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Minnesota Comprehensive Health Association

Final 2023 Benefit Year Report
Results for The Minnesota Premium Security Plan

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Contents

Introduction

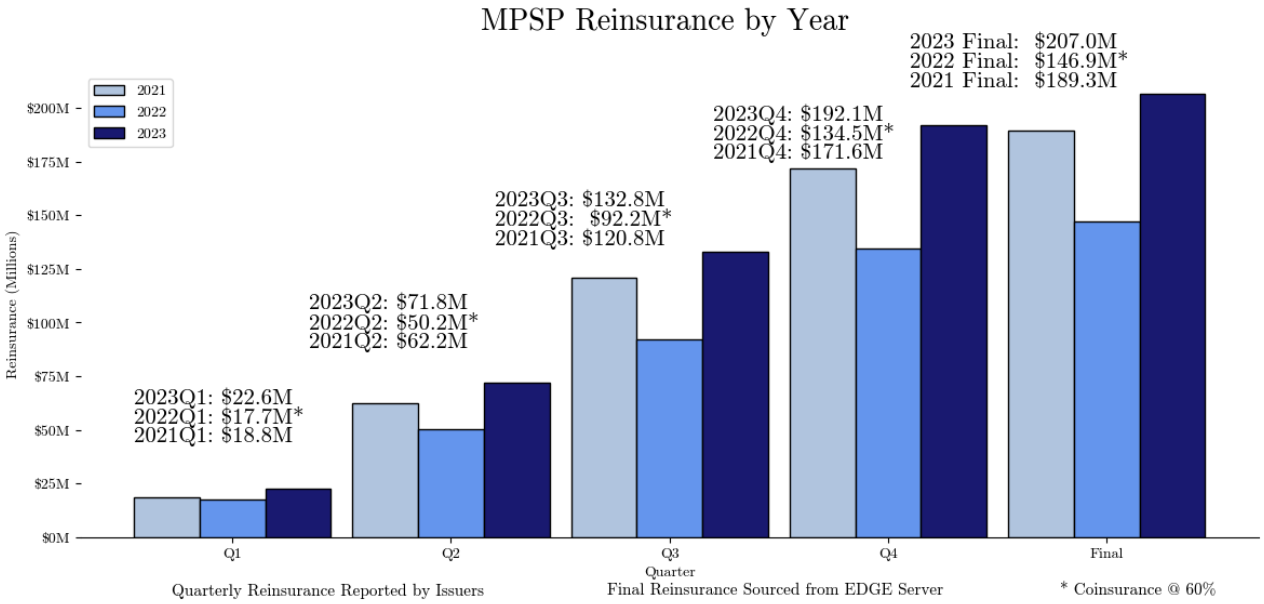
The Minnesota Comprehensive Health Association (MCHA) retained Wakely Consulting Group, LLC, an HMA Company (Wakely) to collect data related to the Minnesota state-based reinsurance program referred to as the Minnesota Premium Security Plan (MPSP), review the data for reasonability, calculate the reinsurance 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 2023 benefit year report for MPSP. Figures and tables in this report supersede figures and values previously communicated in 2023 MPSP quarterly reporting.

Executive Summary

The 2023 benefit year reinsurance amount for MPSP is $206,969,230. 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 21st, 2024 and processed by CMS with an outbound date of either May 21st, 2024 or May 24th, 2024. 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.



For each quarter of the 2023 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 2019 and 2023. Note that each quarter within a year is cumulative. That is, the $22.6 million in the 2023Q1 report is included in the $192.1 million in the

2023Q4 report. The increase between fourth quarter and the final reinsurance amount is primarily caused by claim adjudication and claim systems (e.g. EDGE server vs internal claim system).

In February 2024, Wakely estimated 2023 benefit year reinsurance. The $213.2 million estimate was approximately 3.0% higher ($\approx \frac{\$213.2M}{\$207.0M}$ - 1) than the actual reinsurance amount. The difference was caused by the number of reinsurance eligible enrollees (4,219 estimated vs 4,212 actual) and the average reinsurance amount per eligible enrollee ($50,544 estimated vs $49,138 actual). The combined impact led to an approximate $6.2 million overestimate of the final reinsurance (≈ $213.2M - $207.0M).

Table 1 displays final enrollment and reinsurance under MPSP between 2018 and 2023. The percent change column is measured from the previous year except for the row labeled *2023 Statewide* which is measured from the row labeled *2022 Statewide @ 80%*. Reinsurance increased approximately 40.9% between 2022 and 2023 ($\approx \frac{\$207.0M}{\$146.9M}$ - 1). This was primarily caused by the change in coinsurance from 60% to 80%. After accounting for the coinsurance change, the year-over-year increase is 5.7% ($\approx \frac{\$207.0M}{\$195.9M}$).

Table 1: Reinsurance Amounts and Enrollee Counts

	Distinct RI Enrollees	RI Enrollee % Change	Reported Reinsurance	Reinsurance % Change
2023 Statewide	4,212	7.5%	$206,969,230	5.7%
2022 Statewide @ 80%	*3,919*	4.4%	*$195,864,305*	*3.5%*
2022 Statewide @ 60%	3,919	4.4%	$146,898,229	-22.4%
2021 Statewide	3,754	14.5%	$189,308,067	18.2%
2020 Statewide	3,279	3.0%	$160,210,351	7.0%
2019 Statewide	3,183	8.8%	$149,660,234	9.9%
2018 Statewide	2,925	-	$136,124,512	-

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 2023 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 2023 inbound and the 2023 outbound files for Wakely to use to calculate final 2023 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 2023 benefit year federal high-cost risk pool program. The Data Review section on Page 11 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 2023, the final submission date was May 21st, 2024.

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.

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 one issuer during benefit year 2023 as being an outlier in one or more metrics. This issuer was required to submit a justification or correct the data quality issues. In all instances, the issuer reported that the justification that was 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

2023 Reinsurance Timeline

Table 2 provides the timeline and key dates for calculating 2023 benefit year reinsurance. The 2023 timeline is different than previous years due to CMS extending the EDGE server submission deadline as a result of the Change Healthcare data breach. In January 2024, 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 2024. 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.

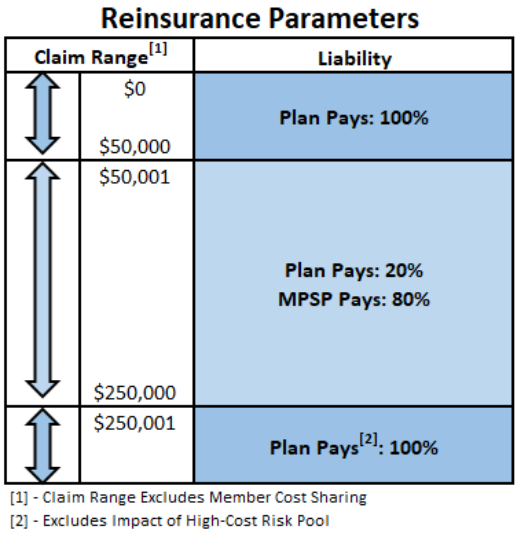
After Wakely's calculations and data review process, each issuer received a file that contained the claims for each reinsurance eligible enrollee for both the preliminary and final data requests. The file permitted issuers to review Wakely's calculation and report any discrepancies before the deadline of June 25th, 2024.

Table 2: 2023 Benefit Year Calculation Timeline

Description	Date
All Issuer Data Call	1/24/2024
Preliminary Data Requested by Wakely	2/2/2024
Preliminary Data Due to Wakely	3/8/2024
Preliminary Results Sent to Issuers	4/5/2024
Final Data Requested by Wakely	5/3/2024
Final Data Due to Wakely	5/28/2024
Final Results Sent to Issuers	6/11/2024
End of MPSP Discrepancy Reporting	6/25/2024

Methodology Description

Wakely used 2023 inbound data that was submitted to the EDGE server through May 21st, 2024 and the outbound files produced on May 21st, 2024 or May 24th, 2024 to calculate final 2023 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 2023 MPSP reinsurance parameters to calculate reinsurance. 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 2023. 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	2023 Reinsurance
HMO Minnesota (Blue Plus)	57129	$55,085,221.74
HealthPartners, Inc.	79888	$46,093,697.24
Medica Insurance Company	31616	$43,387,532.83
Preferred One Insurance Company	88102	$2,285,544.99
Quartz Health Plan MN Corporation	70373	$1,292,694.38
UCare Minnesota	85736	$58,824,538.38
Total Statewide	**-**	**$206,969,229.58**

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 or the CMS website.

Table 4: Reinsurance Amount by Area

Rate Region	2023 Reinsurance	2023 Dist'n	2022 Dist'n	2021 Dist'n	2020 Dist'n	2019 Dist'n
Rating Area 1	$21,019,806	10%	10%	11%	11%	12%
Rating Area 2	$9,003,510	4%	5%	6%	6%	6%
Rating Area 3	$14,549,029	7%	6%	7%	7%	7%
Rating Area 4	$6,441,354	3%	3%	3%	2%	3%
Rating Area 5	$8,024,512	4%	5%	5%	4%	4%
Rating Area 6	$7,425,855	4%	4%	4%	5%	4%
Rating Area 7	$17,323,022	8%	8%	9%	7%	9%
Rating Area 8	$120,725,064	58%	58%	56%	57%	54%
Rating Area 9	$2,457,078	1%	1%	1%	1%	1%
Statewide	**$206,969,230**	**100%**	**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	2023 Reinsurance	2023 Dist'n	2022 Dist'n	2021 Dist'n	2020 Dist'n	2019 Dist'n
Catastrophic	$2,674,421	1%	1%	0%	1%	0%
Bronze	$82,070,951	40%	44%	48%	45%	44%
Silver	$58,962,070	28%	28%	26%	29%	29%
Gold	$62,295,934	30%	26%	25%	25%	26%
Platinum	$965,852	0%	0%	0%	1%	1%
Total	**$206,969,230**	**100%**	**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.[1]

Table 6: Reinsurance Amount by Exchange Status

Exchange Status	2023 Reinsurance	2023 Dist'n	2022 Dist'n	2021 Dist'n	2020 Dist'n	2019 Dist'n
On-Exchange	$142,262,255	69%	69%	67%	69%	69%
Off-Exchange	$64,706,974	31%	31%	33%	31%	31%
Total	**$206,969,230**	**100%**	**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	2023 Reinsurance	2023 Dist'n	2022 Dist'n	2021 Dist'n	2020 Dist'n	2019 Dist'n
Standard	$193,061,955	93%	93%	92%	90%	90%
Zero CS	$235,872	0%	0%	0%	0%	0%
Limited CS	$1,034,332	0%	0%	0%	0%	0%
73% CSR	$12,637,071	6%	7%	7%	9%	9%
94% CSR	$0	0%	0%	1%	0%	0%
Total	**$206,969,230**	**100%**	**100%**	**100%**	**100%**	**100%**

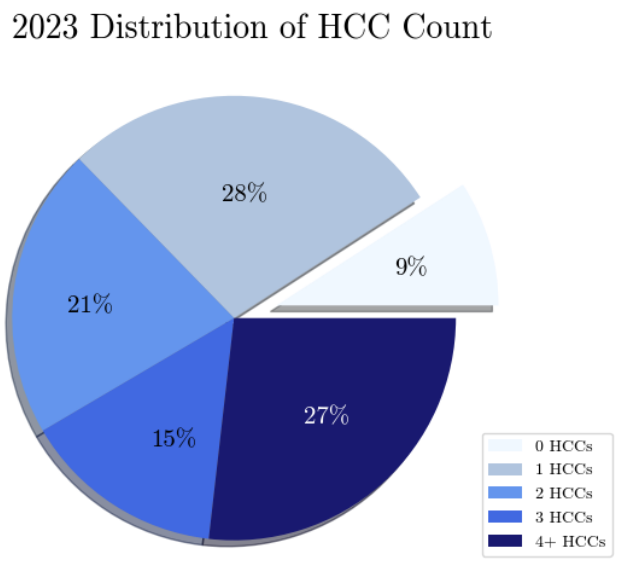
[1] Multiple issuers updated the on- and off-exchange mapping in the data they provided to Wakely between the 2019Q2 and 2019Q3 reports. As a result, the 2019 through 2023 distributions are not directly comparable to quarterly reports prior to 2019Q2.

Reinsurance by Claim Spend

Please see Appendix A for reinsurance by claim spend level.

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 9% 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 2023 for enrollees eligible for reinsurance.

Table 8 provides the final HCC count distribution by reinsurance year.

Table 8: HCC Distribution by Year

HCC Count	2023	2022	2021	2020	2019
0 HCCs	9%	9%	8%	10%	9%
1 HCC	28%	27%	26%	28%	29%
2 HCCs	21%	22%	21%	21%	22%
3 HCCs	15%	13%	15%	14%	13%
4+ HCCs	27%	29%	30%	27%	27%

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.[2]

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.[3] This analysis included a check to ensure that the plan paid amount on both the HCRPDE and the inbound EDGE server files were consistent.

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 2023 individual market. In total, approximately 2% of the population was expected to exceed the $50,000 attachment point based on the 1332 Waiver Application, which was close to the proportion of enrollees exceeding the attachment point in this report. Wakely reviewed the most recent waiver application and a claim distribution was not included in the report.

[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 results shown in Appendix C for the final 2019 through 2023 reports are not directly comparable to the table shown in the quarterly reports prior to 2019Q2.

[3]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 24.0 as a reference for reviewing the submitted EDGE encounter data. For additional information, please see https://www.regtap.info/

2023Q4 MPSP Report Comparison

Wakely compared the list of enrollees contained in the 2023Q4 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 2023Q4 report, then he or she should also be eligible for reinsurance in the final calculation. A small number of enrollees in the 2024Q4 data request were not eligible for reinsurance in the final 2023 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 small demographic (age and gender) differences between inbound and outbound files.

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.

2023 Considerations

This section discusses changes occurring during 2022 and 2023 that impact reinsurance and trends.

1. **Coinsurance Parameter** - The coinsurance rate increased from 60% in 2022 to 80% in 2023. All else being equal, this increased reinsurance payments by 33.3% ($= \frac{80\%}{60\%} - 1$). If the coinsurance rate in 2022 was 80% rather than 60%, the reinsurance reported in 2022 would have equaled \$195,864,305 (=\$146,898,229 $\times \frac{80\%}{60\%}$) and the change between 2022 to 2023 would have been an increase of approximately 5.7% ($= \frac{\$206,969,230}{\$195,864,305} - 1$).
2. **Medicaid Redetermination** - Starting April 2023, Minnesota resumed the regular renewal process for Medicaid eligibility which had been suspended due to the public health emergency. Disenrollment from Medicaid began July 2023 and took several months to complete. Some Medicaid enrollees losing Medicaid eligibility transferred to the individual market. The total annual impact of this transfer was dampened during 2023 given that the transitioning enrollees had less than 12 months of enrollment during benefit year 2023.
3. **Family Glitch Fix - Special Enrollment Period** - In 2023, eligibility for premium subsidies in the individual market was expanded to include families with employer sponsored coverage

with costs that exceeded 9.5% of the family's income. Previously, affordability was determined using the single employee coverage level and not the family coverage level. This change was referred to as the "Family Glitch Fix". Minnesota enacted a Special Enrollment Period (SEP) for families enrolled in a non-calendar year employer-sponsored health insurance product between April 17 through October 31, 2023. All-else-equal, the SEP may have increased enrollment in the individual market; however, the overall impact on MPSP was likely minimal given it was limited to families enrolled in a non-calendar year employer sponsored plan meeting certain requirements.

Coinsurance Change

The total amount of reinsurance paid by MCHA depends on the coinsurance rate, and between 2022 and 2023, the coinsurance rate increased from 60% to 80%. All else being equal for an enrollee, this increased the total amount of reinsurance paid by 33.3%. The table below provides an illustrative example of the increase for a hypothetical member with $100,000 paid claims using an attachment point of $50,000.

Table 9: Coinsurance Change Example

Coinsurance	Paid Claims	Formula	Reinsurance Amt
60% Coinsurance	$100,000	($100,000 - $50,000) x 60%	$30,000
80% Coinsurance	$100,000	($100,000 - $50,000) x 80%	$40,000

Note that the total number reinsurance eligible enrollees is not impacted by the coinsurance change because eligibility for reinsurance depends only on the attachment point. The next table restates Table 1 to be on a per reinsurance eligible enrollee format. The *Reported Reinsurance* column in this table equals the *Reported Reinsurance* in Table 1 divided by the *Distinct RI Enrollees* column.

Table 10: Reinsurance Amounts per Enrollee and Enrollee Counts

	Distinct RI Enrollees	RI Enrollee % Change	Reported Reinsurance	Reinsurance % Change
2023 Statewide	4,212	7.5%	$49,138	-1.7%
2022 Statewide @ 80%	*3,919*	4.4%	*$49,978*	*-0.9%*
2022 Statewide	3,919	4.4%	$37,484	-25.7%
2021 Statewide	3,754	14.5%	$50,428	3.2%
2020 Statewide	3,279	3.0%	$48,860	3.9%
2019 Statewide	3,183	8.8%	$47,019	1.0%
2018 Statewide	2,925	-	$46,538	-

The actual reinsurance per eligible enrollee increased 31.1% between 2022 and 2023 from $37,484 to $49,138. This is close to the expected increase caused by the the coinsurance change.

Deductible Leveraging

In a reinsurance setting, trends for a reinsurer can be higher than the overall cost trend of the reinsured entity due to deductible leveraging. Deductible leveraging occurs when the underlying claim costs for the insurer increases at a rate higher than the increase in the deductible. In context of MPSP, the words attachment point and deductible are synonymous. The example below shows the calculation of liability for an insurance company that has an enrollee with $55,000 in total claims using MPSP's $50,000 attachment point and 20% coinsurance. This example is for illustrative purposes only and does not represent an analysis of the impact of deductible leveraging for MPSP.

Table 10: Deductible Leveraging Example

Description	Amount	Formula	Payer
Deductible	$50,000	min{$55,000, $50,000}	Issuer
Coinsurance	$1,000	($55,000 - $50,000)× 20%	Issuer
Reinsurance	$4,000	($55,000 - $50,000)× 80%	Reinsurer

If the claim increases by 1% because of regular cost trends, then the cost of the claim is now $55,550 (= $55,000 × 1.01), but the cost to the reinsurer increases by approximately 11.0% (= $\frac{\$4,440}{\$4,000}$ - 1). This is shown in the next table.

Table 11: Deductible Leveraging Example – Trended

Description	Amount	Formula	Payer
Deductible	$50,000	min{$55,550, $50,000}	Issuer
Coinsurance	$1,110	($55,550 - $50,000)× 20%	Issuer
Reinsurance	$4,440	($55,550 - $50,000)× 80%	Reinsurer

The impact of deductible leveraging is minimally off-set by a reinsurance cap since the reinsurer is no longer liable for additional costs exceeding the reinsurance cap. Deductible leveraging can impact both the number of enrollees eligible for reinsurance and the average cost of reinsurance per reinsurance eligible enrollee. The overall deductible leveraging trend depends both on the proportion of claims for enrollees exceeding the attachment point and the total change in costs for enrollees exceeding the attachment point.

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. Wakely provides actuarial services to a variety of clients throughout the health industry. Wakely's clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving Wakely's clients. 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 2023.

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,

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Appendix A - Reinsurance by Claim Spend Level

2023 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	226	$51,213	$970	$219,250
$52,508	$58,498	464	$55,385	$4,308	$1,998,995
$58,498	$119,795	2,232	$81,337	$25,070	$55,955,519
$119,795	$200,000	690	$152,757	$82,205	$56,721,698
$200,000	$9,999,999	600	$377,200	$153,456	$92,073,769
Total		**4,212**	**$130,707**	**$49,138**	**$206,969,230**

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 A - Reinsurance by Claim Spend Level

2022 Final Reinsurance Amount by Claim Spend Level (60% Coinsurance)

Incurred Claims		Enrollee Count	Average Incurred Claims Per Enrollee	Average Reinsurance Per Enrollee	Aggregate Reinsurance
Low Range	High Range				
$50,000	$52,508	208	$51,236	$741	$154,216
$52,508	$58,498	417	$55,510	$3,306	$1,378,641
$58,498	$119,795	2,030	$81,153	$18,692	$37,944,165
$119,795	$200,000	697	$151,927	$61,156	$42,625,681
$200,000	$9,999,999	567	$371,412	$114,278	$64,795,526
Total		**3,919**	**$131,418**	**$37,484**	**$146,898,229**

Notes:

1. Average Reinsurance Per Enrollee = min{(Average Incurred Claims - $50,000) × 60%, $160,000}.
2. The claim intervals originate from the 1332 Waiver Application.

Appendix A (Cont.) - 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

			2023		2022	
Rank	**HCC**	**HCC Description**	**Enrollee Count[1]**	**% of Reinsurance Eligible Enrollees**	**Enrollee Count[1]**	**% of Reinsurance Eligible Enrollees**
1	G01	Diabetes	809	19%	761	19%
2	G15A	Chronic Obstructive Pulmonary Disease, Including Bronchiectasis; Severe Asthma; Asthma, Except Severe	677	16%	593	15%
3	HCC142	Specified Heart Arrhythmias	567	13%	533	14%
4	HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders	554	13%	495	13%
5	HCC008	Metastatic Cancer	524	12%	505	13%
6	HCC130	Heart Failure	508	12%	448	11%
7	G08	Disorders of the Immune Mechanism	440	10%	379	10%
8	HCC002	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	377	9%	371	9%
9	G13	Respiratory Arrest; Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	388	9%	399	10%
10	HCC075	Coagulation Defects and Other Specified Hematological Disorders	317	8%	292	7%
11	HCC023	Protein-Calorie Malnutrition	306	7%	344	9%
12	HCC048	Inflammatory Bowel Disease	289	7%	288	7%
13	HCC012	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	256	6%	230	6%
14	HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	232	6%	202	5%
15	HCC253	Artificial Openings for Feeding or Elimination	227	5%	213	5%
16	G02A	Mucopolysaccharidosis; Metabolic Disorders; Endocrine Disorders	256	6%	233	6%
17	HCC156	Pulmonary Embolism and Deep Vein Thrombosis	220	5%	232	6%
18	HCC120	Seizure Disorders and Convulsions	210	5%	204	5%
19	HCC088	Major Depressive and Bipolar Disorders	206	5%	184	5%

Appendix B (Cont.) - Enrollee Count by HCC

Limited to HCCs with at least 100 Enrollees

			2023		2022	
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	190	5%	171	4%
21	HCC131	Acute Myocardial Infarction	184	4%	187	5%
22	G09A	Drug Psychosis; Drug Dependence	164	4%	153	4%
23	HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	153	4%	130	3%
24	HCC118	Multiple Sclerosis	139	3%	142	4%
25	HCC163	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	138	3%	125	3%
26	HCC045	Intestinal Obstruction	137	3%	140	4%
27	HCC125	Respirator Dependence/Tracheostomy Status	116	3%	120	3%
28	HCC011	Colorectal, Breast (Age ¡ 50), Kidney, and Other Cancers	109	3%	<100	-
29	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	109	3%	<100	-
30	HCC042	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	106	3%	113	3%
31	HCC122	Non-Traumatic Coma, Brain Compression/Anoxic Damage	106	3%	118	3%

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

Appendix C - 2023 Benefit Year Reinsurance Amount and Enrollees by Product

Carrier	Product ID	Product Name	Exchange Status	Enrollee Count[1,2]	Reinsurance
Blue Plus	57129MN054	Blue Plus Minnesota Value	On-Exchange	597	$25,595,505
Blue Plus	57129MN053	Blue Plus Minnesota Value	Off-Exchange	335	$14,670,125
Blue Plus	57129MN008	Blue Plus Metro	Off-Exchange	116	$5,211,468
Blue Plus	57129MN009	Blue Plus Metro	On-Exchange	<100	$4,356,745
Blue Plus	57129MN015	Blue Plus Southeast	On-Exchange	<100	$3,680,276
Blue Plus	57129MN014	Blue Plus Southeast	Off-Exchange	<100	$1,571,103
HealthPartners	79888MN031	HealthPartners	Off-Exchange	512	$25,695,832
HealthPartners	79888MN030	HealthPartners	On-Exchange	473	$19,923,357
HealthPartners	79888MN032	HealthPartners	Off-Exchange	<100	$474,508
Medica	31616MN044	Engage by Medica	On-Exchange	227	$14,104,515
Medica	31616MN042	Medica Applause	On-Exchange	206	$10,950,326
Medica	31616MN042	Medica Applause	Off-Exchange	164	$8,856,740
Medica	31616MN044	Engage by Medica	Off-Exchange	<100	$3,224,505
Medica	31616MN047	Bold by M Health Fairview	On-Exchange	<100	$1,557,111
Medica	31616MN043	North Memorial Acclaim by Medica	On-Exchange	<100	$1,440,883
Medica	31616MN021	Medica Value	Off-Exchange	<100	$640,086
Medica	31616MN047	Bold by M Health Fairview	Off-Exchange	<100	$519,035
Medica	31616MN020	Medica HSA	Off-Exchange	<100	$517,306
Medica	31616MN043	North Memorial Acclaim by Medica	Off-Exchange	<100	$400,290
Medica	31616MN045	Altru Prime by Medica	On-Exchange	<100	$327,333
Medica	31616MN049	Medica	On-Exchange	<100	$257,017
Medica	31616MN018	Medica Solo	Off-Exchange	<100	$174,805
Medica	31616MN046	Ridgeview Distinct by Medica	On-Exchange	<100	$155,159
Medica	31616MN049	Medica	Off-Exchange	<100	$119,215

Appendix C - 2023 Benefit Year Reinsurance Amount and Enrollees by Product

Continued...

Carrier	Product ID	Product Name	Exchange Status	Enrollee Count[1,2]	Reinsurance
Medica	31616MN045	Altru Prime by Medica	Off-Exchange	<100	$97,634
Medica	31616MN019	Medica Encore	Off-Exchange	<100	$27,096
Medica	31616MN046	Ridgeview Distinct by Medica	Off-Exchange	<100	$18,477
PreferredOne	88102MN001	PreferredHealth	Off-Exchange	<100	$1,425,086
PreferredOne	88102MN021	Savers	Off-Exchange	<100	$860,459
Quartz	70373MN004	Individual HMO	On-Exchange	<100	$1,089,488
Quartz	70373MN004	Individual HMO	Off-Exchange	<100	$203,206
UCare	85736MN023	UCare Individual and Family Plans	On-Exchange	1146	$58,824,538
			Total	**4,220**	**$206,969,230**

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.
3. Starting January 1st, 2021, Quartz Health Plan MN Corporation (Quartz) entered the individual market in five southeastern counties. This appendix includes Quartz; however, the 2018 through 2020 reports do not.

Appendix D - Minnesota Rating Regions