wakely.com

Minnesota Comprehensive Health Association

2018 Benefit Year Report

Results for the Minnesota Premium Security Plan

June 27th, 2019

Prepared by:
Wakely Consulting Group

Tyson Reed, FSA, MAAA
Consulting Actuary

Wakely

Contents

Introduction

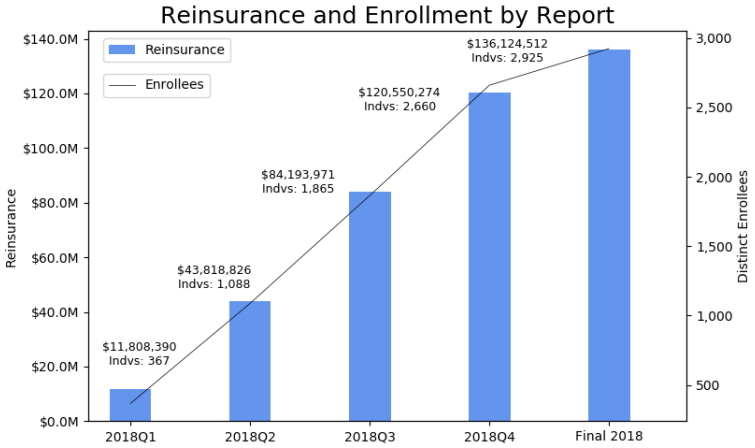
The Minnesota Comprehensive Health Association (MCHA) retained Wakely Consulting Group, LLC (Wakely) to collect data related to the Minnesota state-based reinsurance program referred to as the Minnesota Premium Security Plan (MPSP), review the data for reasonability, calculate the reinsurance payments 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 sole use of MCHA and its Board of Directors. Wakely understands that this report will be made public. Wakely does not intend to benefit third parties and assumes no duty or liability to other parties who receive this work. The report should only be reviewed in its entirety and then only by qualified individuals. This document contains the data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements.

This is the final 2018 benefit year report for MPSP. Figures and tables in this report supersede figures and values previously communicated in the 2018 quarterly and draft annual 2018 reports. The MCHA Board of Directors approved the draft version of this report on June 24th, 2019. Aside from minor grammar edits, the only change to this version of the report is in the EDGE Server Outbound Files section. Wakely was able to review the duplicative claims identified by CMS underlying the EDGE server data and was able to confirm that the issue did not impact reinsurance calculations.

Executive Summary

The reinsurance amount for 2018 benefit year under MPSP is $136,124,512. There were approximately 155,000 enrollees in Minnesota's Non-Grandfathered Individual Market during 2018.[1] 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 by April 30th, 2019 and processed by CMS with an outbound date of May 1st, 2019. 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 2018 benefit year, Minnesota issuers submitted data to Wakely that allowed MCHA to monitor the MPSP program throughout the year. The figure to the right shows the reinsurance and distinct enrollee count underlying each quarterly report and the reinsurance amount in this report. Note that each quarter is cumulative. That is, the $11.8 million in the 2018Q1 report is included in the $120.6 million in the 2018Q4 report. The bars show the reinsurance amount and the line represents the distinct enrollees within each report. The increase between 2018Q4 and the final 2018 reinsurance amount is the

[1] Source: https://mn.gov/commerce/media/news/#/detail/appId/2/id/354562

result of claim runout.

In February 2019, Wakely estimated 2018 benefit year reinsurance. The estimate informed Minnesota Management and Budget's initial February forecast of the MPSP program. The $138.9 million estimate was approximately 2% higher than the reinsurance amount in this report. The difference was caused by both the number of reinsurance eligible enrollees (2,947 estimated vs 2,925 actual) and the average reinsurance cost per eligible enrollee ($47,119 estimated vs $46,553 actual). The combined impact led to an approximate $2.8 million dollar difference between the final 2018 reinsurance amount and Wakely's initial estimate (= $138.9 million - $136.1 million).

Table One below displays final 2018 enrollment and reinsurance under MPSP.

Table One: Reinsurance and Enrollee Count

	Distinct Enrollees	Reinsurance Amount
Statewide	2,925	$136,124,512

The final 2018 reinsurance amount of $136,124,512 is less than the $270 million reinsurance estimate in the Section 1332 Waiver. The largest driver of the difference is the decrease in the size of the individual market between 2015 and 2018.

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 was used to calculate 2018 benefit year reinsurance. From a high-level, there are two types of EDGE files. There are files that issuers submit to the EDGE Server. These files are referred to as *inbound* files. The EDGE server processes these files and then returns another set of data files back to the issuers. These files are referred to as *outbound* files.

Minnesota issuers provided both the 2018 inbound and 2018 outbound files for Wakely to use to calculate final 2018 reinsurance. Officers at each organization signed an attestation regarding the accuracy, truthfulness, and completeness of the EDGE data that they submitted to Wakely. Issuers also certified 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.

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 and the high-cost risk pool programs. Historically, this data was also used to calculate reinsurance under the Federal Transitional Reinsurance Program which 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 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 April 30th of the following year.

Attestation
CMS requires that an employee with the authority to legally and financially bind the issuer attest to the accuracy of the issuer's inbound data submission. CMS has the authority to exclude an issuer from risk adjustment calculations or the high-cost risk pool programs. CMS can impose civil monetary penalties for the violation of risk adjustment data requirements. This includes falsifying or misrepresenting data either intentionally or recklessly.

EDGE Server Outbound Files

After an issuer submits its inbound files to the EDGE server, the EDGE server processes the data. CMS then reviews the data for reasonability. Part of this review includes a Quantity and Quality analysis. Under the quality review, CMS compares key metrics and statistics of an issuer against the nationwide average. If an issuer is identified as an outlier in one or more of the metrics, the issuer is required to provide justification for being an outlier. The issuer has discretion in its response to CMS. CMS also requires that the quantity of data submitted by issuers meet key thresholds measured against self-reported baselines throughout the year. If these thresholds are not met, CMS may exclude issuers from the risk adjustment process and assign the issuer a default risk adjustment charge. None of the Minnesota issuers reported being flagged for quantity outliers. Two issuers were flagged for quality issues that were not related to reinsurance.

Among others, the EDGE server returns a table named the *High Cost Risk Pool Detail Extract* (HCRPDE) which is limited to the claims and enrollment spans eligible for payments under the 2018 benefit year high-cost risk pool program. Wakely relied on this table to identify claims and enrollees eligible for reinsurance for MPSP.

On June 5th, 2019, CMS issued a statement that certain claims in the HCRPDE were potentially duplicated. Issuers nationwide, including issuers in Minnesota, were required to execute an ad hoc query on the EDGE server which identified how many claims were duplicated. Minnesota issuers participating in MPSP provided the output of these ad hoc queries to Wakely. Overall, there were five duplicated claims across the individual and small group markets.[2] Wakely reviewed the impacted claims and all duplicated claims were for enrollees that did not exceed the attachment point. As a result, this issue did not impact the final reinsurance calculation.[3]

Methodology

2018 Reinsurance Timeline

Table Two on the next page provides the EDGE server timeline and key dates for calculating 2018 benefit year reinsurance. In January 2019, Wakely hosted a call with the eligible issuers to outline the spring timeline and the structure of the data request.[4] Issuers provided EDGE server data to Wakely twice during the spring of 2019. 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 preliminary EDGE server data was not used in the final calculation of 2018 benefit year reinsurance.

[2]The HCRPDE contains claims for both the individual and small group markets. Wakely excludes claims in the small group market prior to calculating reinsurance for MPSP.

[3]When Wakely provided the draft annual 2018 report to MCHA, the specific claim identifiers for these claims had not yet been identified in the EDGE server. The impacted issuer provided the claim identifiers to Wakely on June 24th, 2019. As a result, this section has been updated in this version of the report.

[4]The list of eligible issuers was provided to Wakely by MCHA in early 2018 which permitted Wakely to collect and analyze data for quarterly reports referenced throughout this document.

Issuers 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 7th, 2019.

Table Two: 2018 Benefit Year Calculation Timeline

Description	Date
All Issuer EDGE Server Data Call	1/10/2019
Preliminary EDGE Server Data Requested by Wakely	2/22/2019
Preliminary EDGE Server Data Due to Wakely	3/15/2019
Preliminary EDGE Server Results Sent to Issuers	4/1/2019
Final EDGE Server Data Requested by Wakely	4/22/2019
Final EDGE Server Data Due to Wakely	5/10/2019
Final EDGE Server Results Sent to Issuers	5/24/2019
End of Discrepancy Reporting	6/7/2019

Methodology Description

Wakely used 2018 EDGE Server data with an inbound date of April 30th, 2019 and outbound date of May 1st, 2019 to calculate final 2018 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 2018 MPSP reinsurance parameters to calculate reinsurance for each enrollee. The 2018 reinsurance parameters are illustrated in the figure below.

2018 Reinsurance Parameters

Claim Range[1]		Liability
$0	$50,000	Plan Pays: 100%
$50,001	$250,000	Plan Pays: 20% MCHA Pays: 80%
$250,001		Plan Pays[2]: 100%

[1] - Claim Range Excludes Member Cost Sharing
[2] - Excludes Impact of Federal High-Cost Risk Pool Program

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 within that time period. For example, under certain circumstances, an enrollee might have been enrolled in both a silver and a gold plan for a portion 2018. 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.

Wakely reviewed the underlying data for reasonability but did not audit the EDGE server data. The Data Review section of this memorandum outlines Wakely's review of the issuers' EDGE data.

Analysis

This section provides additional detail for the reinsurance amount shown in Table One. The distribution total in the following tables may not add to 100% due to rounding.

Reinsurance by Area

Table Three shows the amount of reinsurance for each of Minnesota's rating regions. The distribution between Metro / Non-Metro has been relatively stable between quarterly reports with a slight shift in reinsurance amounts towards the Metro region.[5] For example, in the 2018Q1 report, approximately 51% of reinsurance was for enrollees in the Metro region. In this report, approximately 55% of reinsurance dollars are in the Metro region. A list of counties in each rating area can be found on either the Minnesota Department of Commerce website or the CMS website.

Table Three: Reinsurance Amount by Area

Rate Region	Reinsurance Amount	Reinsurance Distribution
1 - Olmsted (Rochester)	$14,087,652	10%
2 - St. Louis (Duluth)	$8,541,450	6%
3 - South Central	$8,573,130	6%
4 - South West	$4,683,699	3%
5 - West Central (Chippewa)	$6,308,661	5%
6 - West (Wilkin)	$5,652,439	4%
7 - Central (Crow Wing)	$10,186,629	7%
8 - Metro / St. Cloud	$75,326,973	55%
9 - North West (Kittson)	$2,763,880	2%
Statewide	**$136,124,512**	**100%**

Reinsurance by Metal Level

Table Four on the next page provides the reinsurance amount and distribution by metal tier. There are four different metal tiers in the individual market which reflect different levels of cost sharing an enrollee is expected to pay. 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, but enrollment is limited to individuals who are eligible for hardship exemption or are under the age of 30.

Throughout the year, there has been a gradual shift in payment from the bronze tier into the higher metal tiers. In the 2018Q1 report, approximately 51% of the total reinsurance amount was in the Bronze tier. The proportion of reinsurance decreased to approximately 48% in this report.

[5] Metro includes Anoka, Benton, Carver, Dakota, Hennepin, Ramsey, Scott, Sherburne, Stearns, Washington, and Wright counties

Table Four: Reinsurance Amount by Metal Tier

Metal Tier	Reinsurance Amount	Reinsurance Distribution
Catastrophic	$341,735	0%
Bronze	$64,935,748	48%
Silver	$39,106,733	29%
Gold	$30,339,876	22%
Platinum	$1,400,419	1%
Total	**$136,124,512**	**100%**

Reinsurance by Exchange Status

Wakely analyzed reinsurance amounts for plans purchased on and off Minnesota's exchange, MNCare. Since the 2018Q1 report, there has been a slight shift in reinsurance distribution towards the on-exchange market. In the 2018Q1 report, approximately 66% of the reinsurance dollars were from plans sold on the exchange. In this report, nearly 68% of the reinsurance dollars are from enrollees who bought plans on the Exchange.

Table Five: Reinsurance Amount by Exchange Status

Exchange Status	Reinsurance Amount	Reinsurance Distribution
On-Exchange	$92,165,950	68%
Off-Exchange	$43,958,561	32%
Total	**$136,124,512**	**100%**

Reinsurance by Plan Type

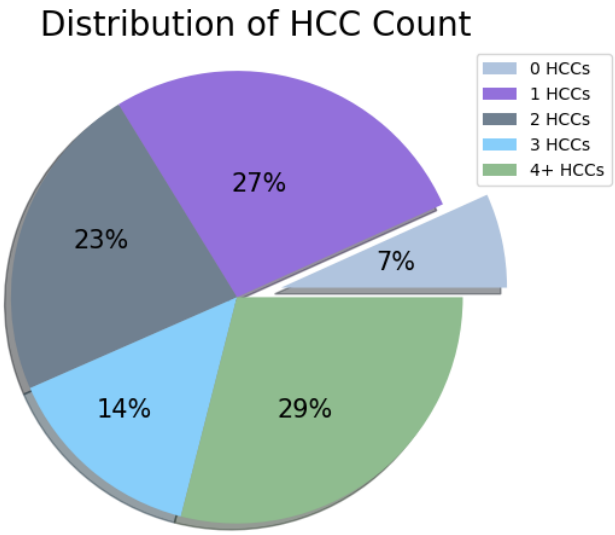
This section provides reinsurance amounts by plan type. In the Affordable Care Act, individuals and families qualify for cost-sharing reduction (CSR) subsidies which lower out-of-pocket costs. There are several different levels of CSRs. The first is 73% which reduces the enrollee's out-of-pocket cost to approximately 27% (= 1 - 73%) of total medical costs. There are other levels of CSR which are not prevalent in Minnesota's market due to Minnesota's Basic Health Plan, MNCare. Finally, there are limited cost-sharing and zero cost-sharing plans for American Indians and Alaska Natives.

Table Six: Reinsurance Amount by Plan Type

Plan Type	Reinsurance Amount	Reinsurance Distribution
Standard	$123,284,703	91%
Zero Cost Sharing	$499,928	0%
Limited Cost Sharing	$241,087	0%
73% CSR	$12,098,794	9%
Total	**$136,124,512**	**100%**

Distribution of HCC Count

The chart below provides the hierarchical condition category (HCC) distribution underlying the EDGE server data. 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 a 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, even though an enrollee may have a claim, he or she may not be assigned to a HCC. 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 a HCC. In comparison, only 7% of enrollees eligible for reinsurance payments do not have a HCC. These enrollees may have experienced a traumatic accident with a diagnosis code that is not used in the HCC model or may have diagnosis codes that were not coded correctly.

The HCC model is hierarchical and similar conditions are grouped together. 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, all diabetic HCCs are grouped together in the Diabetic Group (G01). Similar hierarchies and groupings exist for other conditions. Appendix A gives the list of the most prevalent HCCs and groupings during benefit year 2018 for enrollees eligible for reinsurance.

Reinsurance by Claim Spend

Please see Appendix B for reinsurance by claim spend level.

Data Review

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.[6] 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 review, Wakely found a very small subset of claims that were included in the HCRPDE that did not have an accepted flag in the EDGE server. It is possible that the accepted version of the claim is in the 2017 EDGE server inbound files and not the 2018 EDGE server inbound files. Wakely did not adjust reinsurance for these claims because the HCRPDE was used to identify claims eligible for reinsurance.

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 which is significantly different than the 2018 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 ($1.9\% \approx \frac{2,925}{155,000}$).

2018Q4 MPSP Report Comparison

Wakely compared the list of enrollees contained in the 2018Q4 quarterly report against the list of enrollees in the final EDGE server data. The data used for the quarterly reports was provided by issuers and included only enrollees with claims that exceeded the reinsurance attachment point. In general, if an enrollee was included in the 2018Q4 report, then he or she should also be eligible for reinsurance in the final calculation. A small portion of enrollees appeared in the 2018Q4 requests but were not eligible for reinsurance in the final 2018 calculation. This is explained by either enrollees changing enrollee identifiers between the quarterly reports and final EDGE server submission, an enrollee having a claim retroactively adjusted which caused him or her to drop below the reinsurance attachment point, or claims failing to be accepted to the EDGE server because of 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. Significant 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 no significant differences between CMS and Wakely's risk score assignments.

[6] 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 EDGE Server Business Rules 12.0 to review accepted claims that were not included in the HCRPDE. For additional information, please see https://www.regtap.info/

Cost Sharing Reductions

Between 2014 and 2017, CMS reduced a carrier's reinsurance in the Federal Transitional Reinsurance Program to account for the fact that cost-sharing reduction subsidies were included in plan paid amount used to calculate reinsurance but were reimbursed by the federal government under a separate program. Issuers received advanced payment from the federal government for CSR plans until October 2017 when the program ended. There is a pending court case which could require the federal government to reimburse issuers for 2018 benefit year CSR subsidies. Since CSR subsidies are not currently being paid by the federal government, Wakely did not make an adjustment to 2018 benefit year reinsurance.

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 the report may be made public. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results. This information is proprietary.

Risks and Uncertainties. The assumptions and resulting calculated reinsurance included in this report are inherently uncertain and could change depending on pending court cases and 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 information is incomplete or inaccurate, my 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 additional subsequent events that would impact the results of this analysis.

Contents of Actuarial Report. This document constitutes the entirety of the actuarial report and supersede any previous communications provided to MCHA.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of my knowledge, the report and methods used in the analyses are in compliance 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

Sincerely,

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

Appendix A - Enrollee Count by HCC

Limited to HCCs with at least 100 Enrollees

Rank	HCC	HCC Description	Enrollee Count	% of Reinsurance Eligible Enrollees
1	G01	Diabetes	560	19%
2	G15	Asthma; Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	512	18%
3	HCC008	Metastatic Cancer	437	15%
4	HCC130	Congestive Heart Failure	412	14%
5	HCC142	Specified Heart Arrhythmias	411	14%
6	HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders	333	11%
7	HCC002	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	289	10%
8	G13	Respiratory Arrest; Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	260	9%
9	HCC023	Protein-Calorie Malnutrition	231	8%
10	HCC048	Inflammatory Bowel Disease	206	7%
11	HCC075	Coagulation Defects and Other Specified Hematological Disorders	198	7%
12	HCC156	Pulmonary Embolism and Deep Vein Thrombosis	192	7%
13	G02A	Mucopolysaccharidosis; Metabolic Disorders; Endocrine Disorders	176	6%
14	HCC253	Artificial Openings for Feeding or Elimination	175	6%
15	HCC012	Breast (Age 50+) and Prostate Cancer, Benign/Uncertain Brain Tumors, and Other Cancers and Tumors	169	6%
16	HCC088	Major Depressive and Bipolar Disorders	159	5%
17	HCC120	Seizure Disorders and Convulsions	150	5%
18	HCC118	Multiple Sclerosis	149	5%
19	HCC131	Acute Myocardial Infarction	147	5%
20	HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy	146	5%
21	G08	Disorders of the Immune Mechanism	138	5%
22	HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia	134	5%

Wakely

Appendix A - Enrollee Count by HCC

Limited to HCCs with at least 100 Enrollees

Rank	HCC	HCC Description	Enrollee Count	% of Reinsurance Eligible Enrollees
23	HCC047	Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption	122	4%
24	HCC045	Intestinal Obstruction	120	4%
25	HCC122	Non-Traumatic Coma, Brain Compression/Anoxic Damage	113	4%
26	G09	Drug Psychosis; Drug Dependence	112	4%
27	HCC125	Respirator Dependence/Tracheostomy Status	106	4%
28	HCC163	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections	102	4%

Appendix B - Reinsurance Amount by Claim Spend Level

2018 High Cost Risk Pool Detail Extract (EDGE Server Outbound Date 5/1/2019)

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	1513	$81,257	$25,005	$37,833,247
$119,795	$245,222	643	$164,048	$91,238	$58,666,328
$245,222	$327,784	108	$279,923	$159,773	$17,255,530
$327,784	$374,643	24	$353,047	$160,000	$3,840,000
$374,643	$512,029	58	$436,960	$160,000	$9,280,000
$512,029	$647,250	23	$574,258	$160,000	$3,680,000
$647,250	$9,999,999	24	$1,043,446	$160,000	$3,840,000
Total		**2,925**	**$122,901**	**$46,538**	**$136,124,512**

Average Reinsurance Per Enrollee = min{(Average Incurred Claims - $50,000) × 80%, $160,000}

Note: Claim intervals originate from the 1332 Waiver Application