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2023 Analysis for the State Reinsurance Program

MARYLAND HEALTH BENEFIT EXCHANGE

STATE OF MARYLAND

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Table of Contents

Introduction 1
Reinsurance Payment Parameters 2
Methodology 2
Results 4
Program Solvency 8
Dampening Factor 10
Methodologies 10
Results – Risk Based Cohorts 12
Results – Hybrid Approach 13
Dampening Conclusions 14
Appendices 16
Appendix A: Caveats 16
Appendix B: Disclosures 17

INTRODUCTION

In 2019, the state of Maryland implemented the State Reinsurance Program ("SRP") for the Individual market by using an Affordable Care Act ("ACA") Section 1332 waiver ("Waiver"). The SRP provides funds to health insurers operating in the Individual market to help cover the costs of high-cost members.

Pursuant to the Code of Maryland Regulations ("COMAR") Section 14.35.17.04.B[1], each year the Maryland Health Benefit Exchange ("MHBE") Board of Trustees ("Board") must set the payment parameters for the State Reinsurance Program by determining the attachment point, the coinsurance rate, and the reinsurance cap.

For 2019, 2020, 2021 and 2022, the Board set payment parameters such that the SRP would provide a payment equal to 80% of the claims incurred between $20,000 and $250,000 for each member in the Individual market. The goal was to reduce premiums in the Individual market by 30% (due to direct funding and associated morbidity improvements). Each year, the reinsurance payment parameters were reviewed, yet they have remained unchanged through 2022.

The federal risk adjustment program, operated by the Department of Health & Human Services ("HHS"), also provides payments to insurers for members who are expected to have high costs based on demographic characteristics and diagnosis data.

Because both programs cover some of the same high-risk, high-cost individuals, there is potential that some insurer claims are covered by both programs. This interaction of the reinsurance and risk adjustment programs could inappropriately disrupt the Individual market if adjustments are not made.[2] Therefore, pursuant to Section 14.35.17.04.B.(4), the Board can set a market-level dampening factor provided by the Maryland Insurance Commissioner, if determined necessary to mitigate the interaction of the SRP and the federal risk adjustment program.

The Board determined a dampening factor was again necessary for 2022. The Commissioner established a dampening factor of 0.805, i.e., a reduction of 19.5% to calculated risk adjustment transfers. The Commissioner concluded that a 19.5% reduction was appropriate to address the potential for interaction between the SRP and federal risk adjustment program.

[1] http://mdrules.elaws.us/comar/14.35.17.04

[2] In this report, the word "interaction" refers to payments received by a carrier for the enrolled population whose risk and claims experience would be eligible for payments under both the Federal Risk Adjustment Program and the State Reinsurance Program.

This report has been prepared for the MHBE and the Maryland Insurance Administration ("MIA") to help inform the MHBE Board of Trustees in setting the 2023 parameters for the State Reinsurance Program.

REINSURANCE PAYMENT PARAMETERS

METHODOLOGY

The steps in projecting the impact of the State Reinsurance Program's payment parameters for the 2023 Individual market included:

1) **Reviewing previous reinsurance reports and estimates** – These documents were produced by L&E in 2019, 2020, and 2021 for the 2020, 2021, and 2022 policy years and previously by the Wakely Consulting Group ("Wakely") in 2018 for 2019. These documents included estimated impacts to the Individual ACA market for 2019 and beyond.

2) **Gathering experience data** – L&E collected updated 2021 – 2022[3] claims experience data from the insurers participating in the Individual market, i.e., CareFirst Blue Cross Blue Shield ("CareFirst"), Kaiser Permanente ("Kaiser"), and Optimum Choice Inc. ("Optimum").

3) **Collecting information for projection assumptions** - In addition to claims experience, L&E utilized actual 2022 plan enrollment as well as other information (e.g., benchmark premium changes, expense, and membership assumptions) provided in the 2023 rate filings. L&E also had discussions with the MHBE and MIA concerning any internal carrier or market analyses performed. L&E reviewed data from the Centers for Medicare and Medicaid Services ("CMS"), MHBE, MIA and carriers to calibrate and then project premiums, Advance Premium Tax Credits ("APTC"), and federal pass-through funding.

4) **Updating reinsurance model** – Having performed prior reinsurance program analyses and an additional analysis regarding young adult subsidies[4], L&E refined its projection methodology and expanded the data requests to improve the predictive ability of the model. The biggest change was refining pass-through projections in years when ARPA is in effect to better align with CMS' assumed methodology. As a result, L&E's 2022 pass-through estimate differed from CMS by only 2%.

[3] Claims data is through March 2022.

[4] L&E has performed impact analyses of state funded subsidies in the individual market. The subsidies analyzed focused primarily on young adult and making healthcare coverage more affordable for these individuals.

5) **Modeling enrollment from newly eligible populations** – L&E modeled the impact of those in the "family glitch"[5], and individuals no longer eligible for Medicaid due to redetermination, becoming eligible for APTC beginning in 2023. L&E relied on modeling previously prepared for MHBE and MIA on the family glitch to estimate enrollment and morbidity. L&E reviewed data from MHBE and MACPAC[7] to estimate uptake into the market for those disenrolled from Medicaid.

6) **Developing and projecting reinsurance payments** – Using 2021 full year claims data provided by CareFirst, Kaiser, and Optimum, L&E projected the claims with carriers' assumptions with refinement from discussions with the MHBE and MIA (see Step #3 above) for claims trend, enrollment, and expenses.

7) **Modeling two American Rescue Plan Act (ARPA) scenarios** – L&E projected two federal scenarios: 1) ARPA's higher APTCs will continue through 2022 and return to pre-ARPA levels beginning in 2023, consistent with the current federal regulation; and 2) the higher ARPA APTCs will continue through 2025.

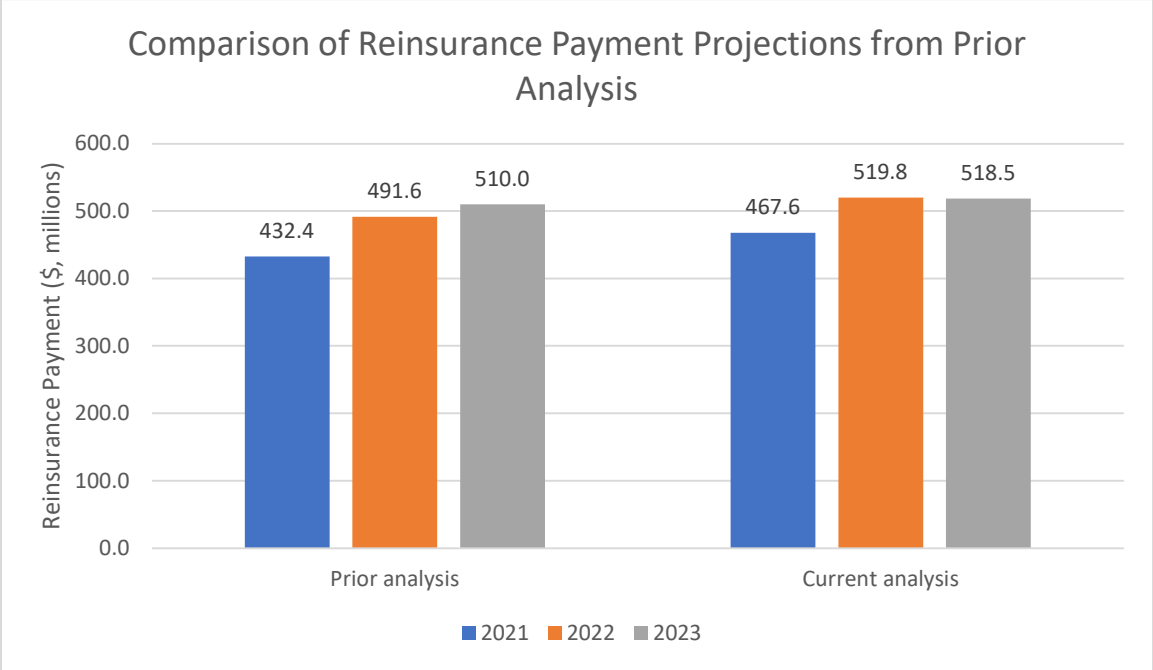
[5] If individual has an offer of employee only coverage deemed affordable by the ACA (costing no more than 9.61% of income in 2022), all household individuals are ineligible for APTC, regardless of the additional cost for covering dependents. Dependents ineligible for APTC under this scenario are referred to as falling into the "family glitch".
[7] https://www.macpac.gov/wp-content/uploads/2022/04/Churn-and-Coverage-Transitions.pdf

RESULTS

Assuming the reinsurance program parameters remain unchanged, L&E projects Maryland's State Reinsurance Program will pay out approximately $467 million in 2021, $519 million in 2022, and $518 million in 2023, assuming ARPA has expired at the end of 2022. L&E projects that the continuation of ARPA-level subsidies into 2023 would raise reinsurance costs by $33 million to $551 million.

For 2021, the actual reinsurance payment is approximately 8.1% higher than what was previously projected by L&E. It appears that the primary reason is that 2021 actual claims were higher than expected due to the ongoing COVID-19 pandemic.

For 2022, the expected claims level was projected forward from 2021 along with a downward adjustment to remove claims from COVID-19 not expected to be incurred in 2022. 2022 also includes the impact of additional enrollment from ARPA and the Young Adult subsidies. See the following graph for a comparison of the prior analysis[8] with the current analysis[9].



The reinsurance program helps stabilize the Individual market by reimbursing carriers for high-cost claims, which in turn, reduces premiums in the market when compared to a scenario without the reinsurance program. The expected premium reductions are driven by a claims reduction due to:

[8] Prior analysis refers to L&E's reinsurance modeling and report from 2021, which utilized 2020 full year and 2021 partial year claims data to project reinsurance payments for 2021 and beyond. The current analysis utilized full year 2021 data to project reinsurance payments 2022 and beyond. There is no change in the reinsurance parameters shown in this graph.

[9] Assumes ARPA has expired at the end of 2022.

1. Reinsurance (as described), and
2. An improvement to the covered population's morbidity due to additional healthy members entering and staying in the Individual market because of the lower premiums resulting from the SRP.
    - Reviewing the 2017-2021 claims experience, most of the change in membership came from the healthiest (or, lowest claims) individuals.

Additionally, there is a premium offset due to the health insurer provider fee (Section 6-102.1 of the Maryland Insurance Code), which is 1.00% for 2020 through 2023. Note, L&E's projections assume the 1% will continue indefinitely (along with the reinsurance program).

After discussion with the MHBE and MIA, it was decided that the L&E projections would use the existing attachment point during the current waiver period. No decision has been made on parameter changes for a second waiver period beginning in 2024. Therefore, the modeling in this analysis assumes an attachment point of $20,000 throughout the life of the program.

After reviewing pass-through information released by CMS for 2021 and 2022, L&E made adjustments to better predict how pass-through amounts change in years where ARPA is active. Excluding ARPA's impact, L&E projects the federal pass-through funding for 2023 to be $271 million. Including ARPA's impact, L&E expects pass-through funding to be $395 million.

Factors influencing 2023 pass-through funding include:

- Kaiser now has the Second Lowest Cost Silver Plan (SLCSP) in its service areas. This accounts for approximately 85% of the Individual market. 2023 benchmark market premium increases in these service areas are projected to be below the average market premium increases, which decrease the pass-through relative to the cost of the SRP.
- If ARPA expires, rolling back ARPA's richer subsidies would decrease pass-through relative to the cost of the SRP.
- The Young Adult subsidy program, fixing the "family glitch", and Medicaid redetermination (discussed below) will increase 2023 enrollment in the Individual market. These populations on average are expected to have lower relative morbidity, which increases the pass-through relative to the cost of the SRP.

COVID-19 Discussion

There continues to be uncertainty regarding how COVID-19 will impact future claims. Based on data provided by the carriers and discussions with MIA, L&E assumed COVID-19 hospitalizations would decline relative to 2021, ranging from 25% in 2022 and 90% in 2024. These adjustments would reduce projected reinsurance claims by $2.7 million in 2022, $5.5 million in 2023, and $4.7 million in 2024.

ARPA Discussion

Given the uncertainty surrounding legislation to extend the enhanced subsidy levels originally introduced by ARPA, L&E has modeled two potential scenarios, the first with ARPA ending in 2022 and the second assuming the expiration occurs at the end of 2025[11].

To model ARPA enrollment increases, L&E used an elasticity model to estimate the subsidies' impact for various age groups based on a member's net premium as a percentage of income. L&E initially modeled the ARPA enrollment increase to be phased in over a two-year period from 2021 to 2022. In the scenario where ARPA continues beyond 2022, no additional enrollment is modeled.

Higher federal APTC levels increase pass-through funding, holding all else equal. 2021 and 2022 federal pass-through dollars reported by CMS have been significantly higher than L&E's original projections prior to the passing of ARPA. L&E projects federal pass-through to be higher by $108 million to $123 million per year in years 2023 to 2025 if ARPA were to continue.

Young Adult Subsidy Program

Effective January 1, 2022, MHBE introduced the Young Adult Subsidy Program, a two-year pilot program which offers premium subsidies in addition to APTC for young adults between the ages of 18 and 34. Using 2022 emerging enrollment[12], L&E is projecting 16,592 new young adults to join the Individual market in 2022. The table below shoes the estimated enrollment change for 2023.

Estimated New Enrollment from the Young Adult Subsidy Program

Subsidy Scenario	2023
ARPA	14,650
No ARPA	-1,614

Under the "No ARPA" scenario, an estimated 7,200 young adults are expected to lapse coverage due to higher net premiums in 2023 versus 2022. This enrollment loss is partially offset by the newly eligible family glitch and Medicaid redetermination populations entering the market beginning in 2023.

Due to their age and decision to forego purchasing insurance before the introduction of the subsidy, this cohort is projected to be significantly healthier than the market wide average. As a result, reinsurance claims for young adults receiving a subsidy are expected to be immaterial.

[11] Initially proposed in the 2021 Reconciliation bill.
[12] Through June 2022.

Family Glitch

In April 2022, the Internal Revenue Service ("IRS") issued a 2023 proposed rule to revise how dependents are eligible for premium tax credits when a family member has an offer of health coverage deemed affordable by the Affordable Care Act. Currently, if an individual has an offer of employer coverage costing no more than 9.61% of household income, all household individuals are ineligible for Individual market subsidies, even if the cost of providing family coverage exceeds 9.61%. Dependents ineligible for subsidies under this scenario are referred to as falling into the "family glitch". While the proposed rule has not been written into law at the time of this report, L&E has assumed the family glitch fix will go into effect January 2023.

L&E relied on modeling previously prepared for MHBE and MIA which modeled enrollment uptake and the cost of providing APTC for family glitch dependents entering the Individual market. A similar elasticity model to the one used for estimating ARPA enrollment was used to measure a member's willingness to take up coverage. The table below shows the projected family glitch enrollment for 2023 through 2025, assuming enrollment is phased in over the three-year period.

Estimated New Individual Market Enrollment from Family Glitch Members

Subsidy Scenario	2023	2024	2025
ARPA	12,256	6,216	1,277
No ARPA	10,104	5,134	1,004

Family glitch members, before becoming eligible for subsidies, were primarily in group coverage where the average morbidity is less than the Individual market. As a result, reinsurance costs for this population are expected to be lower per member. L&E estimates family glitch members will account for approximately $10M in additional reinsurance payments in 2023.

Medicaid Redetermination

As the COVID-19 public health emergency is expected to end, states are required to restart their redetermination processes to identify individuals no longer eligible for Medicaid due to age, income, or other criteria. Many of those disenrolled from Medicaid would become eligible for an APTC.

To estimate the number of newly eligible members due to Medicaid redetermination, L&E relied on data provided by MHBE which showed 216,193[14] individuals were expected to be disenrolled from Medicaid over the next year. The exact date at which redeterminations are expected to begin is unknown at the time of this report. Based on discussions with MHBE and MIA, L&E has

[14] Enrollment estimates were as of April 2022. A 4.7% growth assumption was applied to projected estimated January 2023 enrollment based on historical Medicaid growth during the COVID-19 pandemic.

assumed redeterminations will begin in January 2023. Additionally, L&E assumed that 4%[15] of those no longer eligible for Medicaid will enroll in the Individual market[16]

Estimated 2023 Individual Market Enrollment Due to Medicaid Redetermination

Subsidy Scenario	2023
ARPA	7,571
No ARPA	6,057

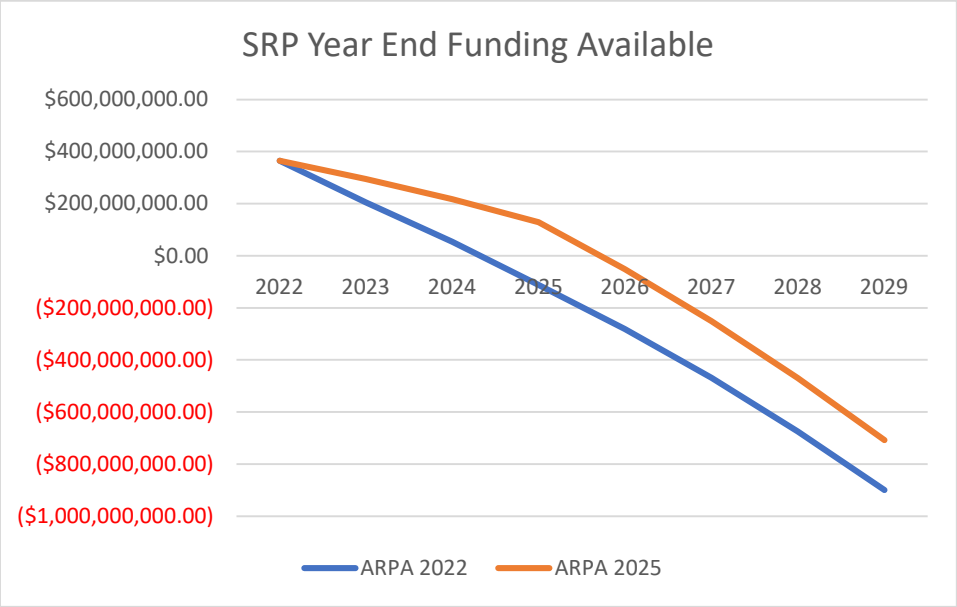
To estimate this population's morbidity, L&E relied on data from carriers who provided claims by CSR variant. This was used as a proxy for FPL level due to the income requirements to qualify for CSR plans. Medicaid redetermination members were categorized into expected FPL levels and an expected morbidity level was calculated based on the claims distribution between the CSR (FPL) levels. These members are expected to have a morbidity level 6.5% higher than a currently enrolled member.

PROGRAM SOLVENCY

L&E's 2021 report projected the SRP would remain solvent through 2030. Based on updated data and refinements to the model, L&E estimates the program will run out of funding beginning as early as 2025 under the ARPA 2022 scenario, assuming no changes to the program. Factors influencing this change from the previous report include:

- The prior analysis assumed the attachment point would increase to $30,000 beginning in 2024. L&E assumes the attachment point in 2024 and beyond will remain at $20,000 as no decision has been made regarding its change at this time.
- The prior analysis assumed ARPA would be in effect indefinitely when determining solvency.
- 2021 claims experience was worse than expected. This resulted in a larger reinsurance payment than originally projected.
- An adjustment was added to reflect lower lapse rates in years where the richer subsidies from ARPA are in effect.
- Approximately $18 million dollars were removed to fund other state programs.
- Additional enrollment growth from the family glitch and Medicaid disenrolled populations.
- Rate increases for the 2023 benchmark premiums that are lower than the overall market rate increases.

[15] Assuming ARPA subsidies are not in effect. If ARPA is continued, L&E projects the rate to increase to 5%.
[16] Source: https://www.macpac.gov/wp-content/uploads/2022/04/Churn-and-Coverage-Transitions.pdf.



While the program is projected to remain solvent through the end of the program's first waiver period, a proposed second waiver period beginning in 2024 is not expected to have the funding necessary to operate until its conclusion in 2028. Therefore, either additional funding will be necessary, or the program's parameters need to be modified to reduce reinsurance liabilities. L&E calculated the required attachment point change necessary for the program to remain operational throughout the second waiver period.

2024 – 2028 Attachment Point Required for SRP Solvency

Subsidy Scenario	Attachment Point Needed
ARPA 2022	$50,000
ARPA 2025	$40,000

The required attachment point changes in the ARPA 2022 and ARPA 2025 scenarios would result in premium increases of 22% and 17% respectively.

To fund the program solely through the State Reinsurance Fee, with no reinsurance parameter changes, beginning in 2024 the fee would need to be increased to the values in the table below.

2024 – 2028 Reinsurance Fee Required for SRP Solvency

Subsidy Scenario	Reinsurance Fee Needed
ARPA 2022	1.96%
ARPA 2025	1.67%

DAMPENING FACTOR

METHODOLOGIES

The first step in evaluating the 2023 dampening factor was to examine 2021 historical data. L&E collected the External Data Gathering Environment (EDGE) server data from the carriers. The EDGE data contains risk scores, diagnosis data, claims data, and premium data.

The assumption-setting process for the dampening analysis was similar to the process for the reinsurance analysis described above and included discussions with the MIA regarding their review of the current filings. In addition to the 2021 EDGE data, L&E utilized enrollment and experience provided in the 2023 rate filings. Premiums were calculated under the expected 2023 scenario with an SRP and the hypothetical scenario in which the SRP did not exist.

L&E assumed slight changes to membership distributions in the market, consistent with the reinsurance analysis.

L&E used the HHS risk adjustment formula for calculating risk transfer payments based on allowable rating factors and risk scores by member. There are two transfer amounts based on the two premium/enrollment scenarios referenced above. For each member, the contributions from the SRP and the HHS high-cost member program were calculated based on projected 2023 claims. The 2023 reinsurance payment parameters were based on the analysis in the Reinsurance Payment Parameters section of this report.

COMAR 14.35.17.02B11 requires that the dampening factor modify payments such that "the claims-to-premium ratio between payers and receivers under the risk adjustment is normalized." This language does not define how to normalize these ratios.

Last year's analysis performed by L&E and the MIA considered three normalization approaches. In each method, the population was divided into cohorts based on their claims and/or risk score profiles. An adjusted loss ratio for each cohort was calculated based on the following formula:

$$Adjusted\ Loss\ Ratio = \frac{Claims - Reinsurance\ Contributions - Risk\ Adjustment\ Receivables}{Earned\ Premium}$$

The 2023 dampening factor was calculated to ensure that the adjusted loss ratios between the payer and the receiver populations, as defined above, were equal.

In this report, L&E calculates the dampening factor in two ways, representing different, but reasonable, interpretations of the statute. These methods, demonstrated in the subsequent sections, are:

- A Risk Score Cohort method that seeks to return members who produce risk adjustment receivables and risk adjustment payables to their loss ratio in the absence of the SRP, and
- A Hybrid Cohort approach which seeks to return the cohort of policies that produce risk adjustment payables and do not incur reinsurance payments to their loss ratio in the absence of the SRP.

A third method used last year has shown significant volatility. Therefore, this method was not included in the analysis.

RESULTS – RISK BASED COHORTS

As stated previously, COMAR 14.35.17.02B11 requires that the dampening factor modify payments such that "the claims-to-premium ratio between payers and receivers under the risk adjustment is normalized." Consistent with the 2022 analysis, this method considers the implications of grouping members by whether they result in positive or negative net risk adjustment transfers.

The first step in calculating the dampening factor under a risk-based method is to group the data by plan-level risk score (PLRS) cohort (instead of by claims). The first table below assumes that the SRP is not in place.

1) Undampened Risk Adjustment, No Reinsurance

		Total				Loss
Risk Score Category	Member Months	Claims	Premium	RA	RI	Ratio
RS 0 to 1	2,076,093	418,845,316	1,592,675,777	($1,146,467,026)	$0	98%
RS 1 to 2	133,976	$92,175,582	$126,372,731	($28,579,828)	$0	96%
RS 2 to 3	124,994	$124,956,111	$119,238,879	$43,616,253	$0	68%
RS 3 to 4	41,740	$54,531,537	$40,911,454	$30,812,019	$0	58%
RS 4 to 5	28,956	$50,486,130	$25,897,687	$36,265,404	$0	55%
RS 5+	173,138	$896,379,671	$181,963,446	$1,064,353,178	$0	-92%
Total	2,578,897	$1,637,374,347	$2,087,059,973	$0	$0	78%
RA Payers	2,164,417	$482,108,615	$1,706,616,900	($1,186,778,495)	$0	98%
RA Receivers	414,480	$1,155,265,732	$380,443,072	$1,186,778,495	$0	-8%

The difference in loss ratios between risk adjustment payers and receivers is equal to 106%. That is, this is the loss ratio differential which would exist if the reinsurance program did not exist.

The next step in the risk-based analysis is to layer in the SRP without any dampening adjustments.

2) Undampened Risk Adjustment, With Reinsurance

		Total				Loss
Category	Members	Claims	Premium	RA	RI	Ratio
RS 0 to 1	2,239,317	$423,055,842	$1,049,157,007	($743,817,933)	$39,400,441	107%
RS 1 to 2	138,954	$89,652,220	$80,041,120	($13,975,468)	$15,176,198	111%
RS 2 to 3	127,485	$119,838,119	$74,457,585	$34,114,562	$29,139,953	76%
RS 3 to 4	41,744	$51,968,907	$25,055,503	$21,914,318	$12,828,881	69%
RS 4 to 5	28,573	$47,874,473	$15,684,210	$24,587,527	$14,381,798	57%
RS 5+	167,434	$846,046,478	$107,558,626	$677,176,994	$406,831,145	-221%
Total	2,743,508	$1,578,436,038	$1,351,954,050	$0	$517,758,416	78%
RA Payers	2,330,239	484,407,861	$1,121,000,845	($766,314,422)	$49,041,849	107%
RA Receivers	413,269	1,094,028,178	$230,953,206	$766,314,422	$468,716,567	-61%

The -220% loss ratio for the highest risk score category demonstrates that carriers would be materially overcompensated for the highest risk subscribers. This clearly demonstrates a material interaction between the risk adjustment program and the SRP. The difference in loss ratios between payers and receivers has grown from approximately 106% to 168%.

To return this loss ratio difference to the targeted, pre-reinsurance 106%, a dampening factor of 15.5% would need to be applied. This is demonstrated below:

3) Risk Adjustment Dampened by 15.5%, With Reinsurance

		Total				Loss
Category	Members	Claims	Premium	RA	RI	Ratio
RS 0 to 1	2,239,317	$423,055,842	$1,049,157,007	($628,295,499)	$39,400,441	96%
RS 1 to 2	138,954	$89,652,220	$80,041,120	($11,804,937)	$15,176,198	108%
RS 2 to 3	127,485	$119,838,119	$74,457,585	$28,816,226	$29,139,953	83%
RS 3 to 4	41,744	$51,968,907	$25,055,503	$18,510,803	$12,828,881	82%
RS 4 to 5	28,573	$47,874,473	$15,684,210	$20,768,836	$14,381,798	81%
RS 5+	167,434	$846,046,478	$107,558,626	$572,004,571	$406,831,145	-123%
Total	2,743,508	$1,578,436,038	$1,351,954,050	$0	$517,758,416	78%
RA Payers	2,330,239	$484,407,861	$1,121,000,845	($647,298,057)	$49,041,849	97%
RA Receivers	413,269	$1,094,028,178	$230,953,206	$647,298,057	$468,716,567	-10%

RESULTS – HYBRID APPROACH

In this approach, all members in the Individual market are assigned to 1 of 4 cohorts, based on whether they produced a positive or negative risk transfer, and whether they triggered a reinsurance payment for their insurance carrier. These cohorts are described below:

Cohort	Risk Adjustment	Reinsurance Payment
Cohort 1	Payor	No
Cohort 2	Payor	Yes
Cohort 3	Receiver	No
Cohort 4	Receiver	Yes

Otherwise, this methodology follows a similar pattern to the other method. Cohort 1 represents those policyholders with no or few health conditions who also did not experience a catastrophic claim. These members produce a loss ratio of 91% in the scenario where there is no SRP.

1) Undampened Risk Adjustment, No Reinsurance

		Total				Loss
Category	Member Months	Claims	Premium	RA	RI	Ratio
Cohort 1	2,129,073	$349,080,307	$1,670,958,232	($1,167,215,896)	$0	91%
Cohort 2	35,344	$133,028,309	$35,658,669	($19,562,599)	$0	428%
Cohort 3	271,351	$158,721,928	$235,337,221	$342,317,577	$0	-78%
Cohort 4	143,130	$996,543,804	$145,105,851	$844,460,918	$0	105%
Total	2,578,897	$1,637,374,347	$2,087,059,973	$0	$0	78%
Total Payor	2,164,417	$482,108,615	$1,706,616,900	($1,186,778,495)	$0	98%
Total Receiver	414,480	$1,155,265,732	$380,443,072	$1,186,778,495	$0	-8%

With the introduction of the reinsurance program, the lowered premium for this cohort produces an increased loss ratio of 101%.

2) Undampened Risk Adjustment, With Reinsurance

		Total				Loss
Category	Member Months	Claims	Premium	RA	RI	Ratio
Cohort 1	2,296,920	$358,999,936	$1,100,418,570	($755,498,670)	$0	101%
Cohort 2	33,319	$125,407,925	$20,582,275	($10,815,752)	$49,041,849	424%
Cohort 3	278,338	$154,570,317	$147,197,737	$236,333,781	$0	-56%
Cohort 4	134,931	$939,457,861	$83,755,468	$529,980,642	$468,716,567	-71%
Total	2,743,508	$1,578,436,038	$1,351,954,050	$0	$517,758,416	78%
Total Payor	2,330,239	$484,407,861	$1,121,000,845	($766,314,422)	$49,041,849	107%
Total Receiver	413,269	$1,094,028,178	$230,953,206	$766,314,422	$468,716,567	-61%

To return the Cohort 1 loss ratio to its original level, a dampening factor of 15.3% is necessary.

3) Risk Adjustment Dampened by 15.3%, With Reinsurance

		Total				Loss
Category	Member Months	Claims	Premium	RA	RI	Ratio
Cohort 1	2,296,920	$358,999,936	$1,100,418,570	($639,565,119)	$0	91%
Cohort 2	33,319	$125,407,925	$20,582,275	($9,156,043)	$49,041,849	416%
Cohort 3	278,338	$154,570,317	$147,197,737	$200,067,649	$0	-31%
Cohort 4	134,931	$939,457,861	$83,755,468	$448,653,513	$468,716,567	26%
Total	2,743,508	$1,578,436,038	$1,351,954,050	$0	$517,758,416	78%
Total Payor	2,330,239	$484,407,861	$1,121,000,845	($648,721,162)	$49,041,849	97%
Total Receiver	413,269	$1,094,028,178	$230,953,206	$648,721,162	$468,716,567	-10%

DAMPENING CONCLUSIONS

Having observed the evolution of various methods of calculating a dampening factor over the last few years, L&E believes the most stable, appropriate methodology is the Risk-Based Cohort approach. This method naturally implements the language of COMAR 14.35.17.02B11 ("payers and receivers under risk adjustment") and neutralizes specifically the impact of the state reinsurance program on those two groups.

L&E notes that significant changes are being made to the HHS risk adjustment model in 2022 and 2023 that could produce larger or smaller transfers. CMS calculated the changes that the new model would have using 2020 data and generally found that transfers would decrease by about 4% due to 2022 changes but then increase by about 2% for 2023 changes.

Because the estimated impacts were based 2020 data (and the impact of COVID-19) and because the information was based on carrier groupings rather than risk cohort groupings, L&E is cautious about the appropriateness of using this information in estimating the 2023 dampening factor.

Additionally, L&E notes that model changes would have similar effects on transfers in both the with and without reinsurance scenarios. So, while the impact of model changes likely isn't zero, the uncertainty around them and their likely being immaterial to the dampening factor justify not explicitly modeling them.

APPENDICES

APPENDIX A: CAVEATS

L&E performed reasonability tests on the data used; however, L&E did not perform a detailed audit of the data. To the extent that the information provided was incomplete or inaccurate, the results in this report may be incomplete or inaccurate.

L&E made several assumptions in performing the analysis. Several of these assumptions are subject to material uncertainty and it is expected that actual results could materially differ from the projections. Examples of uncertainty inherent in the assumptions include, but are not limited to:

- Data Limitations.
  - L&E relied on the data submitted from the insurers for significant portions of this analysis. To the extent that the data is inaccurate, the analysis will be impacted.
- Enrollment Uncertainty.
  - Beyond changes to premiums and market wide programs, consumer responses to these have inherent uncertainty. Therefore, actual enrollment could vary significantly.
- Political and Health Policy Uncertainty.
  - Future federal or state actions could dramatically change 2023 premiums and enrollment.
- Risk Adjustment Transfers.
  - Given historical enrollment changes in the Maryland market, estimates of risk adjustment transfers by cost category is highly uncertain.
- COVID-19 Pandemic
  - Claims data used in modeling is through March 2022 and are materially impacted by the COVID-19 global pandemic.

This report has been prepared for the MHBE and the MIA for discussion purposes in relation to the State Reinsurance Program analysis. Any other use may not be appropriate. L&E understands that this report may be distributed to other parties; however, any user of this report must possess a certain level of expertise in actuarial science and/or health insurance so as not to misinterpret the data presented. Any distribution of this report should be made in its entirety. Any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or warranties as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

APPENDIX B: DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[17], promulgates Actuarial Standards of Practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[18], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

IDENTIFICATION OF THE RESPONSIBLE ACTUARIES

The responsible actuaries are:

- Josh Hammerquist, FSA, MAAA, Vice President & Principal
- Jason Doherty, ASA, MAAA, Consulting Actuary
- Dave Dillon, FSA, MAAA, MS, Senior Vice President & Principal
- Kevin Ruggeberg, FSA, MAAA, Vice President & Consulting Actuary

The actuaries are available to provide supplementary information and explanation.

IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is July 7, 2022. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 6, 2022.

DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Maryland Health Benefit Exchange and the Maryland Insurance Administration. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the companies that participate in the Maryland Individual market. L&E is not aware of anything that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the MHBE and the MIA with an analysis of the 2023 State Reinsurance Program.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.

[17] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conoference of Consulting Actuaries, and the Society of Actuaries.
[18] These organizations adopted identical Codes of Professional Conduct effective January 1, 2001.

- Lewis & Ellis has reviewed the data provided for reasonableness but has not audited it. L&E nor the responsible actuaries assume responsibility for items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- L&E is not aware of other subsequent events that may have a material effect on the findings.

ACTUARIAL FINDINGS

The actuarial findings of the report can be found in the body of this report.

METHODS, PROCEDURES, ASSUMPTIONS, AND DATA

The methods, procedures, assumptions, and data used can be found in the body of this report.

ASSUMPTIONS OR METHODS PRESCRIBED BY LAW

This report was prepared as prescribed by applicable law, statutes, regulations, and other legally binding authority.

RESPONSIBILITY FOR ASSUMPTIONS AND METHODS

The actuaries do not disclaim responsibility for material assumptions or methods.

DEVIATION FROM THE GUIDANCE OF AN ASOP

The actuaries do not believe that material deviations from the guidance set forth in an applicable ASOP have been made.