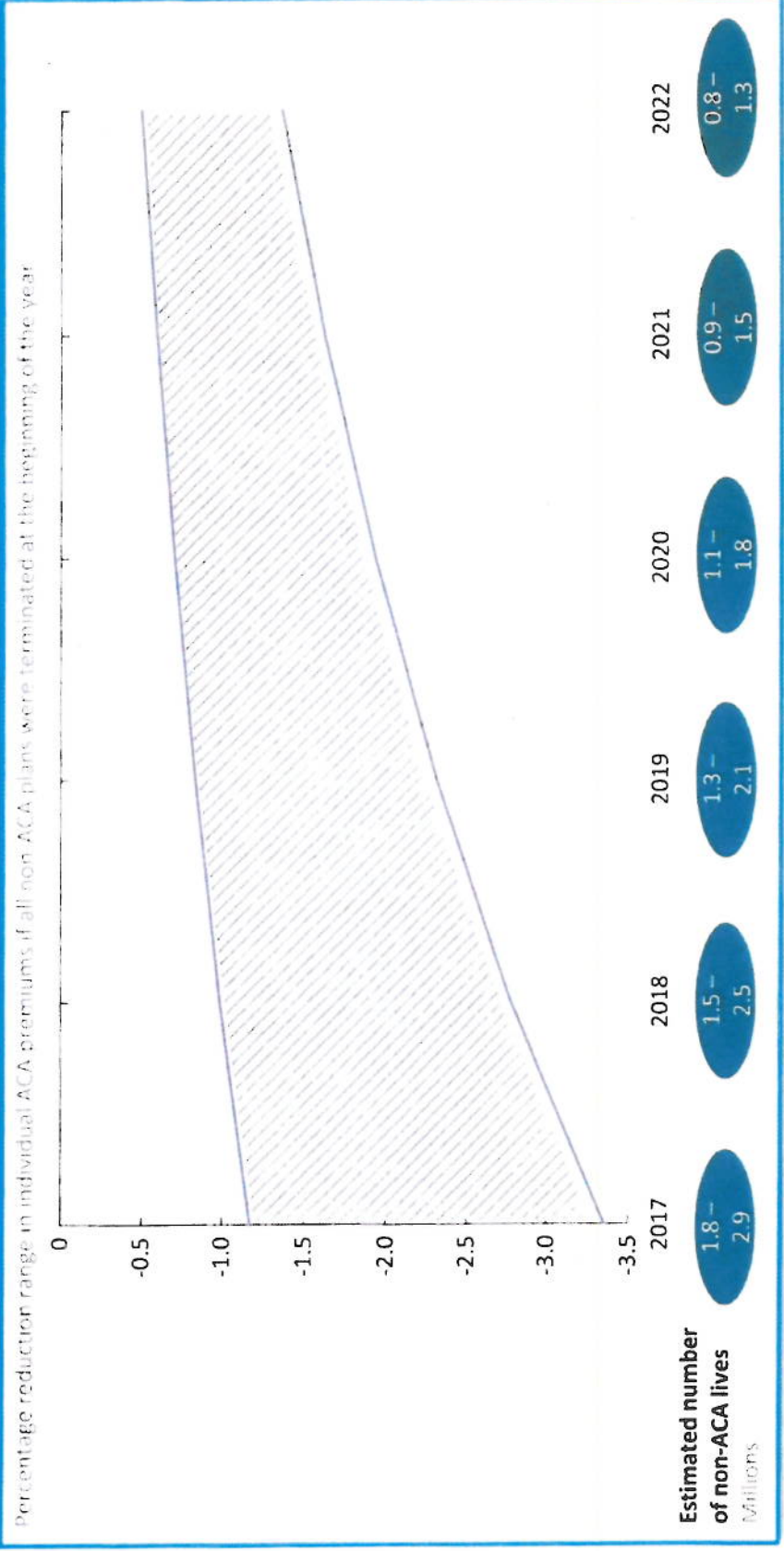


# Topic 2

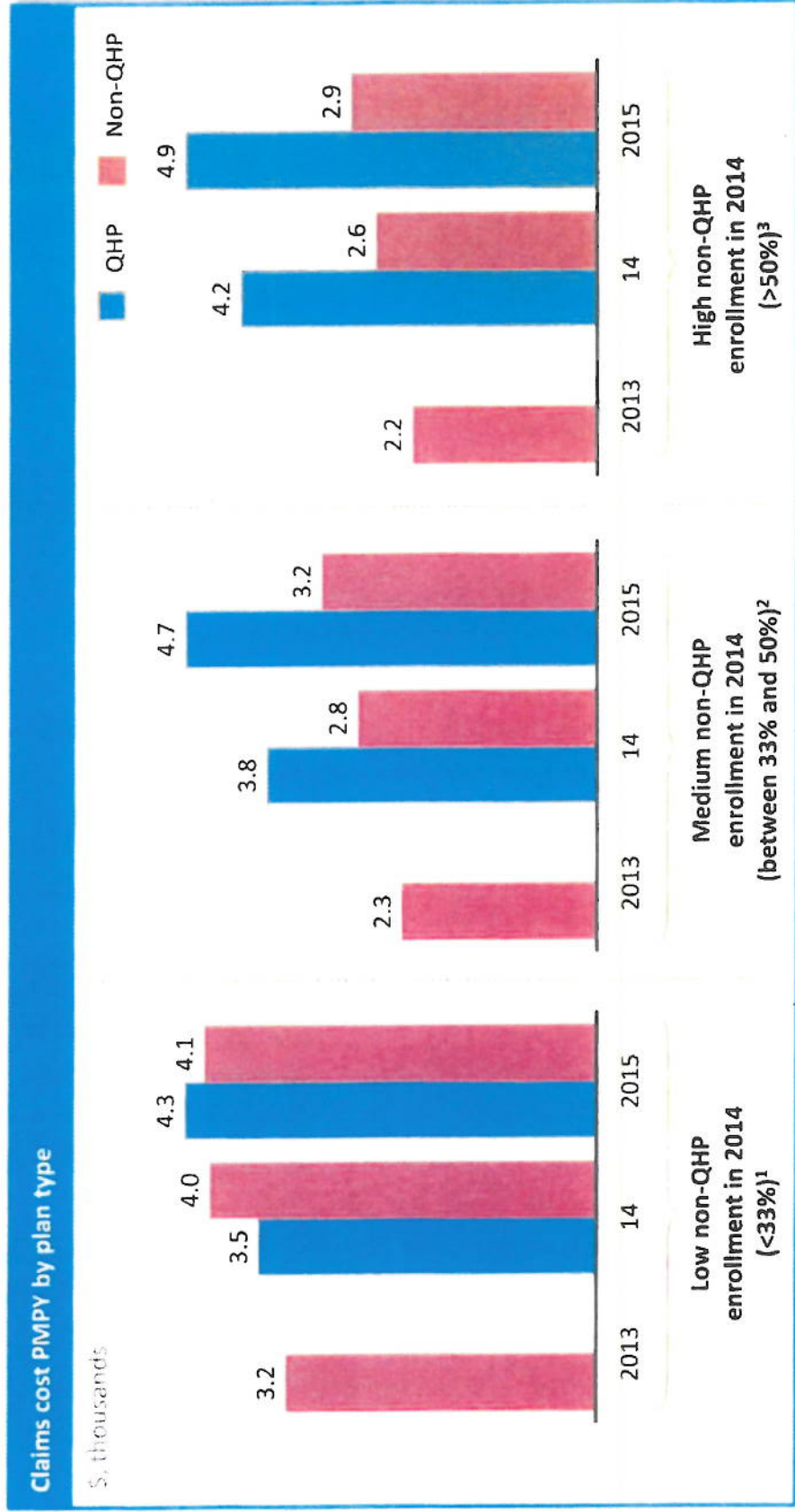
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# ACA premium improvement from terminating non-ACA plans reduces every year that non-ACA plans are extended

Range of individual ACA premiums PMPM reduction from terminating non-ACA plans by year



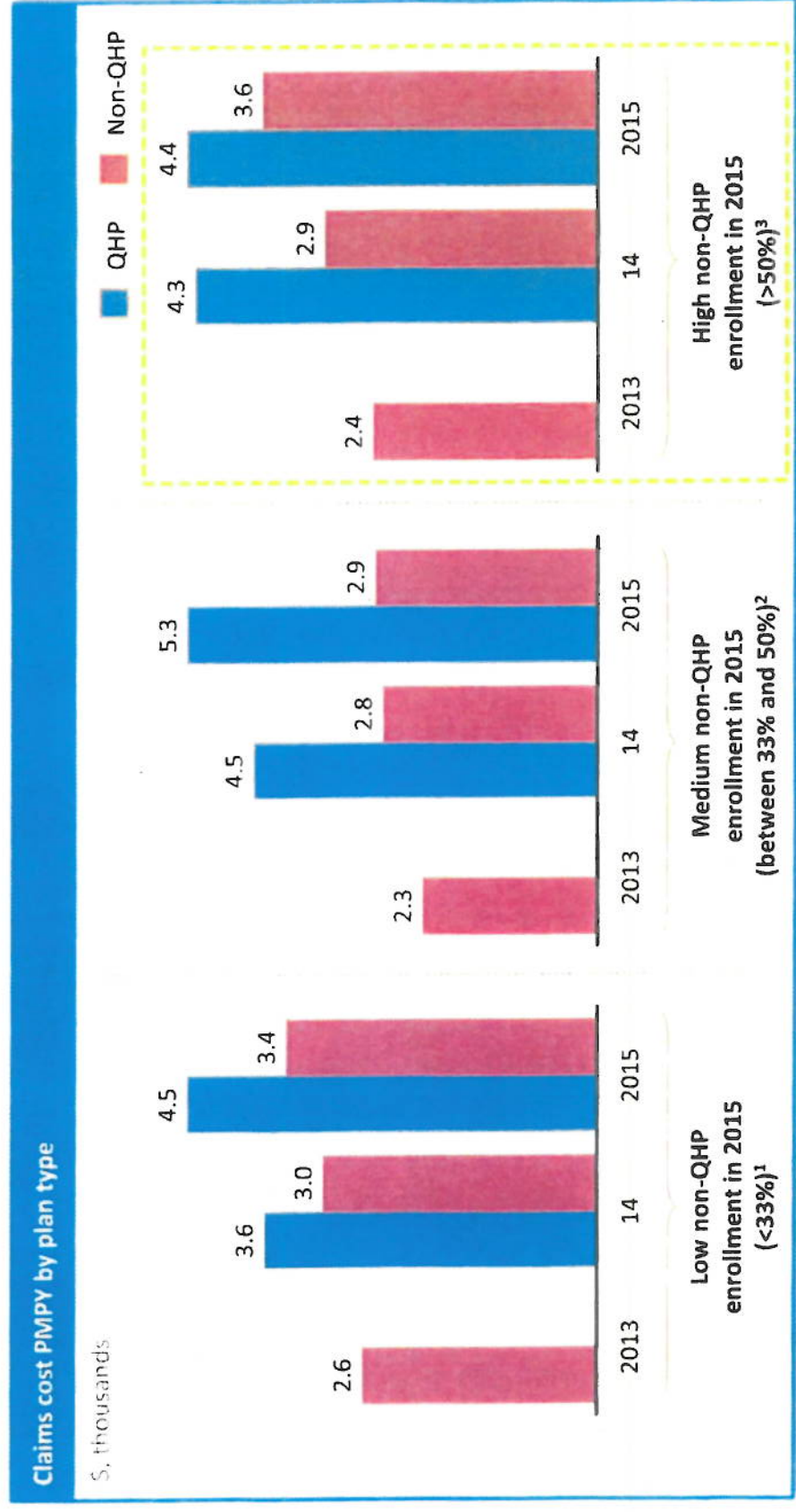
# Claims cost comparison based on 2014 non-QHP enrollment



1 14 states: AL, AR, CA, MA, ME, MN, MT, NH, NJ, NY, OR, RI, VT, WA;  
 2 22 states: AK, CO, DC, DE, FL, GA, HI, ID, IL, IN, KY, LA, MD, MI, ND, NM, PA, SC, TX, VA, WI, WV;  
 3 15 states: AZ, CT, IA, KS, MO, MS, NC, NE, NV, OH, OK, SD, TN, UT, WY

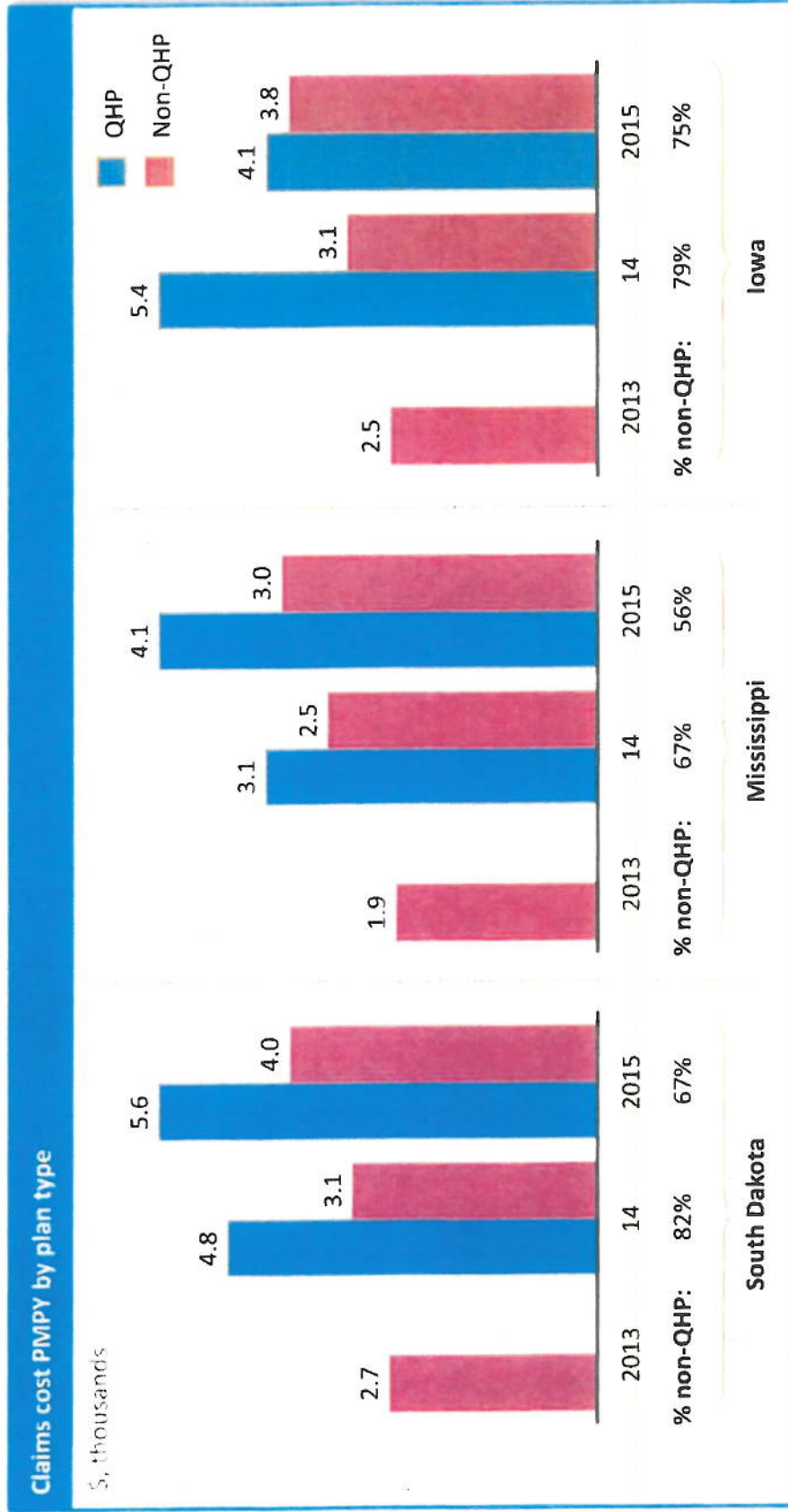
# Claims cost comparison based on 2015 non-QHP enrollment

Detail on next page



<sup>1</sup> 39 states: AK, AL, AR, CA, DC, DE, FL, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MT, ND, NH, NJ, NM, NY, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WV, WY; <sup>2</sup> 9 states: AZ, CO, CT, MO, NC, NE, NV, OH, WI; <sup>3</sup> 3 states: IA, MS, SD

# Claims cost comparison in states with high 2015 non-QHP enrollment



# Appendix

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# Assumptions applicable to pg. 10



Description	Key modeling assumptions
Terminate non-ACA plans at the end of 20XX	<ul style="list-style-type: none"><li>• The model evaluates this impact for years of 2017 – 2022 to demonstrate how the impact varies if non-ACA plans are terminated at various dates. (The lapse rate for the final year is 100%)</li><li>• Rules governing the ACA market remain unchanged</li><li>• 15% of non-ACA members lapse each year; range of 50 – 100% of the lapsing members take-up ACA coverage (with the remaining go uninsured)</li><li>• Range of lives on non-ACA plans in 2017 is estimated to be 2 – 3M</li><li>• Modeling is nationwide and assumes all states have a 3:1 ACA age curve (modeling does not account for potential variances caused by community rating/differing age curves)</li><li>• The model does not separate assumptions for grandmothered plans vs. grandfathered plans. All lives are bucketed into a single non-ACA group</li><li>• Existing non-ACA plans allowed to exist indefinitely, with natural consumer lapsing gradually shrinking the non-ACA market</li><li>• Low enrollment: Low retention rate of non-ACA population between 2015-2017, and low rate of consumer uptake into ACA plans of those lapsing/facing terminated non-ACA plans</li><li>• High enrollment: High retention rate of non-ACA population between 2015-17, and high rate of consumer uptake into ACA plans of those lapsing/facing terminated non-ACA plans</li></ul>

Note: You would have to believe ALL elements of the respective example scenarios detailed here are true for the example outcomes that follow to hold

# Estimating the Effects of the Consumer Freedom Amendment on the Individual Market

July 15, 2017

**PRELIMINARY DRAFT**



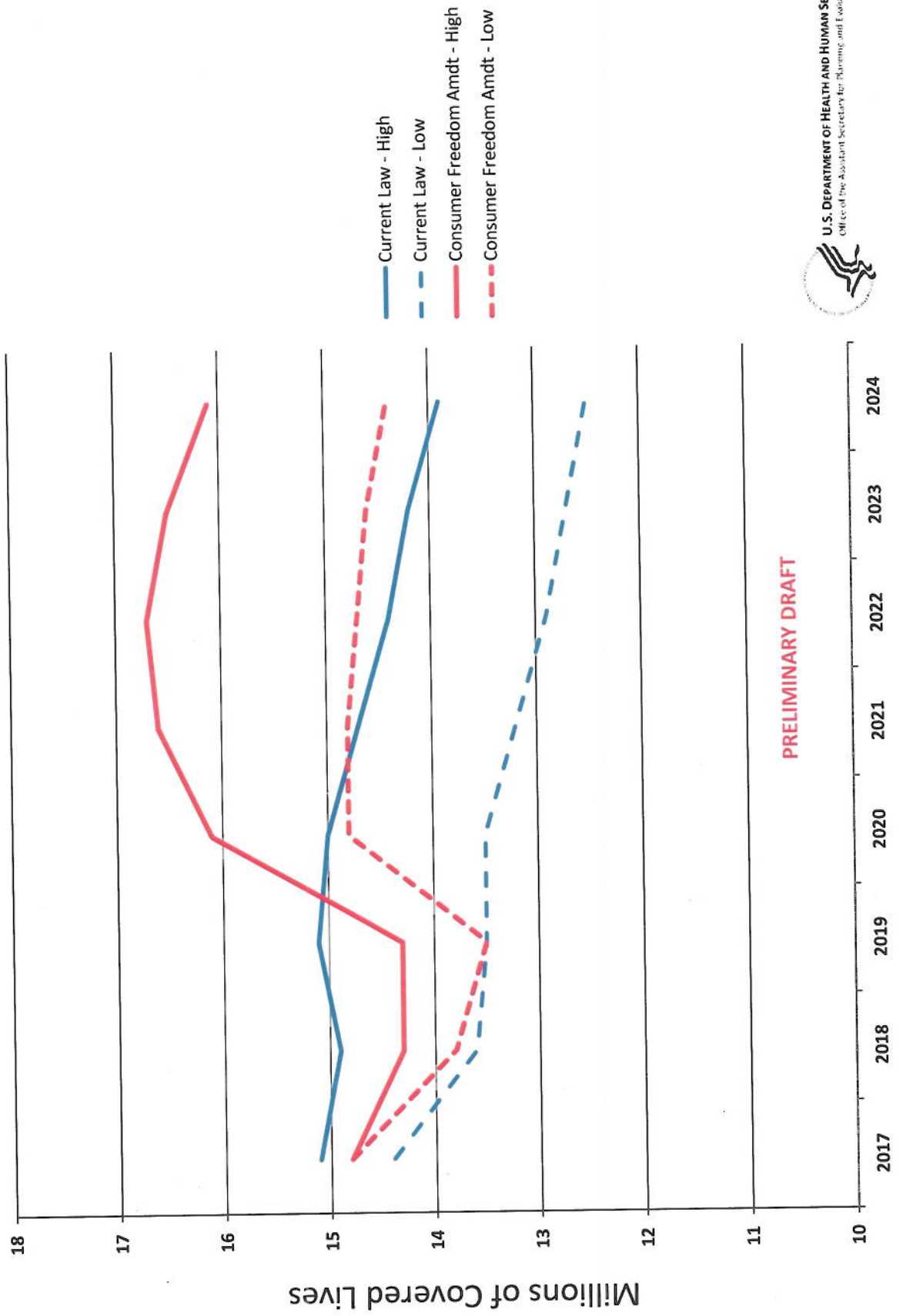
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Office of the Assistant Secretary for Planning and Evaluation

# Overview and Methodology

- In response to a request for technical assistance, we modeled the impact of allowing the sale of non-ACA compliant plans alongside ACA-compliant plans in the individual market, while still maintaining the consumer choice provisions of Section 1312(c)(1) of the Patient Protection and Affordable Care Act. Non-ACA compliant plans sold in plan year 2019 or later may also be referred to as Consumer Freedom Plans throughout this document.
- An alternate scenario absent the requirements of Section 1312(c)(1) of the Patient Protection and Affordable Care Act is also included.
- In both scenarios, it is assumed that an adequate number of issuers offer at least one bronze, silver, and gold qualified health plan, and that all states in 2020 permit all carriers to offer health insurance plans with a lower actuarial value and fewer required benefits without imposing stricter requirements and premium rating rules.
- We divided the nationwide uninsured and individual market populations into demographic cells (based on age, income, and health risk) and their insurance status (uninsured, insured in ACA-compliant plan, insured in a non-compliant plan).
- Using proprietary elasticity estimates, the model compares current year and prior year premium costs for individuals in each age/income/risk category, to determine the number of individuals choosing to purchase, maintain, or drop coverage, or remain uninsured.
- A range of coverage, premium rate, and federal outlay estimates were developed between two scenarios –high total/non-ACA enrollment and low total/non-ACA enrollment – for both the current law and the Consumer Freedom Amendment.
  - The “high” enrollment scenario assumes greater price sensitivity, more enrollment in non-ACA plans prior to 2017, 10% fewer claims as a result of loosened EHB requirements, and \$10B in annual federal funding used as reinsurance each year from 2020-2026.
  - The “low” enrollment scenario assumes lower price sensitivity, half the pre-2017 non-ACA enrollment, 5% fewer claims, and no federal funding.
- A full list of assumptions and limitations of our approach is described in the endnotes.

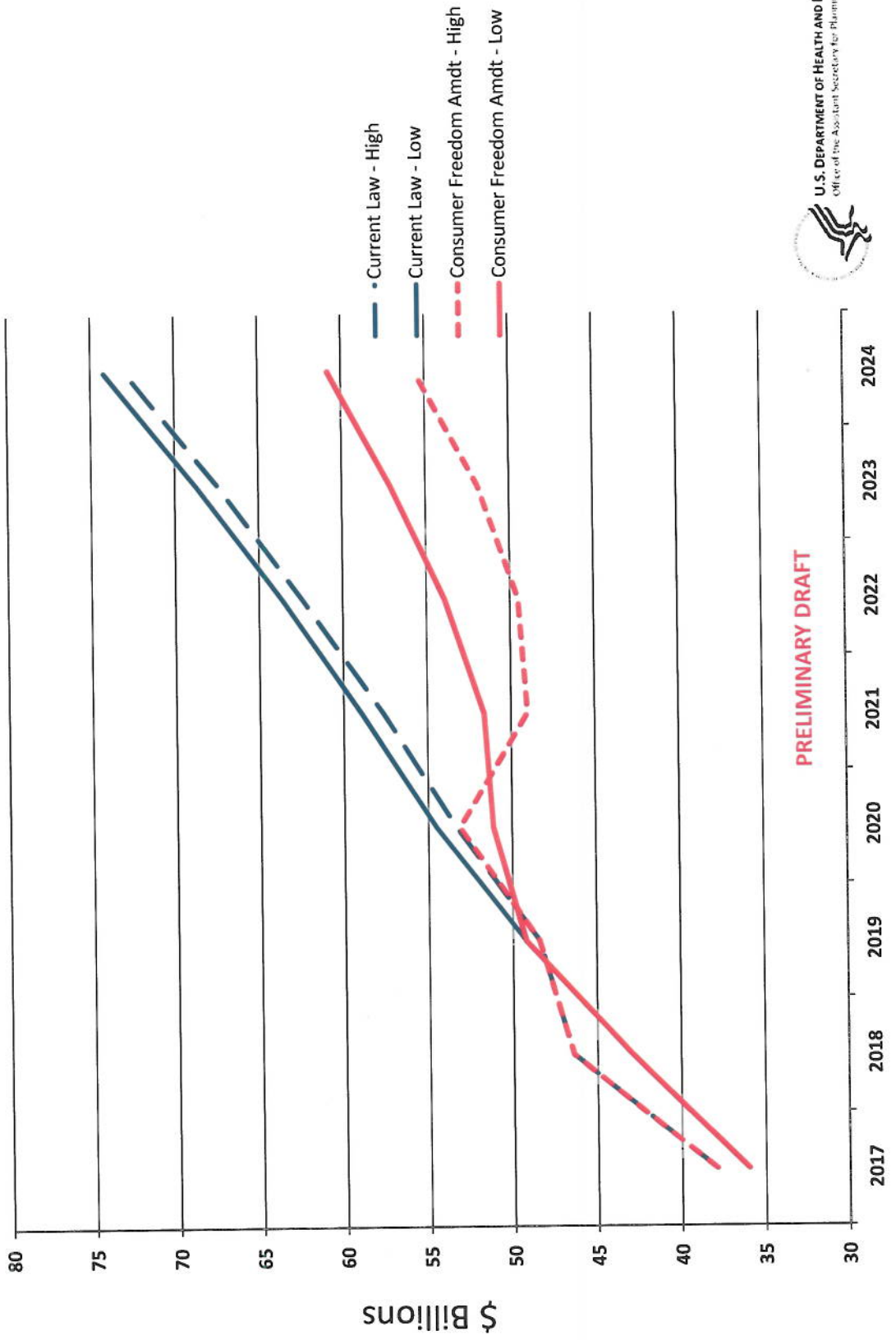


# Total Enrollment - Single Risk Pool



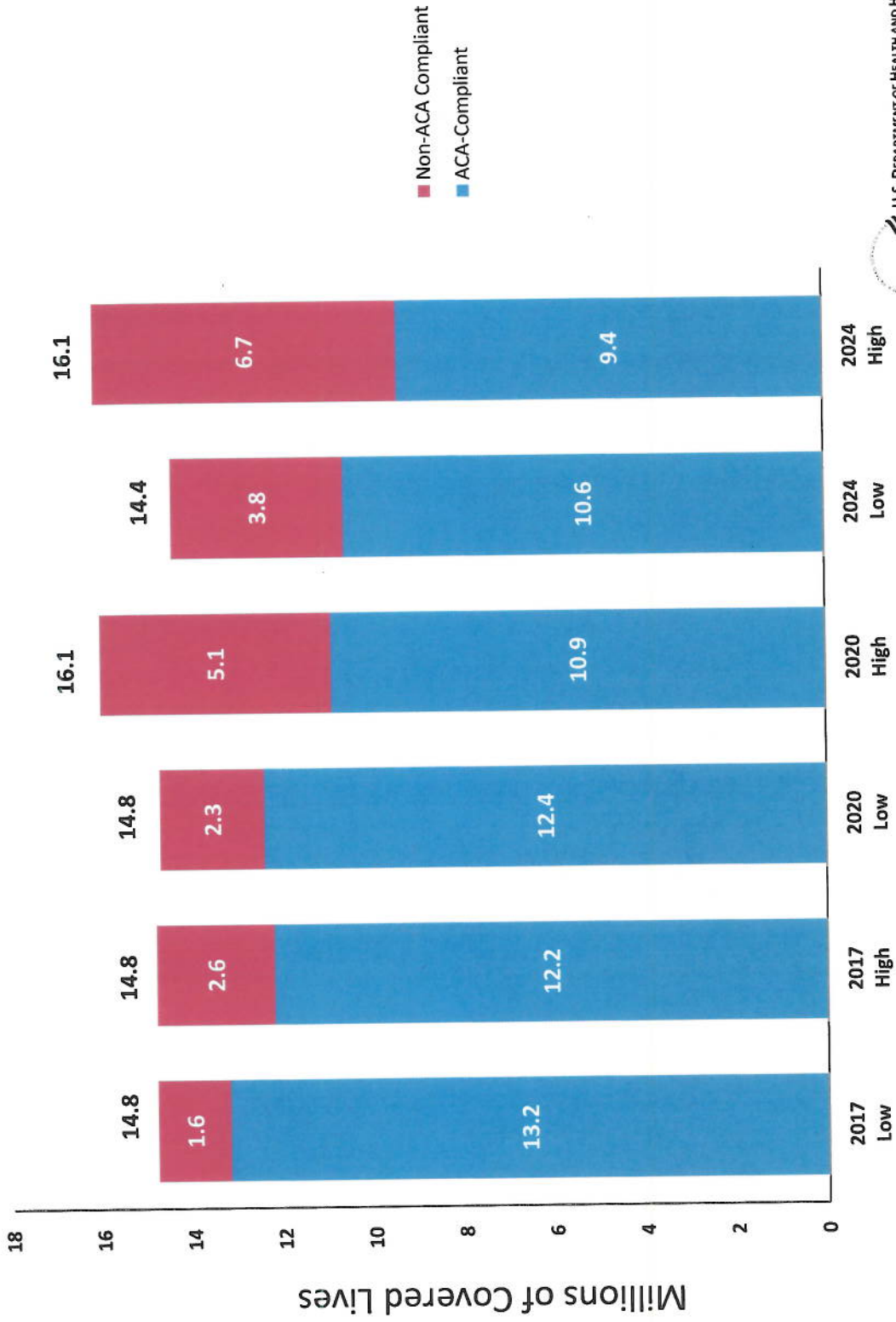
PRELIMINARY DRAFT

# Federal Outlays: APTC, CSRs, and Section 301 Funding - Single Risk Pool



PRELIMINARY DRAFT

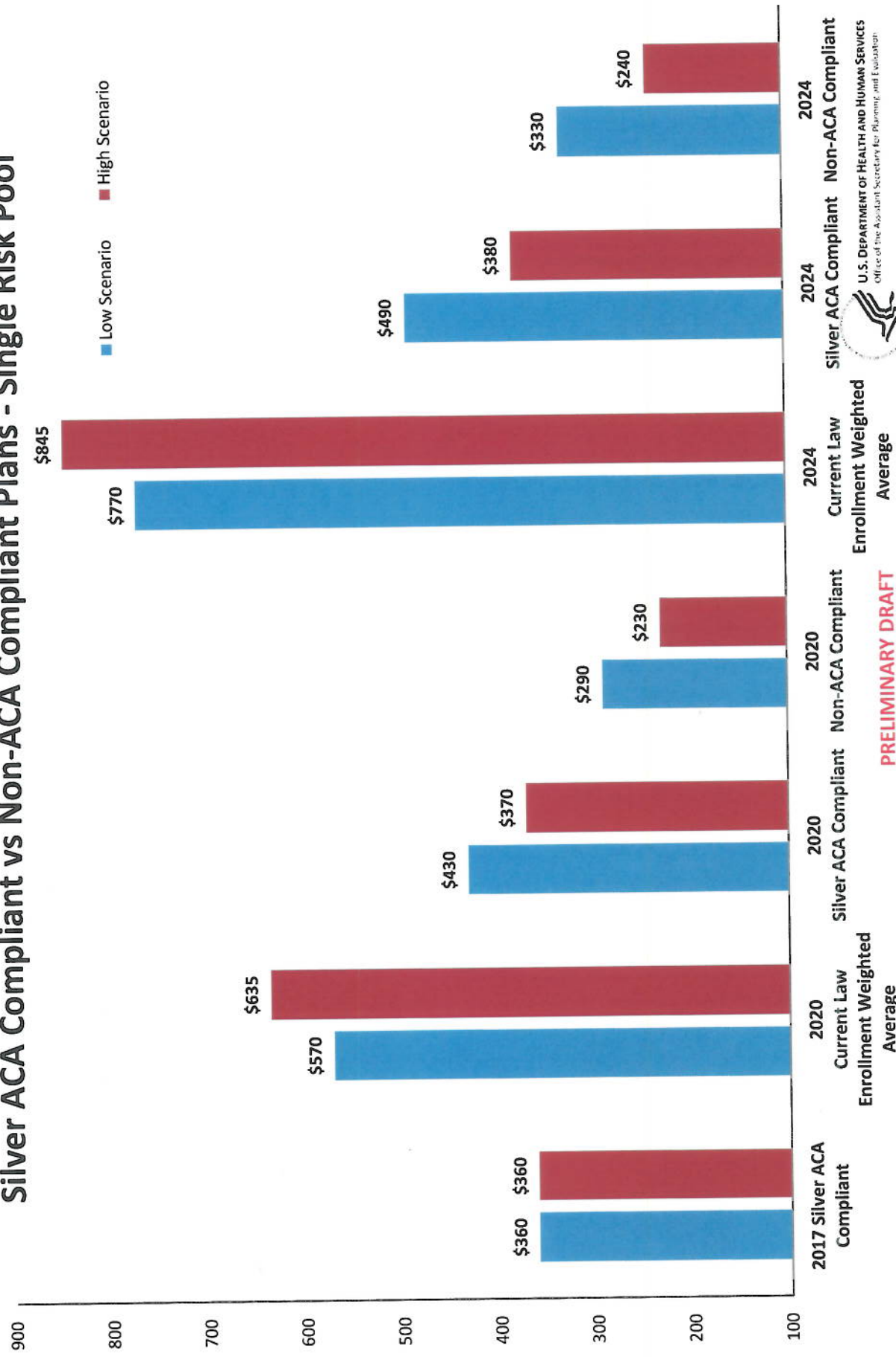
# Individual Market Enrollment: ACA Compliant vs Non-ACA Compliant Plans - Single Risk Pool



PRELIMINARY DRAFT

# Individual Market Monthly Premiums

## Silver ACA Compliant vs Non-ACA Compliant Plans - Single Risk Pool



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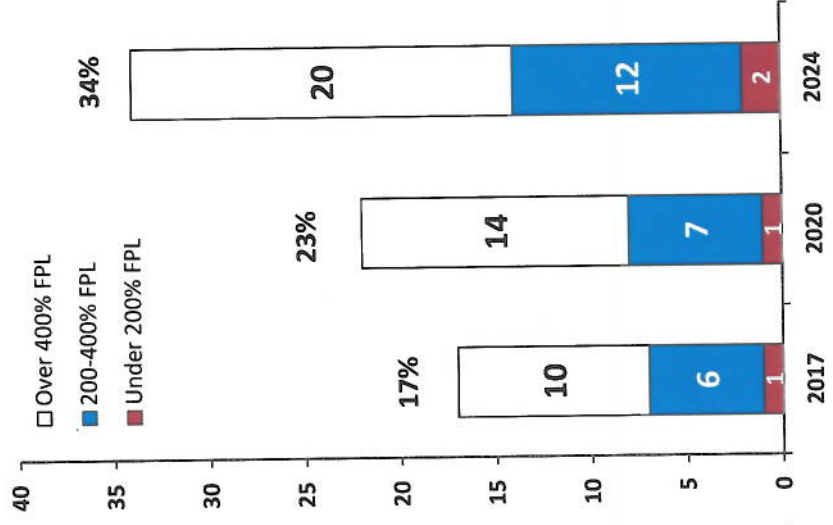
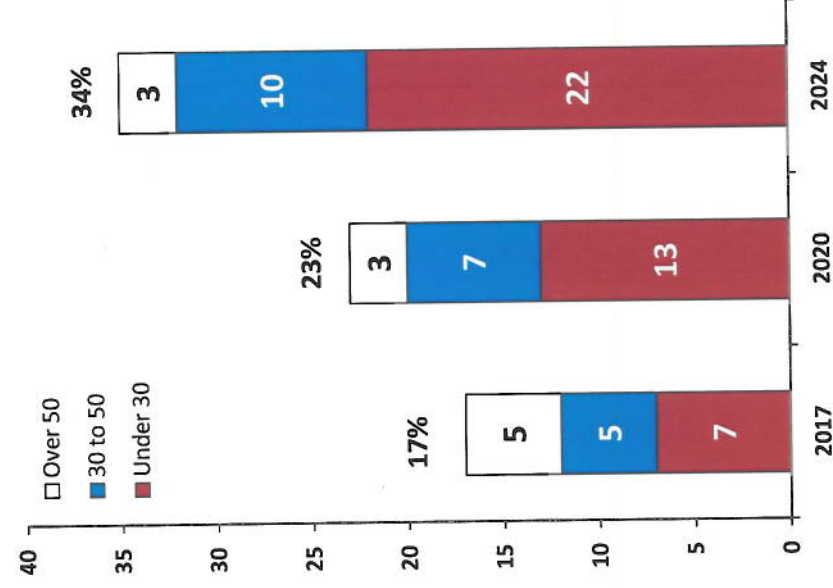
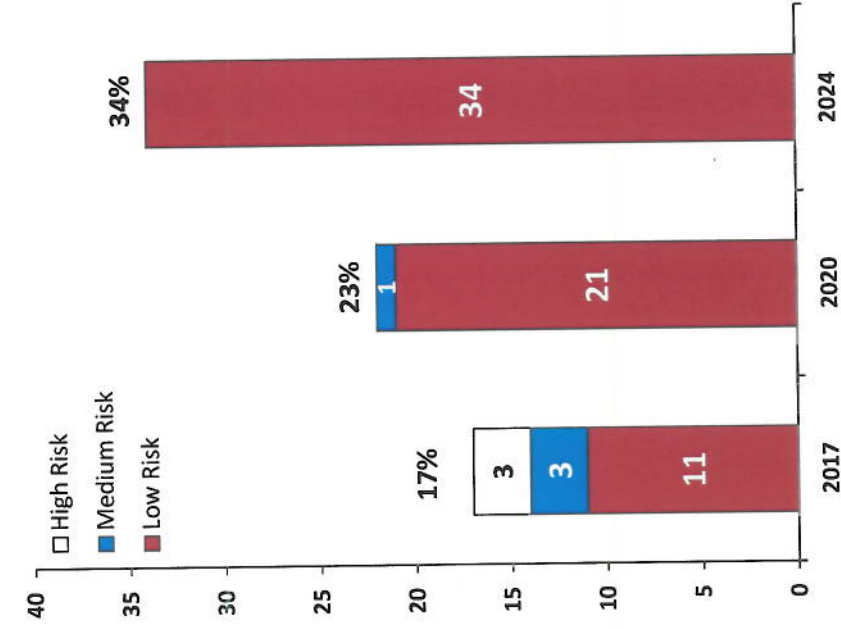
**PRELIMINARY DRAFT**

Scenario premiums are for age 40 and do not include premium assistance under the current law or Consumer Freedom Amendment. Enrollment weighted average contains all ages.

# Individual Market Enrollment:

## Demographic Mix of Non-ACA Compliant Plans - Single Risk Pool

Individual Market Enrollment by risk Individual Market Enrollment by age Individual Market Enrollment by FPL



Totals may differ because of rounding

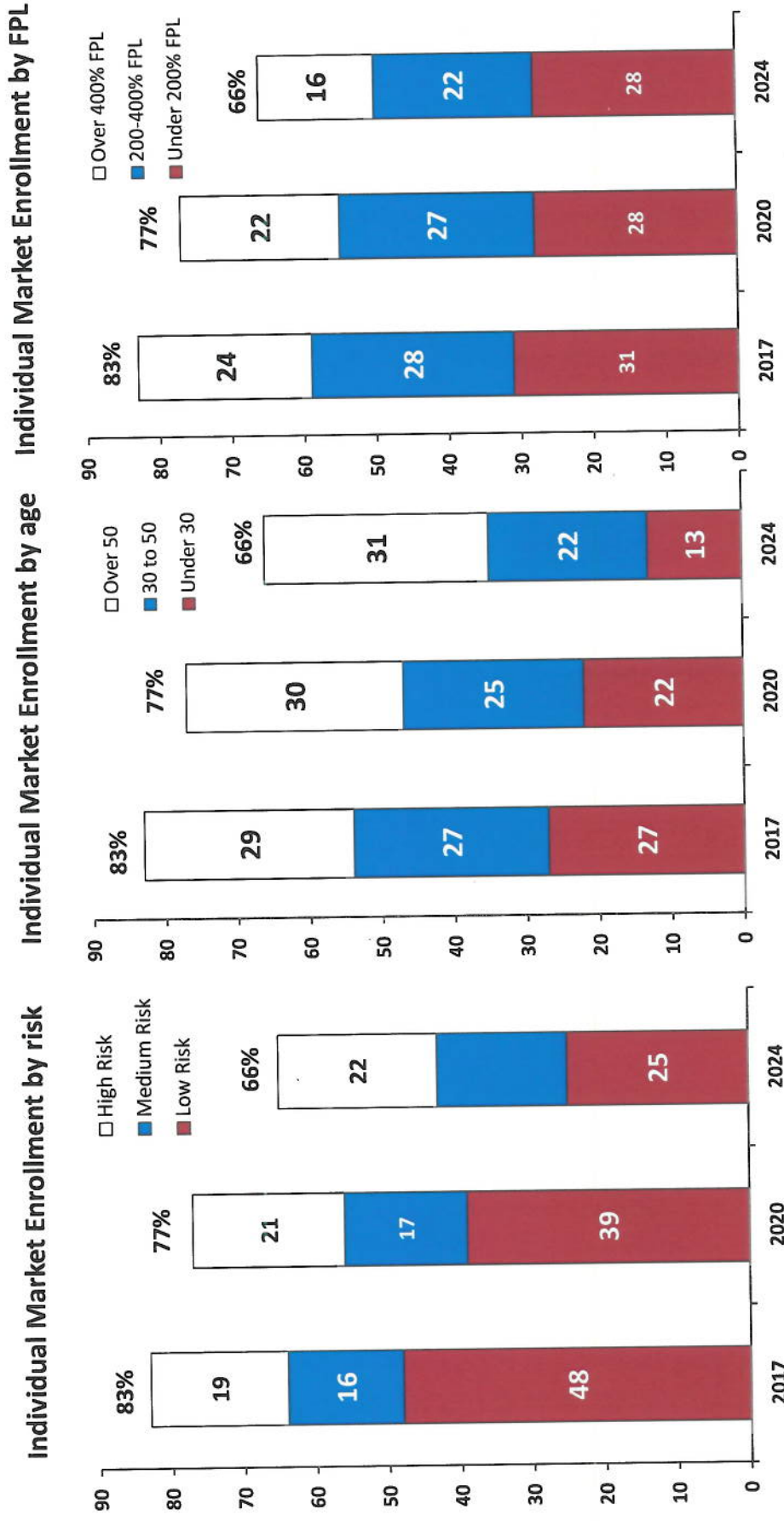


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PRELIMINARY DRAFT

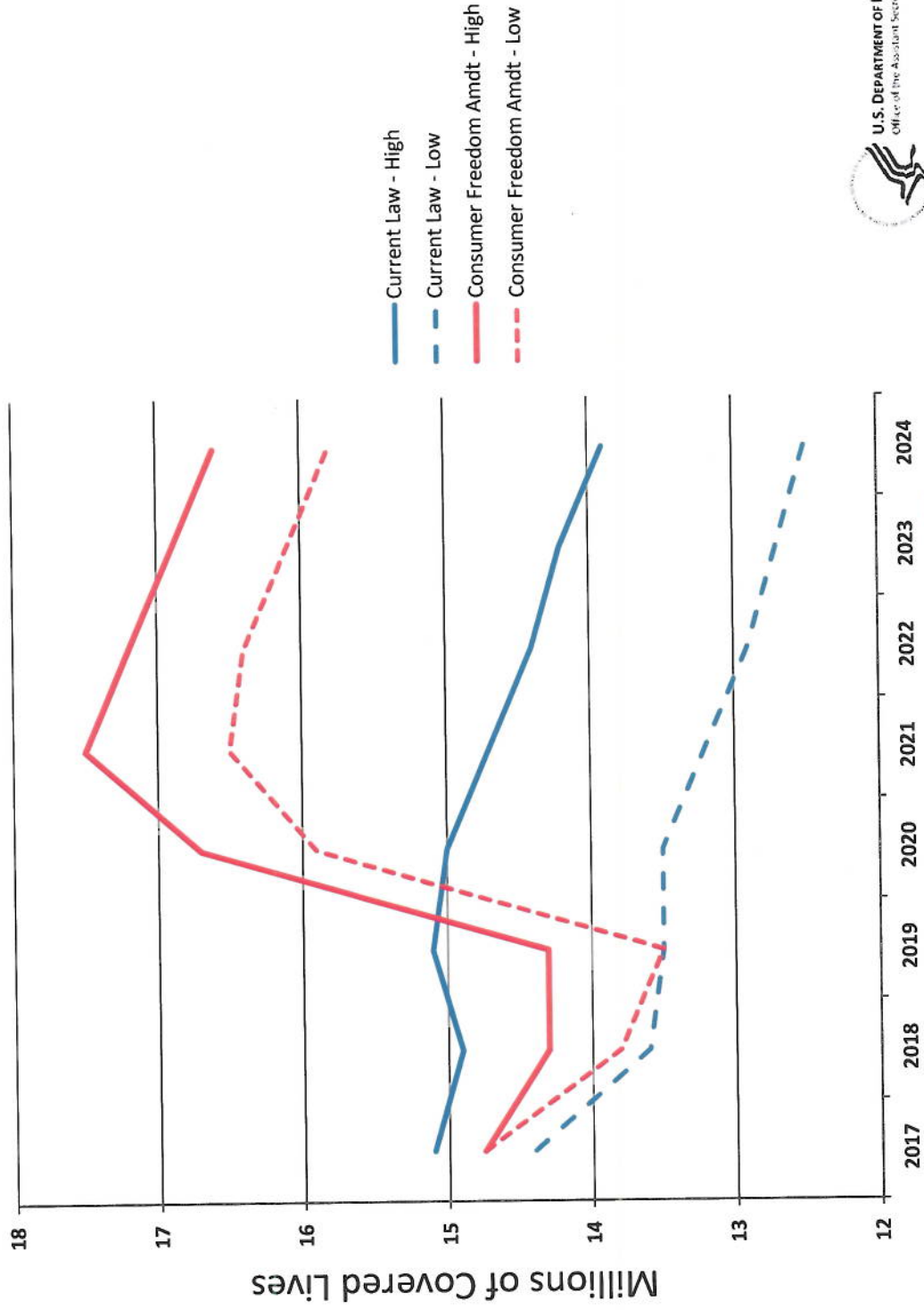


# Individual Market Enrollment: Demographic Mix of ACA-compliant Plans - Single Risk Pool



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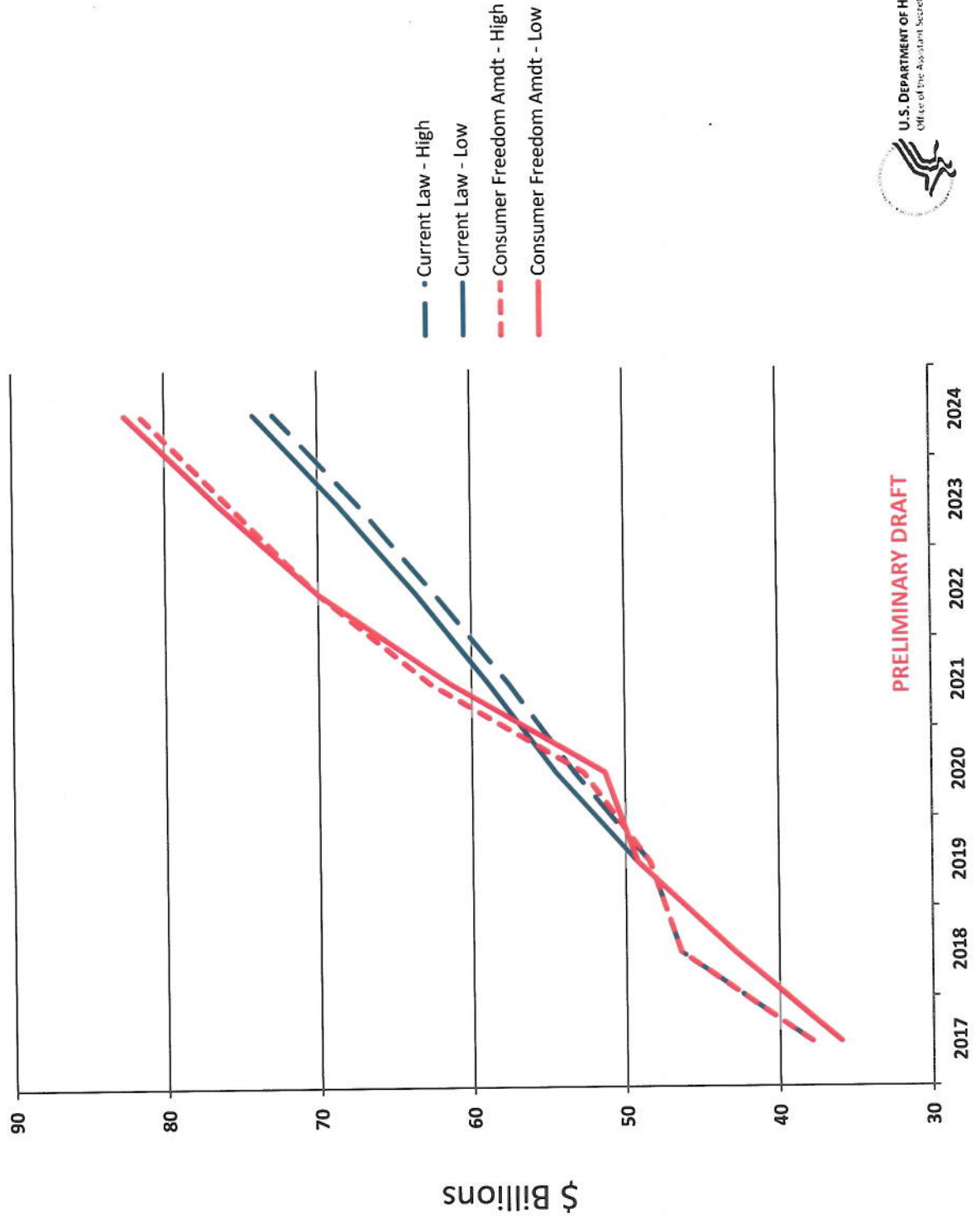
# Total Enrollment - Two Risk Pools



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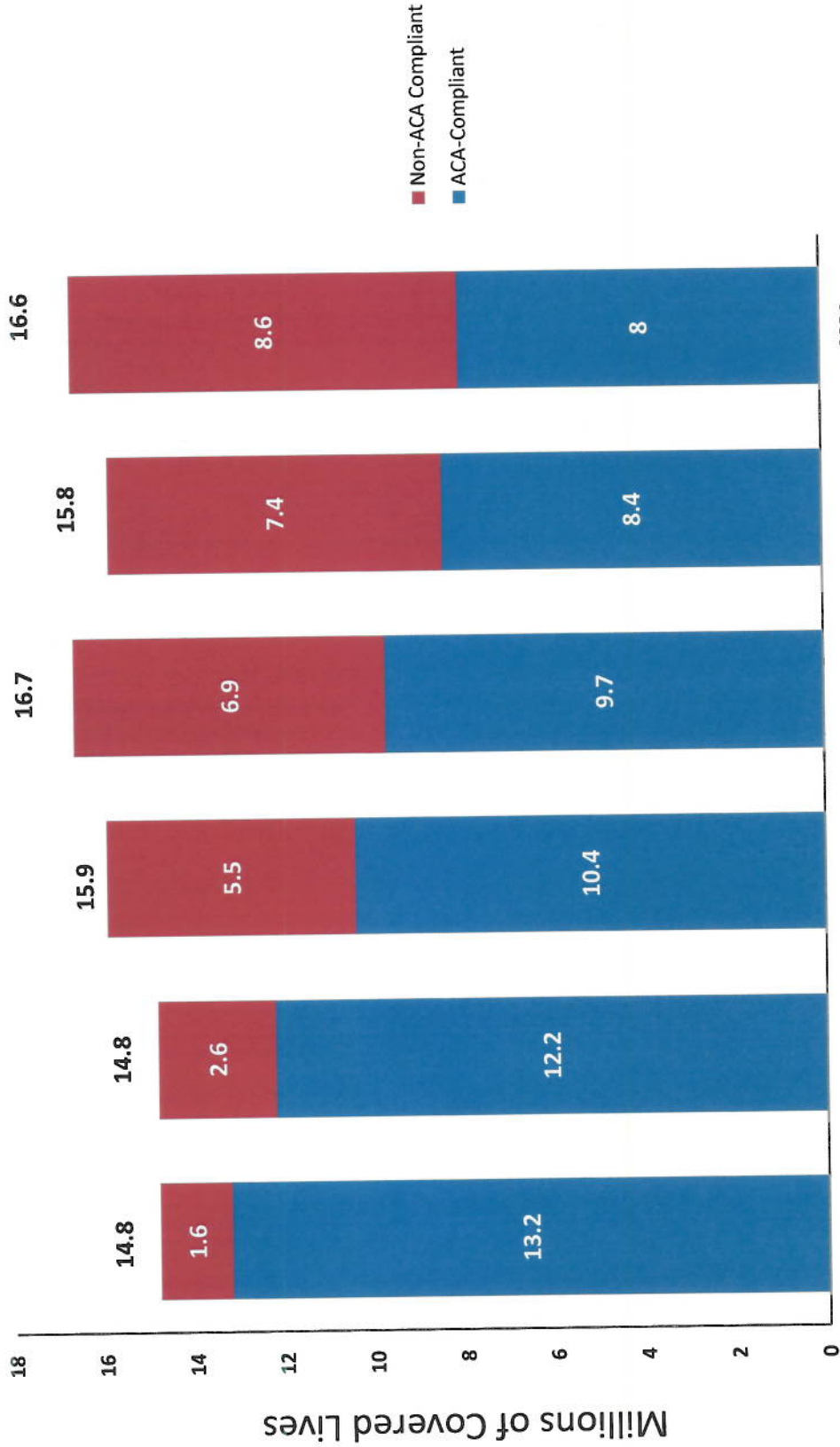
# Federal Outlays

## APTC, CSRs, and Section 301 Funding - Two Risk Pools



PRELIMINARY DRAFT

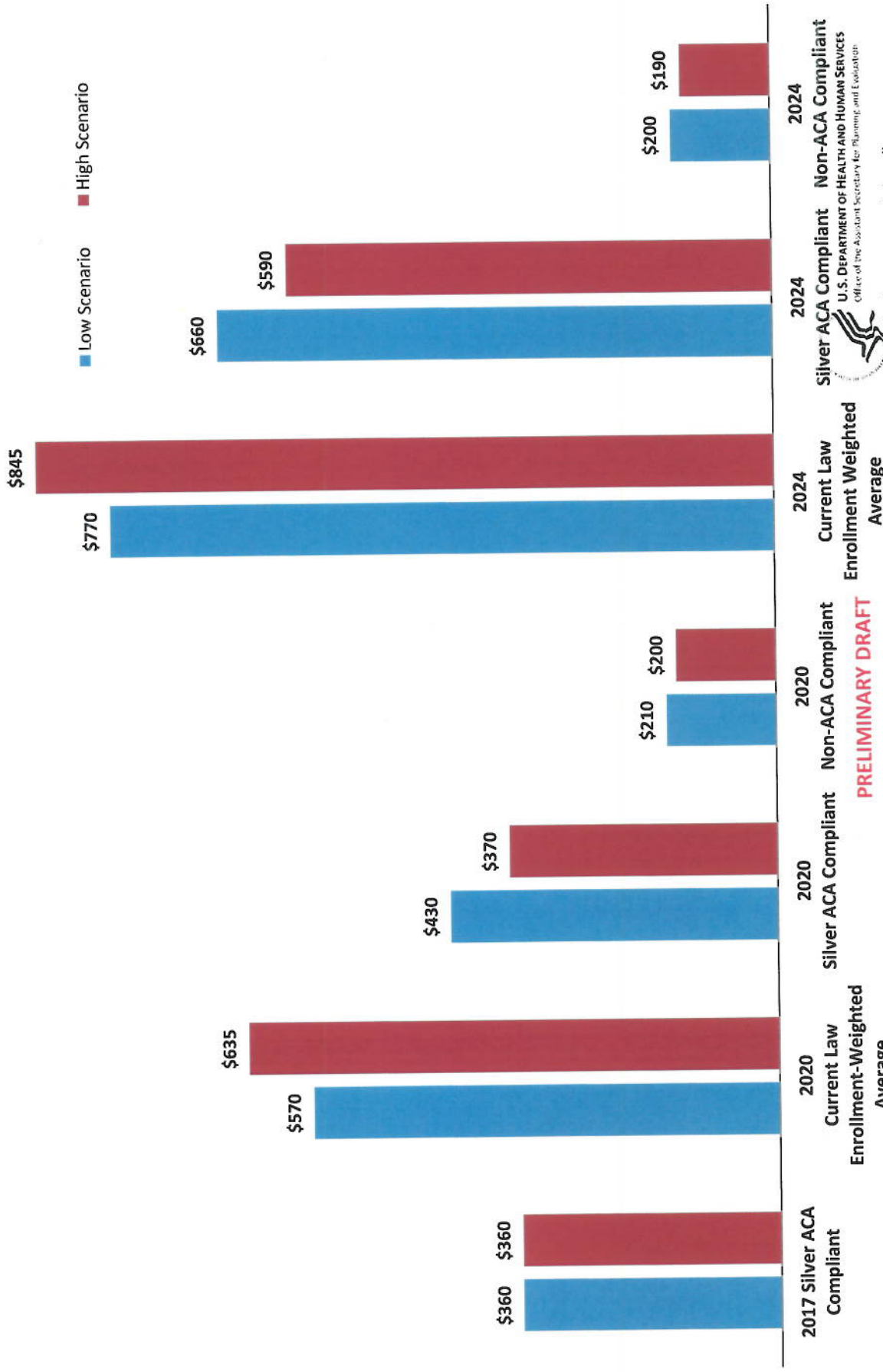
# Individual Market Enrollment: ACA Compliant vs Non-ACA Compliant - Two Risk Pools



**PRELIMINARY DRAFT**

# Individual Market Monthly Premiums

Silver ACA Compliant vs Non-ACA Compliant - Two Risk Pools



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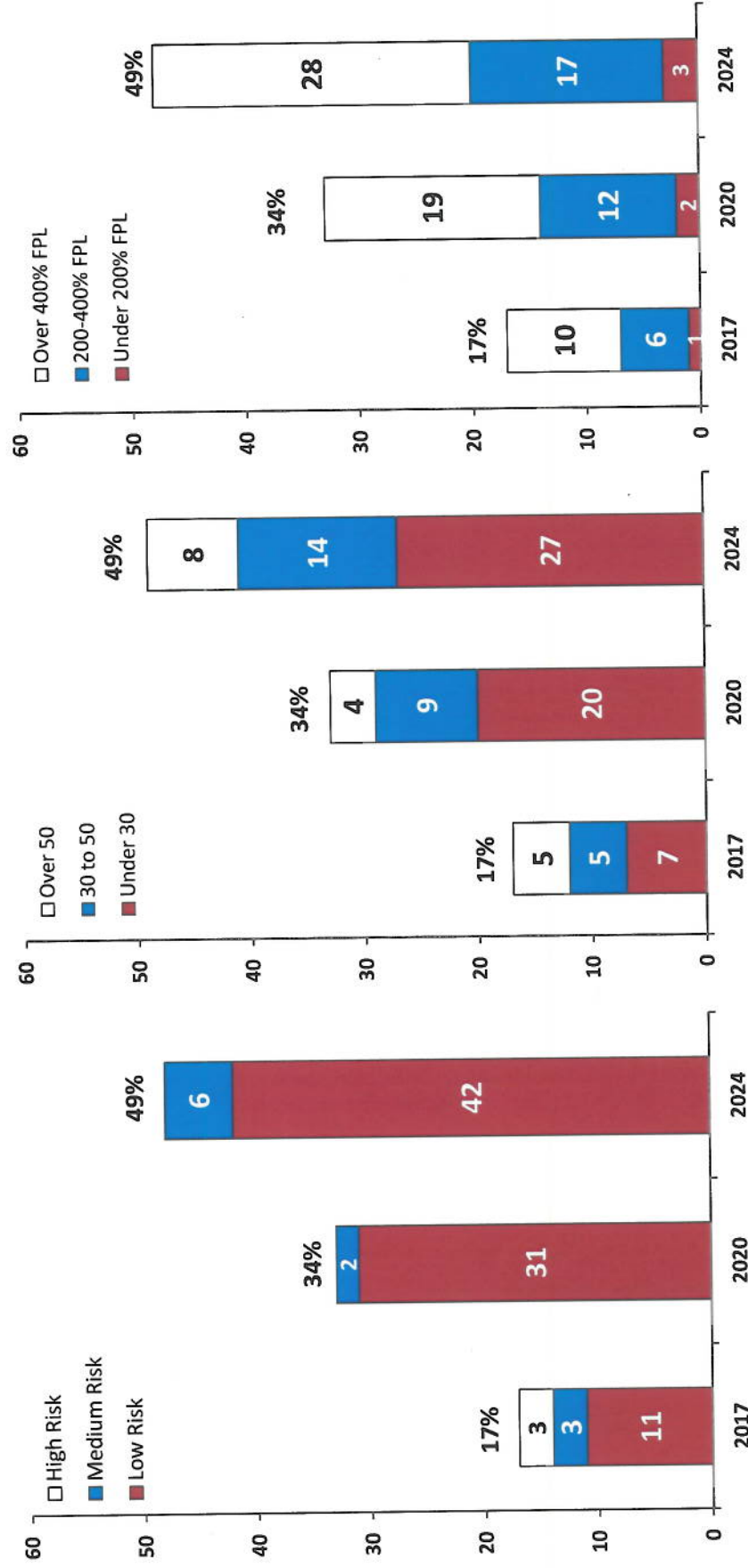
**PRELIMINARY DRAFT**

Scenario premiums are for age 40 and do not include premium assistance under the current law or Consumer Freedom Amendment. Enrollment weighted average contains all ages.

# Individual Market Enrollment:

## Demographic Mix of Non-ACA Compliant Plans - Two Risk Pools

Individual Market Enrollment by risk Individual Market Enrollment by age Individual Market Enrollment by FPL



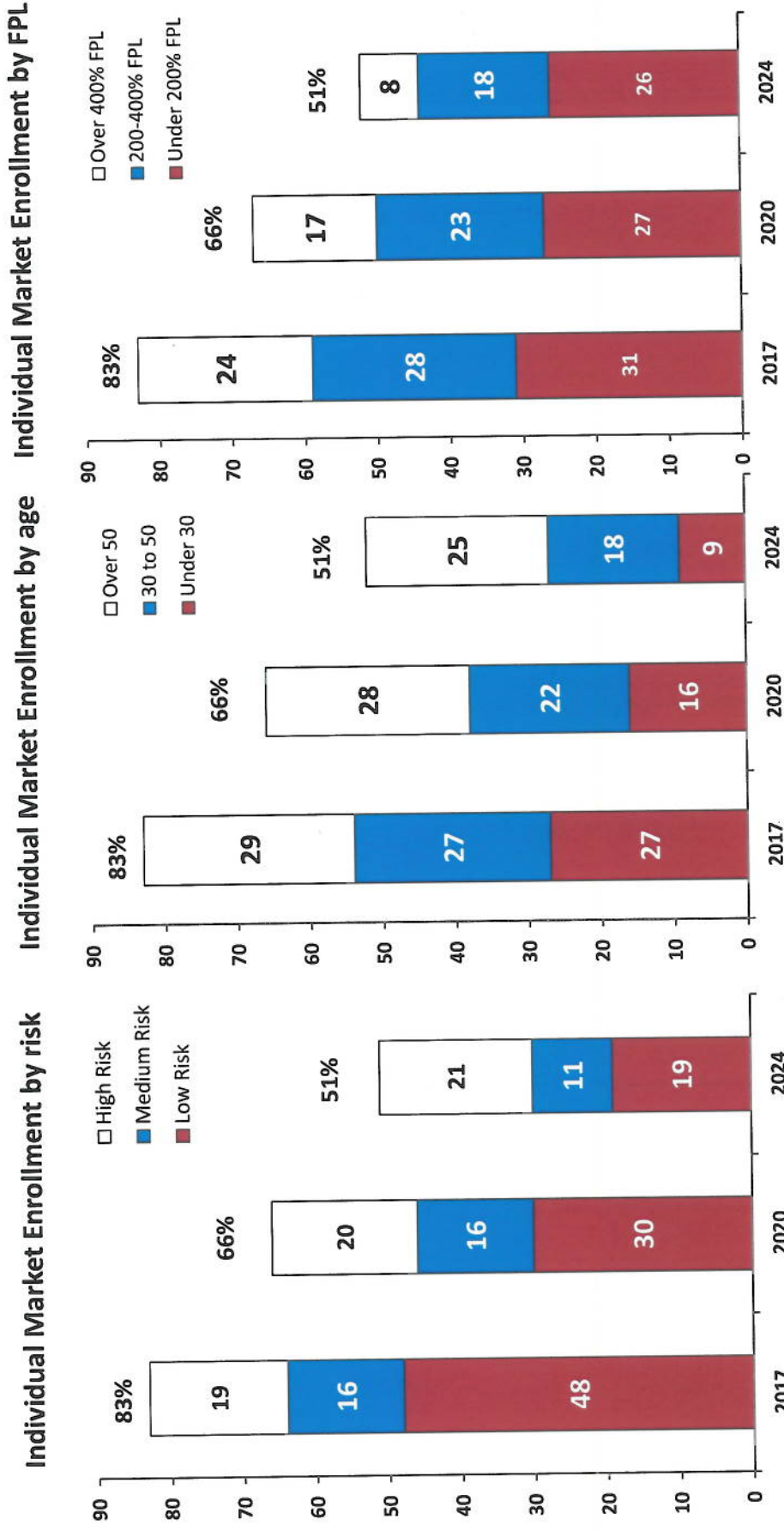
Totals may differ because of rounding



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PRELIMINARY DRAFT

# Individual Market Enrollment: Demographic Mix of ACA Compliant Plans - Two Risk Pools



Totals may differ because of rounding



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PRELIMINARY DRAFT

# Assumptions & Limitations

The range of assumptions behind the modeled scenarios assume all of the details below are true for the model to hold.

- Rules governing the ACA market remain unchanged except for ones explicitly listed below
- In this scenario, it is assumed that an adequate number of issuers offer at least one bronze, silver, and gold qualified health plan, and that all states in 2020 permit all carriers to offer health insurance plans with a lower actuarial value and fewer required benefits without imposing stricter requirements and premium rating rules.
- In years prior to the open sale of non-ACA plans (2017-2019), a 15% lapse rate for non-ACA plans is used
- Range of lives on non-ACA plans in 2017 is estimated to be -2 - 3M
- Modeling is nationwide and assumes all states have a 5:1 age curve, both for ACA and non-ACA plans
- No change in population growth, economic growth, or medical trend
- Price elasticity is determined based on combinations of risk, age, and income
- Probability of enrollees switching between plans is ranged and based on a comparison of out-of-pocket & premium cost difference between a non-ACA plan and ACA bronze plan with higher total cost differentials leading to higher rates of switching
- Non-ACA plan designed with a \$12K deductible and \$12K maximum out-of-pocket limit

## Overall Assumptions

- Health status rating used for non-ACA plans beginning in 2020 in both scenarios
- Federal-level policy change in place to allow for open sale of non-ACA plans, with all states adopting this change and carriers in all markets offering non-ACA plans
- Rating occurs in a single risk pool without risk adjustment between non-ACA plans





# Assumptions & Limitations

## Single Risk Pool Assumptions

- **High total/non-ACA enrollment scenario:**
  - Higher price sensitivity in total cost comparison between ACA and non-ACA plans, leading to higher rates of switching
  - 100% enrollment retention of enrollees who lapse non-ACA coverage from 20 17-2019
  - Higher 2017 starting point of non-ACA enrollment
  - 10% lower claims in non-ACA plans due to EHB reductions
  - \$10B in additional federal funding used as reinsurance in each year 2020-2026
- **Low total/non-QHP enrollment scenario**
  - Lower price sensitivity in total cost comparison between ACA and non-ACA plans, leading to lower rates of switching
  - 50% enrollment retention of enrollees who lapse non-ACA coverage from 2017-2019
  - Lower 2017 starting point of non-ACA enrollment
  - 5% lower claims in non-ACA plans due to EHB reductions
  - No additional federal funding used as reinsurance in each year 2020-2026

## Double Risk Pool Assumptions

- Federal-level policy change in place to allow for open sale of non-ACA plans, with all states adopting this change and carriers in all markets offering non-ACA plans
- Rating occurs in separate risk pools (one for ACA plans and another for non-ACA plans)
- Low enrollment and high enrollment: same as the single risk pool scenario

