



# Medi-Cal Rates: The Politics of Numbers

*California Association of Health Plans*

*23<sup>rd</sup> Annual Conference*

*October 21, 2008*

## Presenters:

---

- **Michael J. Daponde – Attorney, Pillsbury Winthrop Shaw Pittman**
  - **Jeff Flick – Regional Vice President, WellPoint, Inc.  
(Former Regional Administrator, Center for Medicare  
and Medicaid Services)**
  - **Craig B. Keizur – Principal & Consulting Actuary, Milliman**
  - **Stan Rosenstein – Chief Deputy Director,  
Department of Health Care Services**
-

---

I. Introduction

II. Actuarial Soundness

III. Current Methodology in California

IV. The Future of Actuarial Rate-Setting

V. Questions

---

---

## I. Introduction

- Managed care introduced as alternative to fee-for-service
  - Savings to the State
  - Beginning in 2003 – capitation rates must be actuarially sound
-

---

## II. Actuarial Soundness

Rates that:

- **Have been developed in accordance with generally accepted actuarially principles and practices;**
- **Are appropriate for the populations to be covered, and the services to be furnished under the contract; and**
- **Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.**

42 C.F.R. section 438.6(c)(1)(i) (emphasis added).

---

# What Does It Mean?

---

- **Rates should be adequate and fair (not excessive and not insufficient)**
  - **Payment Rates based on actuarially sound rates**
    - **Appropriate base data or adjusted to make data comparable to the Medicaid population**
    - **Actuarially Sound Adjustments (where applicable)**
      - **Aid category**
      - **Age and Gender mix**
      - **Region**
      - **Benefits**
      - **Trends**
  - **Document methods, sources, and assumptions**
  - **Allows for significant flexibility by the state and their actuaries**
-

# Actuary's References Sources

---

- 1) Code of Professional Conduct**
  - 2) Actuarial Standards of Practice (ASOP)**
  - 3) Other sources**
    - a) Practice Notes**
    - b) Textbooks**
    - c) Exam study notes**
    - d) Articles in Professional Journals**
-

## Reference Sources – ASOPs

---

- **Highest standing among actuaries – mandated guidance**
  - **No specific ASOP applies to CMS requirement for Medicaid rate certification**
  - **Many are general and not specific to health actuarial and could be applicable**
  - **Currently, only one ASOP defines “actuarial soundness”**
    - **ASOP 26: “Compliance with the Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Plans**
    - **This definition (next slide) is specific to this standard**
-

## Reference Sources – ASOP #26

---

- **ASOP #26: “Compliance with the Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Plans**

“Small employer health benefit plan **premium rates are actuarially sound if**, for business in the state for which the certification is being prepared and for the period covered by the certification, **projected premiums in the aggregate**, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, **are adequate to provide for all expected costs**, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.”

---

## Reference Sources – Health Practice Note

---

- **Actuarial Certification of Rates for Medicaid Managed Care Programs (August 2005)**
    - Summarizes research on available resources for guidance on defining “actuarial soundness”
    - Proposes definition (to be used within practice note)
    - Provides guidance on aspects of the federal regulation
      - Clarification of regulatory requirements
      - Review and considerations of CMS checklist
      - Overview of documentation requirements
-

## Reference Sources – Health Practice Note

---

- **“Actuarial Soundness” definition**

“Medicaid benefit plan premium rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, **provide for all reasonable, appropriate and attainable costs**, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital.”

---

## Reference Sources – Other Sources

---

- **The Lewin Group: “Rate Setting and Actuarial Soundness in Medicaid Managed Care” (1/23/2006)**
    - Sponsored by The Association for Community Affiliated Plans (ACAP) and the Medicaid Health Plans of America (MHPOA)
    - Observed a lot of variation in how states have responded
    - “...the new actuarial soundness requirements have not severed the link between... payment rates...and state budget considerations...”
    - “If states prioritize short-term budget concerns over actuarial soundness, it could lead to the undermining of their Medicaid managed care programs and of the benefits – such as higher quality health care and greater access to care – that these programs have brought to their Medicaid populations”
    - “...this study demonstrates that the actuarial soundness provision to date seems to have had very little bearing on the rates ultimately paid to the MCOs.”
-

# Actuarial Soundness Impact

---

- **Improved transparency of rate and rating method for CMS**
  - **Addressed some problems**
    - Non-state covered services
    - Non-Medicaid claims
      - Impacts mental health more than medical benefits
  - **Considerable debate among stakeholders (state and plans) on**
    - Reasonable range of results
    - Appropriateness of state “budget” limitations
-

---

### **III. Current Methodology in California**

- Mercer methodology
  - Plan participation/feedback
  - Transparency (lack thereof)
  - “Blended” rates
  - “Hidden tax” – Cost Shifting
-

# Cost Shifting

---

“The gist of the petitioners’ allegations is that if AB 5 decreases the government’s payments to them, they will stop providing services to Medi-Cal patients or will close their doors entirely. Leaving aside the volitional nature of the petitioners making such a choice, **instead of choosing to increase their services and/or charges to their non-Medi-Cal patients in order to replace the decreased revenue from Medi-Cal, or to continue serving Medi-Cal patients and to simply make less money from the government**, there are much more fundamental reasons why the petition cannot withstand scrutiny and why, under the law, it should be dismissed.”

Independent Living Center of Southern California v. Shewry, Department of Health Care Services’ Motion to Dismiss, p. 3, lines 15-23.

---

# Cost Shifting Study

---

- **2007 Milliman Study for large California payer**
  - **Provides a comparison of healthcare provider payment levels between Medicare, Medicaid, and Commercial payers in California**
  - **Relies on State of California Office of Statewide Health Planning and Development (OSHPD) hospital financial data**
  - **Results presented to Energy and Commerce Sub-Committee on Health in September 2008**
  - **Milliman has completed additional cost shift studies in AZ, NY, and WA, and currently working on OR and a nationwide study**
-

# The Impact of Cost Shifting

California Cost Shift (in millions)

---

	Medicare	Medi-Cal	Commercial	Total
Hospital	(\$2,707)	(\$2,423)	\$5,130	\$0
Physician	(\$534)	(\$3,508)	\$4,042	\$0
Total	(\$3,240)	(\$5,931)	\$9,171	\$0

Source: Milliman Report: "California Cost Shift – Hospital & Physician Payment Level Comparison Between Medicare, Medi-Cal, and Commercial Payers in California", August 2007.

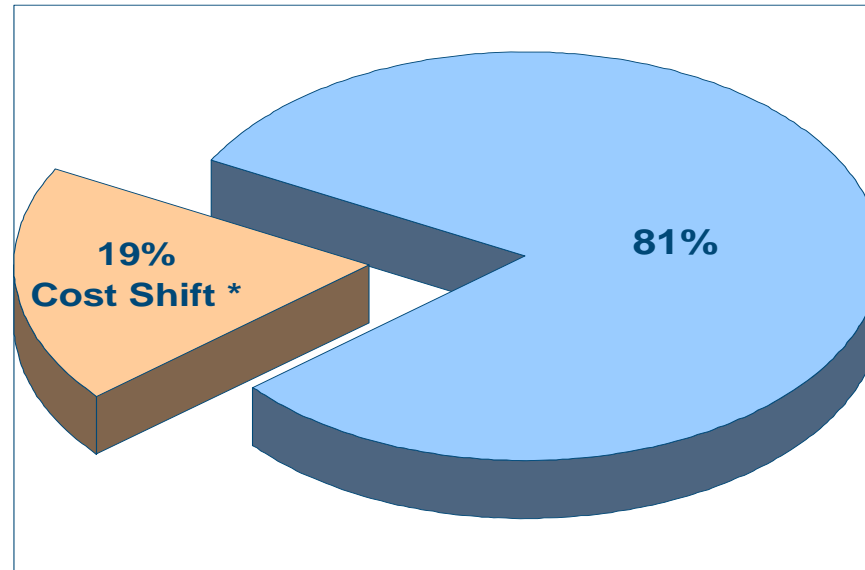
Testimony slides: [http://energycommerce.house.gov/cmte\\_mtgs/110-he-hrg.091808.HealthReform.Fox.pdf](http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.091808.HealthReform.Fox.pdf)

---

# The Impact of Cost Shifting

## California Cost Shift as percent of Commercial Cost

---



**\* 19% Cost Shift for Total equates to 27% for hospital costs and 14% for physician costs.**

Source: Milliman Report: "California Cost Shift – Hospital & Physician Payment Level Comparison Between Medicare, Medi-Cal, and Commercial Payers in California", August 2007.

Testimony slides: [http://energycommerce.house.gov/cmte\\_mtgs/110-he-hrg.091808.HealthReform.Fox.pdf](http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.091808.HealthReform.Fox.pdf)

---

# The Impact of Cost Shifting

## California Hospital Yields

---

- **As a percentage of Medicare Payments**
- **Calculated at hospital level to neutralize impact of hospital charge master differences**

Medicare	100%
Medi-Cal	83%
Commercial	164%

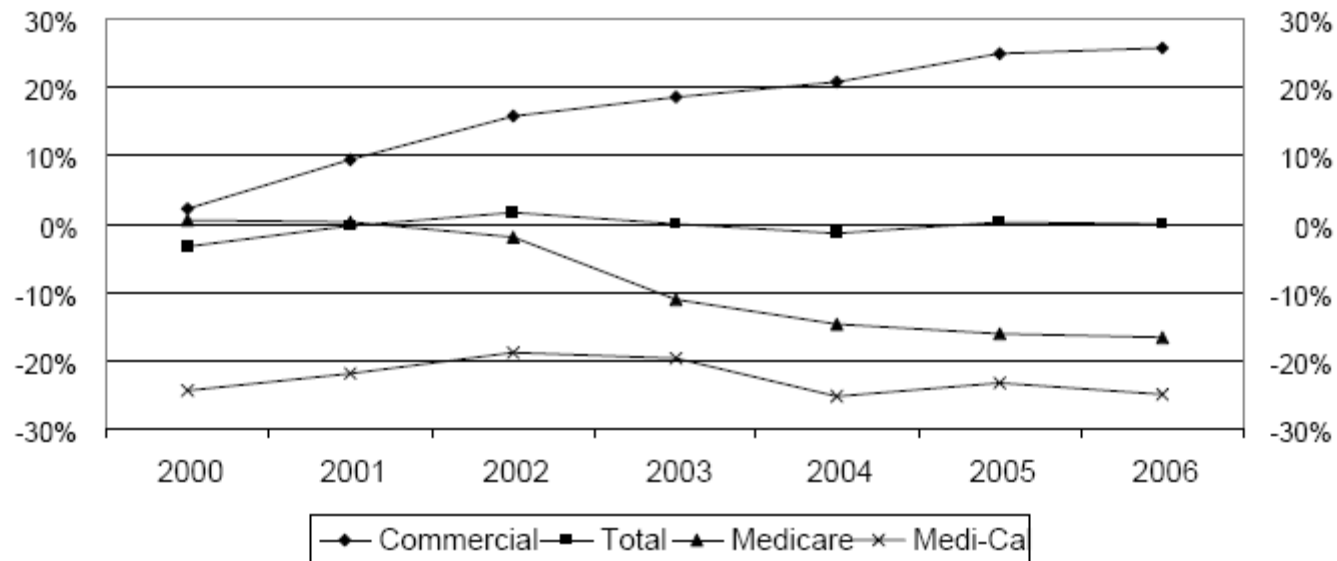
Source: Milliman Report: "California Cost Shift – Hospital & Physician Payment Level Comparison Between Medicare, Medi-Cal, and Commercial Payers in California", August 2007.

Testimony slides: [http://energycommerce.house.gov/cmte\\_mtgs/110-he-hrg.091808.HealthReform.Fox.pdf](http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.091808.HealthReform.Fox.pdf)

---

# The Impact of Cost Shifting

## Hospital Operating Margins By Year



Source: Milliman Report: "California Cost Shift – Hospital & Physician Payment Level Comparison Between Medicare, Medi-Cal, and Commercial Payers in California", August 2007.

Testimony slides: [http://energycommerce.house.gov/cmte\\_mtgs/110-he-hrg.091808.HealthReform.Fox.pdf](http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.091808.HealthReform.Fox.pdf)

# The Impact of Cost Shifting

## Hospital Losses By LOB

---

	2000			2006		
	<i>Hospitals Analyzed</i>	<i>Hospitals with Losses</i>		<i>Hospitals Analyzed</i>	<i>Hospitals with Losses</i>	
		<u>#</u>	<u>%</u>		<u>#</u>	<u>%</u>
Medicare	438	239	55%	385	268	70%
Medi-Cal	438	328	75%	385	304	79%
Commercial	438	162	37%	385	76	20%
Total	438	226	52%	385	167	43%

---

---

## **IV. The Future of Actuarial Rate-Setting**

- Improvements to the methodology
    - Risk adjusters?
    - Transparency?
    - Timing of rate-setting?
  
  - Budget issues
    - Addressing health care inflation?
  
  - Potential cost savings measures
    - Cost-sharing (deductibles/co-pays), optional benefits reduced, asset test for members?
-

---

## V. Questions

---

# Contact Information:

---

## **Michael J. Daponde**

Attorney

Pillsbury Winthrop Shaw Pittman LLP

400 Capitol Mall, Suite 1700

Sacramento, CA 95814

Telephone: (916) 329-4768

Fax: (916) 441-3583

[mdaponde@pillsburylaw.com](mailto:mdaponde@pillsburylaw.com)

## **Craig B. Keizur**

FSA, MAAA

Principal & Consulting Actuary

Milliman

1301 Fifth Avenue, Suite 3800

Seattle, WA 98101-2605

Telephone: (206) 504-5789

Fax: (206) 682-1295

[craig.keizur@milliman.com](mailto:craig.keizur@milliman.com)

---