STATE OF TEXAS
MEDICAID MANAGED CARE
STAR HEALTH PROGRAM RATE SETTING
STATE FISCAL YEAR 2011

Prepared for:
Texas Health and Human Services Commission

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TABLE OF CONTENTS

I. Introduction

Rudd and Wisdom, Inc. has been retained by the Texas Health and Human Services Commission (HHSC) to develop a fiscal year 2011 (FY2011, September 2010 through August 2011) premium rate for the STAR Health program. STAR Health is the new managed health care program for Foster Care clients in Texas that was implemented April 1, 2008. This report presents the rating methodology and assumptions used in developing the FY2011 premium rate.

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 25 years. We have participated in the state's managed care rating process since its inception in 1993. We have worked closely with HHSC staff in developing the STAR Health premium rate.

Rudd and Wisdom has relied on the following data sources as provided by HHSC and Bankers Reserve Life Insurance Company of Wisconsin, the underwriting carrier for the STAR Health program (the carrier):

- Monthly Foster Care enrollment for the period September 2006 through March 2010 with a projection through August 2011. These enrollment figures were provided by HHSC System Forecasting staff.

- Claim lag reports provided by the carrier for the period April 2008 through March 2010. These reports include monthly paid claims by month of service.

- Information provided by the carrier on high volume claimants during the experience period.

- Information from the carrier regarding current and projected payment rates for certain capitated services, such as mental health, dental and vision.

- Financial Statistical Reports (FSR) from the carrier for FY2008, FY2009 and the first six months of FY2010. The FSR contains detailed information regarding monthly enrollment, revenue, incurred claims and administrative expenses, as reported by the HMO.

- Information from the carrier regarding current and projected reinsurance premium rates.

- Information from both HHSC and the carrier regarding recent changes in covered services and provider reimbursement under the Medicaid program.

- Information provided by HHSC regarding the expected impact of FY2010 and FY2011 Medicaid provider reimbursement rate changes.

- Information provided by HHSC regarding the administrative costs for Foster Care clients under the fee-for-service (FFS) plan.

- Information provided by the carrier regarding the administrative costs for Foster Care clients under the STAR Health plan.

- Information provided by the carrier regarding the cost of new services to be provided under STAR Health.

- Current (FY2010) premium rate.

- Information provided by HHSC regarding zero-based DRG rebasing.

- Information provided by HHSC regarding the new Frew Rewards and Sanctions program.

Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data.

II. Overview of the Rate Setting Methodology

The actuarial model used to derive the FY2011 STAR Health premium rate relies primarily on health plan financial experience. The historical claims experience for the program was analyzed and estimates for the base period (April 2008 through March 2010) were developed. These estimates were then projected forward to FY2011 using assumed trend rates. Other plan expenditures such as capitated amounts, reinsurance costs and administrative expenses were added to the claims component in order to project the total FY2011 cost under the plan.

Only one health plan provides services under the STAR Health program. The health plan is reimbursed using a single premium rate which does not vary by age, gender or area. The STAR Health program covers the entire state of Texas. The services used in the analysis include the following:

- Inpatient Hospital
- Outpatient Hospital
- Physician Services
- Other Professional Services
- Lab, X-ray and Radiology Services
- Medical Supplies
- Behavioral Health Services
- EPSDT Medical Services
- Family Planning and Genetics Services
- Comprehensive Care Program Services
- Vision Services
- Hearing Services
- Home Health Services
- Emergency Room Services
- Ambulance Services
- Dental and Orthodontia Services

Under the STAR Health program, prescription drugs are not the financial responsibility of the carrier and were excluded from the rating analysis. Prescription drug services are provided to STAR Health clients but the financial responsibility remains with the state.

After accumulating all of the information to be used in the rate setting process, a comparison of the various sources of claims data was performed to check for consistency. We compared (i) the claim lag reports provided by the HMOs, (ii) the claim amounts reported in the FSRs and (iii) the claim amounts in the encounter data files. There was satisfactory consistency between the three claims data sources.

We projected the FY2011 cost by estimating base period average claims cost and then applying trend and other adjustment factors. (These adjustment factors are described in Section III of this report.) We added capitation expenses for services capitated by the carrier (such as behavioral health and dental services), a net cost of reinsurance, a reasonable provision for administrative expenses and a risk margin.

The analysis of base period claims experience attempted to identify and adjust for any distortions in the data. Significant variations in experience, including the impact from unusually large individual claims, were investigated and adjustments were made if deemed appropriate.

Attachment 1 to this report provides a description of the calculation of the FY2011 STAR Health premium rate. Attachment 2 contains a summary of recent program incurred claims experience. Attachment 3 details the calculation of the rate adjustment factor for provider rate increases.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the STAR Health rate setting process.

Trend Factors

The rating methodology uses assumed trend factors to adjust the base period claims cost to the projection period. The cost trend factors used in this analysis are a combination of utilization and inflation components. The projected trend rate assumptions were developed by the actuary based on an analysis of recent experience for Foster Care clients and the actuary's professional judgment regarding future cost increases. The annual trend assumptions used in the rating analysis were 21.9% for FY2010 and 5.0% for FY2011.

Provider Reimbursement Adjustment

Medicaid provider reimbursement changes were provided for the following services: ambulance services, digestive system surgery, female genital surgery, hearing and vision screening, the 1% provider rate cuts and DRG rebasing. The cost of additional benefits was recognized for new well-child visits, developmental and autism screenings and polycarbonate lenses.

The rating adjustments for these provider reimbursement changes were calculated by applying actual health plan encounter data to the old and new reimbursement basis and the resulting impact determined. Attachment 3 presents a summary of the derivation of these adjustment factors.

Bariatric Surgery

The new Medicaid bariatric surgery benefit began July 1, 2008. The health plans will be financially responsible for bariatric surgery services provided to their Medicaid clients. Given the lack of credible experience data on which to project utilization of the benefit, HHSC has decided to fund the benefit for STAR Health clients using a supplemental payment made to the health plan. For each approved bariatric surgery, the health plan will be paid $23,000. This amount is intended to provide for all covered facility and professional costs related to the surgery including services prior to surgery, the actual surgery, counseling and after-care services.

IV. Administrative Fees and Risk Margin

The rating methodology includes an explicit provision for administrative services. The amount allocated for administrative expenses is $25.00 pmpm plus 5.75% of gross premium. This amount is intended to provide for all administrative-related services performed by the carrier.

The administrative fee includes provision for new services provided under STAR Health that were not previously provided under the FFS plan. These services include the following:

- A dedicated organizational structure for Foster Care clients
- Additional mandatory staffing
- An expanded provider network
- A dedicated member services help line
- A Nurse Line
- Creation of a Foster Care Medical Advisory Committee
- Increased training for staff and providers
- CME credit for physicians
- Creation of a new pre-appeals process
- Coordination with the Department of Family and Protective Services and the court system
- Health Passport (an electronic medical record that is available to multiple parties online)

The premium rate also includes provisions for premium tax (1.75% of premium), maintenance tax ($0.11 pmpm) and a risk margin (2.0% of premium).

V. Summary

The FY2011 premium rate for the STAR Health program is $808.46 per member per month. This rate will be effective for the period September 1, 2010 through August 31, 2011. Attachment 1 shows the derivation of the premium rate.

VI. Actuarial Certification of FY2011 STAR Health Premium Rate

I, David G. Wilkes, am a principal with the firm of Rudd and Wisdom, Inc., Consulting Actuaries (Rudd and Wisdom). I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering this opinion.

Rudd and Wisdom has been retained by the Texas Health and Human Services Commission (HHSC) to assist in the development of the STAR Health premium rate for the period September 1, 2010 through August 31, 2011 and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.6(c).

I certify that the STAR Health premium rate developed by HHSC and Rudd and Wisdom satisfies the following:

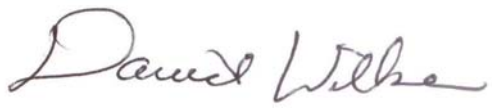
(a) The premium rate has been developed in accordance with generally accepted actuarial principals and practices;

(b) The premium rate is appropriate for the populations and services covered under the managed care contract; and

(c) The premium rate is actuarially sound as defined in the regulations.

We have relied on historical experience data and program information provided to us by HHSC. We have reviewed the data for reasonableness but have not audited the data.

Please note that actual health plan contractor experience will differ from these projections. Rudd and Wisdom has developed this rate on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c). Any health plan contracting with the State should analyze its own projected premium needs before deciding whether to contract with the State.



David G. Wilkes, F.S.A., M.A.A.A.

VII. Attachments

Attachment 1

Summary of FY2011 STAR Health Rating Analysis

The attached exhibit presents summary information regarding the FY2011 STAR Health rate development. Included on the exhibit are base period (FY2009) experience, projected FY2011 enrollment, trend and provider reimbursement adjustment factors, assumed capitation rates, reinsurance and administrative costs.

The actuarial model used to derive the FY2011 STAR Health premium rate relies primarily on health plan financial experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. These estimates were then projected forward to FY2011 using assumed trend rates. Other plan expenditures such as capitated amounts, reinsurance costs and administrative expenses were added to the claims component in order to project the total FY2011 cost under the plan.

Only one health plan provides services through the STAR Health program. The health plan is reimbursed using a single premium rate which does not vary by age, gender or area.

FY2011 STAR Health Rating Analysis
FY2011 Rate Development for the STAR Health Program

	Rating Period FY2011
Base Period Used in Rating	FY2009
Base Period Experience	
Member Months	361,080
Estimated Incurred Claims	199,011,123
Estimated Incurred Claims pmpm	$ 551.16
Projected Rating Period Experience	
Member Months	368,561
Assumed Annual FFS Claims Cost Trend Rate	
- FY2010	21.9 %
- FY2011	5.0 %
Provider Reimbursement Adjustment	-0.36 %
DRG Rebasing Adjustment	0.13 %
Projected Incurred Claims pmpm	$ 703.83
Projected Incurred Claims	259,402,546
Capitation Expenses	
Primary Care Capitation	$ 0.03
Behavioral Health	$ 0.00
Vision Services	$ 2.17
Dental Services	$ 0.00
Settlements and Miscellaneous Expenses	$ 0.00
Total	$ 2.20
Reinsurance Expenses	
Gross Premium	$ 9.25
Projected Reinsurance Recoveries	$ 9.25
Net Reinsurance Cost	$ 0.00
Administrative Expenses	
Fixed Amount	$ 25.00
Percentage of Premium	5.75 %
Premium Tax	1.75 %
Maintenance Tax pmpm	$ 0.1100
Risk Charge	2.0 %
Frew Rewards and Sanctions	$ 0.58
Premium Rate pmpm	$ 808.46
Percentage Increase	12.2 %

Attachment 2

STAR Health Incurred Claims Experience

The attached exhibit presents a summary of STAR Health incurred claims experience during the base period used in the rate setting analysis. For each month during the experience period the exhibit shows enrollment, claims incurred during the month and paid through May 31, 2010 and estimated incurred claims.

FY2011 STAR Health Rating Analysis
Estimated Incurred Claims

Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Apr-08	29,024	14,769,082	1.0000	14,769,082	508.86	
May-08	29,749	15,554,928	1.0000	15,554,928	522.87	
Jun-08	30,260	16,113,451	1.0000	16,113,451	532.50	
Jul-08	30,688	17,524,139	1.0000	17,524,139	571.04	
Aug-08	31,217	16,789,301	1.0000	16,789,301	537.83	
Sep-08	31,348	15,795,545	1.0000	15,795,545	503.88	
Oct-08	31,198	15,716,966	1.0000	15,716,966	503.78	
Nov-08	30,871	15,271,621	1.0000	15,271,621	494.69	
Dec-08	30,494	15,316,061	1.0000	15,316,061	502.26	
Jan-09	30,008	16,297,916	1.0000	16,297,916	543.12	
Feb-09	29,756	16,189,040	0.9996	16,195,159	544.27	
Mar-09	29,712	17,585,442	0.9995	17,594,854	592.18	
Apr-09	29,685	17,648,399	0.9992	17,662,909	595.01	1.169
May-09	29,780	17,250,531	0.9985	17,277,230	580.16	1.110
Jun-09	29,657	16,943,350	0.9979	16,979,698	572.54	1.075
Jul-09	29,565	17,280,990	0.9961	17,348,755	586.80	1.028
Aug-09	29,006	17,423,048	0.9925	17,554,410	605.20	1.125
Sep-09	29,023	18,525,175	0.9908	18,697,613	644.23	1.279
Oct-09	29,136	18,658,509	0.9818	19,004,238	652.26	1.295
Nov-09	29,236	17,358,968	0.9732	17,837,913	610.14	1.233
Dec-09	29,311	17,122,351	0.9511	18,002,552	614.19	1.223
Jan-10	29,217	17,906,929	0.8953	20,000,254	684.54	1.260
Feb-10	29,284	15,022,202	0.7673	19,578,438	668.57	1.228
Mar-10	29,497	7,208,280	0.3514	20,511,702	695.38	1.174
FY2009	361,080			199,011,123	551.16	

Attachment 3

Provider Reimbursement Adjustments

This attachment presents information regarding rating adjustments for the various provider reimbursement and benefit revisions that became effective (or will become effective) after the base period used in rate setting and before the end of FY2011.

The benefit and provider reimbursement changes recognized in the FY2011 rate setting are listed below. The rating adjustments for these provider reimbursement changes were calculated by applying actual health plan encounter data to the old and new reimbursement basis and the resulting impact determined. The attached exhibit presents a summary of the derivation of the adjustment factor.

- Effective September 1, 2009, Medicaid implemented a 2% rate increase for ambulance services.

- Effective September 1, 2009, Medicaid revised the recommended EPSDT schedule to include four additional screens.

- Effective September 1, 2009, Medicaid revised the reimbursement for developmental and autism screens.

- Effective January 1, 2010, Medicaid revised the reimbursement for vision and hearing screens.

- Effective September 1, 2010, Medicaid will revise the reimbursement for digestive system surgery, female genital surgery and medicine/other codes.

- Effective September 1, 2010, Medicaid will reduce reimbursement by 1% for most providers and services.

- Effective September 1, 2010, HHSC is implementing zero-based DRG rebasing. This rebasing effort is intended to update the Standard Dollar Amounts and Relative Weights used in the Medicaid DRG payment system while achieving overall budget neutrality. While the rebasing process may be budget neutral overall, it is not budget neutral by program.

FY2011 STAR Health Rating Analysis
Provider Reimbursement Adjustments*

Estimates Based on FY2008 STAR Health Encounter Data (4/1/2008 - 8/31/2008)

Ambulance Claims	400,665
2% Increase	8,013
Increased EPSDT cost	121,865
Estimated Increased Developmental/Autism Screening Cost	26,286
Vision and Hearing Screening	52,900
Overall Provider Reimbursement Increase	209,065
FY2008 Total Claims	44,576,707
Rate Adjustment Factor	0.47 %

Estimates Based on FY2009 STAR Health Encounter Data

Fee Schedule Changes	31,138
1% Provider Rate Reduction	-1,021,265
Overall Provider Reimbursement Increase	-990,127
FY2009 Total Claims	119,887,879
Rate Adjustment Factor	-0.83 %
Overall Rate Adjustment Factor	-0.36 %

DRG Rebasing Adjustment Factor

Estimated FY2009 Impact (from Bill Warburton)	260,024
FY2009 Incurred Claims	199,011,123
Rate Adjustment Factor	0.13 %

Attachment 4

Frew Rewards and Sanctions

Effective September 1, 2009, HHSC implemented a new provision in the STAR Heath program named Frew Rewards and Sanctions. This benefit is part of the corrective actions order under the Frew lawsuit settlement. The benefit is intended to provide strong incentives for the health plans to invest in THSteps check-up compliance. Those health plans that satisfy HHSC-specified performance targets will retain their full allotment of Frew Rewards and Sanctions funding. Those plans that do not meet the targets will be required to return a portion of their funding.

The attached exhibit presents the calculation of the Frew Rewards and Sanctions monthly amount paid to each health plan for each child enrolled in STAR, STAR+PLUS and STAR Health.

FY2011 STAR Health Rating Analysis
Frew Rewards and Sanctions

	STAR	STAR+ PLUS (4)	STAR Health	Total
Projected FY2011 Member Months Under Age 21 (1)	16,920,490	117,649	377,867	17,416,005
Frew Rewards and Sanctions Amount (2)				10,000,000
Rate Adjustment (3)	$ 0.58	$ 0.07	$ 0.58	$ 0.58

Footnotes:

(1) For STAR, includes TANF Children, Newborns, Expansion Children and Federal Mandate Children risk groups. Excludes those Pregnant Women under age 21. For STAR+PLUS, caseload provided by System Forecasting.

(2) Amount provided by Managed Care Operations.

(3) Equals Frew Rewards and Sanctions amount divided by member months. Includes an allowance for 1.75% premium tax

(4) For STAR+PLUS, applies to Medicaid Only risk group only. Also, because STAR+PLUS does not have separate children's risk groups, the rate applies to all Medicaid Only clients including those age 21 and over. Approximately 12.4% of Medicaid Only clients are under age 21 so the STAR+PLUS add-on factor is adjusted from $0.58 pmpm to $0.07 pmpm (equals $0.58 times 12.4%).