Wakely
An HMA Company

wakely.com

Minnesota Comprehensive Health Association

Final 2021 Benefit Year Report
Results for the Minnesota Premium Security Plan

June 28th, 2022

Prepared by:
Wakely Consulting Group

Tyson Reed, FSA, MAAA
Consulting Actuary

Contents

Introduction

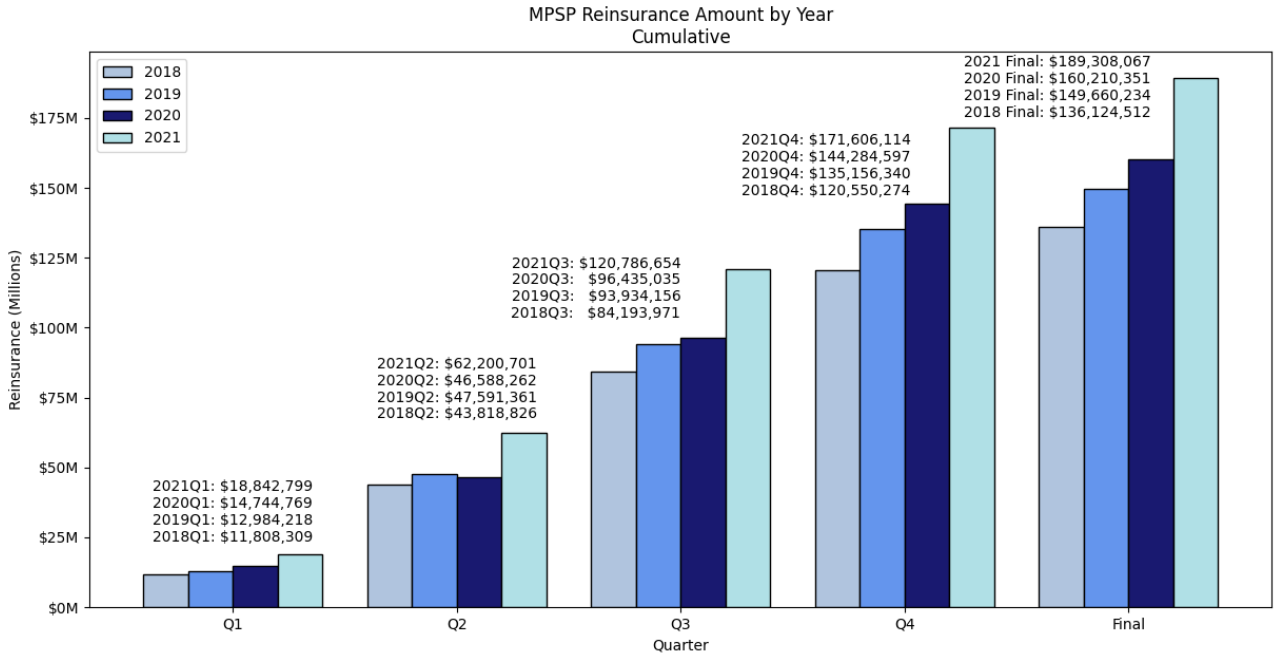
The Minnesota Comprehensive Health Association (MCHA) retained Wakely Consulting Group, LLC, an HMA Company (Wakely) to collect data related to the Minnesota state-based reinsurance program referred to as the Minnesota Premium Security Plan (MPSP), review the data for reasonability, calculate the reinsurance payments to the issuers participating in the program, and provide summary reports for MCHA to distribute, as appropriate, to stakeholders.

This document has been prepared for the use of MCHA and its Board of Directors. Wakely understands that this report will be made public and distributed to stakeholders beyond MCHA and its Board of Directors due to Minnesota Statute §62E.24. Wakely does not intend to benefit third parties and assumes no duty or liability to other parties who receive this work. This report should be reviewed in its entirety. This document contains the data, assumptions, and methods used in these analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements.

This is the final 2021 benefit year report for MPSP. Figures and tables in this report supersede figures and values previously communicated in 2021 MPSP quarterly reporting.

Executive Summary

The 2021 benefit year reinsurance amount for MPSP is $189,308,067. The data that was used to calculate reinsurance is based on enrollment and claim data Minnesota issuers submitted to the CMS External Data Gathering Environment (EDGE) Server through May 2nd, 2022 and processed by CMS with an outbound date of May 3rd, 2022.[1] To calculate reinsurance, Wakely used the High-Cost Risk Pool Detail Extract (HCRPDE) files generated by CMS to identify claims and enrollees eligible for reinsurance.



[1] This includes correction files submitted after the submission deadline and the corresponding updated outbound files.

For each quarter of the 2021 benefit year, Minnesota issuers submitted data to Wakely that allowed MCHA to report on the MPSP program throughout the year. The figure above shows the reinsurance amount reported in each report between 2018 and 2021. Note that each quarter within a year is cumulative. That is, the $18.8 million in the 2021Q1 report is included in the $171.6 million in the 2021Q4 report. The increases between fourth quarter and the final reinsurance amounts are primarily the result of claim runout and claim systems (e.g. EDGE server vs internal claim system).

In February 2022, Wakely estimated 2021 benefit year reinsurance. The $194.7 million estimate was approximately 2.9% ($\approx \frac{\$194.7M}{\$189.3M}$ -1) higher than the actual reinsurance amount. The difference was caused by the number of reinsurance eligible enrollees (3,851 estimated vs 3,754 actual) and the average reinsurance cost per eligible enrollee ($50,550 estimated vs $50,428 actual). The combined impact led to an approximate $5.4 million dollar difference between the final 2021 reinsurance amount and Wakely's estimate (= $194.7M - $189.3M).

Table 1 displays final enrollment and reinsurance under MPSP between 2018 and 2021.

Table 1: Reinsurance and Enrollee Count

	Distinct Enrollees	Reinsurance Amount
2018 Statewide	2,925	$136,124,512
2019 Statewide	3,183	$149,660,234
2020 Statewide	3,279	$160,210,351
2021 Statewide	3,754	$189,308,067

The remainder of this report provides a description of the data used, methodology, additional breakout of reinsurance for reporting, associated caveats, and disclosures.

EDGE Data Description

This section describes the data that Wakely used to calculate 2021 benefit year reinsurance. The EDGE server is a data warehouse that processes data for CMS to administer the risk adjustment program in the individual and small group markets. Files that issuers submit to the EDGE server are referred to as *inbound* files. The EDGE server processes inbound files and returns another set of data files back to the issuers. These files are referred to as *outbound* files. Additional descriptions of each type of file is provided later in this section.

Minnesota issuers provided both the 2021 inbound and the 2021 outbound files for Wakely to use to calculate final 2021 reinsurance. Specifically, Wakely used the HCRPDE outbound file to identify claims and enrollees eligible for reinsurance. This table is limited to the claims and enrollment spans eligible for payments in the 2021 benefit year federal high-cost risk pool program. The Data Review section on Page 10 of this memorandum outlines Wakely's review of the issuers' EDGE data.

EDGE Server Inbound Files

All Minnesota issuers participating in the individual market are required to submit claim and enrollment data to the EDGE server. CMS uses this data to administer the permanent risk adjustment program, which includes the high-cost risk pool program. Historically, CMS used EDGE data to calculate reinsurance under the Federal Transitional Reinsurance Program that ended in benefit year 2016. CMS has extensive business rules that determine if a claim or enrollment span is eligible under the risk adjustment or high-cost risk pool programs. For example, if an issuer submits an inpatient

claim for an enrollee that overlaps with an existing inpatient claim for that enrollee, then the EDGE server will reject the new claim. Issuers are permitted to fix issues with ineligible claims and then resubmit them to the EDGE server until the final submission date of the benefit year. If errors are found in data submissions after the final submission deadline, CMS may require issuers to submit corrected files. For benefit year 2021, the final submission date was May 2nd, 2022.

EDGE Server Outbound Files

After the submission deadline, the EDGE Server processes the submitted inbound files to generate the outbound files. Issuers then receive the processed and summarized versions of the outbound files. There is an attestation and discrepancy-reporting period where an issuer may report to CMS any calculation issues identified by the issuer. For benefit year 2021, the discrepancy reporting period for CMS ended on May 19th, 2022.

In addition, the issuers must respond to any final items flagged by CMS in the quantity and quality data evaluation process. The quantity assessment aims to ensure completeness of submitted data. The quality assessment measures the integrity and accuracy of the data. Both of these assessments are repeated throughout the submission process. CMS identified multiple issuers during benefit year 2021 as being an outlier in one or more metrics. These issuers were required to submit a justification or correct the data quality issues. In all instances, the issuers reported that their justification sent to CMS was accepted or the data issue was resolved prior to the submission deadline.

CMS Attestation

CMS requires that an employee with the authority to both legally and financially bind the issuer attest to the accuracy of the issuer's EDGE data submission. CMS has the authority to impose default risk adjustment transfers for issuers that fail to submit sufficient EDGE data. CMS can also impose civil monetary penalties if issuers violate other federal requirements. This includes falsifying or misrepresenting data either intentionally or recklessly.

MPSP Attestation

Officers at each organization signed an attestation regarding the accuracy, truthfulness, and completeness of the EDGE data that they submitted to Wakely. Issuers attested that if there is an error found in the EDGE server data that impacts reinsurance payments, then the issuer will promptly notify and work with MCHA and Wakely to resolve any discrepancies in reinsurance calculations.

Methodology

2021 Reinsurance Timeline

Table 2 on the next page provides the timeline and key dates for calculating 2021 benefit year reinsurance. In January 2022, Wakely hosted a call with the eligible issuers to outline the spring timeline and the structure of the data request. Issuers provided EDGE server data to Wakely twice during the spring of 2022. The first data request, labeled *preliminary*, was used to work through data transfer issues and to develop the model that was used to calculate final reinsurance. The final benefit year reinsurance calculation used the final EDGE server data request.

After Wakely's calculations and data review process, each issuer received a file that contained the

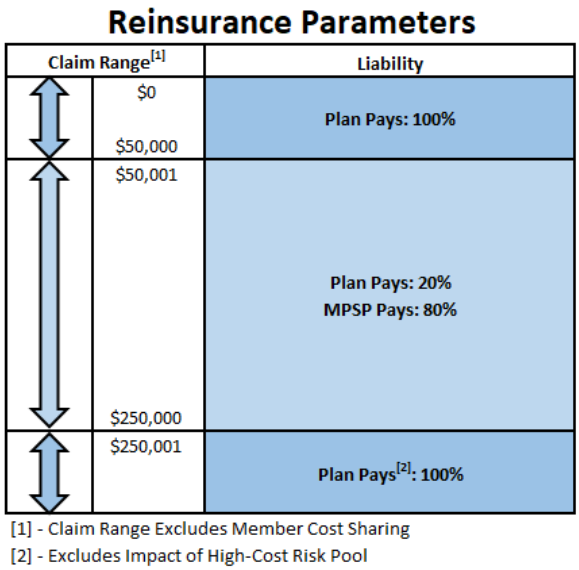
claims for each reinsurance eligible enrollee for both the preliminary and final data requests. The file permitted issuers to review Wakely's calculation and report any discrepancies before the deadline of June 3rd, 2022.

Table 2: 2021 Benefit Year Calculation Timeline

Description	Date
All Issuer Data Call	1/26/2022
Preliminary Data Requested by Wakely	2/25/2022
Preliminary Data Due to Wakely	3/11/2022
Preliminary Results Sent to Issuers	4/8/2022
Final Data Requested by Wakely	4/25/2022
Final Data Due to Wakely	5/6/2022
Final Results Sent to Issuers	5/20/2022
End of MPSP Discrepancy Reporting	6/3/2022

Methodology Description

Wakely used 2021 inbound data that was submitted to the EDGE server through May 2nd, 2022 and the outbound files produced on May 3rd, 2022 to calculate final 2021 benefit year reinsurance. The data included both enrollment and claim-level detail that issuers submitted to the EDGE server and the data returned by the EDGE server to the issuers. Wakely used the HCRPDE outbound file to identify eligible enrollees and claims. For each issuer, Wakely aggregated claims to the enrollee-level and applied the 2021 MPSP reinsurance parameters to calculate reinsurance for each enrollee. The figure below illustrates the 2021 reinsurance parameters.



Wakely aggregated the calculated reinsurance for each issuer to report at the statewide level. For this report, Wakely allocated reinsurance amounts for enrollees transferring between health plan identifiers based on incurred claims. For example, under certain circumstances, an enrollee might have been enrolled in both a silver and a gold plan for a portion of 2021. If 75% of an enrollee's claims occurred in the silver plan and 25% occurred in the gold plan, then Wakely allocated 75% of the reinsurance to the silver plan and 25% to the gold plan. Transferring health plan identifiers does not impact results when reporting at an issuer level; however, when reporting at a more granular level (e.g. metal), reported results may change if another allocation method is used.

Analysis

In compliance with Minnesota Statutes 62E.24 subdivision 2, this section provides additional detail for the reinsurance amount shown in Table 1. The distribution total in the following tables may not add to 100% due to rounding.

Reinsurance by Eligible Health Carrier

Table 3 provides the total reinsurance payments to each eligible health carrier along with the associated carrier's HIOS identifier.

Table 3: Reinsurance Amount by Carrier

Health Carrier	HIOS ID	2021 Reinsurance
HMO Minnesota (Blue Plus)	57129	$46,011,419
Group Health Plan, Inc (HealthPartners)	34102	$41,962,451
Medica Insurance Company	31616	$48,086,516
Preferred One Insurance Company	88102	$1,916,558
Quartz Health Plan MN Corporation	70373	$914,493
UCare Minnesota	85736	$50,416,630
Total Statewide	**-**	**$189,308,067**

Reinsurance by Area

Table 4 shows the amount of reinsurance for each of Minnesota's rating regions. A list of counties in each rating area can be found in Appendix D, the Minnesota Department of Commerce website, or the CMS website.

Table 4: Reinsurance Amount by Area

Rate Region	2021 Reinsurance	2021 Dist'n	2020 Dist'n	2019 Dist'n	2018 Dist'n
Rating Area 1	$20,297,618	11%	11%	12%	10%
Rating Area 2	$10,542,693	6%	6%	6%	6%
Rating Area 3	$12,977,408	7%	7%	7%	6%
Rating Area 4	$5,746,129	3%	2%	3%	3%
Rating Area 5	$8,722,397	5%	4%	4%	5%
Rating Area 6	$7,213,778	4%	5%	4%	4%
Rating Area 7	$16,195,812	9%	7%	9%	7%
Rating Area 8	$105,655,028	56%	57%	54%	55%
Rating Area 9	$1,957,204	1%	1%	1%	2%
Statewide	**$189,308,067**	**100%**	**100%**	**100%**	**100%**

Reinsurance by Metal Level

Table 5 provides the reinsurance amount and distribution by metal tier. Four different metal tiers in the individual market reflect different expected cost sharing levels. The leanest is the bronze plan where an enrollee can expect to pay for about 40% of his or her total medical costs out of pocket in the form of cost sharing such as deductibles, coinsurance, and copays. The richest plan type is the platinum tier where an enrollee can expect to pay approximately 10% of total costs out of pocket. There is a fifth tier called catastrophic. Enrollment in catastrophic plans is limited to individuals who are eligible for hardship exemption or are under the age of 30.

Table 5: Reinsurance Amount by Metal Tier

Metal Tier	2021 Reinsurance	2021 Dist'n	2020 Dist'n	2019 Dist'n	2018 Dist'n
Catastrophic	$545,077	0%	1%	0%	0%
Bronze	$91,082,038	48%	45%	44%	48%
Silver	$49,159,699	26%	29%	29%	29%
Gold	$47,589,501	25%	25%	26%	22%
Platinum	$931,752	0%	1%	1%	1%
Total	**$189,308,067**	**100%**	**100%**	**100%**	**100%**

Reinsurance by Exchange Status

This section provides the reinsurance based on whether the enrollee purchased coverage through Minnesota's exchange, MNSure, or directly through the issuer.[2]

Table 6: Reinsurance Amount by Exchange Status

Exchange Status	2021 Reinsurance	2021 Dist'n	2020 Dist'n	2019 Dist'n	2018 Dist'n
On-Exchange	$126,831,208	67%	69%	69%	68%
Off-Exchange	$62,476,859	33%	31%	31%	32%
Total	**$189,308,067**	**100%**	**100%**	**100%**	**100%**

Reinsurance by Plan Type

This section provides reinsurance amounts by plan type. In the Affordable Care Act, some individuals and families qualify for cost-sharing reduction subsidies (CSR) which lower out-of-pocket costs. There are several different levels of CSRs. The first is 73% which reduces the individual's out-of-pocket cost to approximately 27% (= 1 - 73%) of total medical costs. There are CSR plans available at the 87% and 94% level as well. CSR plans are only available on the exchange. Finally, there are limited cost-sharing and zero cost-sharing plans for American Indians and Alaska Natives.

Table 7: Reinsurance Amount by Plan Type

Plan Type	2021 Reinsurance	2021 Dist'n	2020 Dist'n	2019 Dist'n	2018 Dist'n
Standard	$173,577,638	92%	90%	90%	91%
Zero CS	$593,308	0%	0%	0%	0%
Limited CS	$822,089	0%	0%	0%	0%
73% CSR	$12,563,849	7%	9%	9%	9%
94% CSR	$1,751,184	1%	0%	0%	0%
Total	**$189,308,067**	**100%**	**100%**	**100%**	**100%**

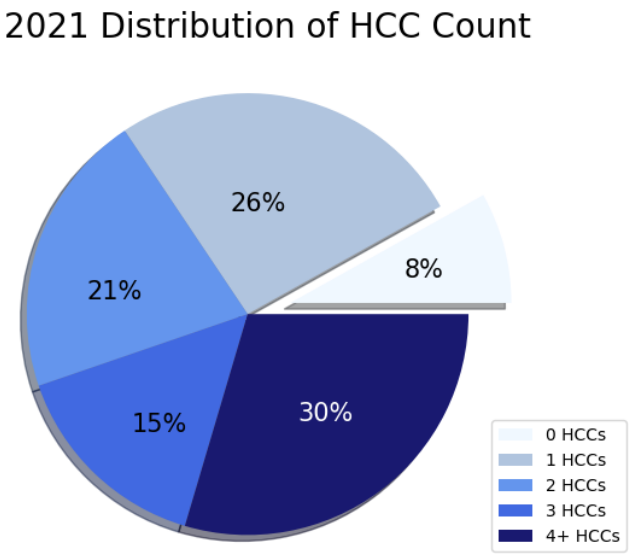
Reinsurance by Claim Spend

Please see Appendix A for reinsurance by claim spend level.

[2]Multiple issuers updated the on- and off-exchange mapping in the data they provided to Wakely between the 2019Q2 and 2019Q3 reports. As a result, the 2019, 2020, and 2021 distributions are not directly comparable to the 2019Q1 and 2019Q2 quarterly reports.

Distribution of HCC Count

The chart in this section provides the hierarchical condition category (HCC) distribution for the reinsurance eligible population. HCCs are used by CMS as part of the risk adjustment process that transfers money in the individual market from issuers that enrolled a healthier population to issuers that enrolled a sicker population. An enrollee is assigned to an HCC based on his or her medical diagnostic history. For example, if an enrollee fractures his or her hip in an accident, the doctor may code the medical claim with a hip fracture diagnosis code. That diagnosis code then identifies that enrollee in the *Hip Fractures and Pathological Vertebral or Humerus Fractures* condition category (HCC226). On the other hand, there are diagnosis codes that do not map to a payment HCC. As a result, an enrollee may not be assigned to an HCC even though he or she may have a claim. Enrollees can have more than one HCC in a year. Typically, the more HCCs an enrollee has, the sicker and more costly he or she is. As a general rule of thumb, approximately 20% of the individual commercial population are assigned to at least one HCC in any given year. In other words, 80% of the general individual commercial population is not assigned to an HCC. In comparison, only 10% of enrollees eligible for reinsurance payments do not have an HCC. These enrollees may have experienced a traumatic accident with a diagnosis code not included in the HCC model, may have a rare condition that is not represented in the HCC model, or may have diagnosis codes that were not coded correctly.



The HCC model is hierarchical and groups together similar conditions. For example, diabetes has three HCCs: Diabetes with Acute Complications (HCC019), Diabetes with Chronic Complications (HCC020), and Diabetes without Complication (HCC021). An enrollee with a diagnosis code in both HCC019 and HCC021 would only be classified as HCC019 to avoid double counting. Finally, the HCC model groups the diabetic HCCs into one Diabetic Group (G01). Similar hierarchies and groupings exist for other conditions. Appendix B gives the list of the most prevalent HCCs and groupings during benefit year 2021 for enrollees eligible for reinsurance.

The table below provides the final HCC count distribution by reinsurance year.

Table 8: HCC Distribution by Year

HCC Count	2021	2020	2019	2018
0 HCCs	8%	10%	9%	7%
1 HCC	26%	28%	29%	27%
2 HCCs	21%	21%	22%	23%
3 HCCs	15%	14%	13%	14%
4+ HCCs	30%	27%	27%	29%

This analysis excludes Prescription Drug Categories (RXCs). RXCs are similar to HCCs except

RXCs are identified using National Drug Codes (NDCs) or service codes that indicate the enrollee's prescription drug utilization.

Reinsurance by Product

Appendix C gives the amount of reinsurance and number of claimants that exceeded $50,000 in claims by product and exchange status. To define product, Wakely used the first ten digits of the HIOS plan identifier and requested that issuers provide a product name associated with the product identifier. For the column labeled *Claimants*, an enrollee is double counted if he or she transferred between products during the experience period. As a result, the claimant count in Appendix C does not match the enrollee count in Table 1. The column labeled *Claimants* shows "*<100*" for product and exchange-status combinations with less than 100 claimants for protected health information (PHI) reasons.[3]

Data Review

This section describes the data checks performed by Wakely during the reinsurance calculation process.

Inbound Files versus High Cost Risk Pool Comparison

Wakely compared the claims in the inbound EDGE server files with an accepted flag against the list of claims underlying the HCRPDE table.[4] This analysis included a check to ensure that the plan paid amount on both the HCRPDE and the inbound EDGE server files were consistent.

During this review, Wakely found instances of original claims referenced by rejected replacement claims in one issuer's data. Wakely notified MCHA, CMS, and the issuer about the anomaly. Subsequently, CMS and the issuer reviewed the issuer's data submissions. In addition to the CMS and issuer review, Wakely also compared the original claims against the rejected replacement claims. To the best of Wakely's knowledge, if the replacement claims were not rejected and the replacements were used to calculate reinsurance instead of the original claims, the calculated reinsurance would not change.[5]

If additional CMS and issuer data review results in different calculated reinsurance amounts, Wakely will work with the appropriate parties to update calculated reinsurance amounts and this memorandum.

1332 Waiver Application Comparison

Wakely compared the portion of enrollees with claims above the attachment point against the claim continuance table located in the actuarial report in Minnesota's 1332 Waiver. The table is based on the 2015 individual market that is significantly different from the 2021 individual market. In total, approximately 2% of the population was expected to exceed the $50,000 attachment point based on

[3]Multiple issuers updated the on- and off-exchange mapping in the data they provided to Wakely between the 2019Q2 and 2019Q3 reports. As a result, the results shown in Appendix C for the final 2019 and 2020 reports are not directly comparable to the table shown in the 2019Q2 quarterly report.

[4]Besides being accepted by the EDGE server, a claim must also meet other requirements to be included in the HCRPDE. For example, a claim must occur during a valid enrollment span. Wakely used the EDGE Server Business Rules 20.0 as a reference for reviewing the submitted EDGE encounter data. For additional information, please see https://www.regtap.info/

[5]Wakely has provided documentation to MCHA on the methodology used to review these discrepancies. For more information regarding Wakely's review, please contact MCHA.

the 1332 Waiver Application, which was close to the proportion of enrollees exceeding the attachment point in this report.

2021Q4 MPSP Report Comparison

Wakely compared the list of enrollees contained in the 2021Q4 quarterly report against the list of enrollees in the final EDGE server data. Issuers provided the data used for the quarterly reports that included only enrollees with claims that exceeded the reinsurance attachment point. In general, if an enrollee was in the 2021Q4 report, then he or she should also be eligible for reinsurance in the final calculation. A small number of enrollees in the 2021Q4 data request were not eligible for reinsurance in the final 2021 calculation. This occurs when an enrollee has claims retroactively adjusted which causes him or her to drop below the reinsurance attachment point. Similarly, claims may fail to be accepted to the EDGE server due to business rules.

Risk Score Comparison

Wakely used the issuers' inbound claim files to independently calculate risk scores and compared the results against risk scores that CMS calculated for the federal risk transfer payment program. As described above, risk scores are calculated using diagnosis codes, pharmacy codes, demographic, and enrollment information submitted to the EDGE server. Differences between Wakely's calculated risk score and the CMS calculated risk score could imply that Wakely was missing diagnosis or pharmacy codes, and as a result, the claims associated with the missing codes.

There were immaterial differences between CMS and Wakely's risk score assignments. These differences were primarily caused by either diagnosis codes on supplemental files that do not impact reinsurance calculation or diagnosis codes occurring during an enrollee's small group market enrollment span (e.g. member transferred between markets).

State Mandated Benefits

Wakely did not adjust the reinsurance calculation methodology for state mandated benefits at the direction of MCHA. Wakely's understanding is that issuers and Minnesota Department of Commerce (DoC) will make the appropriate adjustments to the defrayal payments when issuers submit state mandated benefit data to DoC for reimbursement.

Disclosures and Limitations

Responsible Actuary. I, Tyson Reed, am responsible for this communication. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the management of MCHA. Wakely understands that this report will be made public. Distribution should be made in its entirety and should be evaluated only by qualified users. The parties receiving and reading this report should retain their own actuarial experts when interpreting results.

Risks and Uncertainties. The assumptions and resulting calculated reinsurance included in this report are inherently uncertain and could change depending on EDGE server review. 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 Wakely's calculation. Wakely does not warrant or guarantee that Minnesota issuers will attain the calculated values included in the report. It is the responsibility of those receiving this report to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. I am financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of MCHA.

Data and Reliance. I have relied on others for data and assumptions used in the assignment. I have reviewed the data for reasonableness, but I have not performed an independent audit or otherwise verified the accuracy of the data / information. If the underlying data / information is incomplete or inaccurate, Wakely's estimates and calculations may be impacted, potentially significantly. The information included in the other sections identifies the key data and assumptions.

Subsequent Events. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. I am not aware of any events that would affect the results of this analysis not already discussed above.

Contents of Actuarial Report. This document constitutes the entirety of the actuarial report and supersedes any previous communications provided to MCHA for Benefit Year 2021.

Deviations from Actuarial Standards of Practice (ASOPs). Wakely completed these analyses using sound actuarial practice. To the best of my knowledge and belief, the report and methods used in the analyses comply with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

- ASOP No. 1, Introductory Actuarial Standard of Practice
- ASOP No. 23, Data Quality
- ASOP No. 41, Actuarial Communication
- ASOP No. 56, Modeling

Sincerely,

Tyson Reed, FSA, MAAA
Consulting Actuary
612.800.6545 | Tyson.Reed@wakely.com

Appendix A - Reinsurance Amount by Claim Spend Level

2021 Final Reinsurance Amount by Claim Spend Level

Incurred Claims		Enrollee Count	Average Incurred Claims Per Enrollee	Average Reinsurance Per Enrollee	Aggregate Reinsurance
Low Range	High Range				
$50,000	$52,508	211	$51,220	$976	$206,019
$52,508	$58,498	411	$55,282	$4,226	$1,736,883
$58,498	$119,795	1,896	$80,874	$24,699	$46,830,194
$119,795	$200,000	678	$152,540	$82,032	$55,617,886
$200,000	$9,999,999	558	$363,677	$152,181	$84,917,085
Total		**3,754**	**$131,385**	**$50,428**	**$189,308,067**

2020 Final Reinsurance Amount by Claim Spend Level

Incurred Claims		Enrollee Count	Average Incurred Claims Per Enrollee	Average Reinsurance Per Enrollee	Aggregate Reinsurance
Low Range	High Range				
$50,000	$52,508	155	$51,198	$958	$148,534
$52,508	$58,498	354	$55,457	$4,365	$1,545,383
$58,498	$119,795	1,761	$80,824	$24,659	$43,424,822
$119,795	$200,000	557	$153,704	$82,963	$46,210,511
$200,000	$9,999,999	452	$349,424	$152,392	$68,881,102
Total		**3,279**	**$126,091**	**$48,860**	**$160,210,351**

Notes:

1. Average Reinsurance Per Enrollee = min{(Average Incurred Claims - $50,000) × 80%, $160,000}.
2. The claim intervals originate from the 1332 Waiver Application which have been combined to ensure each cohort has at least 100 enrollees.

Appendix A (Cont.) - Reinsurance Amount by Claim Spend Level

2019 Final Reinsurance Amount by Claim Spend Level

Incurred Claims		Enrollee Count	Average Incurred Claims Per Enrollee	Average Reinsurance Per Enrollee	Aggregate Reinsurance
Low Range	High Range				
$50,000	$52,508	177	$51,219	$975	$172,613
$52,508	$58,498	389	$55,448	$4,358	$1,695,271
$58,498	$119,795	1,678	$80,984	$24,787	$41,592,460
$119,795	$200,000	527	$152,994	$82,395	$43,422,371
$200,000	$9,999,999	412	$374,574	$152,373	$62,777,520
Total		**3,183**	**$126,132**	**$47,019**	**$149,660,234**

2018 Final Reinsurance Amount by Claim Spend Level

Incurred Claims		Enrollee Count	Average Incurred Claims Per Enrollee	Average Reinsurance Per Enrollee	Aggregate Reinsurance
Low Range	High Range				
$50,000	$52,508	173	$51,263	$1,010	$174,801
$52,508	$58,498	359	$55,413	$4,330	$1,554,606
$58,498	$119,795	1,513	$81,257	$25,005	$37,833,247
$119,795	$200,000	522	$150,761	$80,609	$42,077,922
$200,000	$9,999,999	358	$360,572	$152,190	$54,483,936
Total		**2,925**	**$122,901**	**$46,538**	**$136,124,512**

Notes:

1. Average Reinsurance Per Enrollee = min{(Average Incurred Claims - $50,000) × 80%, $160,000}.
2. The claim intervals originate from the 1332 Waiver Application.

Appendix B - Enrollee Count by HCC

Limited to HCCs with at least 100 Enrollees

			2021		2020	
Rank	**HCC**	**HCC Description**	**Enrollee Count[1]**	**% of Reinsurance Eligible Enrollees**	**Enrollee Count[1]**	**% of Reinsurance Eligible Enrollees**
1	G01	Diabetes	732	19%	597	18%
2	G15A	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis; Severe Asthma; Asthma, Except Severe	635	17%	521	16%
3	HCC142	Specified Heart Arrhythmias	536	14%	435	13%
4	HCC130	Heart Failure	507	14%	393	12%
5	HCC008	Metastatic Cancer	500	13%	437	13%
6	G13	Respiratory Arrest; Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	465	12%	357	11%
7	HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders	443	12%	456	14%
8	HCC002	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	394	10%	341	10%
9	HCC023	Protein-Calorie Malnutrition	359	10%	263	8%
10	G08	Disorders of the Immune Mechanism	312	8%	183	6%
11	HCC075	Coagulation Defects and Other Specified Hematological Disorders	310	8%	225	7%
12	HCC048	Inflammatory Bowel Disease	262	7%	245	7%
13	HCC156	Pulmonary Embolism and Deep Vein Thrombosis	254	7%	227	7%
14	G02A	Mucopolysaccharidosis; Metabolic Disorders; Endocrine Disorders	244	6%	192	6%
15	HCC012	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	208	6%	160	5%
16	HCC131	Acute Myocardial Infarction	206	5%	165	5%
17	HCC120	Seizure Disorders and Convulsions	200	5%	146	4%
18	HCC253	Artificial Openings for Feeding or Elimination	192	5%	173	5%
19	HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	187	5%	126	4%

Appendix B (Cont.) - Enrollee Count by HCC

Limited to HCCs with at least 100 Enrollees

			2021		2020	
Rank	**HCC**	**HCC Description**	**Enrollee Count[1]**	**% of Reinsurance Eligible Enrollees**	**Enrollee Count[1]**	**% of Reinsurance Eligible Enrollees**
20	G09C	Alcohol Use with Psychotic Complications; Alcohol Use Disorder, Moderate/Severe, or Alcohol Use with Specified Non-Psychotic Complications; Drug Use Disorder, Mild, Uncomplicated, Except Cannabis	185	5%	<100	-
21	HCC088	Major Depressive and Bipolar Disorders	164	4%	150	5%
22	G09A	Drug Psychosis; Drug Dependence	150	4%	106	3%
23	HCC045	Intestinal Obstruction	149	4%	139	4%
24	HCC118	Multiple Sclerosis	144	4%	151	5%
25	HCC163	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	140	4%	115	4%
26	HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	137	4%	120	4%
27	HCC125	Respirator Dependence/Tracheostomy Status	133	4%	106	3%
28	G21	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders; Major Congenital Heart/Circulatory Disorders; Atrial and Ventricular Septal Defects, Patent Ductus Arteriosus, and Other Congenital Heart/Circulatory Disorders	120	3%	141	4%
29	HCC135	Heart Infection/Inflammation, Except Rheumatic	117	3%	<100	-
30	HCC122	Non-Traumatic Coma, Brain Compression/Anoxic Damage	107	3%	106	3%
31	HCC150	Hemiplegia/Hemiparesis	104	3%	<100	-
32	G03	Necrotizing Fasciitis; Bone/Joint/Muscle Infections/Necrosis	102	3%	<100	-
33	HCC146	Ischemic or Unspecified Stroke	101	3%	<100	-

1. An enrollee may have multiple HCCs and could be double counted if combining enrollee counts between HCCs.

Appendix C - 2021 Benefit Year Reinsurance Amount and Enrollees by Product

Carrier	Product ID	Product Name	Exchange Status	Enrollee Count[1,2]	Reinsurance
Blue Plus	57129MN008	Blue Plus Metro	Off-Exchange	160	$7,118,012
Blue Plus	57129MN009	Blue Plus Metro	On-Exchange	140	$6,037,429
Blue Plus	57129MN054	Blue Plus Minnesota Value	On-Exchange	321	$14,953,602
Blue Plus	57129MN053	Blue Plus Minnesota Value	Off-Exchange	202	$10,586,579
Blue Plus	57129MN015	Blue Plus Southeast	On-Exchange	<100	$5,266,780
Blue Plus	57129MN014	Blue Plus Southeast	Off-Exchange	<100	$1,924,258
Blue Plus	57129MN052	Blue Plus Strive	On-Exchange	<100	$67,317
Blue Plus	57129MN051	Blue Plus Strive	Off-Exchange	<100	$3,664
Blue Plus	57129MN007	Blue Plus Western	On-Exchange	<100	$53,778
HealthPartners	34102MN007	GHI AM Off Exchange	Off-Exchange	471	$23,581,457
HealthPartners	34102MN008	GHI NAM Off Exchange - HP Ind	Off-Exchange	<100	$734,321
HealthPartners	34102MN009	GHI NAM Off Exchange - HP Ind Ded	Off-Exchange	<100	$46,411
HealthPartners	34102MN001	GHI On Exchange	On-Exchange	361	$17,600,263
Medica	31616MN045	Altru Prime by Medica	On-Exchange	<100	$436,209
Medica	31616MN045	Altru Prime by Medica	Off-Exchange	<100	$197,306
Medica	31616MN047	Bold by M Health Fairview	On-Exchange	<100	$516,014
Medica	31616MN047	Bold by M Health Fairview	Off-Exchange	<100	$298,240
Medica	31616MN044	Engage by Medica	On-Exchange	208	$13,460,702
Medica	31616MN044	Engage by Medica	Off-Exchange	<100	$3,531,514
Medica	31616MN042	Medica Applause	On-Exchange	319	$15,413,486
Medica	31616MN042	Medica Applause	Off-Exchange	198	$10,567,765
Medica	31616MN019	Medica Encore	Off-Exchange	<100	$160,000
Medica	31616MN020	Medica HSA	Off-Exchange	<100	$557,191
Medica	31616MN018	Medica Solo	Off-Exchange	<100	$337,290

Appendix C - 2021 Benefit Year Reinsurance Amount and Enrollees by Product

Continued...

Carrier	Product ID	Product Name	Exchange Status	Enrollee Count[1,2]	Reinsurance
Medica	31616MN021	Medica Value	Off-Exchange	<100	$644,494
Medica	31616MN043	North Memorial Acclaim by Medica	On-Exchange	<100	$1,362,374
Medica	31616MN043	North Memorial Acclaim by Medica	Off-Exchange	<100	$212,743
Medica	31616MN046	Ridgeview Distinct by Medica	On-Exchange	<100	$359,525
Medica	31616MN046	Ridgeview Distinct by Medica	Off-Exchange	<100	$31,664
PreferredOne	88102MN001	PreferredHealth	Off-Exchange	<100	$1,113,064
PreferredOne	88102MN023	PreferredOne	Off-Exchange	<100	$3,890
PreferredOne	88102MN021	Savers	Off-Exchange	<100	$799,604
Quartz	70373MN004	Individual HMO	On-Exchange	<100	$887,099
Quartz	70373MN004	Individual HMO	Off-Exchange	<100	$27,394
UCare	85736MN023	UCare Individual and Family Plans	On-Exchange	1,046	$50,416,630
			Total	**3,769**	**$189,308,067**

Notes:

1. Products with less than 100 enrollees are labeled as < 100 for protected health information (PHI) reasons.
2. The *Enrollees* column counts enrollees that transfer between products more than once. As a result, the total enrollees in this section differs from the enrollee count shown previous portions of this report.

Appendix D - Minnesota Rating Regions