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Minnesota Comprehensive Health Association

Final 2020 First Quarter Report

Results for The Minnesota Premium Security Plan

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Wakely Consulting Group

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Consulting Actuary

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 carriers participating in the program, and provide summary reports for MCHA to distribute as appropriate to stakeholders. This report is not intended to project final year-end 2020 reinsurance amounts.

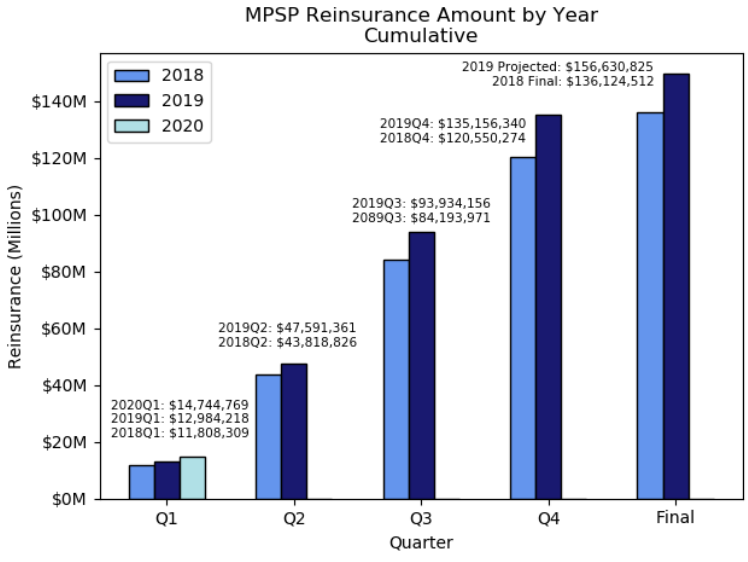
This document has been prepared for the use of MCHA and its Board of Directors. Wakely understands that this report will be made public and distributed to stakeholders beyond MCHA and its Board of Directors due to Minnesota Statutes §62E.24. Wakely does not intend to benefit third parties and assumes no duty or liability to other parties who receive this work. The 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.

Executive Summary

MPSP preliminary reinsurance amounts payable to issuers between January and March 2020 total approximately $14.7 million for 448 distinct enrollees. The data underlying this analysis was provided by Minnesota carriers eligible for reinsurance under MPSP. The figure below shows the reinsurance underlying both the 2019 and 2020 quarterly reports. The 2019Q4 reinsurance in the chart is based on the projected 2019 reinsurance and not the final 2019 reinsurance due to the fact that 2019 benefit year reinsurance has not been finalized as of the release of this report.

The final 2020 reinsurance amounts and enrollee counts will increase significantly from the 2020Q1 values shown below. The final reinsurance will be calculated in compliance with Minnesota Statutes §62E.23 and will be based on an entire year of claim experience.

The total reinsurance amount in the 2020Q1 quarterly report is approximately 13.7% higher than reinsurance amount in the 2019Q1 quarterly report. There are many reasons reinsurance can change between years. Total medical costs typically increase due to changes in utilization, cost of services, and mix of services. In addition to regular trends, a reinsurer's trends can be impacted by deductible leveraging. Finally, if the size of the market changes, then so will the number enrollees eligible for reinsurance.



Since COVID-19 was first diagnosed in Minnesota at the end of 2020Q1, the overall impact of COVID-19 on MPSP is not reflected in this report. The COVID-19 section of this report discusses considerations related to COVID-19.

Table 1 provides enrollment and reinsurance information underlying the 2018Q1, 2019Q1, and 2020Q1 reports.

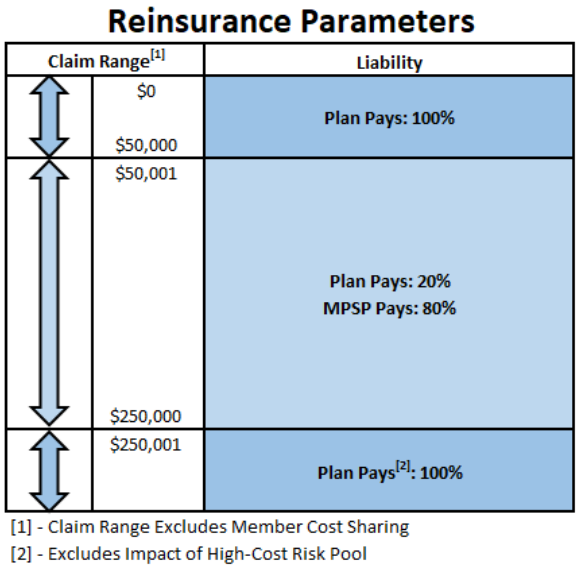
Table 1: Reinsurance Amounts and Enrollee Counts

	Distinct Individuals	Reported Reinsurance
Statewide 2020Q1	448	$14,744,769
Statewide 2019Q1	393	$12,984,218
Statewide 2018Q1	367	$11,808,390

The remainder of this report provides a description of the methodology, additional breakout of reinsurance by region, metal level, and other various reporting variables, along with associated caveats and disclosures.

Methodology

Carriers participating in Minnesota's Non-Grandfathered Individual Commercial Market provided Wakely with January through March 2020 claim experience with paid dates through April 2020 in a template developed by Wakely. The template included both enrollment and claim experience at the carrier level. The template also included enrollee-level data for Minnesotans enrolled in the individual market that carriers identified with claims above the attachment point of $50,000. Wakely then aggregated these templates and calculated reinsurance payments using the reinsurance parameters shown in the figure below. Wakely validated this amount against the carrier provided calculations.



The enrollee-level data supplied by carriers accounted for movement between HIOS plan identifiers. For example, under certain circumstances, an enrollee might have been enrolled in both a silver and gold plan for a portion of the benefit year. This transferring does not impact results when reporting at a carrier level; however, when reporting at a more granular level (e.g. metal), reported results may change depending on the allocation method. For this report, Wakely allocated reinsurance estimates for enrollees transferring between cohorts based on incurred claims within that time period. For example if 75% of an enrollee's claims occurred in a silver plan and 25% occurred in a gold plan, then 75% of the reinsurance for the individual was allocated to the silver plan and 25% to the gold plan.

Analysis

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. The 2019Q1 is shown next to the 2020Q1 distribution for reference. Once 2019 benefit year reinsurance is finalized, Wakely will include a final 2019 column on the following tables.

Reinsurance by Area

The table in this section shows the amount of reinsurance for each of Minnesota's nine rating regions. A list of counties in each rating area can be found on either the Minnesota Department of Commerce website or the CMS website.

Table 2: Reinsurance Amount by Area

Rate Region	2020Q1 Reinsurance	2020Q1 Dist'n	2019Q1 Dist'n	2018Q1 Dist'n
Rating Area 1	$2,087,716	14%	17%	16%
Rating Area 2	$627,826	4%	5%	5%
Rating Area 3	$984,703	7%	4%	10%
Rating Area 4	$422,615	3%	1%	2%
Rating Area 5	$548,597	4%	4%	6%
Rating Area 6	$513,150	3%	4%	2%
Rating Area 7	$1,083,280	7%	7%	7%
Rating Area 8	$8,393,330	57%	58%	51%
Rating Area 9	$83,552	1%	1%	1%
Statewide	**$14,744,769**	**100%**	**100%**	**100%**

Reinsurance by Metal Level

The table in this section provides the reinsurance 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 with enrollment limited to enrollees who are eligible for a hardship exemption or are under the age of 30.

Due to the cost sharing levels of the different metal types, the distribution may shift between metal levels as 2020 completes.

Table 3: Reinsurance Amount by Metal Tier

Metal Tier	2020Q1 Reinsurance	2020Q1 Dist'n	2019Q1 Dist'n	2018Q1 Dist'n
Catastrophic	$123,162	1%	0%	1%
Bronze	$6,981,058	47%	49%	51%
Silver	$4,342,298	29%	30%	27%
Gold	$3,098,949	21%	20%	20%
Platinum	$199,303	1%	1%	1%
Total	**$14,744,769**	**100%**	**100%**	**100%**

Reinsurance by Exchange Status

This section provides the reinsurance based on whether the member purchased coverage through Minnesota's exchange, MNSure, or directly through the issuer. 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 2020Q1 distribution is not directly comparable to the 2018Q1 and 2019Q1 quarterly reports.

Table 4: Reinsurance Amount by Exchange Status

Exchange Status	2020Q1 Reinsurance	2020Q1 Dist'n
On-Exchange	$9,505,754	64%
Off-Exchange	$5,239,015	36%
Total	**$14,744,769**	**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. CSR plans are only available on the exchange. 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 5: Reinsurance Amount by Plan Type

Plan Type	2020Q1 Reinsurance	2020Q1 Dist'n	2019Q1 Dist'n	2018Q1 Dist'n
Standard	$13,511,321	92%	93%	91%
Zero Cost Sharing	$170,432	1%	0%	0%
Limited Cost Sharing	$0	0%	0%	1%
73% CSR	$1,063,016	7%	6%	9%
Total	**$14,744,769**	**100%**	**100%**	**100%**

Reinsurance by Claim Spend

Please see Appendix A for reinsurance by claim spend level.

Distribution of HCC Count

Previous reports in 2018 and 2019 included a hierarchical condition category (HCC) distribution for reinsurance eligible enrollees. Since HCC identification is correlated with the length of time an individual is enrolled during the benefit year, using a partial year of experience may not accurately reflect the final HCC distribution. For example, an enrollee with twelve months of enrollment has more time to visit a physician compared to an enrollee with only three months of enrollment. The HCC distribution for 2020 benefit year reinsurance will be provided in future reports similar to 2018 and 2019 reporting.

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 may be double counted if he or she transferred between products during the experience period. As a result, the claimant count in Appendix C may not match the enrollee count in Table 1 in future reports. The column labeled *Claimants* shows "*<100*" for product and exchange-status combinations with less than 100 claimants for protected health information (PHI) reasons. 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 2020Q1 report is not directly comparable to the table shown in the 2019Q2 report. Appendix C is comparable to the 2019Q3 and 2019Q4 reports.

COVID-19

As a result of COVID-19, the final 2020 benefit year reinsurance amount may be very different than 2018 and 2019 results. The data underlying this report includes claims with a date of service or a discharge date between January 2020 and March 2020. Since Minnesota first started experiencing cases of COVID-19 in March 2020,[1] the experience underlying this report does not include the full impact of COVID-19. Going forward, key considerations for MPSP include, but are not limited to:

1. **Market Transitions** - Since the aggregate reinsurance amount depends on the size and morbidity level of the market, changes to enrollment will either increase or decrease reinsurance payments made by MPSP. Due to significant job or income loss, membership may transition between health care markets. For example, if a significant number of individuals lose employer sponsored coverage, there will likely be an enrollment shift to either the individual commercial or Medicaid markets. Similarly, enrollees in the individual commercial market may transition to Medicaid. Moreover, the morbidity differences between the transitioning populations may be different than the morbidity level of the previous individual market. The overall net impact of these market transitions is not yet known since there is a lag in enrollment changes and claim data.

2. **Deferred Services** - The individual commercial market as a whole will likely experience a decrease in utilization for the first half of 2020 as a result of Governor Walz's Executive Order that delayed elective medical procedures.[2] Since some reinsurance eligible enrollees cannot delay care, it is possible that COVID-19 will impact MPSP differently than the individual market as a whole. It is too early to know if deferred services will cause future pent up demand.

3. **COVID-19 Cases** - It is likely that some of the Minnesotans admitted to the hospital for COVID-19 were enrolled in the individual commercial market. Whether or not these individuals exceed the reinsurance attachment point depends the severity of the case (e.g. admitted to intensive care unit).

Future reports will include additional discussion related to COVID-19 as necessary.

[1] Minnesota Department of Health - Situation Update for COVID-19
[2] FAQ: Executive Order Delaying Medical Procedures

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 6: 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% (= $\frac{\$4,440}{\$4,000}$ - 1). This is shown in the next table.

Table 7: 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.

Cost Sharing Reductions

The Federal Transitional Reinsurance program utilized a formula to reduce a carrier's paid amount to account for the fact that cost-sharing reductions (CSRs) were reflected in plan paid amount but were already reimbursed by the Federal government. Since the CSR program ended in 2017, Wakely is assuming that CSR subsidies will not be funded by the Federal government in 2020; therefore, Wakely did not adjust calculated reinsurance amounts for CSR using the Federal Transitional Reinsurance program methodology. If CSR payments are reinstated during 2020, Wakely will review this assumption and work with carriers to ensure that reinsurance payments made to carriers do not exceed the total amount paid by the carrier for any eligible claim pursuant to Minnesota Statute 62E.23.

Data Review

Wakely compared the portion of enrollees with claims above the attachment point underlying the carrier submitted templates against the claim continuance table located in the actuarial report in Minnesota's 1332 Waiver. The table is based on the 2015 individual market. In the comparison,

the actual portion of enrollees with claims above the attachment point was lower than the expected portion of enrollees with claims above the attachment point. This is likely caused by the underlying carrier data being based on a partial year of experience with limited claim runout. For example, the enrollee-level dataset excludes enrollees that will exceed the attachment point because of claims that are incurred between April and December 2020.

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 use of the management of MCHA. Wakely understands that the report will be made public and distributed to other stakeholders. Distribution to such parties should be made and evaluated in its entirety. The parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from Wakely's estimates. Wakely does not warrant or guarantee that Minnesota carriers will attain the estimated values included in the report. It is the responsibility of those receiving this output 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 any 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.

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

Signed,

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Consulting Actuary
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Appendix A - Reinsurance Amount by Claim Spend Level

Reported at Total Levels Due to Limited Enrollment in Each Cohort

Incurred Claims		Enrollee Count	Average Incurred Claims Per Enrollee	Average Reinsurance Per Enrollee	Aggregate Reinsurance
Low Range	High Range				
$50,000	$52,508				$40,900
$52,508	$58,498				$268,667
$58,498	$119,795				$6,482,952
$119,795	$200,000				$ 4,472,961
$200,000	$9,999,999				$3,479,290
Total		**448**	**$95,073**	**$32,912**	**$14,744,769**

Notes:

1. Enrollee count and average reinsurance per enrollee not included for all ranges due to PHI reasons (e.g all but one cohort had less than 100 enrollees).
2. Average Reinsurance Per Enrollee = min{(Average Incurred Claims - $50,000) × 80%, $160,000}.
3. The claim intervals originate from the 1332 Waiver Application.
4. This distribution is expected to change as 2020 completes.

Appendix B - Enrollee Count by HCC

This appendix is not included and will be included in future reports. Please see the section labeled *Distribution of HCC Count* for more information.

Appendix C - Estimated Reinsurance Amount and Claimants by Product

Carrier	Product ID	Product Name	Exchange Status	Claimants[2]	Reinsurance
UCare	85736MN023	UCare Individual and Family Plans	On-Exchange	<100	$2,362,462
HealthPartners	34102MN007	GHI AM Off Exchange	Off-Exchange	<100	$2,361,980
HealthPartners	34102MN001	GHI On Exchange	On-Exchange	<100	$1,769,593
Medica	31616MN042	Medica Applause	On-Exchange	<100	$1,661,530
Medica	31616MN044	Engage by Medica	On-Exchange	<100	$1,322,523
BP	57129MN015	Blue Plus Southeast	On-Exchange	<100	$912,985
BP	57129MN008	Blue Plus Metro	Off-Exchange	<100	$795,206
Medica	31616MN042	Medica Applause	Off-Exchange	<100	$588,365
BP	57129MN007	Blue Plus Western	On-Exchange	<100	$528,804
BP	57129MN009	Blue Plus Metro	On-Exchange	<100	$407,722
BP	57129MN014	Blue Plus Southeast	Off-Exchange	<100	$377,737
BP	57129MN052	Blue Plus Strive	On-Exchange	<100	$301,762
HealthPartners	34102MN008	GHI NAM Off Exchange - HP Ind	Off-Exchange	<100	$230,378
Medica	31616MN044	Engage by Medica	Off-Exchange	<100	$193,396
BP	57129MN051	Blue Plus Strive	Off-Exchange	<100	$187,792
BP	57129MN053	Blue Plus Minnesota Value	Off-Exchange	<100	$161,481
BP	57129MN017	Blue Plus Northeast	On-Exchange	<100	$160,000
BP	57129MN016	Blue Plus Northeast	Off-Exchange	<100	$97,084
BP	57129MN006	Blue Plus Western	Off-Exchange	<100	$96,181
Medica	31616MN043	North Memorial Acclaim by Medica	On-Exchange	<100	$59,319
PreferredOne	88102MN021	Savers	Off-Exchange	<100	$50,672
Medica	31616MN021	Medica Value	Off-Exchange	<100	$39,686
Medica	31616MN020	Medica HSA	Off-Exchange	<100	$23,404
PreferredOne	88102MN001	PreferredHealth	Off-Exchange	<100	$22,846
BP	57129MN054	Blue Plus Minnesota Value	On-Exchange	<100	$19,054

Appendix C - Estimated Reinsurance Amount and Claimants by Product

Carrier	Product ID	Product Name	Exchange Status	Claimants[2]	Reinsurance
HealthPartners	34102MN009	GHI NAM Off Exchange - HP Ind Ded	Off-Exchange	<100	$11,717
Medica	31616MN043	North Memorial Acclaim by Medica	Off-Exchange	<100	$1,089
			Total	**448**	**$14,744,769**

Notes:

1. Products with less than 100 claimants are labeled as < 100 due to protected health information (PHI) reasons.
2. The *Claimants* column counts enrollees that transfer between products more than once. As a result, the total claimants in this section may differ from the enrollee count shown in Table 1 in future reports.