February 15, 2017

Lieutenant Governor Nancy Wyman, Chair of the Board
And Members of the Board of Directors of Access Health CT

RE: Connecticut Exchange Adverse Selection Study - Based on 2015 and 2016 Data

Dear Board of Directors of Access Health CT,

Connecticut General Statute § 38a-1084 (25) requires Access Health Connecticut (AHCT) to:

> *Report at least annually to the General Assembly on the effect of adverse selection on the operations of the exchange and make legislative recommendations, if necessary, to reduce the negative impact from any such adverse selection on the sustainability of the exchange, including recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. The exchange shall evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the Affordable Care Act, self-insured plans, plans sold through the exchange and plans sold outside the exchange.*

AHCT retained Wakely Consulting Group (Wakely) to perform the aforementioned adverse selection analysis. The purpose of this memorandum is to summarize the results of our analyses, outline the methodology and assumptions used, and recommend policy options (as needed) to address the impact of potential adverse selection on the operation of the exchange. This document satisfies the ASOP 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

It is important to note that in any insurance market where individuals and/or groups have a choice of coverage, it is impossible to completely remove adverse selection as decisions will generally be made based on a cost benefit analysis. The impact of adverse selection may be mitigated by implementing and enforcing regulations and policies that restrict the ability of enrollees or carriers to engage in risk selection by mandating rating methodologies or limiting alternatives in the market. In particular, for this analysis where AHCT is looking to mitigate negative impacts of adverse selection on the sustainability of the exchange, these policies and regulations should concentrate on the causes of adverse selection that result in materially increasing overall premium rates in the exchange.

In general, we measured risk using morbidity as defined by the federal risk adjustment methodology such that higher risk scores indicate higher morbidity.

Our analysis shows that there are some potential indications of adverse selection in the Connecticut individual health insurance market, and there is less evidence of adverse selection in the small group market due to its limited credibility. Wakely's conclusions are summarized below.

1. For individual non-grandfathered plans, on Exchange plan enrollees have higher average ages and risk scores than off exchange plan enrollees, which indicates potential adverse selection. However, due to the mitigating impacts of the ACA risk adjustment mechanism, we do not believe that this results in any increased premium or other negative impacts on the sustainability of the exchange.

2. The portion of enrollees in grandfathered plans is small and continues to shrink. A review of average reported age and claims experience indicates deterioration in the remaining pool. Due to the dwindling size, policy changes to mitigate any adverse selection impact are not warranted.

3. Small group exchange data is not fully credible by metal tier; therefore, Wakely could not make any conclusions regarding adverse selection in the small group market. This data may be analyzed in future studies as more data becomes available.

4. Because small group data was not fully credible, Wakely considered national self-funded data, to supplement the Connecticut data, but we are not able to conclude whether there is adverse selection in the small group market. This should be closely monitored as more data becomes available to ensure healthier small groups do not move to a self-funded basis leading to adverse selection (i.e., healthier groups opting out of the fully insured risk pool to get lower, experience-based cost options).

5. Wakely recommends considering the following policy changes in order to mitigate the impact of adverse selection.

    a. AHCT should continue to review the special enrollment period (SEP) eligibility requirements for alignment with policies implemented by CMS.

    b. AHCT should encourage exploration of mechanisms, such as 1332 waivers, available to states to stabilize the individual and small group marketplaces.

Finally, the legislative requirement requests recommendations to ensure that regulation of insurers and health benefit plans are similar for qualified health plans offered through the exchange and health benefit plans offered outside the exchange. Since federal regulations (including federal rate filing regulations) are meant to level the playing field between plans on and off the exchange, it is Wakely's understanding that the Connecticut Insurance Department (CID) used the same criteria to review both on and off exchange filings, thereby ensuring similar review and regulation for both on and off exchange plans. Note that Wakely did not do a review of differences in the CID's review processes. If there are differences in CID's review processes, the reasons for the differences should be carefully considered and justified.

BACKGROUND INFORMATION

The following concepts are provided for background information. These concepts are referenced throughout the report.

Adverse Selection: Individuals have more information about their health status than insurance companies do. Individuals using this information to enroll in health insurance plans that are most beneficial to them (or not enroll in health insurance at all if they believe themselves to be healthy) is called adverse selection. For example, consumers who are most in need of health care will be more likely to purchase insurance. Consumers with specific conditions may look for insurance plans that have certain hospitals in network that are known for treating that condition or may look for plans that have more favorable cost sharing for certain services that they are likely to use more often. This is the generally accepted definition of adverse selection. This definition has been complicated through components of the Affordable Care Act (ACA), which is discussed later in the report.

Risk Selection: Risk selection is a topic that is related to adverse selection. It occurs when insurers have an incentive to avoid enrolling consumers who are in worse health and likely to require costly medical care. Under the ACA, carriers are not able to deny coverage or charge higher premiums based on health status, but they may still offer products or structure plan designs in such a way that they are more attractive to healthier individuals or deter individuals with certain conditions.

Federal Risk Adjustment Program: The goal of the federal risk adjustment program is to discourage insurers from trying to enroll members with only certain types of risk (i.e. healthier members). The risk adjustment program transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees. The goal is that insurers will then have to compete on other aspects, such as quality and efficiency, rather than depending on insuring low risk members to remain competitive and sustainable in the marketplace.

All non-grandfathered fully insured plans in the individual and small group markets (both in and out of the exchange) are required to participate in the federal risk adjustment program. However, there are separate risk adjustment calculations for the individual and small group market segments, unless the state chooses to combine them. The program also aims to stabilize premiums on and off the exchange, since non-grandfathered, on and off the exchange fully insured plans are in the same pool for risk adjustment calculations. Risk adjustment is performed separately for catastrophic plans than for the rest of the metal tiers, because catastrophic plans are targeted mostly toward a younger population.

Single Risk Pool: The single risk pool is a provision in the ACA that prevents insurers from segmenting their enrollees and charging higher premium rates to certain groups of members. This provision applies to all non-grandfathered plans on and off the exchange. Each insurer is required

to rate all of its enrollees as a single group when setting premiums, with adjustments only for age, region, family composition, plan, and tobacco use. If an insurer has enrollees inside and outside of the exchange, all of their enrollees must still be treated the same in rating. There are separate single risk pools for individual and small group market segments unless the state chooses to combine the markets. Catastrophic plans are contained in the single risk pool from a rating perspective; however, Centers for Medicare and Medicaid Services (CMS) allows insurers to adjust catastrophic premium rates to reflect the expected demographics, and risk adjustment for catastrophic plans is calculated separately from plans in the metal level tiers.

Grandfathered Plans: Grandfathered plans are health plans that were in existence prior to March 23, 2010, when the ACA was signed into law. There is also a requirement that the plans have not changed in significant ways that decrease benefits or increase costs to policyholders. These plans do not have to follow certain requirements of the ACA, including single risk pool rating and risk adjustment. Typically, enrollees in grandfathered plans are expected to be healthier since the plans do not offer some of the components of ACA that would be desirable to sicker enrollees. Grandfathered plans are not open to new enrollees. For comparison, non-grandfathered plans must generally take all applicants (with few exceptions).

DATASOURCES

Wakely used various data sources to complete this analysis.

- All carriers with more than 500 covered lives in 2015 and 2016[1] (as reported in the NAIC Supplemental Health Care Exhibit) in either the Connecticut individual or small group markets provided the following information to Wakely:
    - 2015 and 2016 risk adjustment transfer reports from the U.S. Department of Health and Human Services (HHS). These are used to identify differences in the reported relative health risk of individuals enrolled in plans available on the exchange compared to those offered only off the exchange.
    - Grandfathered, non-grandfathered, and self-insured membership for 2015, 2016, and mid-year 2017. These are used to identify the size of the grandfathered and self-funded populations in order to identify the potential adverse selection impact of these plans.
    - Plans provided membership weighted by the Federal age curve for evaluation of selection by age on the exchange.
    - Grandfathered, non-grandfathered, and self-insured premiums and claim experience for 2015 and 2016. The experience was used to evaluate loss ratios before and after application of risk adjustment payments.

[1] HealthyCT chose not to respond to the data request or survey this year.

- Carriers were given the opportunity to submit survey responses providing their perspective on actual or potential adverse selection in the market.
- Unified Rate Review Templates (URRTs)[2] are used to identify whether or not plans were offered on the exchange in 2015 and 2016. The URRTs were provided by AHCT or obtained through CMS public use files. The URRTs were also used to identify product type: HMO versus non-HMO.
- The summary reports on risk adjustment transfers[3] released by CMS for 2015 and 2016 were used to verify risk transfer amounts provided by each of the carriers.
- Wakely reviewed 2018 rate filings for carriers with plans on the exchange to identify any indication of adverse selection assumptions built explicitly into the rates.
- HHS Agency for Healthcare Research and Quality's (AHRQ) Medical Expenditure Panel Survey (MEPS) data was used to estimate the proportion of small group market enrollees in self-funded plans.

METHODOLOGY AND RESULTS

In performing this study, Wakely analyzed three types of adverse selection, including: adverse selection between on and off exchange plans, adverse selection between grandfathered and non-grandfathered plans, and adverse selection related to self-funding in the small group market.

In addition, Wakely provided all carriers with the opportunity to participate in a survey to share their perspective on any actual or potential adverse selection in the market. The questions were regarding the three types of adverse selection described above, but also asked if the carriers were aware of any other adverse selection in the Connecticut market. The survey questions can be found in Appendix A. The results from this survey supplemented the quantitative methods that are outlined below. Wakely also reviewed Connecticut's 2018 rate filings for carriers participating on the exchange for indications of adverse selection.

Measures of Adverse Selection

For most components of this study, Wakely measured adverse selection using the definition that a segment of the market may attract enrollees with higher or lower health risk than another segment of the market as measured by higher or lower federally defined risk scores or risk

[2] URRTs are required federal templates filled out by carriers in a single risk pool compliant plan. The template requires carriers to provide information needed to review rate increases and ensure compliance with the single risk pool, allowable market level index rate adjustments to reflect reinsurance and risk adjustment, and other federal rating requirements.

[3] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf and https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf

adjustment transfers. This methodology was used to assess adverse selection between on and off exchange plans and adverse selection between grandfathered and non-grandfathered plans.

This methodology is comparable to how adverse selection was defined prior to the implementation of the ACA. These risk scores may or may not correspond fully to differences in healthcare costs since they depend on the methodology used in the federal risk adjustment model (and any inherent issues with that model in predicting healthcare costs). The risk scores may give an indication of adverse selection; however, they cannot be relied on to conclusively confirm whether adverse selection exists.

An analysis of loss ratios by metal tier and exchange status before and after consideration of risk adjustment was completed to allow for an evaluation of whether potential adverse selection also results in financial imbalance (as defined by loss ratios before and after risk adjustment). For example, one segment may be attracting a riskier population, but they may be receiving adequate revenues through the addition of the federal risk adjustment program.

Adverse Selection Between On and Off Exchange Plans

Wakely defined adverse selection between plans on and off the exchange as the potential for differences in the health risk level for enrollees in plans on the exchange compared to those off the exchange. This may occur either due to differences in the populations that are attracted to plans on versus off the exchange (i.e. federal subsidies are only available to eligible individuals and families that purchase coverage on the exchange) or risk selection on the part of the carriers (while some carriers have plans both on and off the exchange, there are other carriers with plan offerings only off the exchange).

Unless otherwise noted, all data in this section reflects fully insured, non-grandfathered individual data, as the small group data is not fully credible and the grandfathered and self-insured segments are addressed in separate sections.

Table 1a: Individual 2015 and 2016 Billable Member Months by Metal Tier On and Off the Exchange

Metal Tier	2015			2016		
	On Exchange	Off Exchange	Total	On Exchange	Off Exchange	Total
Platinum	12,082	8,746	20,828	16,508	-	16,508
Gold	182,267	196,691	378,958	127,320	191,920	319,240
Silver	635,376	486,902	1,122,278	646,413	419,879	1,066,292
Bronze	224,624	203,629	428,254	213,440	167,369	380,809
Catastrophic	14,184	6,397	20,581	14,508	5,885	20,393
Total	**1,068,533**	**902,365**	**1,970,898**	**1,018,189**	**785,052**	**1,803,241**

The variance in the distribution of member months between on and off exchange plans is shown in Table 1b. We would expect members who are sicker to enroll in higher metal tier plans, while those that are healthier would enroll in lower metal tier plans (with an exception for those eligible for cost-sharing reduction subsidies, who would likely enroll in a silver level plan on the exchange). If there is a significant difference in the distribution between the on and off exchange enrollees, it may be an indication of adverse selection.

There is a slightly higher proportion of on exchange member months in silver plans, which is reasonable due to the availability of cost share reduction plans in this segment.

Table 1b: Individual Member Month Distribution by Metal Tier On and Off the Exchange

Metal Tier	2015 On Exchange	2015 Off Exchange	2015 Total	2016 On Exchange	2016 Off Exchange	2016 Total
Platinum	1%	1%	1%	2%	NA	1%
Gold	17%	22%	19%	13%	24%	18%
Silver	59%	54%	57%	63%	53%	59%
Bronze	21%	23%	22%	21%	21%	21%
Catastrophic	1%	1%	1%	1%	1%	1%
All Tiers	100%	100%	100%	100%	100%	100%

The following exhibits use the plan level risk score (PLRS) to demonstrate selection by metal tier and on vs. off-exchange plans. The PLRS is an element of the federal risk adjustment calculation and reflects the plan's actuarial value as well as the plan's enrollee health status risk (including demographic health risk factors). The PLRS also incorporates the family status where non-billable children impose more risk.

Exhibit 1: Enrollee Selection by Metal Tier and Plan Level Risk Score (PLRS)

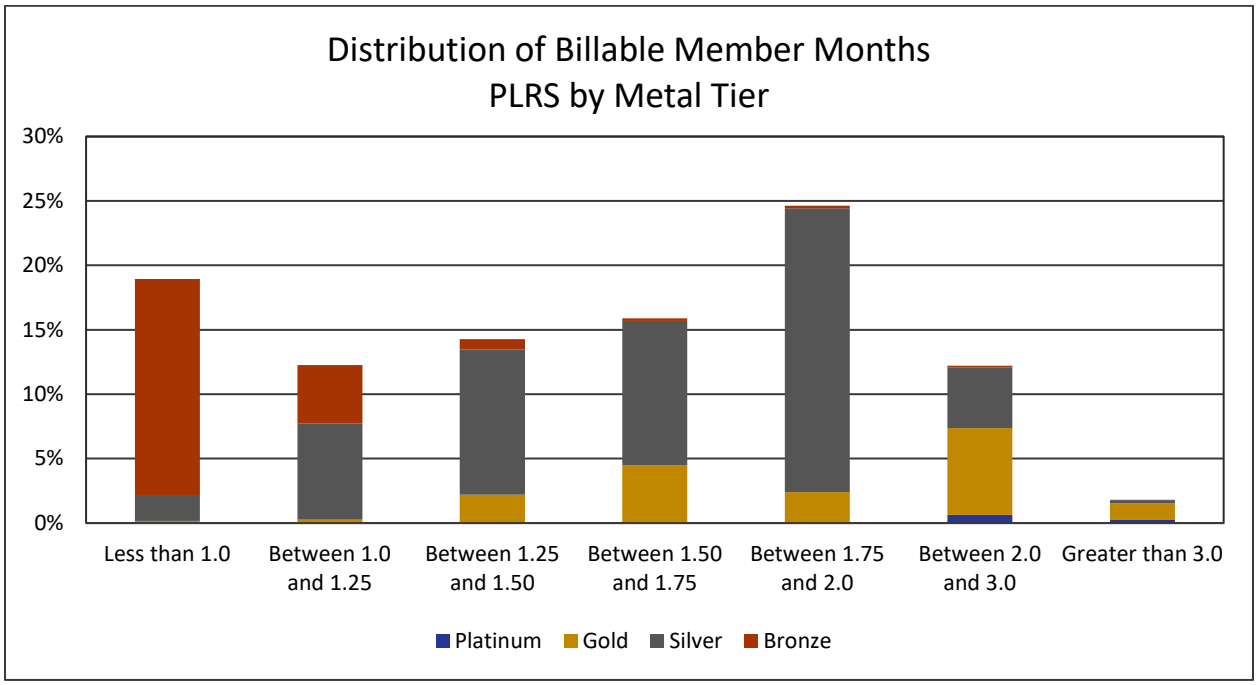
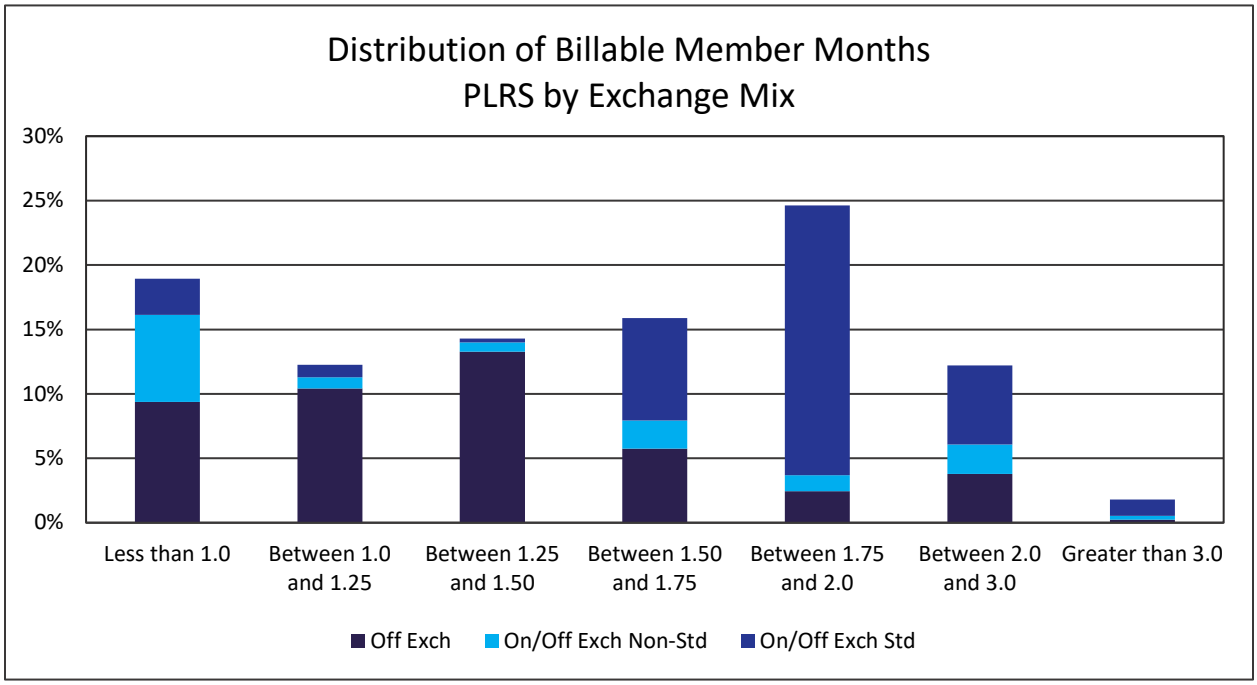


Exhibit 2: Enrollee Selection by Exchange, Plan and Plan Level Risk Score (PLRS)



Wakely also analyzed the HHS risk adjustment transfer data for the 2015 and 2016 Connecticut individual market. Carriers provided Wakely with their risk adjustment transfer reports supplied by HHS. Wakely calculated the total risk adjustment transfer PMPM amounts on and off the

exchange by metal tier using the plan level risk adjustment transfer amounts calculated by HHS. It is important to note that the silver risk scores, and therefore the risk transfers, include a 12% load for members who are enrolled in a 87% or 94% cost-sharing reduction plan variation[4]. This 12% load reflects higher utilization anticipated by enrollees eligible for federal cost sharing reduction subsidies. Wakely thought it appropriate to include this impact, since the federal program assumes that this sector of the population has costs that are 12% higher than the formula otherwise suggests.

Table 2 shows the overall risk adjustment transfer per member per month (PMPM) on and off the exchange by metal tier and product type along with the statewide premium for each risk pool (metals and catastrophic). The transfer payments represent the differences in the risk profiles between the various metal tiers and on and off exchange and are scaled based on the geographic area and induced demand (based on metal tiers) represented within each rate cell. A positive risk transfer PMPM amount represents a net receivable for that market segment (indicating higher health risks), while a negative risk transfer PMPM amount represents a net payable for that market segment (lower health risks). For example, in 2015, for gold on exchange plans, the average receivable was $230 PMPM to each plan. The bronze on exchange plans, however, had an average payable of $162 PMPM. This indicates that gold on exchange plans generally have higher risk enrollees, since they receive a transfer payment while bronze on exchange plans have lower risk enrollees on average, since they disburse a transfer payment. The 2016 risk adjustment transfers show a similar pattern to the 2015 risk adjustment transfers.

Table 2: Comparison of 2015 and 2016 Risk Transfer PMPMs
On and Off Exchange by Metal Tier

Metal Tier	2015			2016		
	On Exchange	Off Exchange	Statewide Premium	On Exchange	Off Exchange	Statewide Premium
Platinum *	♦	♦	$431.05	♦	♦	$438.57
Gold	$230	$68	$431.05	$200	$85	$438.57
Silver	$50	($64)	$431.05	$41	($42)	$438.57
Bronze	($162)	($179)	$431.05	($145)	($150)	$438.57
Total	$38	($44)	**$431.05**	$27	($34)	$438.57
Catastrophic	($6)	$15	$154.27	($32)	$54	$148.39

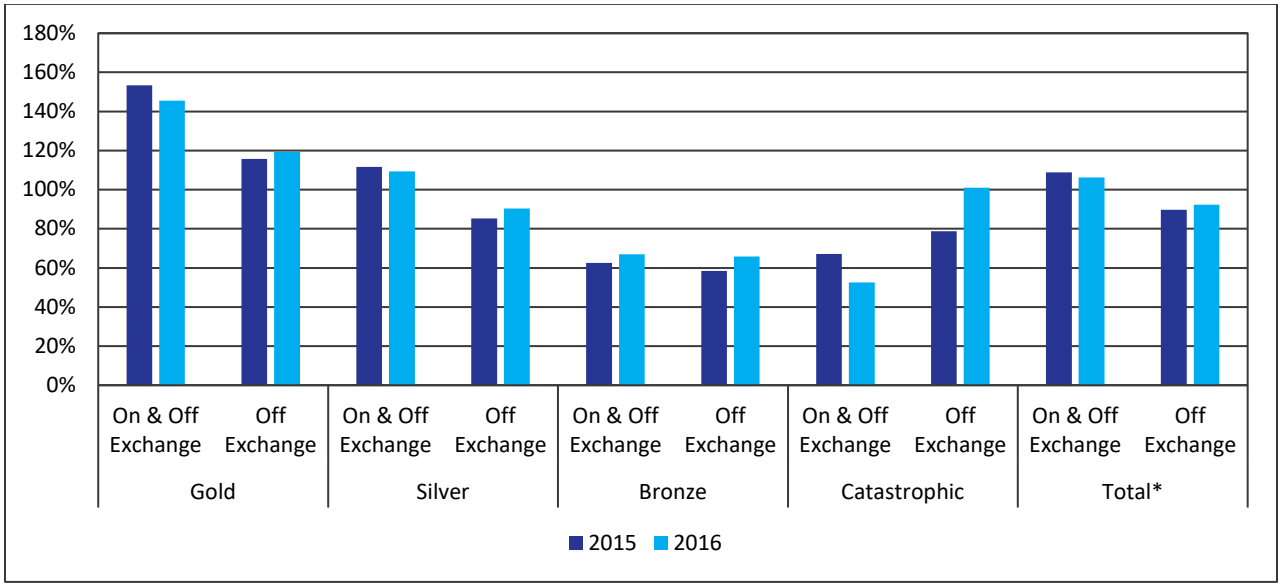
♦ Proprietary information suppressed.

[4] Cost share reduction plans are plans with the same structure as a base silver plan, but they have richer cost sharing components (such as lower deductible, out of pocket maximums, copays or coinsurance) than the base silver plan. Eligible enrollees can buy a cost share reduction plan for the same price as the base silver plan (before premium subsidies are applied) if they have income under 250% of the Federal Poverty Level (additionally CSR variants are available under specific circumstances to American Indians and Alaskan Natives). Cost share reduction plans are offered only on the exchange.

Exhibit 3 compares the transfer for each metal level, product type, and on versus off exchange combination to the statewide premium for the applicable risk pool in order to provide a scale reference for the transfer. Each entry in the "On Exchange" and "Off Exchange" column is the statewide premium including the applicable transfer amount over the statewide premium without the transfer amount. For example in 2016, the gold on exchange entry is the sum of the gold on exchange transfer of $200 and the statewide premium of $438.57 divided by the statewide premium of $438.57, or [$200 + $438.57] / $438.57 = 146%.

Exhibit 3 also provides a metric for comparing the risk transfer on the exchange to the risk transfer off the exchange by metal tier and in total. Overall, members enrolled in plans offered on the exchange (excluding catastrophic plans) have higher risk in 2015 and 2016 (measured by the risk adjustment formula relative to the statewide premium) than enrollees in plans offered only off the exchange. This indicates that there may be adverse selection between enrollees who purchase coverage on the exchange compared to off the exchange at various metal levels. However, there are wide variations by metal level and product type. For example, the bronze and catastrophic plans offered on the exchange have a lower risk than those offered only off the exchange, indicating that within the lower metal tiers, there may be adverse selection in the opposite direction (i.e., against the off exchange plans).

Exhibit 3: Comparison of 2015 and 2016 Risk Transfer PMPM Amounts to Statewide Premium



*Represents non-catastrophic plans only.

The silver plans have higher risk (measured by the risk adjustment formula relative to the statewide premium) on the exchange than off the exchange. Due to the 12% cost share reduction load that is built into on exchange silver plans in the risk adjustment scores, it is reasonable that the on exchange metric is higher than that off the exchange. However, the risk of the enrollees in

the silver on exchange plans would be higher even if the cost share reduction load were excluded. Although the off exchange risk is lower than on exchange, it is difficult to argue that it has a negative impact to the on exchange premium or sustainability. In fact, the risk adjustment mechanism results in a transfer from the off exchange plans to the on exchange plans, reducing the on exchange revenue requirement and maintaining the sustainability of the exchange.

Since the risk transfer payments are designed to balance each plan's risk, it is important to demonstrate whether the mechanism is achieving the desired purpose. Exhibit 4a and Exhibit 4b summarize loss ratio before and after the impact of the risk adjustment transfers, reflecting the estimated net revenue impact. Only those carriers whose survey data was at the required level of detail or who had data available in the URRT public use files are included in the tables. The values presented in Exhibit 4a and 4b do not reflect transitional reinsurance payments, cost-sharing reconciliation payments or risk corridor payments available during each year.

Exhibit 4a: Comparison of 2014 and 2015 Loss Ratios before Risk Adjustment Transfers (Paid Claims/Premium)

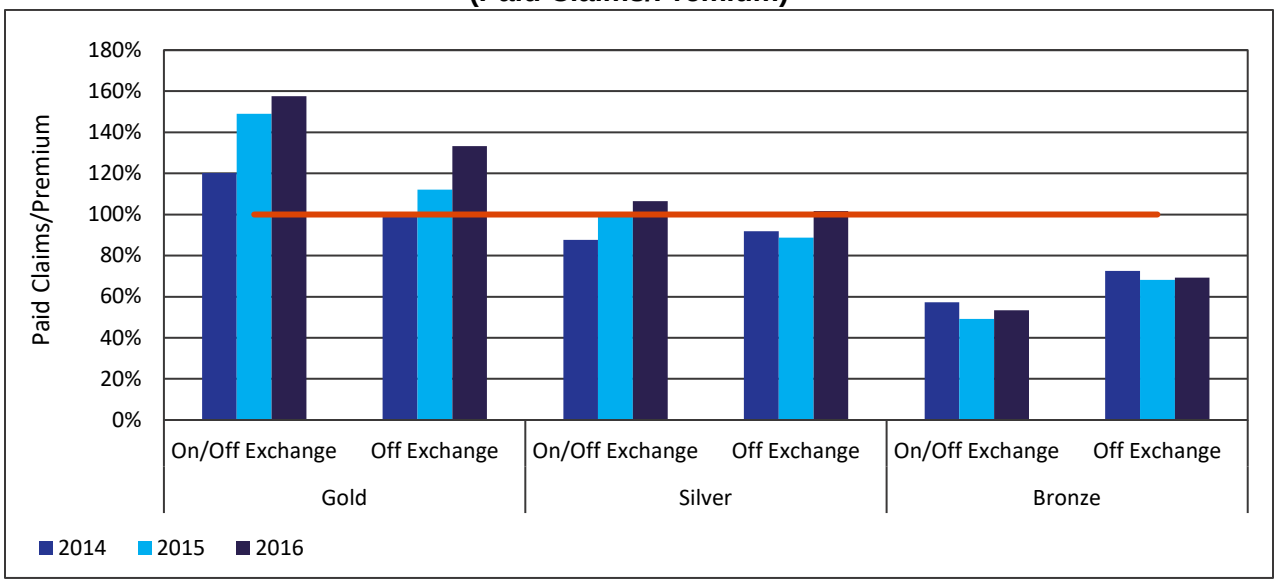
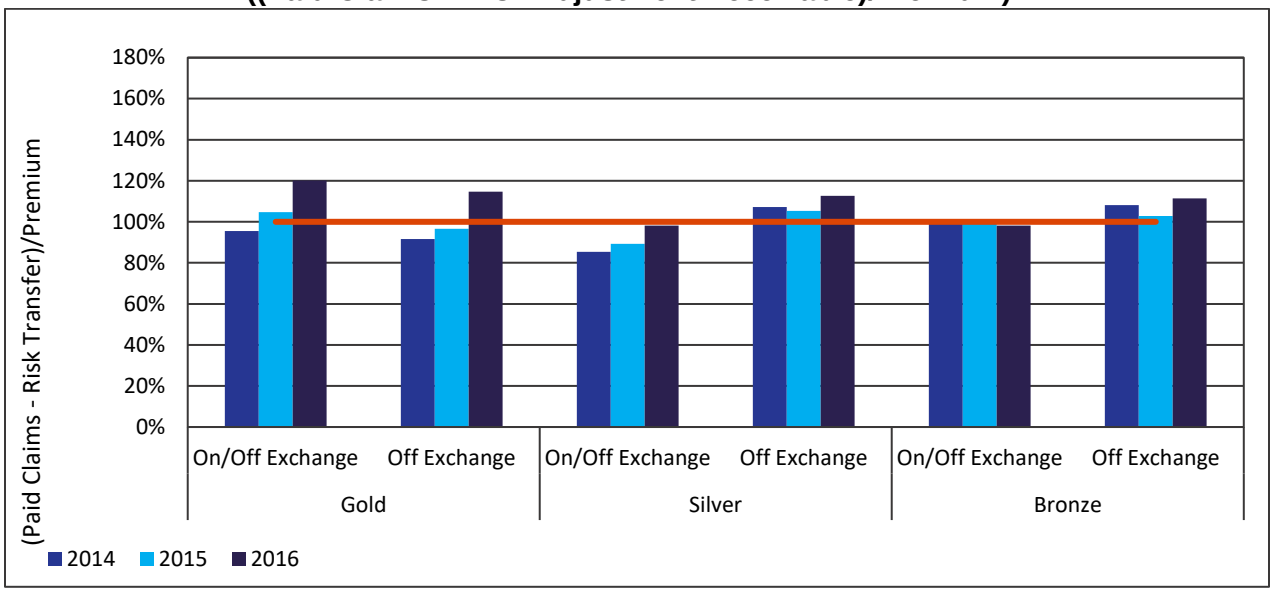


Exhibit4b: Comparison of 2014 and 2015 Loss Ratios after Risk Adjustment Transfers ((Paid Claims – Risk Adjustment Receivable)/Premium)



From Exhibits 4a and 4b, one may observe the relative smoothing impact of the risk adjustment transfer payments on the adjusted loss ratios. Bronze plans initially viewed as performing well, are performing much worse upon consideration of transfer payments.

The most important observations from Exhibit 4b is that although off exchange plans have a lower average risk from Exhibit 3, on a net risk adjustment basis they perform worse. Although not demonstrable with the data detail available, this is in part likely due to the preferential 12% load for cost share reduction silver plans on the exchange.

One component of the risk adjustment formula is demographics. Carriers indicated in the past that the average age for on exchange plans exceeded those off exchange. For 2015-2017, carriers provided membership weighted by the Federal age curve. The variation in Table 3 supports observations that a portion of the higher risk identified in Exhibit 3 is due to enrollees with higher average ages enrolling on the exchange. The variation in average age may also be a driver of the variance in profitability observed on versus off exchange as the risk adjustment transfer formula favors older enrollees.

Table 3: Comparison of Weighted Average Federal Age Factor[5] (For Non-Catastrophic Metal Tiers)

Time Period	On Exchange	Off Exchange	Ratio of On Exchange to Off Exchange
2015	1.786	1.595	112%
2016	1.781	1.615	110%
Mid-2017	1.811	1.627	111%

SMALL GROUP

Due to the very low portion of small group membership enrolled on the exchange in 2015 or 2016 (approximately 2,000 enrollees in all metal tiers or less than 1% of total enrollment), the comparison between on and off exchange markets would not be a credible indicator of adverse selection in the small group market. This comparison may be performed in future years as more data becomes available and assuming increased on exchange enrollment.

Although Wakely cannot confirm that adverse selection exists between on exchange and off exchange small group business, the lack of small group enrollment on the exchange is a sustainability issue that should continue to be examined outside the context of adverse selection. It is our understanding that there may be regulatory differences between on and off exchange small group markets that may need to be addressed (e.g. employee choice), which make off exchange programs more attractive.

SURVEY RESPONSES

In the survey, carriers were asked the following question:

> *Do you believe that there is adverse selection between members selecting on exchange plans and off exchange non-grandfathered plans? If so, what do you believe is driving the adverse selection? Are there any policy solutions you would recommend to mitigate adverse selection?*

All carriers on the exchange responded that they were seeing adverse selection between on exchange and off exchange plans. However, carriers were not consistent in how they are seeing adverse selection in their experience. Carriers said that experience was showing on exchange members having an older average age and higher risk scores than off exchange members, which could be due to differences in health status for members who are eligible for premium subsidies

[5] The average age factor is based on the 2018 Federal age curve.

and cost share reduction subsidies compared to those not eligible. Carriers expressed that individual mandate penalties and the risk adjustment program continue to be the best defense against adverse selection. Unfortunately, with the passage of the December 20, 2017 Tax Bill, Congress set the individual mandate penalty to $0 starting in 2019, making it meaningless and raising concerns for increased selection in the future.

In spite of this, carriers overwhelmingly said that the risk adjustment program does not completely account for each carrier's risk. Carriers' critiques and comments on the current federal risk adjustment program included the following:

- The determination of relative risk is based on an inefficient model and subject to the accuracy (or inaccuracy) of each carrier's data.
- The changes made to the risk adjustment program in the 2018 Notice of Benefit and Payment Parameters to include durational factors and pharmacy indications in the risk adjustment program formula is supported by carriers. Other formulaic changes suggested for the small group market which tends to be less transient are transferability of risk scores as enrollees or groups move from carrier to carrier or exclusion of new groups during initial enrollment years from the calculation.
- The federal risk adjustment process tends to be inefficient with greater focus on chronic conditions as opposed to acute conditions.
- In general, the risk adjustment program only captures variance in risk profiles of carriers and can't address the issue of overall selection in the market.
- Carriers recognized this as a very complicated issue that lacks a perfect solution.

Wakely Conclusions and Recommendations

The on and off exchange markets have a similar distribution of enrollees by metal tier which does not indicate adverse selection. The responses from the carrier survey also indicate that there may be adverse selection between enrollees on the exchange and off the exchange.

Because the distribution of enrollment by PLRS and the overall risk transfers indicate that the risk profile of the on exchange members are higher, Wakely's conclusion is that adverse selection is likely present between the off and on exchange markets. However, when considering the mixed results by metal tier and the mitigating impacts of risk adjustment which prevent wide premium rating variation between on and off exchange, we do not believe that adverse selection is negatively impacting the sustainability of the exchange.

However, based on the concerns with the federal risk adjustment program discussed above, Wakely recommends that Connecticut participate with other states and carriers to lobby for improvements in the federal risk adjustment formula to continue to improve its accuracy since all states are using the federal risk adjustment model (starting in 2017). Improving the risk

adjustment program may reduce the impact of adverse selection between on and off exchange plans and across carriers. The risk adjustment program will not help mitigate overall selection driven by factors such as the weakening of the individual mandate and increasing barriers to entry driven by higher premiums.

Adverse Selection between Grandfathered and Non-Grandfathered Plans

Adverse selection between grandfathered and non-grandfathered plans occurs when individuals in grandfathered plans (who are typically healthier and lower cost than the average individual market enrollee) remain in their grandfathered plan rather than move into a non-grandfathered ACA-compliant plan because it is in their best financial interest to do so. If the grandfathered plan enrollees were to enroll in a non-grandfathered plan (or if grandfathered plans were terminated either due to state regulation or the choice of the carrier), there would likely be some improvement to the non-grandfathered individual market risk pool.

QUANTITATIVE ANALYSIS

To identify potential adverse selection between grandfathered and non-grandfathered plans, Wakely began by analyzing enrollment reports received from the carriers to identify the remaining grandfathered business in the individual and small group markets.

Wakely collected grandfathered and non-grandfathered enrollment data for 2014, 2015, 2016 and mid-2017 from each carrier with 500 or more members.

As of 2017, only a very small number of lives continue to be enrolled in grandfathered plans in the individual market. The carriers did not report any remaining grandfathered enrollment in the small group market. The summarized results are shown in Table 6.

Table 4: Grandfathered Enrollment as a Proportion of Total Reported Enrollment in the Individual Market by Year

Time Period	Grandfathered Enrollment	Total Enrollment	Proportion Grandfathered
2014	34,857	134,741	25.9%
2015	4,769	173,424	2.7%
2016	793	155,864	1%
Mid-2017	738	145,207	1%

Based on the diminished enrollment as of mid-year 2017, we expect that moving the remaining grandfathered plans into QHP plans will likely have a negligible impact on the overall risk in the individual risk pool.

SMALL GROUP

Small group plans did not have any remaining grandfathered enrollment in the market as of June 2017 based on the data collected from the carriers. Therefore, Wakely did not analyze the impact of adverse selection due to grandfathered plans in the small group market.

WAKELY CONCLUSIONS AND RECOMMENDATIONS

Wakely does not recommend any changes in policy to address the adverse selection related to individual grandfathered plans. This recommendation is based on the following:

- The portion of grandfathered enrollment in the Connecticut individual market is small and will continue to decline.
- The effort to gain an understanding of the relative risk and adverse selection of the grandfathered membership specific to Connecticut is immense, requiring carriers to submit detailed data for risk analysis purposes.

However, Wakely recommends that Connecticut consider sun-setting the availability of grandfathered plans, as the time and cost of maintaining operations and reviewing rates for a business segment with such a small membership likely does not make economic sense.

Adverse Selection Related to Self-Funding in the Small Group Market

Self-funding in the small group market is an approach where employers assume all or some of the risk of covering the costs of their employees' medical needs. This is different from a fully insured environment where the employer pays a fixed cost per covered member to the carrier and the carrier assumes the risk of medical claims. Adverse selection can occur when groups with healthier employees choose to self-fund, which takes them out of the small group single risk pool. It can result in higher costs for groups in the single risk pool if a significant number of healthier groups implement this approach.

QUANTITATIVE ANALYSIS

Wakely summarized changes in the prevalence of self-funding among small employers, both in Connecticut and nationwide, based on the HHS Agency for Healthcare Research and Quality's (AHRQ) Medical Expenditure Panel Survey (MEPS) to identify the potential for adverse selection related to self-funding in the small group market. In addition, Wakely reviewed the 2018 on exchange small group rate filings, on one carrier referenced explicit adjustments for adverse selection. However, given the limited availability of data related to the self-funded market, it would be difficult to obtain sufficient data to quantify the premium impact of self-funding on the small group market. We believe, however, that significant increases in small group self-funding will be a good indicator of potential adverse selection.

Using MEPS sample data, Wakely derived the number of enrollees in self-funded small group plans from 2012 to 2016. In addition, Wakely derived the proportion of enrollees in self-funded plans compared to enrollees in all small group plans from 2012 to 2016 to provide a scale reference for changes in the number of enrollees. Both of these measures were used to give an indication of whether there is the potential for material adverse selection in the small group market due to self-funding. If the number of enrollees in self-funded small group plans has been increasing, that may be an indication of adverse selection. It is important to note that the following results are based on survey data that is extrapolated to statewide statistics. In some cases, the sampling methodology used in MEPS may not be credible, as noted below.

Table 5 contains the derived enrollee count from 2012 to 2016 in self-funded small group plans with fewer than 50 employees in Connecticut. The enrollee count from 2012 to 2013 stays relatively consistent; however, from 2013 to 2014, there is an increase in self-funded small group enrollees of 68% based on the survey results. 2015 results were significantly outside the range or responses and determined to not be credible. 2016 levels compared to 2014, increased by 1%.

Table 5: Estimated Enrollees in Self-Funded Small Group (<50 Employees) Plans in Connecticut
(Derived from MEPS)

Time Period	Enrollee Count	Trend
2012*	23,812	
2013*	21,893	-8%
2014	36,677	68%
2015*	Not Credible	
2016	37,185	1%**

* May not be derived from a credible sample.
**2016 over 2014 trend.

In addition, Wakely used the MEPS data to derive the percentage of small group enrollees that were in self-funded small group plans in each year. The results in Table 6 show that a similar proportion of small group enrollees were in self-funded plans in 2012 and 2013, however, the proportion increased significantly in 2014 and maintained similar levels through 2016 based on the surveyed sample.

Table 6: Percent of Enrollees in Self-Funded Small Group (<50 Employees) Plans Compared to All Small Group Plans in Connecticut (Derived from MEPS)

Time Period	Percent of Small Group Enrollees in Self-Funded Plans
2012*	20%
2013*	16%
2014	32%
2015*	39%
2016	31%

*May not be derived from a credible sample.

The combination of these two tables indicates a potentially large increase in the number of self-funded small group plans corresponding with the implementation of the ACA. However, the MEPS results indicate that the Connecticut data for 2012, 2013, and 2015 do not meet the standard for reliability or precision, so it is difficult to know the accuracy of these three years of data in determining the impact of adverse selection.

On a national basis (which is considered credible), MEPS data shows there are not large changes in the number of enrollees in self-funded small group plans or the proportion of enrollees in self-funded small group plans (compared to all small group plans) from 2012 to 2016. This indicates that there may not be adverse selection in self-funded small group plans nationally. However, since some states have implemented regulations regarding stop loss insurance levels, the transition of groups to self-funding arrangements in those states could be mitigated. In addition, other insurance dynamics may vary across states, causing the data to be not comparable or applicable to the Connecticut market.

For perspective, we pulled NAIC Supplemental Health Care Small Group filings from 2011 to 2016. Lives covered by small group health insurance has been declining over the years in Connecticut. The cause may be attributed to either a) small group plans transitioning to self-funded or b) small group plans leaving the marketplace completely.

Table 7: Small Group Supplemental Health Care Exhibit – Connecticut[6]

	2011	2012	2013	2014	2015	2016
Number of Certificates or Policies	133,247	123,026	119,984	96,878	91,160	87,241
% Change in Certs. Or Policies		-7.7%	-2.5%	-19.3%	-5.9%	-4.3%
Number of Covered Lives	260,533	239,565	222,503	187,757	172,724	163,266
Member Months	3,207,238	2,958,769	2,745,579	2,490,710	2,119,959	1,884,148

As discussed previously, self-funded small group plans are generally not subject to state health insurance regulation. They are also not subject to several requirements of the ACA, including that premium rating be based on the single risk pool concept. Because the small group market under the ACA requires plans to be rated under a single risk pool, while self-funded plans are allowed to reflect the employer's specific risk, it is assumed that self-funded plans will attract low risk groups while high risk groups will select ACA-compliant small group plans.

In addition, employers that self-insure frequently reduce their risk by purchasing reinsurance. Even if the employer has generally healthy employees, a single catastrophic claim can strain the employer. Reinsurance (or stop-loss insurance contracts) protect against catastrophic claims by covering claim costs that exceed a set amount (called an attachment point). This can be either for a single enrollee or for aggregate claims over a set period. Unless prohibited by state law, a stop-loss insurer can offer insurance policies to self-funded plans with very low attachment points. In this situation, the stop loss insurer assumes nearly all of the employer's claims risk. If stop loss insurance is not adequately regulated, it can cause adverse selection because a self-funded plan with a low attachment point is essentially a fully insured product, but because it is self-funded, it is allowed to set premiums based on health status and claims experience. If a state has adequate stop loss insurance regulation, fewer small groups may be willing to self-fund, since they would have to take on more of the risk of their employees' health care costs.

SURVEY RESPONSES

In the carrier survey, Wakely asked the following questions:

> *Have you seen any adverse selection related to the enrollment in the self-funded market versus the fully-insured small group market? If so, please describe and provide any suggestions as to how the adverse selection could be reduced.*

[6] Data Source: S&P Global Market Inelligence

Carriers indicated that there is an increased interest in the small group market for self-funding, however; the size of the market in Connecticut is relatively small. The self-funded market does have the ability to attract favorable risk groups via underwriting for health status. If small group participation in the self-funded marketplace grows it has the potential to drive market place selection pulling healthier groups out of the fully insured market.

WAKELY CONCLUSIONS AND RECOMMENDATIONS

Due to the credibility issues with the Connecticut-specific MEPS results, the question of whether the national MEPS statistics are representative of the Connecticut market, and the carriers not indicating the impact of adverse selection in the self-funded market, Wakely is unable to conclude whether there is potential adverse selection in the self-funded market. However, carrier responses indicate that self-funding is not yet a concern in Connecticut. Wakely recommends that Connecticut closely monitor the small group market for trends toward self-funding and consider implementing regulation in order to mitigate any potential adverse selection in the small group market.

Additional Issues Impacting Adverse Selection

Special Enrollment Periods

In the carrier survey, Wakely asked the following questions:

Early last year tighter restrictions were introduced on special enrollment period (SEP) enrollment. Have you seen a change in enrollment in 2017 and 2016 from these changes? Are there other changes to SEP enrollment you would suggest to address adverse selection?

In past years, several carriers indicated that the most significant issue affecting adverse selection are special enrollment periods (SEP)[7]. Carriers expressed that experience (i.e., health risk) is significantly worse for those members enrolling during the SEP compared to the open enrollment period (OEP). SEPs allows individuals to enroll in a plan outside the annual open enrollment period if they indicate they have had a change in circumstances (e.g., having a baby, marriage, loss of other health coverage).

AHCT has responded to these concerns last year by requiring that individuals provide proof of a qualifying reason instead of using "self-attestation" for certain qualifying life events. Qualifying

[7] The special enrollment period is a time period outside of open enrollment in which people can sign up for health coverage following certain qualifying life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage.

events may include: (1) Marriage (2) Birth, adoption, court ordered coverage of a child, or having a foster child placed in the home. (3) Relocation to Connecticut from another state or outside of the country. (4) Loss of other minimum essential coverage including the following situations such as change in employment or change in employer coverage, divorce, expiration of COBRA, or change in eligibility for Medicaid or CHIP.

With almost a year of experience under the new rules, carriers are reporting mixed results on the impact of reductions in SEP enrollment. Concerns were raised that continued uncertainty regarding the enforcement of the individual mandate creates instability and the potential for continued SEP issues.

Carriers expressed that it would also be beneficial if the exchange (or CID) could reduce the number of SEP-triggering events to more closely align with Medicare Advantage and employer-based coverage. Additional solutions suggested are the inclusion of a requirement to maintain coverage through the year or establishing waiting periods[8] delaying the start of coverage for a period of time after a qualifying event. Lastly, it is suggested that SEP coverage eligibility be limited to the newly eligible only for certain qualifying events and not the entire family, for example births and adoptions.

Legislation and Regulatory Guidance

Association health plans, short-term insurance, and HRAs

On October 12, 2017, President Trump issues an Executive Order covering association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs). The executive order provided no firm orders or mandates for action other than to consider and propose regulation. At the writing of this report, regulatory guidance on Association Health plans [9](AHP) has been proposed but not finalized. Under the proposed regulation, associations of employers or self-employed individuals could form an AHP for the purpose of purchasing insurance. These AHPs would not have to comply with individual or small group market ACA regulations. The inclusion of the self-employed as eligible for AHP is a significant change to Employee Retirement Income Security Act (ERISA) law. Historically AHPs have had a troubled past. For example, the American Academy of Actuaries notes that AHPs have had a history of insolvencies.[10] Under the proposed regulation, states will continue to retain some authority over AHPs, however it is possible that a state's regulatory efforts could be limited if it is inconsistent with the new federal guidance or if the final regulations changes. For example,

[8] At this time waiting periods would not be allowable under current regulations.

[9] https://www.gpo.gov/fdsys/pkg/FR-2018-01-05/pdf/2017-28103.pdf, released January 5, 2018, with comment period open until March 6, 2018.

[10] https://www.actuary.org/content/association-health-plans-0

the proposed regulation notes that a state could have a minimum benefit requirement for large group plans, which would apply to AHPs.

With the introduction of AHPs, healthier risks who could benefit from underwriting and exclusion from the single risk pool could result in a deterioration of the remaining ACA markets. The American Academy of Actuaries has noted that the proposed regulation could result in adverse conditions[11]. The impact of expanded availability of short-term insurance and expanded use of HRA funds is unknown pending regulatory guidance however it is possible these regulations could increase adverse selection in the ACA markets. [12]

CSR Payments Announcement October 2017

While not in the executive order, in October 2017 the White House announced it would end cost sharing reduction (CSR) payments immediately. CSRs are payments made to insurers to reimburse them for the required reduced cost-sharing for enrollees enrolled in cost-sharing variants. Eligibility for cost-sharing variants is generally limited those enrollees who select a silver tier qualified health plan (QHP) through an exchange and have household incomes between 138% and 250% of the federal poverty level (FPL) in Connecticut. Carriers opted to file 2018 rates with the assumption the CSR's would not be paid.

Individual Mandate December 2017

The Tax Bill that passed on December 20, 2017, in which the individual mandate was restated to a 0% or $0 penalty, essentially eliminating it for 2019. The elimination of the penalty will have a significant negative impact on the overall market selection, driving increasing premiums and possibly limiting market participation to the subsidized population.

Other Issues or Business Strategies

As part of the adverse selection study, Wakely sent out a carrier survey (included in Appendix A) to gauge whether there are any other issues or business strategies in the market that may result in adverse selection, and whether the carriers had any suggested solutions to address these issues.

In the carrier survey, Wakely asked several questions requesting feedback on how legislative uncertainty may be driving selection in the marketplace.

Carriers did not express any concerns regarding the 2018 shortened enrollment period, most felt it would be a benefit to have enrollment completed earlier to ensure effectuated enrollment for January 1. Carriers stated they have observed contraction in the individual marketplace, either

[11] Ibid

[12] https://www.actuary.org/files/publications/Executive_Order_Academy_Comments_110717.pdf

driven by the perceived weakening in the penalty (prior to legislative action setting it to $0 for 2019) or the disparity in the penalty and the premiums.

On- versus off-exchange migration has been observed over past years, likely driven by premium increase differentials. Further migration is anticipated in response to premium rate change differentials driven by CSR defunding.

Only one responding carrier indicated a concern that increasing premiums and cost-sharing may drive unsubsidized healthy enrollees to opt out of the marketplace. This would result in spiraling cost in the marketplace that may not be sustainable. This is further accentuated by voluntary and non-voluntary carrier exits from the market that add to uncertainty in the marketplace.

A few carriers suggested strengthening the individual mandate penalties and/or apply pre-existing condition waiting limits for those with gaps in coverage. It was also suggested that the individual penalty could take the format of penalties similar to Part D, where the penalty increases the longer accessing coverage is delayed.

Some carriers also identified third-party payments as a marketplace issue. Although CMS limits third-party payments and the inappropriate steerage of Medicare and Medicaid beneficiaries into the individual market, consequences imposed by CMS to date have not been an adequate deterrent.

In addition to the above responses regarding selection in the marketplace, we asked carriers the following questions about other modifications that could be made to the Connecticut ACA marketplace:

> *Many States across the country are pursuing changes to their ACA programs through the application for 1332 waivers. Are there any particular 1332 waiver solutions that you feel Connecticut should further explore to enhance market stability?*

Carriers expressed support for an exploration of 1332 waiver programs that would reduce premiums and stabilize the market. Most suggested a reinsurance-type program either traditional or risk-based similar to the Alaska waiver.[13] Most seemed receptive to exploring an approach that would combine state funding with federal pass-through funding to create a reinsurance program. The source of any state funding will be a focus as assessments against the market the program is designed to help would not be desirable.

[13] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf

Caveats and Limitations

The following issues were considered out of scope for the project and were not taken into consideration:

- Any analysis related to dental or other non-medical coverage
- Data collection or analysis related to markets other than individual and small group
- Analysis beyond the study years (2015 and 2016)
- Calculation of risk scores from claim data
- Audit or cleaning of carrier data
- Adverse selection across carriers

Transitional policies (non-grandfathered policies in place in 2013 that were allowed to renew in some states into 2016), were not allowed in Connecticut, so they were not considered as part of this analysis.

Wakely only collected summary level risk adjustment and enrollment data for carriers that had more than 500 covered lives in 2015 and2016. This limitation is expected to have a negligible impact on results.

The 2012, 2013 and 2015 MEPS data for Connecticut were marked by AHRQ as not meeting the standard for reliability or precision, and therefore the results of the analysis using the data should be considered with caution.

Adverse selection can be measured in a number of ways. Wakely defined adverse selection by comparing risk metrics, risk adjustment transfers, and loss ratios before and after risk adjustment payments in various segments of the market to determine whether segments were attracting higher or lower risk. Different approaches may result in conclusions that vary from those included in this report.

Responsible Actuary. Julie Andrews and Brittney Phillips are the actuaries responsible for this communication. Julie is a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. Brittney is a member of the American Academy of Actuaries and an Associate of the Society of Actuaries. Both meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the use of AHCT to discuss the potential impact of adverse selection on the operations of the exchange and fulfill the legislative reporting requirements as stated in C.G.S. §38a-1084(25). Wakely does not intend to benefit third parties and assumes no duty or liability to those third parties. Any third parties receiving this work should consult their own experts in interpreting the results. This report, when distributed, must be

provided in its entirety and include caveats regarding the variability of results and Wakely's reliance on information provided by Connecticut carriers and AHCT.

Risks and Uncertainties. The assumptions and resulting estimates and conclusions included in this report are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuary is financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent from AHCT and any Connecticut carrier.

Data and Reliance. Wakely relied on information supplied by AHCT, the health plans and publicly available sources in this assignment. We have reviewed the data for reasonableness but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. Any errors in the data will affect the accuracy of the analysis and the conclusions drawn in this report. When performing financial and actuarial analyses on the current data, assumptions must be made where there is incomplete data. Improvements in data will allow for more accurate analyses and consistent reporting.

Subsequent Events. There are no known relevant events subsequent to the date of information received that would affect the results of this report.

Contents of Actuarial Report. This document and the supporting exhibits constitute the entirety of the actuarial report and supersede any previous communications on the project. This report is provided to AHCT to discuss the potential impact of adverse selection on the operations of the exchange and fulfill the legislative reporting requirements as stated in Connecticut Public Act No. 11-53 section 25. Any other use of this report may not be appropriate. Wakely does not intend third parties to rely on this report for any other purpose than considering the potential impact of adverse selection in the 2015 and 2016 Connecticut health insurance markets and assumes no duty or liability to parties other than AHCT who use or receive this work. This report should only be reviewed and considered in its entirety.

Deviations from ASOPS. Wakely completed the analysis using sound actuarial practice. To the best of our knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.

Should you have any questions, please feel free to call to discuss.

Sincerely,

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Appendix A

Survey Questions Sent to Carriers

1. Do you believe that there is adverse selection between members selecting on exchange plans and off exchange plans? If so, what do you believe is driving the adverse selection? Are there any policy solutions you would recommend to mitigate adverse selection?

2. Do you feel that the federal risk adjustment program adequately accounts for adverse selection? If not, do you have suggestions for how the program could be improved to adequately account for adverse selection?

3. Have you seen any adverse selection related to the enrollment in the self-funded market versus the fully-insured small group market? If so, please describe and provide any suggestions as to how the adverse selection could be reduced.

4. Early last year tighter restrictions were introduced on special enrollment period (SEP) enrollment. Have you seen a change in enrollment in 2017 and 2016 from these changes? Are there other changes to SEP enrollment you would suggest to address adverse selection?

5. Have you seen any change in attrition patterns, potentially as a result of changes in perception of mandate enforcement?

6. Are there concerns that the shorter enrollment window for 2018 will impact selection?

7. The ongoing uncertainty over the funding of cost-sharing reduction (CSR) payments continues to be a concern for the industry across the country. State have taken widely variant positions on the approach to this uncertainty for 2018 rate filings. How would you like to see Connecticut accommodate plans for unfunded CSR payments? Under the current environment, what is your greatest concern regarding CSR payments?

8. There is general uncertainty in the country regarding health care and recent legislative attempts at repeal & replace. Have you seen any unexpected spending patterns (e.g. higher than expect Rx spend – i.e. hoarding) that may be driven by this uncertainty?

9. Many States across the country are pursuing changes to their ACA programs through the application for 1332 waivers. Are there any particular 1332 waiver solutions that you feel Connecticut should further explore to enhance market stability?

10. Have you seen any changes in off-exchange enrollment in the individual market?

11. There has been some reporting that small businesses who dropped small group coverage in favor of individual coverage are now shifting back to the small group market. Have you noticed this pattern, is this a potential concern in the small group market?

12. In your opinion, are there any other issues or business strategies in the market that may be impacting adverse selection? Do you have any suggested solutions to address these issues?