January 11, 2016

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 2014 Data

Dear Board of Directors of Access Health CT,

Connecticut statute, C.G.S. §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.

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 can 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—higher risk scores indicating higher morbidity.

With only one year of experience, it is difficult to conclude definitively whether there is adverse selection in the market that is negatively impacting the exchange. Our analysis showed that there may be some indications of adverse selection in the Connecticut individual health insurance market and there is less evidence of adverse selection in the small group market. Wakely did see some potential indications of adverse selection in the analysis, based on the definition of adverse selection as

differences in morbidity as measured by the federal risk adjustment methodology. Wakely's conclusions are summarized below.

1. For individual non-grandfathered plans, on exchange plan enrollment has higher average risk scores than off exchange plan enrollment, 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. Enrollment in individual grandfathered policies appears to continue to experience favorable selection. Since the portion of enrollees in grandfathered plans is small and expected to continue shrinking, policy changes to mitigate any adverse selection impact are likely 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. Data indicates that there may be adverse selection resulting from an increase in the Connecticut self-funded small group market; however, the data is 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 consider changes to the special enrollment period (SEP) eligibility requirements, such as considering stricter requirements for members during the SEP and establishing a mechanism to allow for termination of enrollment in the case of misrepresentation or fraud.

    b. Improving the risk adjustment program may reduce the likelihood of risk selection between on and off exchange plans. Wakely recommends that AHCT participate with other states and carriers to lobby for improvements in the federal risk adjustment formula to improve its accuracy. An second, less practical option would be to consider the possibility of implementing a state-specific risk adjustment program. While state-specific risk adjustment has some advantages, such as allowing for recognition of cost differences by state, the administrative complexity and cost relative to the opportunity for program improvement has been prohibitive for most individual states to undertake. To date, we are only aware of one state that has fully implemented a state-specific risk adjustment program at a cost of more than four million dollars.

c. Connecticut may want to consider fully implementing a stop loss insurance regulation similar to the National Association of Insurance Commissioners (NAIC) model stop loss insurance regulation (or a modified version of it) in order to limit the adverse selection that may occur due to migration of small groups to self-funded plans.

6. 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 will be 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 will be 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 individual 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 idea 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).

DATA SOURCES

Wakely used various data sources to complete this analysis.

- All carriers with more than 500 covered lives in 2014 (as reported in the NAIC Supplemental Health Care Exhibit) in either of the Connecticut individual and small group markets provided the following information to Wakely:
    - 2014 carrier risk adjustment transfer reports from the U.S. Department of Health and Human Services (HHS). These were 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.

  - Monthly grandfathered and non-grandfathered membership from January 2014 through June 2015. These were used to identify the size of the grandfathered population in order to identify the potential adverse selection impact of grandfathered plans.

- 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)[1] were used to identify whether or not plans were offered on the exchange in 2014. The URRTs were provided by AHCT.
- The summary report on risk adjustment transfers[2] released by CMS was used to verify risk transfer amounts provided by each of the carriers.
- Wakely reviewed 2016 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.
- Proprietary Wakely data was used to assess the health risk of enrollees in grandfathered plans compared to enrollees in non-grandfathered plans on a national level.
- The NAIC Stop Loss Insurance Model Act was reviewed as a potential recommendation to mitigate risk segmentation in the small group market.

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

[1] 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.

[2] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

also reviewed Connecticut's 2016 rate filings for carriers participating on the exchange for indications of adverse selection; however, we did not identify any indications or mention of adverse selection (other than those related to the expansion of the small group market to include groups with 51 – 100 employees, which was not ultimately implemented).

Measure 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/risk 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.[3]

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).

[3] After implementation of the ACA, other metrics may be more appropriate to assess adverse selection in the market than pure risk scores, since the ACA includes provisions to mitigate adverse selection. These include new rating requirements (such as guaranteed issue coverage and single risk pool rating) and a new risk adjustment program that compensates issuers that enroll a higher proportion of individuals with high cost conditions. Other metrics such as analysis of loss ratios by metal tier or exchange status after consideration of risk adjustment may be a more appropriate way to gauge adverse selection. 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. Another indication of adverse selection may be variances in risk above what carriers are paid for through allowable rating factors in addition to federal risk adjustment transfers. However, obtaining the additional data to perform such an analysis is a significant undertaking. Since Wakely is currently only analyzing one year of data for indications of potential adverse selection, the additional complexity of this method was not deemed necessary. Wakely will discuss with AHCT what the best approach is for completing future analyses.

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.

Quantitative Analysis

As a first step in analyzing potential adverse selection between on and off exchange plans, Wakely considered the distribution of Connecticut members in the different metal tiers on and off the exchange in 2014 using data provided from the carriers.

The data represented in the "On Exchange" column of Table 1a are plans offered on the exchange, but includes enrollees in the same plan if purchased off the exchange. The data represented in the "Off Exchange" column are non-grandfathered, fully insured plans offered only off the exchange.

As can be seen in Table 1a, approximately 62% of 2014 member months are in plans offered on the exchange. In addition, there are no platinum plans offered on the exchange. Generally, the highest risk enrollees will choose platinum plans. Since there are only platinum plans off the exchange, this may contribute to adverse selection off the exchange.

Table 1a: Individual 2014 Member Months by Metal Tier On and Off the Exchange

Metal Tier	On Exchange	Off Exchange	Total
Platinum	-	2,525	2,525
Gold	149,059	75,002	224,060
Silver	457,960	266,351	724,311
Bronze	97,451	75,703	173,153
Catastrophic	8,663	14,712	23,375
Total	713,133	434,293	1,147,425

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.

The on exchange (which includes members enrolled in the same plans off exchange) and off exchange only member month distributions are similar. 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. Wakely would actually have expected this variance to be higher. The exchange has a slightly higher proportion of gold and silver plan member months, while a slightly higher proportion of

off exchange member months are in bronze and catastrophic plans. However, the variances do not indicate significant adverse selection between the market segments.

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

Metal Tier	On Exchange	Off Exchange	Total
Platinum	0%	1%	0%
Gold	21%	17%	20%
Silver	64%	61%	63%
Bronze	14%	17%	15%
Catastrophic	1%	3%	2%

Wakely also analyzed the HHS risk adjustment transfer data for the 2014 Connecticut individual market. Carriers provided Wakely with their 2014 risk adjustment transfer reports supplied by HHS. Only carriers with more than 500 covered lives in 2014 were asked to supply their data. This resulted in six of the seven carriers offering plans in the 2014 individual market supplying their federal risk adjustment data to Wakely. The carrier that did not supply their data had a negligible risk adjustment transfer. 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 cost-sharing reduction plan[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 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, for gold on exchange plans, the average receivable was $127.56 PMPM to each plan. The bronze on exchange plans, however, had an average payable of $140.47 PMPM from each plan. This indicates that gold on

[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. Cost share reduction plans are offered only on the exchange.

exchange plans generally have higher risk enrollees, since they receive a transfer payment, and bronze on exchange plans have lower risk enrollees on average, since they disburse a payment.

Table 2: Comparison of 2014 Risk Transfer PMPMs On and Off Exchange by Metal Tier

Metal Tier	On Exchange	Off Exchange	Statewide Premium
Platinum *	N/A	$510.56	$461.23
Gold	$127.56	$40.73	$461.23
Silver	$11.48	-$51.23	$461.23
Bronze	-$140.47	-$16.93	$461.23
Total	**$15.02**	**-$25.22**	**$461.23**
Catastrophic	-$75.08	$44.21	$267.58

* Metal tier is not considered fully credible due to lower enrollment.

Table 3 compares the transfer for each metal level and on or 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, the gold on exchange entry of 1.28 is the sum of the gold on exchange transfer of $127.56 and the statewide premium of $461.23 divided by the statewide premium of $461.23, or [$127.56 + $461.23] / $461.23 = 1.28.

Table 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 9% higher risk (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. 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).

Table 3: Comparison of 2014 Risk Transfer PMPM Amounts to Statewide Premium

Metal Tier	On Exchange	Off Exchange	Ratio of On Exchange to Off Exchange Within Metal Level
Platinum *	N/A	2.11	N/A
Gold	1.28	1.09	1.17
Silver	1.02	0.89	1.15
Bronze	0.70	0.96	0.72
Total	1.03	0.95	1.09
Catastrophic	0.72	1.17	0.62

* Metal tier is not considered fully credible due to lower enrollment.

The silver plans have 15% 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. Since not all of the on exchange silver enrollees will have the 12% load (only those in the higher cost share reduction plans have the load included), even with the load removed the risk of the enrollees on exchange would still be higher than those off the exchange. Even though 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.

Due to the very low portion of small group membership enrolled on the exchange (approximately 6,500 member months in all metal tiers or < 1% of total enrollment), Wakely did not believe the comparison between on and off exchange markets would 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?*

Only one carrier who has plans offered both on and off the exchange answered that they did not believe there was adverse selection. The three other responding carriers stated 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. Some carriers stated that experience for policies issued in 2014 and later was worse in off exchange plans compared to on exchange plans, even after accounting for federal risk adjustment. Other 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 and cost share reduction subsidies compared to those not eligible. There was not a conclusive answer regarding the impact adverse selection was having on carriers between on and off exchange market segments, except that carriers reported being exposed to it. However, carriers expressed that the individual mandate penalties and risk adjustment program (to some extent) continue to be the best defense against adverse selection.

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

- The program adequately accounts for some conditions, but for other conditions, claims can vary widely among members with the same diagnosis, and risk adjustment does not always close the gap in the cost of care between members. One carrier used applied behavioral analysis (ABA) for attention deficit disorder as an example of a condition not adequately covered under the federal risk adjustment program. The carrier implied that they covered ABA, but they were not being adequately compensated for the service through the federal risk adjustment transfers.

- The risk adjustment program does not adequately address certain demographic categories (e.g. children).

- The federal risk adjustment process does not appear to recognize the selection and utilization dynamic that occurs for richer plan designs. One carrier shared that their post-risk adjustment experience in the individual market (both on and off exchange) is much worse in their higher metal level plans than their lower metal level plans.

- The determination of relative risk is based on an inefficient model and subject to the accuracy (or inaccuracy) of each carrier's data.

Carriers recognized that this is a very complicated issue that seemingly lacks a perfect solution; however, they provided the following input on how the risk adjustment program may be improved:

- Provide an adjustment for partial year enrollees that varies by metal level and number of effective months.
- Allow the inclusion of telehealth claims and provide clarifying guidance on the appropriate coding of such claims.
- Members that change carriers during a calendar year create coding issues for both carriers. Being able to set the risk score for a person based on the individual's total claims during the year, regardless of carrier, would help remedy this situation.
- Allow the inclusion of pharmacy claims in order to more accurately assess the relative risk of members.
- Continue to refresh the risk score coefficients utilizing the most recent claims data to reflect the experience specific to this unique marketplace as well as capture emerging trends (e.g. Sovaldi® and other Hepatitis-C drugs).

One insurer voiced that they believe carriers are looking at "winning" and "losing" conditions under the risk adjustment program to determine if there are categories of people with certain conditions that are more or less attractive to the insurer based on the expected costs of the condition and the risk adjustment payments. If carriers believe that people with certain conditions are "better risk" based on the payments coming from the risk adjustment program, they may adjust their plan design, network development, etc. to make changes that would be more or less attractive to certain segments of the population going forward. It is especially important to address this shortcoming of the current risk adjustment program to discourage this type of discriminatory behavior in order to minimize risk selection.

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. However, there are other potential indications of adverse selection. Platinum plans are only available off exchange, which may attract enrollees with higher risk (although enrollment is insignificant). The risk transfers indicate overall higher risk on the exchange than off the exchange, although there are wide variations by metal tier. The responses from the carrier survey also indicate that there may be adverse selection between enrollees on the exchange and off the exchange, but the comments were inconsistent among the carriers.

Because 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 disparities 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 improve its accuracy since the majority of states are using the federal risk adjustment model. Improving the risk adjustment program may reduce the impact of adverse selection between on and off exchange plans and across carriers. A second, less practical option would be that AHCT consider the possibility of implementing its own risk adjustment program. However, due to the administrative complexity and cost of developing, implementing and operating a state-specific program relative to the opportunity for program improvement, it is not likely that the benefits of implementing a state-specific program would outweigh the costs.

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. 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 the time period January 2014 to June 2015 from each carrier with 500 or more members in 2014. Carriers with fewer than 500 lives in 2014 were not included in this analysis; however, the impact of this simplification is expected to be negligible. In 2014, the non-grandfathered enrollment also contained enrollment in 2013 plans that continued into 2014 before terminating at the end of the policy year.

In the individual market, there were three carriers with grandfathered enrollment from January 2014 to June 2015, including Aetna, ConnectiCare, and UnitedHealthcare. As of June 2015, only ConnectiCare and UnitedHealthcare continue to have grandfathered enrollment. The carriers did not report any remaining grandfathered enrollment in the small group market.

The summarized results are shown in Table 4. As of January 2014, 12.5% of the total individual market enrollees were in grandfathered plans. By June 2015, the percentage of enrollees in grandfathered plans had been reduced to 4.4%.

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

Month	Grandfathered Enrollment	Total Enrollment	Proportion Grandfathered
201401	16,495	131,490	12.5%
201402	15,612	140,746	11.1%
201403	14,985	148,159	10.1%
201404	14,488	158,895	9.1%
201405	14,158	171,839	8.2%
201406	13,864	170,843	8.1%
201407	13,722	169,904	8.1%
201408	13,509	167,914	8.0%
201409	13,285	165,876	8.0%
201410	13,082	164,107	8.0%
201411	12,762	161,817	7.9%
201412	12,176	158,121	7.7%
201501	8,191	163,048	5.0%
201502	7,932	164,498	4.8%
201503	7,783	177,797	4.4%
201504	7,726	173,917	4.4%
201505	7,673	172,554	4.4%
201506	7,567	171,300	4.4%

Due to a small and declining portion of grandfathered enrollment remaining in the market, Wakely did not request detailed claims, demographic, utilization, and plan coverage information from carriers since the impact of adverse selection is expected to continue declining in the future.

However, Wakely did consider other sources to assess the adverse selection that might exist in these plans and the impact to the individual market. Wakely reviewed publicly available Connecticut rate filings for the individual carriers with grandfathered enrollment to identify loss ratios between grandfathered and non-grandfathered plans for the most recent available years. However, adequate information was not available in the rate filings to make comparisons that were on the same basis between the carriers. As such, these comparisons are not included in the report.

As an alternative, Wakely considered risk metrics from proprietary Wakely data for enrollees in grandfathered plans compared to enrollees in non-grandfathered plans on a nationwide basis. A

national study[5] reports that grandfathered plan enrollees have approximately 15% lower risk scores (after accounting for allowable rating factors and normalizing for metal tier) than non-grandfathered ACA-compliant plans. This indicates that enrollees remaining in their pre-ACA grandfathered plans are, on average, healthier than enrollees in ACA-compliant plans. Assuming a 15% lower risk score in grandfathered plans and assuming 4.4% of the market is in grandfathered plans, moving the grandfathered plans into QHP plans would result in an approximate 0.7% reduction to the overall risk in the individual risk pool.

Small group plans did not have any remaining grandfathered enrollment in the market as of June 2015 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.

Survey Responses

When the carriers were asked if they believed the presence of grandfathered plans in the market has an impact on adverse selection, the majority indicated that they did believe the presence of grandfathered plans adversely impacted the non-grandfathered plans in the market. Carriers indicated that this is due to the members in grandfathered plans being previously medically underwritten and, as such, these members are commonly healthier and present less adverse selection risk than the non-grandfathered members. In addition, the enrollees in grandfathered plans have a choice between their grandfathered plan and an ACA-compliant plan, which can inherently lead to some anti-selective behavior.

One carrier commented that because the grandfathered block is a closed block (so there can be no new entrants into grandfathered policies) and there are no federal subsidies available for grandfathered plans as there are for ACA-compliant plans, the expectation is that these enrollees will steadily migrate to ACA-compliant plans over time.

Only one of the responding carriers indicated that the presence of grandfathered plans in the market did not have an impact on adverse selection.

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.

[5] The national study was performed by Wakely and is based on proprietary information. The results are available only to Wakely and those carriers participating in the study.

- 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 detail data for risk analysis purposes.

- The relative impact to the overall individual risk pool is expected to be relatively small and will continue to decline.

However, Wakely recommends that Connecticut consider sunsetting the availability of grandfathered plans as at some point, as the time and materials 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. Wakely did not find any explicit adjustments for adverse selection in our review of the 2016 on exchange small group rate filings, and 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 2014. In addition, Wakely derived the proportion of enrollees in self-funded plans compared to enrollees in all small group plans from 2012 to 2014 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.

Since the small group market is not expanding in Connecticut to include employers with fewer than 100 employees, Wakely limited the analysis to groups fewer than 50 employees.

Table 6 contains the derived enrollee count from 2012 to 2014 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.

Table 6: D Enrollees in Self-Funded Small Group (<50 Employees) Plans in Connecticut by Year Derived from MEPS

Year	Enrollee Count	Trend
2012*	23,812	
2013*	21,893	-8%
2014	36,677	68%

* May not be derived from a credible sample.

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 7 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 based on the surveyed sample.

Table 7: Percent of Enrollees in Self-Funded Small Group (<50 Employees) Plans Compared to All Small Group Plans in Connecticut by Year Derived from MEPS

Year	Percent of Small Group Enrollees in Self-Funded Plans
2012*	20%
2013*	16%
2014	32%

*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 and 2013 do not meet the standard for reliability or precision, so it is difficult to know the accuracy of these two years of data in determining the impact of adverse selection.

To supplement the potentially non-credible Connecticut data, Wakely considered the national MEPS data. 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 2014. 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 may be mitigated. In addition, other insurance dynamics may vary across states, causing the data to be not comparable or applicable to the Connecticut market.

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.

The NAIC published the Stop Loss Insurance Model Act[6], which would prohibit the sale of stop-loss insurance set below reasonable attachment points in states that adopt the model. As of January 2014, the NAIC indicated that four states have adopted the law in a substantially similar manner. It also shows that 20 states have not adopted the most recent version of the NAIC model, but have either adopted an older version of the NAIC model or legislation or regulation derived from other sources such as Bulletins or Administrative Rulings. While Connecticut has issued bulletins regarding small group stop loss, Connecticut has not implemented the model regulation regarding stop loss insurance.[7]

Since Connecticut bulletins may vary from what other states have adopted, it is difficult to conclude whether the national MEPS data is representative of Connecticut.

Survey Responses

In the carrier survey, Wakely asked the following question:

[6] http://www.naic.org/store/free/MDL-92.pdf

[7] Connecticut has adopted Bulletin Numbers HC-108 & PC-80 as well as Bulletin Numbers HC-95 AND PC-75 related to small group stop loss. Bulletins can be found at the following locations: http://www.ct.gov/cid/lib/cid/BulletinHC-108andPC-80.pdf and http://www.ct.gov/cid/lib/cid/Bulletin_HC-95_and_PC-75.pdf.

Have you seen an increase in enrollment in the self-funded small group market since the implementation of the ACA?

All of the carriers that provided responses said that they had not seen a significant increase in enrollment in the self-funded small group market.

In addition, we asked all carriers whether they had seen any adverse selection related to the enrollment in the self-funded market versus the fully insured small group market. Although not all carriers responded to the question, all responding carriers expressed that they had not seen any adverse selection in the self-funded small group market versus the fully insured small group market in Connecticut. However, carriers who provide self-insurance services may have little incentive to share their perspectives on adverse selection in self-funded groups since any changes in regulation of self-funded plans may have an adverse impact on that line of business.

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, the increase in the self-insured small group market indicates that the small group risk pool is losing members to the self-insured business. Wakely recommends that Connecticut closely monitor the small group market for trends toward self-funding and consider implementing regulation around stop loss insurance in order to mitigate any potential adverse selection in the small group market. While Connecticut has some bulletins in this regard,[8] implementing the full NAIC Stop Loss Insurance Model Act, which includes provisions for certification of compliance and indexing of the thresholds, may be an appropriate additional step to consider.

Additional Issues Impacting Adverse Selection

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.

Only one responding carrier indicated that there were no additional issues in the market pertaining to adverse selection.

Other carriers responded that one of the most significant issues impacting adverse selection is the special enrollment period (SEP)[9]. The SEP allows individuals to enroll in a plan outside the annual open

[8] Ibid.

[9] 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.

enrollment period if they indicate they have had a change in circumstances (e.g., having a baby, marriage, loss of other health coverage). 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). In addition to the loss ratio being significantly higher for this population, the proportion of enrollees who enroll in a plan and drop the coverage in the first three months is significantly higher compared to members enrolling during the OEP.

Carriers indicated that the adverse selection in the SEP compared to the OEP could be alleviated if qualifying-event documentation or self-attestation was required for all SEP enrollees for all qualifying events. Carriers expressed that it would also be beneficial if the exchange (or CID) could establish ways that allow for termination of enrollment if there is any misrepresentation or fraud. One carrier expressed that internal analysis in their company has revealed that many SEP enrollees do not have qualifying events (and are enrolling under false pretenses), and that the high lapse rates in the first three months suggests that some enrollees are purchasing coverage through the SEP, utilizing services, and then dropping coverage. This lack of persistency in coverage can lead to higher premiums since these enrollees are presumably only paying premiums for the period of time in which they are utilizing the most services.

The other issue that carriers addressed in their responses is that carriers are not able to charge appropriate premium rates that correspond with the underlying risk that is being insured due to various components of ACA. One component that was brought up in particular was the prescribed 3:1 age slope that does not allow carriers to accurately reflect and rate for the true difference in cost by age. This leads to cross-subsidization in which older (and presumably less healthy) enrollees receive better value from their premiums than younger enrollees receive and may result in younger enrollees choosing not to insure, creating adverse selection. Since this rating requirement is in federal law, this issue will continue until or unless the requirement is changed. Therefore, carriers must rely on the risk adjustment program to sufficiently cover any shortfalls due to adverse selection caused by this requirement.

Wakely Conclusions and Recommendations

Wakely recommends considering stricter requirements for members enrolling during the special enrollment periods (SEP) such as requiring documentation for all SEP enrollees for all qualifying events. In addition, the legislature could consider establishing a mechanism to allow for termination of enrollment in the case of misrepresentation or fraud. It is Wakely's understanding that AHCT is aware of the SEP issues and is already considering alternative approaches.

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 first study year (2014)
- 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 2014. This limitation is expected to have a negligible impact on results.

The 2012 and 2013 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 and risk adjustment transfers in various segments of the market to determine whether segments were attracting higher or lower risk. It is important to understand that this approach defines adverse selection as the difference in risk adjustment transfers, where some stakeholders may view adverse selection as the variation in financial results after differences in risk adjustment transfers are netted out. Different approaches may result in conclusions that vary from those included in this report.

RELIANCE

Wakely relied on the following information:

- Risk adjustment data, grandfathered/non-grandfathered enrollment data, and survey responses provided by Connecticut carriers
- Rate filing data, such as URRTs and actuarial memoranda, provided by AHCT
- Publicly available data including MEPS data

Wakely relied upon several sources of data provided by the carriers of Connecticut and AHCT, as well as data from publicly available sources. We made assumptions in the analysis, and relied upon qualitative responses from Connecticut carriers, to estimate and comment on the impact of adverse selection on the operations of the exchange in Connecticut.

We reviewed the supplied information for reasonability, but we did not audit the data or information. To the extent that there are any errors in the data that was used or in the way it was interpreted by Wakely, the results of the adverse selection study could be materially impacted.

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 C.G.S. §38a-1084(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 2014 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.

The authors of this report, Danielle Hilson and Chris Bach, are members of the American Academy of Actuaries. Danielle is a Fellow of the Society of Actuaries, and Chris is an Associate of the Society of Actuaries. Both Danielle and Chris are qualified to perform the adverse selection study described in this report.

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

Sincerely,

Danielle W. Hilson, FSA, MAAA
Consulting Actuary
Wakely Consulting Group
danielleh@wakely.com
720-282-4962

Christine S. Bach, ASA, MAAA, FCA
Senior Consulting Actuary
Wakely Consulting Group
chrisb@wakely.com
612-800-6429

Cc: James R. Wadleigh, Jr., AHCT Chief Executive Officer

Steven J. Sigal, AHCT Chief Financial Officer

Susan Rich-Bye, AHCT Director of Legal Affairs and Policy

Shan Jeffreys, AHCT Director of Marketplace Strategies

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 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?

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. Do you believe the presence of grandfathered plans in the market has an impact on adverse selection?

4. Please share any data you have exhibiting the relative health risk between grandfathered and non-grandfathered plans. Provide background on how to interpret any data shared.

5. Have you seen an increase in enrollment in the self-funded small group market since the implementation of the ACA? If so, please provide any evidence or data to support this trend.

6. 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.

7. 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?

8. Are you comfortable with Wakely identifying you in connection with your responses, or would you prefer your responses to be de-identified?