A MILLIMAN GLOBAL FIRM
Milliman
Consultants and Actuaries

8500 Normandale Lake Blvd.
Suite 1850
Minneapolis, MN 55437
Tel +1 952 897.5300
Fax +1 952 897.5301
www.milliman.com

September 19, 2005

Mr. R. Jason Wiley
Managed Care Rate Setter
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3853

Re: 2006 Benefit Changes – Preliminary Adjustment Factors

Dear Jason:

This letter discusses the impact we estimate benefit changes in Minnesota's public program plans will have on the MCOs' cost levels in 2006. The letter provides background on these issues and describes the data and method we used to calculate adjustment factors for each of the changes.

The purpose of this analysis is to assist the Minnesota Department of Human Services (DHS) with setting payment rates for contracting health plans for these programs. The results may not be appropriate for other purposes.

The results contained in this letter are intended only for use by DHS and the federal agency that must approve the capitation rates used for the PMAP and MinnesotaCare (MNCare) programs. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This letter should be reviewed only in its entirety. It assumes the reader is familiar with Minnesota's Medicaid programs and managed care rating principles.

The results in this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Differences between estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is almost certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience is different than expected. Accordingly, DHS should continue to carefully monitor actual experience and make adjustments as necessary.

In performing this analysis, we have relied on data and other information provided to us by DHS and the plans with which it contracts. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We have performed a limited review of the data used directly in our analysis for reasonableness and consistency, and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Removal of $500 Cap on Dental Benefits

A $500 cap that was placed on dental benefits for certain enrollees effective October 2003 is being removed. This change will affect MCO capitation rates effective January 1, 2006. We recommend applying rating factors to current rates which will effectively reverse the factors applied in 2003 when the caps became effective.

We considered making an additional adjustment to reflect the impact that this dental cap (or any benefit cap) could be expected to have on trends. However, the trend rates applied to the capitation rates at the time the cap became effective did not reflect any reduction for the cap. Therefore, we do not believe that such an adjustment is needed here.

Table 1: Adjustment Factors for Removal of $500 Dental Cap

Program	Affected Rate Cells	Adjustment Factor
PMAP	Non-Pregnant Adults	1.0029
PGAMC	All	1.0015
MNCare	Adults w/ Children, >175% FPG	1.0065
	Adults w/ Children, <175% FPG	1.0002
	Adults w/ Children, <75% FPG	1.0001

MinnesotaCare Limited Benefit Set

Effective January 1, 2006, the $5,000 annual maximum is being removed and benefits have been enhanced to include certain mental health / chemical dependency and diabetic supplies for those eligible for MinnesotaCare Limited Benefit enrollees (MLBs). Table 2 summarizes the adjustment factors that we recommend be applied to the 2005 rates for this change.

Table 2: Summary MLB Specific Benefit Changes

Benefit Change	Adjustment Factor
Elimination of $5,000 Annual Maximum	1.2812
Mental Health / Chemical Dependency Coverage	1.0250
Diabetic Supplies Coverage	1.0090
$5 Copay on Chiropractic Services	0.9970

We understand that DHS has implemented a $5,000 annual maximum versus the $2,000 annual maximum as stated in the law, and so our analysis is structured on the removal of the $5,000 annual maximum. Similar to the dental cap analysis, we recommend applying rating factors to the current rates which will effectively reverse the factors applied in October 2003 when the annual maximum was implemented.

Based on our September 2003 analysis, we would expect the reversal of the $5,000 annual maximum would increase costs by 28.1%. (Note the total rate adjustment of 31.3% for MLBs reported in our 2003 analysis included adjustments for additional benefit changes such as the $50 copay on ER visits. Again, since trend rates are determined on an aggregate basis, no reductions were made to the trend applied to MLB rates in 2004 or 2005 to reflect the benefit cap, and I do not believe an adjustment is needed to reverse it.

Also from our September 2003 analysis, we obtained detailed utilization and claim experience for certain 2001 service categories, including mental health coverage. We used this data to estimate the utilization and average charge for mental health / chemical dependency services. Our understanding is that currently, mental health services are only covered for MLB enrollees if they are provided through a psychiatrist. Going forward, other appropriately licensed, non-physician providers will also be covered.

Our method was to trend forward the mental health claim cost experience provided by the MCOs for similar populations for our 2003 analysis. The per member per month claim cost trended forward to 2004 is $ 8.58. We reduced this by 15% to recognize that a $5 copay will apply. We divided this into the estimated 2004 claim cost for MLBs. We estimated the 2004 claim cost for MLBs by taking the average capitation rate in 2004 multiplied by an expected loss ratio of 92%. We also applied an adjustment to remove the impact of the $5,000 cap. Based on this analysis, we estimate that the mental health / chemical dependency benefit will increase MLB costs by 2.5%.

In estimating the rate increase attributed to the coverage of diabetic supplies, we relied on the assumptions used in DHS's fiscal note analysis of the change. In particular, we assumed that 8% of the MLB enrollees have a diabetic diagnosis and that the cost per member per month of the supplies will be $36. We estimated the average increase in rates for coverage of diabetic supplies to be 0.9%.

Finally, the law was changed to state that copays will now apply to any health care provider and not only physicians. However, we understand that DHS has provided guidance to the plans in the past, so that they already apply copays to most providers and that only mental health and chiropractic providers are not currently included. We made an adjustment for

mental health providers as described above. We also valued the impact of chiropractic visits, using utilization data provided for our 2003 benefit change analysis, and assumed an average charge of $35.

Psychiatric Consultations

Effective January 1, 2006, PMAP will cover psychiatric consultations to primary care physicians. Based on a review of our internal data sources, the utilization of this service is immaterial, and so we recommend no adjustment be made at this time. That being said, this is a very specific situation—psychological consultations through primary care physicians for a Medicaid population, and our databases may not be directly applicable. Therefore, we would be very willing to review any additional data or information the plans might provide that would indicate that some adjustment is justified.

By way of background, we did ask the plans to tell us if they currently provide coverage for this service and, if so, what the 2004 utilization was. We also asked that they provide the expected average reimbursement per service in 2006. Seven MCOs responded and all indicated that they do not currently cover this service and/or that they had no utilization in 2004. One MCO provided current reimbursement rates (the codes involved are not unique to psychiatric consultations). We would like additional input from the MCOs regarding expected utilization.

Mental Health Telemedicine

Most of the MCOs indicated that they currently reimburse for this service, but have had low or no utilization. Since it is generally being covered by the MCOs already, and utilization is still relatively low, we do not expect any material impact to costs due to this change in the statute and recommend no adjustment to capitation rates.

Drugs for Erectile Dysfunction/Impotency

Drugs used for the treatment of impotence or erectile dysfunction will no longer be covered by any program. We asked the health plans to provide utilization and average reimbursement by product for CY 2004 for these drugs. The majority of the health plans provided the utilization per 1,000 based on the total membership of each program. Because the benefit change does not affect all rate cells within a program, we adjusted the utilization rates provided by the plans to reflect the member months of the presumed affected rate cells.

Table 3 below summarizes the cost reduction by program to the health plans because of the elimination of these drugs.

Table 3: Drugs for Erectile Dysfunction/Impotency Benefit Adjustment Factors

Program	Affected Rate Cells	Adjustment Factor
PMAP < 65	Males, Ages 50-64	0.9807
PMAP Aged	Non-Medicare	0.9987
PGAMC	Males	0.9983
MNCare	Males, Ages 50-64	0.9860

Infant Circumcision

Effective August 1, 2005, newborn circumcision will not be covered except where necessary for medical or well-established religious reasons. We collected utilization experience from the plans. However, the utilization provided fluctuated dramatically from plan to plan and we were unable to determine the reasons for this. Instead, we assumed that 75% of male infants are circumcised. This is based on research which examines recent circumcision rates in the Midwest. We also used an assumption from DHS' fiscal note analysis that 90% of these procedures would be eliminated as a result of the new law, which provides for coverage only because of medical necessity or religious requirements. This assumption appears reasonable if the statute is administered narrowly by the MCOs. We also relied on DHS's fiscal note in assuming that the average charge for these services is $91. We then calculated an average per member per month cost reduction attributed to the elimination of these services. Finally, we assumed a uniform distribution of members by month of age within the 0-1 rate cell categories. I believe this is reasonable, based on FFS membership information we reviewed last year as part of our newborn analysis.

Table 4 shows the adjustment factors that I am recommending be applied to the 2005 rates to reflect this benefit change.

Table 4: Infant Circumcision Benefit Adjustment Factors

Program	Affected Rate Cells	Adjustment Factor
PMAP < 65	Males, Ages 0-1	0.9899
MNCare/MA	Males, Ages 0-1	0.9862

Sex Reassignment Surgery

Sex reassignment surgery will no longer be covered. We understand that DHS understands this to include any related services, such as drug therapy. Prior to that, the surgery and related services were only covered for individuals who began sex reassignment therapy prior to July 1, 1998.

We requested recent experience data from the MCOs for such services, and all the MCOs who responded indicated that they had not had any recent claims. Therefore, I do not expect this change to affect cost trends and recommend no adjustment to capitation rates.

Copayments

Prescription Drugs

The prescription drug monthly copay maximum is decreasing from $20 to $12 for the MA and GAMC programs, effective August 1, 2005. Rates will be adjusted on January 1. DHS provided us with a distribution of FFS member months by monthly member copayment amounts. We used this distribution to estimate the per member per month impact of this benefit change. Table 5 below shows the adjustment factors that I am recommending be applied to the 2005 rates to account for this benefit change.

Table 5: Impact of Prescription Drug Maximum Copay

Program	Affected Rate Cells	Adjustment Factor
PMAP < 65	Non-Pregnant Adults, Ages 21-64	1.0006
PMAP Aged	Non-Medicare	1.0012
GAMC	All	1.0006

Non-Preventive Visits

MNCare parents and adults without children under 75% of FPG and Families with children under 275% of FPG will have a $3 copay on non-preventative visits, effective September 1, 2005. We relied on the CY 2004 utilization for non-preventative services provided to us by the health plans and assumed an average office visit charge of $60. (This charge is intended to include the cost of lab tests and other ancillary services.) We estimated the cost impact of applying the $3 copay will reduce the costs of the health plans by 1.10% for the affected rate cells. Table 6 summarizes the affected rate cells and the adjustment factor.

Table 6: Adjustment Factors for Non-Preventive Visits Copay

Program	Affected Rate Cells	Adjustment Factor
MNCare	Adults w/out Children, <75% FPG	0.9890
	Adults w/ Children, <175% FPG	
	Adults w/ Children, >175% FPG	

This impact comes from two sources: (1) office visits that never take place due to the disincentive provided by the copay and (2) the value of the $3 in avoided charges for those office visits that still take place. In particular, we assumed that office visits would be reduced by 10.7%. This is consistent with the assumption made in our 2003 copay analysis. We are assuming that copays will not be waived.

The $3 copay on non-preventative visits for GAMC is also being eliminated. However, DHS has indicated it does not intend to increase payment rates as a result of this change, so we have not valued it.

Non Emergent ER Visits

Effective September 1, 2005, a $6 copay will apply to nonemergency visits to a hospital-based emergency room for MNCare Parents and Adults without Children under 75% of the FPG. We are still discussing with DHS what the impact of "prudent person" standards to which the MCOs may be subject will be on this change. In particular, if a majority of these services will still be provided as an emergency service due to this standard, savings would be minimal.

HealthMatch

Last year, we provided a set of rate adjustment factors for HealthMatch, a new program expected to result in a significant migration of MNCare enrollees into PMAP. We understand that this program was not implemented in September 2005, as anticipated when we developed the factors and that it is now not expected to be implemented until 2007. Therefore, we believe it is appropriate to reverse the impact of these factors for 2006. Table 7 below shows the reversal factors that would be appropriate, assuming 2006 rates are being calculated using 2005 rates as a base.

Tables 7: Demographic Rate Adjustment Factors
To Reverse 2005 HealthMatch Rate Adjustment

Rate Cell	Gender	
	Male	Female
Families with Children		
0 – 1	1.002	1.002
1 – 2	1.002	1.002
2 – 15	1.003	1.003
16 – 20	1.007	1.005
21 – 49	0.999	1.001
50+	1.004	1.004
Pregnant Women	NA	1.001

GAMC/MNCare Migration

We are in the process of finalizing our GAMC/MNCare migration analysis, and will send you the results as soon as possible.

Part D for Under 65

Medicare Part D benefits will no longer be covered under Minnesota's medical assistance program. I recommend that the adjustments found in Table 8 be applied to the applicable PMAP Families with Children and Pregnant Women rate cells.

We relied on detailed PMAP claim experience provided by the health plans. Three of the health plans (UCare, Medica, and MHP) provided Part D claim experience for Under 65 Dual Eligibles. We used the 2004 experience, combined for all three plans, for each of the PMAP Families with Children and Pregnant Women rate cells as a basis for projection.

Table 8: Part D PMAP Under 65 Rate Adjustment Factors

Rate Cell	Gender	
	Male	Female
Families with Children		
16 – 20	0.9992	0.9996
21 – 49	0.9896	0.9951
50+	0.9735	0.9824
Pregnant Women	NA	0.9994

We recommend using the ratio of one minus the ratio of (1) the projected 2006 dual eligible Part D claims to (2) the projected 2006 all benefit, all enrollee PMAP Families and Children and Pregnant Women claims, which are the values in Table 8. These values were derived by trending the 2004 dual eligible Part D claims experience to 2006 using a trend rate of 14.7%. This trend rate is from Table 3 in our letter on the Seniors Dual Eligible analysis. We then trended the 2004 all benefits claims experience to 2006, for all PMAP Families and Children and Pregnant Women enrollees, using a 7.02% trend rate. This trend rate is taken from our Trend and Surplus letter. It is the preliminary demographic trend rate found in Exhibit B Section IV column (a), corresponding to the PMAP Families and Children and Pregnant Women health plan experience.

We deemed the data for the 16-20 year-old rate cells not to be credible. Therefore, we assumed that the rate reduction for the 16-20 year-old rate cells is 8% of the rate reduction for the 21-49 year-old rate cells, based on our review of the used the 2001-2004 experience.

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Jason, please contact me if you have any questions about this letter. You can reach me at (952) 820-2481 or at leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim, FSA, MAAA
Principal & Consulting Actuary

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