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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: Proposed PGAMC Revenue Adjustment Methodology

Dear Jason:

Over the past year or so, we have discussed the concerns that some of DHS' contracting MCOs have expressed about the differences in the rate setting methodology used for the PMAP and PGAMC programs. We have developed a methodology that DHS can use to adjust PGAMC revenues to level the playing field between the plans. This letter provides further background on the issues involved and presents this relatively straightforward methodology. This is the same methodology introduced in my letter of September 22, 2004, updated to reflect 2004 experience.

The results contained in this letter are intended only for use by DHS for the purpose of setting capitation rates for the PGAMC program. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work.

We assume the reader is familiar with Minnesota's Medicaid programs and managed care rating principles. The results in this letter 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.

Data Reliance

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.

Variability of Results

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.

Background

PMAP capitation rates are subject to CMS approval and are required to be actuarially sound, which generally means they must be set in such a way that participating plans could be expected to at least break even in aggregate on the affected business, assuming prudent management. On the other hand, PGAMC capitation rates are not subject to CMS approval and have historically had loss ratios in excess of 100%. That is not expected to change during the upcoming rate effective period (calendar year 2006).

Plans that contract with DHS to provide coverage to PMAP enrollees must also agree to provide coverage to PGAMC enrollees who select the plan. This creates an uneven playing field to the extent that certain plans have a greater concentration of PGAMC business than others, since PGAMC business is expected to lose money, while PMAP business is expected to at least break even in aggregate.

Proposed Methodology

We developed a three step process to determine adjustments to PGAMC revenue levels, which is intended to normalize underwriting results assuming a constant concentration of PGAMC business across plans. Exhibit A to this letter illustrates the method using 2004 operating results.

Step 1> Analyze reported 2004 experience.

We reviewed 2004 PMAP and PGAMC revenues and expenses, as reported in the Minnesota State Supplement Report #1 “Statement of Revenue, Expenses and Net Income,” and restated incurred claims as reported by the plans. We then made adjustments to the PMAP and PGAMC statutory revenue to remove the 2003 un-accrued withhold that was recognized in 2004 and to reflect the return of 100% of the 2004 withhold.

For PMAP, we reversed the 2003 and 2004 newborn, non-pregnant women, and other plan specific payment adjustments. We relied on the 'Incentive Withhold IHS Gross Adjustment Summary.xls' provided to us by DHS for these adjustments. This effectively set the 2004 revenue to what it would have been, had no adjustments been made. We then re-applied the 2004 portion of the non-pregnant women and other plan specific adjustments. We used our newborn and non-pregnant women refunds letter dated October 22, 2004 (including follow-up letters) to allocate the December 2004 payment for the period 10/2003–12/2004 into 2003 versus 2004 and by adjustment category (i.e. newborn, non-pregnant women and other plan specific) amounts.

The 2004 rates reflected newborn coverage for a full year. However, the newborns were not covered in 2004 until the fourth quarter. As a result, the experience only reflects one quarter of newborn experience. Therefore, we adjusted the PMAP 2004 restated incurred claims to reflect newborn coverage for an entire year.

On this basis, PGAMC revenue was 16.3% of PMAP revenue across all MCOs. This is equivalent to saying that, on average, PGAMC made up 14.0% of total PMAP/PGAMC revenues. This percentage (16.3%) varied by plan from a low of 7.3% to a high of 36.3%. Combined PGAMC loss ratios (claims and expenses) averaged 113.5% across the plans, varying from a low of 60.4% to 132.1%. The combined loss ratio for the PMAP program averaged 99.7% across all MCOs.

Step 2> Restate each plan's experience, assuming an equal concentration of PGAMC business.

We increased or decreased the PGAMC revenue for each plan, so that PGAMC revenue is equal to 16.3% of PMAP revenue. For each plan, we made a proportionate change in PGAMC incurred claims and expenses. For this purpose, for each $1 change in revenue, we made a $1.135 change in claims and expenses. That is, we used the overall average combined loss ratio mentioned above (113.5%) to estimate the impact of these revenue changes on underwriting results.

We do recognize that the individual plans have combined loss ratios on their PGAMC business that are higher or lower than the average of 113.5%. The argument could be made that this difference is due to each plan's relative ability to control the cost of this business, so that each plan's individual loss ratios should be applied to the change in revenue instead of the average loss ratio. However, we note that the relative performance of each plan has changed from year to year within the PGAMC line of business. Using the average loss ratio in the calculation somewhat recognizes that plans that do extremely well or poorly in one year are likely to have experience closer to average the next year.

There is no net impact of these changes across all plans. The resulting impact on each plan's combined loss ratio is shown on the attached exhibit (Exhibit A).

Step 3> Calculate an adjustment to each plan's PGAMC revenue to level the playing field.

We propose making an adjustment to each plan's PGAMC revenue equal to the change in revenue from Step 2 minus the change in claims and expenses from Step 2. This is equivalent to transferring expected average losses from plans that have a higher concentration of PGAMC to plans that have a lower concentration. The change in PGAMC revenue ranges from a low of -16.8% to a high of 7.4%. Of course, the aggregate change across plans is zero, since the adjustment is intended to be revenue neutral in total.

Refinements

I expect the plans may suggest adjustments to this analysis during rate negotiations. I look forward to discussing these as they come up.

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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 leigh.wachenheim@milliman.com.

Sincerely,

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

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