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State Flexibility for ACA Risk Adjustment in Maryland's Individual Market

State of Maryland
Maryland Health Benefit Exchange

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Introduction

The State of Maryland Health Benefit Exchange ("Maryland") retained Wakely Consulting Group, LLC ("Wakely"), through Bolton Partners, to analyze Affordable Care Act (ACA) risk adjustment in the individual market and if allowable changes to the statewide average premium calculation may improve the appropriateness of risk adjustment transfers. Maryland is currently applying for a 1332 waiver, which would allow for a state-based reinsurance program. In 2018, the Department of Health and Human Services ("HHS") granted states flexibility to apply for an adjustment to the risk adjustment methodology to best meet their own needs, especially if unique market circumstances produce a misalignment between risk adjustment transfers and actuarial risk. This flexibility could first affect the 2020 benefit year. This paper will outline the basics of ACA risk adjustment, what flexibilities HHS granted states to alter the methodology, how risk adjustment has historically aligned with actuarial risk in Maryland's individual market, and finally, how allowable adjustments to risk adjustment may affect financial results for individuals grouped by their cost category.

Summary

In the 2019 Notice of Benefit and Payment, HHS allowed states to request a reduction in the calculated risk adjustment transfer amounts of up to 50% if state-specific market dynamics warrant an adjustment. Maryland is planning to implement a state-based reinsurance program for the 2020 benefit year, contingent on 1332 waiver approval. We have modeled these reinsurance payments and considered them in our analysis.

Maryland asked Wakely to model different potential reduction percentages to the statewide average premium in the risk adjustment methodology and to quantify the impact for the different cost quartiles. Maryland also asked Wakely to identify an estimated reduction in the statewide average premium to address the potential for double counting in the reinsurance and risk adjustment programs, which might distort financial results.

Wakely has estimated that a reduction in transfers of 30% would result in closer alignment of relative actuarial risk and risk adjustment transfers for the 2020 benefit year. This recommendation was significantly influenced by the presence of the 2020 risk adjustment program. Our results would change materially if that program were not implemented or were changed in material ways. Table 1 below summarizes financial results by cost category grouping before and after the proposed reduction in statewide average risk adjustment premium:

Table 1: Claims to Premium Ratios[1]
Impact of 30% Risk Adjustment (RA) Premium Dampening
Estimated 2020 Individual Market Using the 2019 Risk Adjustment Model
Maryland Reinsurance (RI) Program Reflected

Claims Category	Claims to Premium Ratio (Adj for RA and RI)	Claims to Premium Ratio (Adj for RA and RI) – 30% RA Dampened	Member Distribution
No Claims	1.15	0.80	10%
1st Quartile	1.04	0.73	16%
2nd Quartile	1.18	0.86	20%
3rd Quartile	1.13	0.89	22%
4th Quartile	1.36	1.38	26%
Above $20,000	-1.54	0.83	6%
Total	1.00	1.00	100%
Standard Deviation	1.11	0.23	n/a

As shown above, the Claims to Premium Ratios by claims category are more uniform after dampening the statewide average risk adjustment premium by 30%. We modeled other reduction percentages as well. The 30% reduction produced favorable results under various other combinations of assumptions although other reduction percentages may be appropriate and still produce improved results as compared to no change.

We relied on information from the issuers and the state and used historic data to model these results. Actual results may vary from our estimates for many reasons, including, but not limited to, issuer premium increases, enrollment and morbidity changes due to the recent regulatory changes, and details surrounding the actual 2020 risk adjustment methodology which are not yet available.

This document has been prepared for the sole use of and reliance by Maryland. Other uses may be inappropriate. Wakely understands that the report will be made public and provided to the Centers for Medicare & Medicaid Services (CMS). This document contains the results, data,

[1] The Claims to Premium ratio is defined as: (Claims – Risk Adjustment Amounts – High Risk Pooling Payment – Reinsurance Receipts) / Premium

assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Anyone receiving this report should rely on their own experts in interpreting the results.

Background: ACA Risk Adjustment

Starting in 2014, the Affordable Care Act ushered in a number of commercial market reform rules. Plans in the individual and small group markets were no longer allowed to deny coverage based on pre-existing conditions and were generally required to rate enrollees via adjusted community rating. Risk adjustment was included as one of the key program features that was intended to provide for a stable market. As HHS outlined in their 2016 white paper on risk adjustment:

"The intent of risk adjustment is to allow a plan enrolling a higher proportion of high-risk enrollees to charge the same average premium (other factors being equal) as a plan enrolling a higher proportion of low-risk enrollees, shifting the focus of plan competition to plan benefits, quality, efficiency, and value"[2]

In essence, the policy goal is to reduce the incentives for issuers to avoid high-risk enrollees and instead incentivize issuers to maximize profitability through improvements in efficiency and quality. HHS finalized the ACA risk adjustment methodology in the 2014 Notice of Benefit and Payment Parameters regulation. The methodology is designed to compensate issuers for enrolling members with excess actuarial risk. The risk adjustment transfer formula, which determines payments and charges for issuers, measures the difference between the revenue requirement given the health status of the plan's enrollees and the pre-risk adjustment premium revenue generated by the plan's enrollees. The difference between the actuarial risk the plan takes on and the revenue the plan receives is the risk adjustment transfer. All of the calculations and transfers occur within a market and state. For example, risk adjustment calculations and budget neutral transfers occur within Maryland's non-catastrophic individual market separate from Maryland's small group market. While the transfers and calculations occur within a state, the overall HHS risk adjustment model is calibrated on a national data set and the same methodology is applied across every state in the country, as of 2018.[3]

[2]https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf

[3] States that operate their own Exchange have the option of operating their own risk adjustment program. As of 2018 HHS operates risk adjustment in all 50 states and DC.

2019 Payment Notice Changes

In the 2019 Payment Notice[4] finalized in April 2018, HHS granted states the flexibility to dampen the level of risk adjustment transfers between plans. The HHS risk adjustment methodology uses the state average premium to scale risk adjustment transfers (i.e., make them state specific). In the 2019 Payment Notice, HHS admits that the current methodology may require some adjustment to risk adjustment transfers to more accurately account for unique state-specific factors. HHS is allowing states to apply for a modification to the historical risk adjustment methodology to improve the accuracy of the resulting transfers. States may request that risk adjustment transfers be dampened by up to 50% in their individual, small group, or merged markets.

To receive approval for the reduction, states must first identify the state-specific rules (e.g., rating rule) or market dynamic that warrants an adjustment to risk adjustment transfers. Then, the state must identify the reduction percentage requested (i.e., any value up to 50%) that is appropriate given the state-specific rule or market dynamic. This can be done either through analysis that demonstrates how the transfer adjustment is warranted given the state specific factors or it must show that the adjustment is estimated to have an impact so small that it will have a de minimis effect (less than 1%) on issuers who receive risk adjustment payments.

Requirements for Submission

To gain approval for a state-specific adjustment, states must submit analysis demonstrating why the adjustment will more precisely account for risk differences in a state or that the change will have a de minimis impact. It must submit this evidence no later than August 1 for two calendar years into the future (e.g. August 1, 2018 is the submission deadline for the 2020 benefit year). This submission does not require an actuarially certified memorandum. HHS retains the flexibility for approving a reduction amount that is less than what the state requested. The request and supporting evidence will be published in future years' proposed Payment Notices to seek public comment. HHS will publish its approval or denial in the applicable year's final Payment Notice.

2017 View of Maryland's Individual Market

The first step to understanding if an adjustment is necessary for the 2020 benefit year is to examine the historical data. Wakely examined the 2017 benefit year and how effective the ACA risk adjustment methodology was at compensating issuers for actuarial risk. To do this, Wakely collected EDGE data (i.e., claim costs and premiums) alongside the risk adjustment transfer

[4] https://www.gpo.gov/fdsys/pkg/FR-2018-04-17/pdf/2018-07355.pdf

amounts. For a fuller description of the methodology, please see Appendix A. Wakely "bucketed" claim costs into 6 separate categories. The first category is members who had no claims in 2017. The last category is members with claims in excess of $20,000 (which is the attachment point for the reinsurance program in 2019). For the remaining four categories, members were allocated equally to four cost groups based on their claims costs in 2017. While the number of unique members is the same for each quartile, the average members in the four quartiles vary because of each category's members' duration of coverage in 2017.

Table 2 below shows claims to premium ratios without risk adjustment amounts included under the 2017 model, with risk adjustment included under the 2017 model, and with risk adjustment amounts included under the 2019 model. Each Claims to Premium Ratio column shows the ratio for each claims category, normalized to an overall 1.00.

Table 2: Claims to Premium Ratios
With and Without 2017 Risk Adjustment and Impact of 2019 Model

Claims Category	Claims to Premium Ratio - Without RA	2017 Claims to Premium Ratio – Adj for 2017 RA Model	2017 Claims to Premium Ratio – Adj for 2019 RA model	Average Members Distribution
No Claims	0.00	0.82	0.73	13%
1st Quartile	0.02	0.71	0.65	18%
2nd Quartile	0.10	0.78	0.74	20%
3rd Quartile	0.27	0.73	0.72	21%
4th Quartile	1.13	0.87	0.94	22%
Above $20,000	9.54	4.03	4.21	5%
Total	1.00	1.00	1.00	100%
Standard Deviation	3.79	1.33	1.41	n/a

As can be seen in Table 2 above, risk adjustment (RA) transfers correlate strongly with actuarial risk. As actuarial risk increases, so do risk adjustment transfers, which levels the ratios once risk adjustment is taken into account. The standard deviation of the financial results decreases notably under risk adjustment. While there is some variation in between levels of claims cost and levels of risk adjustment, generally the tiers align. The exception is the "Above $20,000" category where the claims to premium ratio is significantly higher than the other categories even after risk adjustment.

Wakely additionally updated the 2017 experience with the 2019 risk adjustment model. The fourth column of Table 2 captures an estimate of what the 2017 ACA individual market could have experienced if the 2019 risk adjustment methodology had been used rather than the 2017 risk adjustment model. This includes the high cost pooling program, which is scheduled to start for 2018 transfers. The 2019 model affects the results and increases the standard deviation in claims to premium ratios, although not significantly.

2020 Market Dynamics

The state of Maryland has applied for a reinsurance based 1332 waiver. If approved, Maryland would operate a claims cost based reinsurance program that would expend an estimated $459 million dollars of reinsurance in 2020. Wakely estimates that this program would directly result in a premium reduction of 30% (due to the funding and additional premium reduction due to morbidity improvements). While Maryland has not yet officially solidified the payment parameters for the 2020 benefit year, comparable reinsurance parameters for the 2019 benefit year produce reinsurance parameters of a $20,000 attachment point, cap of $250,000, and coinsurance of 80%. Given the large amount of reinsurance dollars expended and the low attachment point, there is potential for an issuer being compensated beyond their actuarial risk in risk adjustment.

To estimate the 2020 premium and enrollment in the individual market, Wakely used similar assumptions as in the analysis for Maryland's 1332 waiver application.[5] Wakely collected 2017 EDGE data specific for this analysis, which allows for a detailed allocation of risk adjustment transfers, but also creates a slightly different starting point than used in the waiver analysis. Risk adjustment transfers were calculated and allocated to a member under both the 2017 and estimated 2019 risk adjustment methodology. 2018 emerging issuer data, Kaiser Family Foundation estimates on the impact of the effective mandate repeal, and other actuarial assumptions were used to estimate Maryland's individual market, including the effects of reinsurance. Please note the estimates included in this report differ slightly from those included in the 1332 report, but any differences are small and not expected to impact the results of this analysis. The differences are primarily due to the starting data being slightly different and that some assumptions in this analysis are at a more granular level. In addition, the catastrophic members have been removed from the risk adjustment analysis so that only the non-catastrophic single risk pool is included in the analysis.

[5]https://www.marylandhbe.com/wp-content/uploads/2018/06/Final_Maryland%201332%20State%20Innovation%20Waiver%20to%20Establish%20a%20State%20Reinsurance%20Program%20-%20May%2031%202018.pdf

Table 3 below includes Wakely's estimates from the waiver on the key characteristics of the 2020 individual market, including the effects of reinsurance.

Table 3: 2020 Baseline Estimates and Effects of Reinsurance

	2020
Baseline	
Total Non-Group Enrollment	169,776
Total Non-Group Premium PMPM	$776.34
Total Premiums	$1,581,638,554
After Reinsurance	
Reinsurance Funding	$459,000,000
Reduction in Premiums (Reinsurance Funding)	-29.0%
Reinsurance Assessment	0.0%
Reduction in Premiums (Improved Morbidity)	-1.4%
Total Reduction in Premiums	-30.0%
Total Non- Group Premium PMPM	$543.36
Change in Total Non-Group Enrollment	5.7%
Total Non-Group Enrollment	179,439
Total Premiums	$1,169,998,256

Impact of Reinsurance by Claim Category and Proposed Adjustment

Table 4 shows the change in the claims to premium ratios for estimated 2020 data after risk adjustment (using the estimated 2019 risk adjustment model), after risk adjustment and reinsurance, and with the risk adjustment dampened by 30%. As with Tables 1 and 2, all ratios are normalized so that the overall ratio is 1.00.

Table 4: Claims to Premium Ratios
Impact of Reinsurance and 30% Reduction in Statewide Average Premium

Claims Category	Claims to Premium Ratio (Adj for RA only)	Claims to Premium Ratio (Adj for RA and RI)	Claims to Premium Ratio (Adj for RA and RI) – 30% RA Dampened	Member Distribution
No Claims	1.14	1.15	0.80	10%
1st Quartile	0.96	1.04	0.73	16%
2nd Quartile	1.08	1.18	0.86	20%
3rd Quartile	1.00	1.13	0.89	22%
4th Quartile	0.83	1.36	1.38	26%
Above $20,000	1.40	-1.54	0.83	6%
Total	1.00	1.00	1.00	100%
Standard Deviation	0.19	1.11	0.23	n/a

The ratios for the 2020 data without reinsurance are notably different than the ratios seen in the 2017 base experience. The primary driver of this is the large increase in premiums experienced and estimated from 2017 to 2020. These large increases in premium result in significantly larger risk adjustment transfers per member per month (PMPM) for the reinsurance category, which improves the financial results of this cohort of members. The variation by claim cohort has also lessened significantly.

While the premium increases evened out the variability by cohort, the introduction of reinsurance dramatically changes the adjusted claims to premium ratios. This change in dynamics comes from two sources. First, for enrollees who are eligible for reinsurance payments, the combination of risk adjustment payments and reinsurance payments makes this cohort of individuals far more profitable on average than any other cohort. The second source is that the reduction in state average premium due to reinsurance reduces transfers for all individuals and categories. The result is enrollees who are sicker on average but not eligible for reinsurance tend to be under-compensated. The combination of both these factors means that, in effect, the combination of risk adjustment and reinsurance in Maryland, without adjustment, produces risk adjustment transfers that do not consistently reflect actuarial risk across the different cost categories.

As also shown in Table 4, enrollees receiving reinsurance have drastically adjusted claims to premium ratios compared to a no reinsurance scenario. The cost category of those receiving reinsurance payments has an estimated relative claims to premium ratio of negative 1.54 which indicates that reinsurance and risk adjustment receipts exceed claims.

The impacts of the reinsurance program can be moderated by reducing risk adjustment transfers by a fixed percentage. As can be seen in Table 4, adjusted premium to claims ratios exhibit far less variation with the reduction in transfers of 30%. This factor was selected because it produces the minimal variation among cost categories based on the assumptions used in the analysis (different assumptions will produce different reduction factors). Additionally, adjusted claims to premium ratios (i.e., actuarial risk) maintain a strong correlation to risk transfers using this method.

We relied on information from Maryland, CMS, the Maryland issuers, and other outside information. The 2020 risk adjustment methodology has not yet been released. There is inherent, significant uncertainty regarding how premium increases, market enrollment decreases, and member migration will affect market dynamics and morbidity, and risk adjustment transfers. We made simplifying assumptions and adjustments given available information and practical considerations. Financial results may vary considerably from our estimates and the results we have modeled may not materialize for the market as a whole, and especially for each issuer.

While the potential reinsurance program will lower premiums in the individual market, it produces unique, Maryland-specific distortions to the financial results when the risk adjustment and reinsurance programs are combined. To maintain the proper correlation of risk transfers to actuarial risk, regardless of enrollees cost level, Wakely's analysis and estimates support a reduction in transfers of 30%. Given the uncertainties of the 2020 market and resulting risk adjustment transfers, other reduction values may be appropriate.

Appendix A: Data and Methodology

The following outlines the methodology used to develop the analysis included in this report.

Data Collection

The data collected for this study was provided by the health insurance companies in the state of Maryland. Detailed encounter and high-level summary data was collected from CareFirst and Kaiser. The detailed encounter data was provided in the 2017 EDGE server files from the issuers. The high-level summary data included 2018 premium and enrollment experience by month by HIOS ID, metal level and other breakouts. In addition, Cigna provided their 2017 RATEE (EDGE server) file to provide Wakely with the means of calculating the risk transfers for 2017.

Wakely processed the provided 2017 detailed encounters to calculate member level claims, premiums, and risk transfer amounts. This information was then summarized to create the baseline data for the analysis. No adjustments were made to the EDGE data. For example, prescription drug rebates and other potential claim adjustments were not made.

Since claims and premium information was not available for Cigna, all Cigna members are assumed to have experience and risk profile similar to the CareFirst PPO plans. This was done since the risk transfers per member most closely aligned with the CareFirst PPO plans.

2017 Risk Transfer Methodology

The 2017 risk transfers were calculated using RATEE files provided by each issuer at the rating area and 14-digit plan identifier level. Geographic cost factors were calculated using the information provided in the RATEE files. At the time this analysis was performed, the final risk transfers were not yet published by CMS.

2019 Risk Transfer Methodology

The 2019 risk transfer methodology (2019 risk weights and 2019 age rating factors) was calculated using the encounter data provided by the issuers. The plan liability risk score and age rating factors were then used to calculate the 2019 risk transfers based on 2017 experience. Note that for the purpose of the historic 2017 risk transfer calculations, the statewide average premium was held flat from 2017 to understand the impact solely from the change in the risk adjustment model from 2017 to 2019. The exception to this is that the state average premium was reduced by 14% reduction to account for variable administrative expenses and aligns with the 2019 risk adjustment methodology that will be applied. The geographic cost factors were not adjusted for any premium changes. The key reason for not updating these factors is that premiums were not adjusted for the new factors. In addition, Cigna's ARF values remain constant with no adjustment

made for the 2019 allowable rating factor (ARF), and a trended risk score factor was applied to their plan liability risk score (PLRS). Finally, the amount of high risk pool claims that will be covered under the 2019 risk adjustment methodology were removed. This includes 60% of claims over $1,000,000.

Claims and Reinsurance Allocation

Claims were aggregated at the member level from the provided EDGE encounter medical and claims files. Claims and enrollment spans from the encounter file were only included if they were active on the EDGE server (accepted and non-orphaned). Cross-year medical claims were included in the paid amounts for members who had these types of claims.

Reinsurance based on the 2017 experience and 2019 parameters was calculated for each member based on the aggregation of paid amounts for each member. An attachment point of $20,000, a coinsurance amount of 80%, and a reinsurance cap of $250,000 were used to calculate each member's reinsurance amount.

Quartile Category Determination

Six different claim cost groupings were developed for the purpose of this analysis. Catastrophic members were removed from this grouping so that the analysis was based solely on members in the non-catastrophic single risk pool.

1. No Claims - The members in this category have no claims attributed to them in 2017.
2. Quartile Categories - Four quartiles were created based on a member's paid amount if the member had incurred a claim and had less than $20,000 total paid in 2017 (not hitting the reinsurance attachment point). These categories have the same amount of unique members in each quartile. However, given the duration of members with less claims are lower than the duration of members with higher claim costs, the average members increases from the 1st to 4th quartile.
    a. 1st Quartile: Members with total claim less than $184.50
    b. 2nd Quartile: Members with total claims between $184.50 and $659.00
    c. 3rd Quartile: Members with total claims between $659.00 and $2,028.90
    d. 4th Quartile: Members with total claims between $2,028.90 and $20,000
3. Above $20,000 - Any member eligible for reinsurance payments, with above $20,000 of paid claims, is included in this category.

Estimating 2020 Enrollment, Claims and Premiums

The 2020 data was estimated with the following adjustments that are consistent with the waiver application. One primary difference is that catastrophic members, claims and premiums were removed from the analysis.

All estimates for 2020 were made at the claim cost category level. Some assumptions were made in more detail and the weighted assumptions were applied at the claim cost category level.

1. **Enrollment and migration**. Non-catastrophic enrollment was estimated to decrease from 2017 to 2020 by approximately 21%. It was assumed that more members in the "No Claims and 1st Quartile" dropped coverage compared to the higher cost members, although all claim cost categories assumed some level of enrollment losses. Based on 2018 enrollment, there was also some migration assumed between HIOS IDs. In our analysis, for simplicity, we assumed that the distribution of enrollment by demographic, rating area, and metal level remained constant within a cost grouping. We also assumed, that members who migrated to a different issuer would take on the premium and claims of the members is the same quartile as the new issuer but the risk adjustment transfers followed the member.

2. **Claims costs.** Claims per member per month (PMPM) were trended approximately 7.5% annually, although the trend varied by issuer.

3. **Premiums**. Actual premium increases were used for the 2017 to 2018 premium increase. Given the de-funding of cost sharing reduction plans, we included different premium increases for silver and non-silver plans. For 2018 to 2019, consistent with the waiver we used an overall premium increase of 15% (prior to the impact of reinsurance) although the increase varied by issuer. Note that the carriers have filed larger rate increases, on average, for 2019 but the actual rate increase that will be approved is not known. If larger premium increases are passed on, it could impact the results of the analysis. For 2020, an assumption was made that premiums will increase approximately 6% for all issuers. This includes a trend increase, adjusts for the removal of the 2019 reinsurance assessment, and adjusts for the addition of the provider insurer fee for 2020 (there was a moratorium on the fee for 2019).

4. **Reinsurance**. The reinsurance PMPM was adjusted from 2017 to match the waiver application funding amount of $462 million. Since only the non-catastrophic single risk pool is included in the analysis, the $462 million was targeted for the non-catastrophic plans. In reality there were some members who would have been eligible for reinsurance in the catastrophic plans in 2017 but the amount of reinsurance would have been small and ignoring these catastrophic plan reinsurance claims is not expected to impact the analysis. Similarly, some members in the 4th quartile would

likely be eligible for reinsurance in 2020 given claim cost trends. For simplicity the total reinsurance amounts were kept in the reinsurance category. For any analyses that includes the impact of reinsurance, the premiums were adjusted for the impact of reinsurance. This is around 30% overall but varies by issuer.

5. **High risk pool**. For simplicity, the high risk pool PMPMs were trended similar to the claim trends. Also for simplicity, the estimated national fee of 0.3% for the high risk pool was not explicitly included but assumed to be included in the premiums.

Risk Transfer Adjustments

Once the estimates were made for the 2020 individual market, Wakely re-calculated the risk adjustment transfers for multiple scenarios: with risk adjustment only, with risk adjustment and reinsurance, and with a dampened risk adjustment and reinsurance.

Transfers were scaled based on the changes in premiums. For a change in overall transfers due to members leaving the market, the difference in transfers were allocated back to the various cost categories. The risk adjustment modification factor applies uniformly to all assumed transfer amounts, and is applied prior to the reallocation of funds to “force” projected risk transfers to be net $0. We made simplifying assumptions and adjustments to the transfers given available information and practical considerations.

No changes were made to the premium assumptions based on the changes in risk adjustment transfers.

Claim to Premium Ratios

Once the estimates for 2020 were calculated, premium to claim ratios were developed for the three scenarios mentioned: adjusting only for risk adjustment, adjusting for risk adjustment and reinsurance, and adjusting for damped risk adjustment and reinsurance. Administration costs, taxes, or additional expenses that could affect profitability were not included in the analysis. For each claim cost grouping, the claims were adjusted for risk adjustment transfers, high risk pool claims, and reinsurance (if appropriate) and then divided by the premium. For scenarios with reinsurance, the premiums and related risk adjustment transfers were adjusted for the lower premium expected due to the reinsurance program. For the last scenario, different dampening factors were tested to understand the various impacts of each factor. Finally, for comparison purposes all ratios were adjusted so that the overall claims to premium ratio for all claim cost categories was a 1.00.

Appendix B: Reliance and Caveats

Wakely performed high-level reasonability tests on the data but did **not** audit the data. To the extent that the information provided to us is incomplete or inaccurate, the results in this report and the corresponding model will need to be revised accordingly. This report may only be used for discussion purposes in relation to the risk adjustment dampening analysis. Any other use may not be appropriate.

The following is a list of the data Wakely relied on for the analysis:

- A complete set of 2017 EDGE Server XML data was collected from the primary insurers in the non-group market, including:
    - The inbound enrollment, medical, pharmacy, and supplement files that were submitted by each insurer to the EDGE Server
    - The corresponding response files that apply an accept/reject status to the claims in the inbound files
    - The final outbound files that were produced in May 2016. These files include the risk adjustment, reinsurance, and enrollee claims detail/enrollee claims summary reports
    - 2017 RATEE files for the carrier that did not submit EDGE data (carrier has small enrollment in 2017 and no longer offers a product in the individual market)
- Issuer submitted 2018 premium and enrollment information by metal and exchange status
- The 2016 , 2017, and 2018 Open Enrollment Report PUF produced by HHS[6] [7] [8]
- Effectuated Enrollment Reports released by CMS[9]

[6] https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report

[7] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html

[8] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

[9] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

- Kaiser Family Foundation Survey[10]
- Additional data and feedback from Maryland's insurers, Maryland Insurance Administration, and the Maryland Health Benefit Exchange.

Wakely made some assumptions in working with the available data. These assumptions may impact the results of the analyses and were reviewed by Maryland for reasonability.

The following are additional caveats that could have an impact on results:

- **Data Limitations**. Wakely received data submissions for full year 2017 and emerging 2018 experience from insurers offering non-group market ACA-compliant plans. Wakely relied on the data submitted from all insurers for significant portions of this analysis. We reviewed the data for reasonability, but we did not audit the data. To the extent that the data is not correct, the results of this analysis will be impacted.
- **Political Uncertainty**. There is significant policy uncertainty. Future federal actions or requirements in regards to short-term duration plans, association health plans, reinsurance funds, income verification, and / or CSR payments could dramatically change premiums and enrollment in 2020.
- **Enrollment Uncertainty**. Additionally, there is enrollment uncertainty. Beyond changes to potential rates and policy, individual enrollee responses to these changes also has uncertainty. All of these uncertainties result in limitations in providing point estimates on enrollment estimates in 2020.
- **Premium Uncertainty**. Given the impact of several regulations (mandate repeal, association plans, short-term duration plans, etc.), there is uncertainty in how insurers may respond in their 2020 premiums and the enrollment and morbidity impact on costs. These uncertainties result in limitations in providing point estimates.
- **Risk Adjustment Transfers**. The details of the 2020 risk adjustment model are not yet available. In addition, given the large enrollment changes between 2017 and 2020, estimates of risk adjustment transfers by cost category is uncertain. Simplifying assumptions and adjustments to the transfers were made given available information and practical considerations.
- **Reinsurance Operations**. This analysis assumes that Maryland's 1332 reinsurance waiver will be approved and that the impact to premiums and claims will be as estimated

[10] https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/

in the waiver. If actual operations of the reinsurance program differ from the data configurations used in this analysis or if the actual reinsurance dollars differ significantly from those assumed, Wakely's analysis would need to be adjusted to match actual reinsurance results.

Appendix C: Disclosures and Limitations

Responsible Actuaries. Julie Peper is the actuary responsible for this communication. She is a Member of the American Academy of Actuaries and Fellow of the Society of Actuaries. She meets 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 Maryland. Distribution to parties should be made in its entirety and should be evaluated only by qualified users. Wakely understands that this report may be used as part of Maryland's risk adjustment flexibility application and understands it may be shared with CMS, the general public, or other relevant stakeholders as part of the flexibility approval process. 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 our estimates. Wakely does not warrant or guarantee that Maryland 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. The responsible actuaries are 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 the state of Maryland.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and reliances.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report, including actions in regards to mandate enforcement by the state of Maryland. Additionally, final federal regulations on short-term limited duration plans have not yet been released. Material changes as a result of Federal or state regulations change on short-term limited duration plans or association plans may also have a material impact on the results. In addition, any changes in issuer actions as well as emerging 2018 enrollment and experience could impact the results. Changes to current Maryland practice of loading CSR amounts to Silver plans only could also impact the results. The 2020 risk adjustment methodology has not yet been released. Changes

to the risk adjustment model or transfer formula could have an impact. Finally, this paper assumes that Maryland's reinsurance program, which is contingent on approval of its 1332 waiver, will operate in 2020. Disapproval of the 1332 waiver or spending of amounts different than what was estimated in the report could have a material impact. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of the actuarial report and supersedes any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our 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. 23, Data Quality

ASOP No. 41, Actuarial Communication