

**America's Health
Insurance Plans**

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Comment #25 – 5/15/14 – 8:31 p.m.

May 15, 2014

Medicaid Managed Care
Actuarial Standards Board
1850 M Street, NW, Suite 300
Washington, DC 20036

**RE: Proposed Actuarial Standard of Practice (ASOP) –
Medicaid Managed-Care Capitation Rate Development
and Certification**

Dear Sir or Madam:

We are writing on behalf of America's Health Insurance Plans (AHIP) in response to the request for review and comment on the Exposure Draft of the "Proposed Actuarial Standard of Practice, Medicaid Managed-Care Capitation Rate Development and Certification" published by the Actuarial Soundness Board in December 2013. The draft is of significant interest to AHIP's member organizations, many of which participate in state Medicaid and CHIP programs.

AHIP commends the Actuarial Soundness Board for recognizing the need to develop an Actuarial Standard of Practice (ASOP). While the 2005 Practice Note¹ developed by the American Academy of Actuaries (AAA) has provided direction to actuaries for the development of actuarially sound rates for Medicaid managed care organizations (MCO), it does not have the same standing as an ASOP. The proposed ASOP provides much needed guidance that will promote a more consistent application of the actuarial soundness requirement, and AHIP believes it is an important and positive contribution to ensure better compliance with the standard. This guidance is especially important given the increasing use of Medicaid managed care to cover Medicaid Expansion populations and dual eligibles who may not have previously been enrolled in health plans and for whom little, if any, relevant rate development experience exists.

Our detailed comments below follow the sections of the Exposure Draft and conclude with responses to two of the questions posed in the Transmittal Memorandum.

¹ American Academy of Actuaries Health Practice Council Practice Note, "Actuarial Certification of Rates for Medicaid Managed Care Programs" (August 2005).



Section 2. Definitions (page 1)

- **Section 2.1 -- Actuarially Sound/Actuarial Soundness.** This provision defines Medicaid capitation rates as being actuarially sound when projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. The definition also includes examples of what constitutes “other revenue sources” and what “costs” are to be included in determining the rate such as health benefits, health benefit settlement expenses, administrative expenses, government-mandated assessments, fees and taxes, and the cost of capital.

AHIP supports the clarification that “government-mandated assessments, fees, and taxes” are to be considered in the definition of costs because it ensures that federal assessments, fees, and taxes are included in the determination of actuarial sound rates. This is an important improvement over the actuarial soundness definition in the 2005 AAA Practice Note, which specifically references only state-mandated assessments and taxes. The express inclusion of federal assessments is particularly critical in light of the health insurer fee mandated by Section 9010 of the Affordable Care Act.

One type of MCO cost that is not specifically cited in the proposed definition is underwriting gain, which is an essential element of actuarially sound rates because it compensates the MCO for the risk it assumes under the contract. In Section 3.2.11.b of the Exposure Draft, the actuary is directed to include a provision for underwriting gain to provide for the cost of capital and a margin for risk or contingency. We support this provision on underwriting gain and believe its importance to rate development should be reinforced in the definition of actuarial soundness by including it in the examples of costs to be considered in developing actuarially sound rates.

Section 3. Analysis of Issues and Recommended Practices (page 4)

- **Section 3.1 -- Overview.** The overview cites the regulatory provision, Title 42 CFR 438.6(c), which requires capitation rates paid by the state to MCOs to be certified as actuarially sound. During economic downturns, states may include specific budget factors that reduce rates to meet fiscal targets. Certifying rates that include budget factors is inconsistent with the actuarial soundness standard. We recommend language be added to the section to clarify that these budget factors should not be incorporated into actuarially sound rates.
- **Section 3.2.1 -- Form of the Capitation Rates (Single Rate or Capitation Rate Ranges).** This provision states that a capitation rate certification may apply to a single point estimate



capitation rate or a range of capitation rates, and that if a range of capitation rates is prepared, the contracted rates with an MCO may be at either end of the range or a point within the range. AHIP is concerned that the provision allows the state to select a rate at the low end of a range although the aggressive assumptions underlying the rate may not be realistically achievable. We recommend the section be amended to emphasize that the actuarial certification of a rate range must ensure that rates at both ends of the rate range are reasonably attainable. Given the importance of ensuring that the rate range is attainable, we also recommend the ASB consider developing a definition of “attainable” that takes into account the covered populations and other unique characteristics of a state’s Medicaid managed care program. In addition, the ASOP should specify that rate ranges and the position of the specific rate within the rate range should be fully disclosed to Medicaid health plans prior to the start of the payment year.

- **Section 3.2.3 -- Rebasing and Updating of Rates.** This provision provides direction to an actuary who is rebasing the rates or updating existing rates for subsequent rating periods. AHIP supports inclusion of the provision and recommends that it be expanded to address a concern regarding the timing of the effective date for the capitation rate when rates are rebased or updated. It is our understanding there have been instances when the rebased or updated rates are not certified until after contracts have been signed with the MCOs and/or the rating period has begun. This delay in certifying the rates on a timely basis does not permit MCOs to evaluate the impact of new rates and can place a participating MCO at unanticipated financial risk if the rates are lower than initially projected prior to the completion of the rebasing or update. We recommend the addition of language in the section to emphasize that timely completion of updates to rates is essential to permit a thorough review by MCOs of the new rates prior to their effective date.
- **Section 3.2.7.f -- Program, Benefit, or Policy Adjustments.** The provision describes other types of policy adjustments to base year data that the actuary should consider when establishing actuarially sound rates. It is our understanding that when making these adjustments, states may use fee-for-service (FFS) data to update the base year data, but may not share the methodology, assumptions, and data used in the adjustment. This is especially problematic when the actuary uses historical FFS data which do not accurately reflect factors in the rating year as the basis for updating assumptions that are incorporated into the rate. We recommend the proposed ASOP be revised to provide that actuaries should disclose to MCOs the methodology, assumptions, and data that serve as the basis for any such adjustments and recommend that language be added to the section which states actuaries should avoid using FFS data as the basis for these adjustments that is more than one year removed from the rating year.



- **Section 3.2.8 -- Claim Cost Trends.** This provision directs the actuary to include appropriate adjustments for trend in the development of the rates. The types of changes that could affect these trends include demographics and benefit levels, as well as policy or program changes.

There are other significant elements that are not mentioned in Section 3.2.8 that can affect claim cost trends, such as medical technology and pharmaceutical advancements. These advancements may represent significant improvements in outcomes but often at a cost that is much greater than current treatment. The cost implications for MCOs can be exacerbated when these treatments are needed by a population that is disproportionately represented in the Medicaid population. We recommend this section be amended to provide that actuaries should reflect new technological and pharmaceutical advancements in the trend assumptions that are incorporated into rates to ensure that the rates are actuarially sound.

- **Section 3.2.9 -- Managed-Care Adjustments.** This provision provides direction to actuaries about the application of managed-care adjustments based on the assumption that the program will “move from the level of managed care underlying the base data to a different level of managed care during the rating period”. Adjustments to the rates may be made to reflect anticipated changes in utilization, unit cost, or both.

When addressing the application of managed-care adjustments, the provision does not distinguish between changes from base year data that are likely to be achievable when a new Medicaid managed care program is implemented and managed care efficiencies have not previously been implemented and the nature and scope of changes that can be expected when a program is well-established and the baseline data already reflect the impact of Medicaid health plan performance. To ensure rates will be actuarially sound, the adjustments proposed by the actuary should be supported by data that demonstrate the basis for the assumptions, distinguish between new and established programs, and ensure the performance underlying the assumptions is reasonably attainable. Moreover, the actuary should make available to MCOs the data that supports any managed-care adjustments incorporated into rates.

Section 3.2.9 also notes that “the changes reflected in the adjustments should be attainable in the rating period...” Designing and implementing the changes needed to attain expected efficiencies often require a transition period prior to realizing savings attributable to these activities. Therefore, establishing managed care factors based upon an assumption that MCO activities can be implemented quickly enough to generate savings throughout an entire rate year may not be consistent with attainable results. We recommend the provision be clarified to require managed-care adjustments to reflect savings reasonably attainable over the course of the entire rate year.



- **Section 3.2.11.b – Underwriting Gain.** The provision addresses inclusion of underwriting gains in actuarially sound rates and states that the “methods used to develop the underwriting gain provision of the **capitation rate** should be appropriate to... the type and level of risk borne by the **MCO.**” In light of the level of uncertainty inherent in rate development for new populations including Medicaid Expansion and dual eligibles, we recommend that the ASOP advise actuaries to consider this uncertainty in the development of the underwriting gain assumption that is incorporated into the rate.
- **Section 3.2.11.d -- Non-Medical Expenses.** This provision directs the actuary to include an adjustment for any taxes, assessments, or fees that MCOs are required to pay out of the capitation rates. It also directs the actuary to apply an adjustment to reflect the costs of the taxes, assessments, or fees when they are not deductible as an expense for corporate tax purposes.

AHIP supports the provision as proposed. This section of the Exposure Draft provides important clarification on how actuaries are to accommodate all taxes and assessments including the recently implemented Health Insurer Provider Fee created by Section 9010 of the Affordable Care Act. While many actuaries have recommended the federal ACA insurer fee and a factor for non-deductibility be included in a MCO’s capitated rate, some states delayed incorporating these elements into Medicaid health plan rates due to the lack of clarity about how it is to be addressed. AHIP believes the provision appropriately directs the actuary to include the costs for the fee and non-deductibility and will promote more consistent application across the states.

- **Section 3.2.13 -- Reinsurance, Risk Corridors, and Other Risk-Sharing Arrangements.** This provision provides direction for considering the effect of any risk-sharing arrangements between MCOs and the state Medicaid agency or the federal government. The structures and methodologies of risk-sharing arrangements vary by states, including the type and whether the state and MCO share in both losses and gains. Some states share risk when there are losses or gains, while other states may require the MCO to share gains with the state although the state does not share the risk when the MCO experiences a loss under the contract. In an arrangement where the MCO bears the entire risk for the loss, we recommend that the provision be revised to permit an increase in margin to reflect the greater risk assumed by the MCO.

Also, risk-sharing arrangements such as risk corridors are especially important tool for states that expand Medicaid health plan programs to new populations for whom there may not be accurate base year data available to develop actuarially sound rates. We recommend the provision note the important role risk corridors can play in these new programs.



- **Section 3.2.14 Performance Withholds/Incentives.** The provision establishes considerations for actuaries when incorporating performance-based withholds or incentives into actuarially sound rates and provides that rates should “reflect the value of withholds for targets that the MCOs can reasonably achieve.” It is our understanding that states are establishing withholds of as much as 5% based on criteria that may be difficult to achieve. We recommend the provision be revised to place stronger emphasis on evaluation by the actuary of the attainability of the criteria for MCOs to earn back funds withheld as part of these programs and provide that actuarial soundness should be determined without including amounts associated with the withhold unless this more stringent test is met.
- **Section 3.2.16 -- Inaccurate or Incomplete Information Identified after Opinion or Rate Certification.** This section provides direction when an actuary determines that he or she used inaccurate or incomplete information after certifying rates. In this case, the proposed ASOP requires the actuary to notify the principal but does not address whether CMS or MCOs should be notified or propose remedial action. We recommend this section be revised to provide the actuary should disclose to CMS and MCOs inaccurate or incomplete information that has been identified along with needed corrections to rates and the updated information and assumptions supporting the revisions.
- **Section 3.4 -- Documentation.** This provision directs the actuary to document methods, assumptions, procedures, and sources of data and requires the documentation to be in a form that another actuary qualified in the same field could assess the reasonableness of the work. AHIP supports these requirements. However, the provision is silent on whether the documentation should be shared with other stakeholders such as MCOs. We believe that ensuring MCO plan actuaries are able to replicate the methods, assumptions, procedures, and sources of the data used to determine their accuracy and validity and provide input is a crucial component in the development of actuarially sound rates. MCOs have the expertise required to assess the reasonableness of the work and to identify potential corrections and improvements in the methods, assumptions, procedures and data used to determine the rates. We recommend revising this section to provide that such information sharing should take place during the rate development process.

Comment Questions Posed by the Exposure Draft

In the Transmittal Memorandum (page iv), of the Exposure Draft, several questions are listed for readers’ consideration. AHIP has comments on two of the questions.



1. This ASOP has been prepared to apply to both the actuaries developing actuarial statements of opinion for a Medicaid MCO and to actuaries developing rate certifications under 42 CFR 438.6(c). Is this appropriate?

Yes, we believe that it is appropriate to have the ASOP apply to both sets of actuaries because the guidance it provides is directly relevant to the responsibilities of actuaries working on behalf of both states and MCOs.

2. As written, this ASOP applies to Children's Health Insurance Program (CHIP) managed-care capitation rate development. Is this appropriate?

Yes, we agree that it is appropriate to apply the ASOP to CHIP MCO rate development because the actuarial soundness of rates is critical to the viability of plan participation under both programs. For the same reason, we recommend the application of the ASOP to Medicaid Expansions and state programs for dual eligibles under CMS's capitated Financial Alignment Demonstrations.

We appreciate this opportunity to comment on this important document. Please contact me at 202-778-3209 or cschaller@ahip.org or Howard Weiss, Vice President, Public Programs Policy, at 202-778-3252 or hweiss@ahip.org if additional information would be helpful or if you have questions about the issues or recommendations we have raised.

Sincerely,

A handwritten signature in black ink that reads "Candace Schaller". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Candace Schaller
Senior Vice President, Federal Programs