Enrollment Dynamics and Health Care Utilization in the ACA Individual Market

America's Health Insurance Plans

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Executive Summary

In August 2025, the Centers for Medicare & Medicaid Services (CMS) published data on Affordable Care Act (ACA) Marketplace enrollment records that had no insurance claims recorded each year for benefit years 2019−2024.[1] Wakely was retained by America's Health Insurance Plans (AHIP) to evaluate the potential reasons for reported changes in the percent of non-claimants in some individual health insurance markets over the reported period. This report explains what that statistic measures and how best to interpret it.

The publication of these data has generated some debate. Some have interpreted the reported rates of no recorded claims, as well as increase in the number of non-claimants, as evidence of enrollment in coverage without the knowledge or consent of the enrollee, suggesting the appearance of fraud. This report clarifies what data in the no-claims metric measures, highlight legitimate drivers of claims variation, and explain legitimate factors that can increase the rates of non-claimants.

Wakely's analysis first looked at limitations in the data itself, affecting conclusions that can be drawn from it. The CMS "no-claims" data reports the number of enrollments—not unique enrollees—with no claims over the course of a benefit year. These data are drawn from the External Data Gathering Environment (EDGE) system used to support ACA risk adjustment and the no-claims metric is an administrative tool used within EDGE to assess data quality—not as a measure of fraud, access, or coverage value. When an individual enrolls for only part of the year, enrolls late, or switches plans, EDGE counts each enrollment. As noted in CMS's methodology, this situation may result in overcounts for members enrolled in multiple plans during a given benefit year. Analysis of CMS's no-claims data, therefore, may suggest that an individual associated with an enrollment received no medical care when, in fact, the enrollee may have received services through a different plan.

Next, we examined structural considerations that could affect the number of non-claimants in a given year. Using national ACA individual market data, Wakely's analysis shows that enrollment duration and timing strongly influence no-claims statistics. Consumers who are enrolled for shorter periods or later in the year are much less likely to have a recorded claim. Our analysis found that, in 2023, 63 percent of enrollees with fewer than four months of coverage had no claims. These patterns became more common in recent years due to higher levels of enrollees switching plans or enrolling mid-year because of special enrollment periods and transitions from Medicaid coverage. When consumers frequently enroll or switch plans during the year, the number of records with no claims naturally increases. In years with high churn such as 2023-2025, these dynamics mechanically raise non-claimant counts.

[1] Centers for Medicare & Medicaid Services. 2019−2024 Enrollees Without Claims by State Market Metal Level. August 8, 2025. Available at: https://www.cms.gov/files/document/enrolleeswithoutclaims-2019-24.xlsx.

To gain additional understanding of potential drivers of the elevated non-claimant ratios in the individual market, Wakely reviewed its ACA database to highlight key dynamics contributing to the higher non-claimant ratios. The rest of this paper discusses the data used to measure non-claimant ratios and its limitations, changes in enrollment patterns in 2022 and 2023 in the individual market, as well as how changes in 2025 relative to 2024 may result in lower non-claimant ratios.

Wakely's analysis found that several structural factors influenced the recent rise in non-claimants in the ACA individual market:

1) Short enrollment durations from the 2023–2024 Medicaid redetermination cycle, which shifted millions mid-year into marketplace coverage
2) Higher Special Enrollment Period (SEP) volume and late-year enrollment
3) Increased plan switching that created multiple member IDs for the same individual, inflating EDGE-based counts
4) Claims adjudication lag, especially in the year's final months, which temporarily overstates non-utilizers
5) CMS suppression of low-dollar claims
6) Measurement of capitated services, including many behavioral health encounters, from EDGE files

Together, these dynamics predictably elevate no-claims rates during periods of churn, late enrollment, and population shifts.

In short, this metric should be interpreted as just one measurement of fraud. Enrollment churn, short enrollment periods, and the overlap with post-pandemic Medicaid determinations all contribute to the volume of no-claims. Policymakers and stakeholders should view the CMS no-claims statistics as a measure that requires context, not as proxy for ACA enrollment integrity or coverage adequacy.

Introduction

Scope and Objective

This analysis is designed to study the plausible explanations of the drivers of increases in non-claimants in the individual market in the years 2021–2023, when enhanced premium tax credits (ePTCs) were available, in addition to other market nuances such as Medicaid redetermination, compared with the years 2019–2020, prior to the enactment of ePTCs.

What Does CMS No-Claims Measure?

CMS recently published data from the EDGE server, which issuers submit for risk adjustment and other ACA program purposes.[2] The data CMS released show an increase in the percentage of enrollees with no reported claims in EDGE between 2019 and 2024.[3] While this metric is straightforward, the EDGE data follow certain strict rules that influence the measurement of non-claimants and conclusions about individual market enrollment. Historically, CMS has used the rate of non-claimants to evaluate the quality of data used for the risk adjustment program rather than to draw conclusions about enrollment trends. The rules around EDGE data influence non-claimant ratios; thus, external enrollment factors (e.g., short durations, late-year effectuations, plan switching, etc.), the availability of ePTCs, and improper enrollments have likely increased the rate of non-claimants in recent years.

Member ID Versus Unique Enrollee

As part of the EDGE data requirements, a member's ID must be masked so that it excludes any personally identifiable information.[4] Consequently, a unique member ID corresponds to a specific plan. If a member switches issuers, it typically results in a member having a new member ID. Consequently, the same person may have multiple unique member IDs if the individual changes issuers mid-year.

A non-claimant, as noted above, is any unique member ID associated with an ACA individual market plan that has no paid medical claims recorded for the entire benefit year. This measure differs from the percent of unique individuals without claims as a person who changes issuers mid-year could be counted twice as having no claims because the measurement is at the plan member ID level, not the unique individual member.

EDGE data include important nuances that may affect the ratio of non-claimants and contribute to drivers of variation over the years of interest, including:

- **Claims Run Out/Lag:** Paid claims data often understate actual utilization, especially at the end of the year, due to delays in claims processing. Only claims that have been fully adjudicated and paid are counted. Pending or denied claims as of the timing of data collection may impact measurement. If there are more claims occurring toward the end of the year, for example, due to a number of members joining later in the year, this may result in a greater portion of enrollees being classified as non-claimants.

[2] Ibid.
[3] It is important to note that the COVID pandemic had a significant impact on utilization patterns in 2020 and 2021. While we do not delve into that dynamic in detail in this paper, it should be noted that non-claim ratios during those years were affected by the pandemic.
[4] 45 CFR 153.720. Available at: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-153/subpart-H/section-153.720.

- **Suppression Rules**: CMS may suppress small dollar claims or certain categories, which can slightly inflate the count of non-claimant members. It is unclear how stable the percentage of enrollees affected is year to year.

- **Capitated Claims**: Some health care services are capitated, meaning an insurer pays a fixed amount to medical providers each month on behalf of eligible enrolled members for a set of services regardless of whether the members use those services. For example, some behavioral health care, primary care, and chronic disease management services are increasingly paid on a capitated basis, such as through an Accountable Care Organization (ACO). EDGE rules impute capitated claims to a fee-for-service calculation, as opposed to spreading costs across all members, which is also an acceptable way of measuring costs. This decision can increase the number of non-claimants.

- **Plan Switching**: To the extent that a member switches plans from one carrier to another carrier mid-year, and the member incurred claims with one insurer but not the other, such a member would show up in the data twice—once as a claimant and once as a non-claimant. Thus, the same person who incurred claims that year would also be reported as a non-claimant, thereby overstating the number of non-claimants. As noted earlier, the measurement of non-claimants is at the member ID level (i.e., enrollments), meaning that the data do not capture the number of unique individuals without claims. A member with multiple coverages in a month will be counted multiple times for that month. Consequently, in years with higher volume of plan switching, such as monthly plan switching which was allowed under CMS's low-income special enrollment period (SEP) rules from March 2022 to July 2025, the number of non-claimants, as measured by EDGE, could increase regardless of whether the number of unique members with no claims is constant.

Potential Factors that Could Increase Non-Claimant Ratios

Several factors are most likely to affect and inflate the non-claimant ratios are more prevalent in the individual market, particularly during the years at issue, than they typically would be in other commercial health insurance markets. Two such drivers of non-claimants that are relevant and more pronounced for benefit years 2023 and 2024 include:

- **Short Enrollment Spans:** Members who are enrolled for only part of the year have fewer opportunities to incur claims.

- **Late-Year Effectuations:** Individuals who join plans in the fourth quarter often have minimal utilization.

It is important to note that both of these trends were likely to increase in 2023 and 2024 for reasons unrelated to the availability of ePTCs. In particular, benefit years 2023 and 2024 had higher than normal churn rates and late-year effectuations because of the lengthy and unprecedented Medicaid unwinding and redetermination processes, coupled with SEP opportunities. The

combination of these temporary events, processes, and policies would logically lead to an artificial increase in the rate of non-claimants during this period.

To study how the shorter enrollment spans and late-year enrollments would affect non-claimant ratios, Wakely used its national individual ACA data[5] (WACA) from 2019 to 2023 (latest year available as of this report) to study the trends in proportion of non-claimant enrollees, enrollment duration, and timing of enrollment. Individual market data includes millions of members and broadly representative of nationwide enrollment trends. During the period measured, WACA data mirror national data in that the large enrollment growth in the South shifted the geographic composition. Consequently, national claimant ratios may be more heavily weighted toward this region. For further details on the WACA data, see the Appendix.

In the analysis, non-claimants were defined as individuals with no reported claims on an allowed dollar basis (claims gross of member cost sharing) during that plan year. To best align with CMS's methodology, we did not adjust EDGE capitation payments methodology on behalf of these members. In addition, both CMS's and Wakely's methodology measure enrollees at the member ID level rather than unique enrollee level. This approach could lead to higher non-claimant ratios. While this allows for a better comparison to the CMS data, it does likely result in the non-claimant ratios included in this report being overstated. The next section discusses the findings on exploring these hypotheses.

Findings

MEDICAID REDETERMINATION CHURN

An important consideration in the analysis is Medicaid redetermination impacts. On April 1, 2023, states began processes to "unwind" the Medicaid continuous enrollment policy that had been in effect under the federal COVID-19 Pandemic Public Health Emergency that expired in May 2023. This lengthy process for redetermining eligibility for Medicaid enrollees continued through late 2024. Some disenrolled Medicaid enrollees were eligible for ACA individual market coverage and consequently enrolled. The timing of disenrollments influenced the timing of ACA enrollment, spanning a two-year period. Most Medicaid enrollees entering the ACA market were enrolled for less than a year, resulting in a marked increase in shorter enrollment durations. Shorter duration enrollees tend to correlate with more non-claimants than longer duration enrollees.

[5] Wakely. Wakely Affordable Care Act (ACA) Database. 2025. Available at: https://www.wakely.com/products/aca-database/.

ENROLLMENT SPAN VS. CLAIM INCIDENCE (EXCHANGE ONLY)

The following table shows the percentage of enrollees by enrollment duration and year:[6]

Exhibit 1. Distribution of Enrollment by Duration and Year (Exchange only)[7]

Enrollment Duration	2019	2021	2022	2023
< 4 months	15%	16%	17%	20%
4-8 months	17%	25%	17%	23%
8+ months	67%	59%	65%	56%
Grand Total	**100%**	**100%**	**100%**	**100%**

The chart above shows that significant growth occurred in shorter durations in 2023, likely driven by Medicaid redetermination. The increase in the proportion of enrollees with shorter duration has direct implications on the proportion of non-claimants as can be seen in the next exhibit.

PROPORTION OF NON-CLAIMANTS BY ENROLLMENT DURATION

The chart below shows the proportion of members that are non-claimants by month duration spans and year.

Exhibit 2. Non-Claimants by Enrollment Duration and Year (Exchange only)

Enrollment Duration	2019	2021	2022	2023
< 4 months	57%	54%	59%	63%
4-8 months	30%	27%	32%	43%
8+ months	17%	10%	15%	22%
Grand Total	**25%**	**21%**	**25%**	**35%**

Shorter enrollment spans consistently show a higher proportion of non-utilizers than enrollments of longer durations—an intuitive finding as new members require time to become familiar with their benefits, provider networks, and to schedule appointments. Members enrolled for less than a year are expected to have lower utilization. The findings in Exhibit 1, which shows the increase in the number of short duration enrollments, combined with those in Exhibit 2, which shows that shorter duration enrollments have higher proportions of non-claimants, demonstrate that the decrease in enrollment duration should increase the total percentage of non-claimants in 2022 and even further in 2023.

[6] We do not show 2020 because the COVID shutdown distorted results. COVID-related disruptions in care occurred in 2021, although to a lesser extent than 2020; therefore, 2021 data may not be representative of a typical year. We note the WACA does not completely align with CMS data for 2021.

[7] The overall number of enrollees in the WACA dataset during this period is between 1.5 and 3 million. Consequently, no individual cell listed should be affected by small sample sizes from year to year.

We note that analyses[8] reported in *Health Affairs* from both the Health Care Cost Institute and Covered California (the agency that operates California's Exchange) closely align with the above analysis. The report notes, "The factor that appears to have the biggest impact on non-utilization is enrollment tenure."[9] Shorter coverage duration increases non-utilization rates and enrollment durations decreased during the period examined.

TIMING OF ENROLLMENT

The timing of enrollment also affects utilization and reported claims in EDGE. Exhibit 3 shows the distribution of members by timing of enrollment.

Exhibit 3. Distribution of Members by Timing of Enrollment

Plan Year	Jan–Apr	May–Aug	Sept–Dec
2019	91%	5%	4%
2020	90%	6%	4%
2021	80%	13%	8%
2022	86%	6%	8%
2023	76%	12%	13%

Medicaid redetermination resulted in more enrollees joining later in the year, especially in 2023. Similar to prior exhibits, the greater proportion of 2023 enrollees joining later in the year correlates with higher rates of non-utilization as Exhibit 4 illustrates.

NON-CLAIMANTS BY TIMING OF ENROLLMENT

Exhibit 4 shows the proportion of enrollees who are non-utilizers by timing of enrollment:

Exhibit 4. Non-Claimants by Timing of Enrollment

Plan Year	Jan–Apr	May–Aug	Sept–Dec
2019	23%	28%	42%
2020	18%	26%	39%
2021	16%	28%	42%
2022	21%	34%	56%
2023	28%	46%	59%

Members who enrolled in May to August and in September through December are much more likely to be non-utilizers. Exhibit 3, which shows that the proportion of enrollees gaining coverage

[8] Rubino B, Wolf E. Covered California's Data Tells A Fuller Story About ACA Marketplace Utilization. *Health Affairs Forefront*. September 22, 2025. doi: 10.1377/forefront.20250919.339396

[9] Ibid

later in the year increased in 2023, combined with Exhibit 4, which shows that those joining later in the year are more likely to be non-utilizers, illustrates that the increase in later year enrollment put upward pressure on the percent of enrollees with no claims. This pattern is expected to continue into 2024 but should subside in subsequent years. In particular, without Medicaid redetermination, individuals will be more likely to be enrolled for longer periods of time and earlier in the year; therefore, they are more likely to incur claims.

UTILIZERS BY DURATION OF ENROLLMENT

Exhibit 5 below shows the per member per month (PMPM) claims cost (on an allowed basis i.e., including member cost sharing) and a simplified loss ratio[10] by enrollment duration for utilizers and non-utilizers, separately, on the exchanges in 2023.

Exhibit 5: Non-Utilizers Claims Cost and Simplified Loss Ratio by Duration

Enrollment Duration / Utilizer Status	Allowed PMPM	Loss Ratio
< 4 months	$483.28	97%
Utilizers	$1,210.59	130%
Non-Utilizers	$0.00	72%
4-8 months	$495.62	89%
Utilizers	$845.82	100%
Non-Utilizers	$0.00	71%
8+ months	$526.30	81%
Utilizers	$665.66	83%
Non-Utilizers	$0.00	72%

Exhibit 2 showed that 63 percent of the enrollees who were enrolled for fewer than four months were non-utilizers. Exhibit 5 above shows that even though enrollees with less than four months of enrollment are mostly non-utilizers, the ones who did utilize services, used significantly more than the average. The loss ratio of this cohort is 102 percent, implying that insurers are paying more in claims than they collect in premiums for members enrolled for fewer than four months. A similar dynamic exists for members enrolled for four to eight months, although to a lesser extent.

Conclusion

CMS no-claims reported counts reflect structural enrollment and timing factors. Higher rates of non-claimants are predictable, and as explained in this report, there are several legitimate drivers of these rates that align with expectations.

[10] Loss ratio is calculated as the paid claims net of reinsurance, pharmacy rebates, and risk adjustment divided by gross premiums. Consequently, changes to the risk adjustment methodology affect loss ratios.

In benefit years 2022 and 2023, significant factors unrelated to the ePTCs affected the percent of enrollees without claims. In particular, Medicaid redetermination, as well as changes to SEP eligibility during this period, increased the amount of churn in the individual market; a greater proportion of enrollees had short coverage duration and enrolled later in the year. Both of these dynamics increased the rate of enrollees with no claims. The increased churn also potentially interacted with how non-claimant ratios are measured using EDGE data. In particular, measurement at the member ID level rather than unique enrollee numbers may result in an inflated rate of non-claimants.

This analysis aligns with the findings in other recent research showing that lower enrollment duration and higher rates of non-utilizers are correlated.[11] Consequently the expectation is that rates of non-utilization should decrease as enrollees have longer durations in a calendar year. Preliminary recent analysis by Wakely aligns with that expectation. While non-claimant ratios[12] increased in 2023 and 2024, they are likely decreasing in 2025. This expectation aligns with the finding that churn in the ACA individual market was a major factor in the increase in non-claimant ratios during prior years.

Finally, it is important to note that in the CMS data, on a raw basis, the number of claimants dramatically increased during this period. If the number of non-claimants dramatically decreases, without a corresponding decrease in the number of claimants, there could be significant pressure on premiums.

[11] Rubino B, Wolf E. Covered California's Data Tells A Fuller Story About ACA Marketplace Utilization. *Health Affairs Forefront*. September 22, 2025. doi: 10.1377/forefront.20250919.339396

[12] Anderson M, Chin CY, Cohen M. Update: 2025 Individual Market Risk Pool Considerations. 2025. Available at: https://www.wakely.com/blog/update-2025-individual-market-risk-pool-considerations/.

Appendix: Methodology

This report clarifies what the no-claims metric measures, highlights legitimate drivers of claims variation, and explains reasons for the increase. It does not attempt to measure the prevalence, origin, or effect of unauthorized or improper enrollments, nor does it attempt to quantify, explain, or analyze any levels of fraud in markets during the years at issue. Rather, it focuses on legitimate factors that can increase the rates of non-claimants.

The data used for this analysis were derived from the Wakely Affordable Care Act (WACA) Database, with dates ranging from 2019 to 2023. WACA contains member-level data from several issuers nationwide within the ACA individual market. Summary information was collected for each member within the individual market (with separate records for each year), including:

- Whether they purchased coverage on or off the exchange
- Their total allowed costs incurred over their enrollment span
- The month in which they enrolled
- The duration of their enrollment for

From there, members were categorized as either a utilizer, meaning they had greater than $0 in allowed costs, or a non-utilizer. The results were then aggregated across each year by enrollment duration buckets of fewer than four months, four to eight months, and greater than eight months. Additionally, members were grouped into buckets based on the month that they enrolled in their plan (January–April, May–August, and September–December). These data were used in two key components of the analysis.

- **Enrollment Duration:** Focusing on the on-exchange population, the distribution of unique members between the three enrollment duration buckets was calculated for each year, along with the proportion of members assigned a non-utilizer status.
- **Timing of Enrollment:** The proportion of total enrollees and the percentage of non-utilizers that fell into each enrollment month bucket was determined for each year of data. Further, the loss ratio for both data splits was calculated using the total amount paid net of reinsurance, Rx rebates, and risk adjustment divided by gross premiums.

The results from the analyses above allowed for a comparison of non-utilizer enrollment trends with the enrollment trends of the overall population across multiple years of data.

Note that we did not include capitation claims in our analysis to align with CMS methodology and this may overstate the number of non-claimants. Furthermore, members who changed insurers

mid-year would be counted twice—once under each insurer's data. Our understanding is that the Centers for Medicare & Medicaid Services (CMS) methodology also does not account for members changing insurers mid-year. When members change insurers mid-year, the deductibles get reset and provider networks may be different between insurers causing members to potentially change their medical providers. As a result, members may not use services under the new insurer until the following year, which may result in overstating the non-claimant counts.

Reliances

We relied on the WACA Database to determine average costs for the example members. WACA is an aggregated database based on de-identified EDGE server input and output files (including enrollment, claims, and pharmacy data) from the 2023 benefit year submitted through April 2024, along with supplemental risk adjustment transfer and issuer-reported financial information, representing approximately 1.6–5.8 million lives annually from the individual ACA on-exchange markets. We added in publicly available data published by CMS, such as the 2023 plan finder data and the medical loss ratio (MLR) data. The de-identification applies to identifiers specific to enrollee, issuer, and location. We performed reasonability tests on the data but did not audit or verify the data. The dataset is subject to change if issues are found or reported to us. We may release updates to the dataset if the changes are significant and relevant to the analysis.

Potential limitations of the WACA data include:

- Issuer-specific data management will affect results. Omitted claims, erroneously coded claims, erroneous enrollment records, and other data issues may not reflect actual ACA cost and diagnosis experience.
- A number of fields are populated using HIOS-ID level assumptions that are provided by the issuers. These include the CSR Claims Adjustment field, the Rx Rebates field, and the assorted admin fields (IT and Quality Expenses through Other Admin in the WACA_2023_OUT_DET table). Wakely allocates these expenses to the member level and applies a small fuzzing factor (slightly increasing or decreasing each value). We do not audit these assumptions or attempt to reconcile them with other sources.
- A subset of issuers nationwide submitted data to the database. We believe the database represents a fair cross section of nationwide experience, but limitations in this regard will affect results.
- There may be irregularities in enrollment date reporting. Given that this analysis relies heavily on enrollment dates, systematic irregularities or errors in enrollment date reporting may affect results, potentially significantly. Given the volatility of market conditions since the inception of ACA plans in 2014, we note that no pattern observed in a particular year is guaranteed to carry over to future years, as issuers continue to adjust pricing and changing regulatory conditions. Nationwide observations in one year may differ significantly by state and by issuer and may vary in future years. Great care must be taken when applying nationwide observations to localized scenarios. Also note that experience from benefit years subsequent to 2023 may have a different mix of states and issuers than were in data from benefit year 2023, so great care must be taken when investigating longitudinal trends.
- We excluded data for both enrollees in American Indian (limited/no-cost sharing) CSR plans and enrollees in Medicaid Private Option plans (these only occur in a few states).

- In cases where enrollees switched market, metal tier, or CSR tier, we left the enrollment records as is rather than impute a single market, metal, and CSR tier for each unique member ID. Given that premiums, deductibles, and maximum out-of-pocket costs often reset after such changes in plan type and given that cost and premium differences by plan type are of primary importance in this analysis, we believe that leaving the enrollment records unchanged will provide the most accurate and meaningful results in the context of this analysis.
- Coding practices may affect results. Mental health diagnoses are particularly susceptible to discretionary coding. Overall prevalence, as well as comparative prevalence between stratifications, should be interpreted with care in light of this limitation.

The 2020–2022 experience will exhibit the significant impacts of the COVID-19 pandemic, including:

  - Deferred care from members and providers avoiding medically discretionary visits
  - Lower coding trend from deferred care and other disruptions
  - Significant claims related to COVID-19 including inpatient admissions, vaccine administration, and testing administration and materials.
  - Ongoing impacts to morbidity from post-COVID Complications

Disclosures and Limitations

Responsible Actuary. Karan Rustagi is the actuary responsible for this communication. He is a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. He meets the Qualification Standards of the American Academy of Actuaries to issue this report. Michael Cohen, PhD, also contributed to this report.

Intended Users. This information has been prepared for the sole use of AHIP and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. Wakely understands that the report may be made public. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their actuarial experts in interpreting results.

Risks and Uncertainties. The illustrative examples included in this analysis are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. **Actual results will vary from our examples, and impacts will vary by region.** Wakely does not warrant or guarantee the values included in the analysis. It is the

responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. We 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 to AHIP.

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.

Subsequent Events. Subsequent events may affect the findings in this report. Changes in state policy, economic conditions, federal legislation, and other factors and emerging data could result in material changes to this analysis.

Contents of Actuarial Report. This document and the supporting exhibits/files constitute the entirety of the actuarial report and supersede 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 comply 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