STATE OF TEXAS
MEDICAID MANAGED CARE
STAR HEALTH PROGRAM RATE SETTING
STATE FISCAL YEAR 2012

Prepared for:
Texas Health and Human Services Commission

Prepared by:
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I. Introduction

Rudd and Wisdom, Inc. has been retained by the Texas Health and Human Services Commission (HHSC) to develop a fiscal year 2012 (FY2012, September 2011 through August 2012) premium rate for the STAR Health program. STAR Health is the 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 FY2012 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 FY2012 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 April 2008 through February 2011 with a projection through August 2012. These enrollment figures were provided by HHSC System Forecasting staff.

- Claim lag reports provided by the carrier for the period April 2008 through February 2011. 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, FY2010 and the first six months of FY2011. 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 FY2011 and FY2012 Medicaid provider reimbursement rate changes.

- Information provided by HHSC regarding FY2010 health plan claims cost by type of service for certain services. This information was obtained from the encounter database.

- 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 administrative services provided under STAR Health.

- Current (FY2011) STAR Health premium rate.

- Information provided by HHSC regarding the proposed DRG rebasing to become effective September 1, 2011.

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 FY2012 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 (FY2010, September 1, 2009 through August 2010) were developed. These estimates were then projected forward to FY2012 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 FY2012 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 FY2012 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, taxes and 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 FY2012 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 2.3% for FY2011 and 5.0% for FY2012.

Provider Reimbursement Adjustment

Medicaid provider reimbursement changes were provided for the following services: digestive system surgery, female genital surgery, hearing and vision screenings, the two one percent provider rate cuts effective 9/1/2010 and 2/1/2011, the inclusion of wrap payments for FQHCs effective 9/1/2011, DRG rebasing, legislative mandated provider rate reductions and the transition of outpatient imaging services to a fee schedule.

The legislative mandated provider rate reductions included the following:

- 8% hospital rate reduction
- 10.5% laboratory rate reduction (excludes DSHS and physician lab)
- 10.5% durable medical equipment reduction. Achieve via targeted rate reductions that vary by service
- 5% reduction for all other providers excluding ambulance, private duty nursing (children only), home health (children only), dental, orthodontics, physicians (includes psychiatrists, optometrists, radiologists, podiatrists and orthodontists), FQHCs, Rural Health Centers and TEFRA reimbursed hospitals.

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.

IV. Administrative Fees and Risk Margin

The rating methodology includes an explicit provision for administrative services. The amount allocated for administrative expenses is $23.50 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 ($0.105 pmpm) and a risk margin (2.0% of premium).

V. Summary

The FY2012 premium rate for the STAR Health program is $759.44 per member per month. This rate will be effective for the period September 1, 2011 through August 31, 2012. Attachment 1 shows the derivation of the premium rate.

VI. Actuarial Certification of FY2012 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, 2011 through August 31, 2012 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:

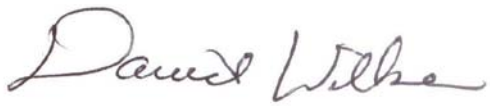
(a) The premium rate has been developed in accordance with generally accepted actuarial principals and practices;

(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 FY2012 STAR Health Rating Analysis

The attached exhibit presents summary information regarding the FY2012 STAR Health rate development. Included on the exhibit are base period (FY2010) experience, projected FY2012 enrollment, trend and provider reimbursement adjustment factors, assumed capitation rates, reinsurance and administrative costs.

The actuarial model used to derive the FY2012 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 FY2012 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 FY2012 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.

FY2012 STAR Health Rating Analysis
Rate Development for the STAR Health Program

	Rating Period FY2012
Base Period Used in Rating	FY2010
Base Period Experience	
Member Months	357,143
Estimated Incurred Claims	211,975,445
Estimated Incurred Claims pmpm	$ 593.53
Projected Rating Period Experience	
Member Months	400,313
Assumed Annual FFS Claims Cost Trend Rate	
- FY2010	2.3 %
- FY2011	5.0 %
Provider Reimbursement Adjustment	-3.19 %
DRG Rebasing Adjustment	-0.45 %
Projected Incurred Claims pmpm	$ 614.63
Projected Incurred Claims	246,042,711
Capitation Expenses	
Primary Care Capitation	$ 0.03
Behavioral Health	$ 0.00
Vision Services	$ 2.40
Dental Services	$ 46.00
Settlements and Miscellaneous Expenses	$ 0.63
Total	$ 49.06
Reinsurance Expenses	
Gross Premium	$ 11.92
Projected Reinsurance Recoveries	$ 11.92
Net Reinsurance Cost	$ 0.00
Administrative Expenses	
Fixed Amount	$ 23.50
Percentage of Premium	5.75 %
Premium Tax	1.75 %
Maintenance Tax pmpm	$ 0.105
Risk Charge	2.0 %
Premium Rate pmpm	$ 759.44
Percentage Increase	-5.6 %

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 February 28, 2011 and estimated incurred claims.

FY2012 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Apr-08	29,024	14,144,145	1.0000	14,144,145	487.33	
May-08	29,749	14,557,305	1.0000	14,557,305	489.34	
Jun-08	30,260	14,992,190	1.0000	14,992,190	495.45	
Jul-08	30,688	16,264,087	1.0000	16,264,087	529.98	
Aug-08	31,217	15,702,540	1.0000	15,702,540	503.01	
Sep-08	31,348	14,825,798	1.0000	14,825,798	472.94	
Oct-08	31,198	14,507,201	1.0000	14,507,201	465.00	
Nov-08	30,871	14,366,145	1.0000	14,366,145	465.36	
Dec-08	30,494	14,359,876	1.0000	14,359,876	470.91	
Jan-09	30,008	15,308,801	1.0000	15,308,801	510.16	
Feb-09	29,756	15,057,923	1.0000	15,057,923	506.05	
Mar-09	29,712	16,280,229	1.0000	16,280,229	547.93	
Apr-09	29,685	16,449,690	1.0000	16,449,690	554.14	1.137
May-09	29,780	16,036,878	1.0000	16,036,878	538.51	1.100
Jun-09	29,657	15,797,540	1.0000	15,797,540	532.67	1.075
Jul-09	29,565	16,085,826	1.0000	16,085,826	544.08	1.027
Aug-09	29,006	16,286,411	1.0000	16,286,411	561.48	1.116
Sep-09	29,034	17,574,492	1.0000	17,574,492	605.31	1.280
Oct-09	29,149	17,512,409	1.0000	17,512,409	600.79	1.292
Nov-09	29,258	16,507,655	1.0000	16,507,655	564.21	1.212
Dec-09	29,347	17,388,711	1.0000	17,388,711	592.52	1.258
Jan-10	29,224	18,042,558	0.9995	18,051,397	617.69	1.211
Feb-10	29,306	16,811,879	0.9995	16,820,668	573.97	1.134
Mar-10	29,587	18,368,938	0.9994	18,380,304	621.23	1.134
Apr-10	29,763	18,151,825	0.9989	18,172,678	610.58	1.102
May-10	30,130	17,771,981	0.9982	17,803,895	590.90	1.097
Jun-10	30,470	17,507,735	0.9968	17,563,806	576.43	1.082
Jul-10	30,837	17,693,509	0.9958	17,767,901	576.19	1.059
Aug-10	31,038	18,295,709	0.9926	18,431,529	593.84	1.058
Sep-10	31,327	17,434,515	0.9914	17,585,766	561.36	0.927
Oct-10	31,518	17,033,921	0.9861	17,274,679	548.09	0.912
Nov-10	31,700	16,599,790	0.9716	17,084,566	538.95	0.955
Dec-10	31,580	15,943,130	0.9300	17,143,151	542.85	0.916
Jan-11	31,551	13,717,877	0.7800	17,587,022	557.42	0.902
Feb-11	31,930	4,460,234	0.2600	17,154,744	537.26	0.936
FY2008	150,938			75,660,267	501.27	
FY2009	361,080			185,362,319	513.36	1.024
FY2010	357,143			211,975,445	593.53	1.156
9/10-12/10	126,125			69,088,161	547.78	0.927

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 (FY2010) and before the end of FY2012.

The benefit and provider reimbursement changes recognized in the FY2012 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 factors.

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

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

- Effective September 1, 2010 and again on February 1, 2011, Medicaid reduced reimbursement by 1% for most providers and services.

- Effective September 1, 2010, HHSC revised the rating methodology to exclude from the claims experience base any amounts paid by a health plan to a related party in excess of 100% of Medicaid.

- Effective September 1, 2011, HHSC is implementing the legislative mandated provider rate reductions described below.

    - 8% hospital rate reduction
    - 10.5% laboratory rate reduction (excludes DSHS and physician lab)
    - 10.5% durable medical equipment reduction. Achieve via targeted rate reductions that vary by service
    - 5% reduction for all other providers excluding ambulance, private duty nursing (children only), home health (children only), dental, orthodontics, physicians (includes psychiatrists, optometrists, radiologists, podiatrists and orthodontists), FQHCs, Rural Health Centers and TEFRA reimbursed hospitals.

- Effective September 1, 2011, HHSC is implementing a new fee schedule for outpatient imaging services.

- Effective September 1, 2011, HHSC is implementing DRG rebasing. This rebasing effort is intended to update the Standard Dollar Amounts and Relative Weights used in the Medicaid DRG payment system. The final Standard Dollar Amounts are not expected to be made available to the MCOs until around August 1, 2011. As a result, we have assumed, for

purposes of these rate calculations, that the revised reimbursement level will not be incorporated into MCO provider contracts until November 1, 2011.

- Effective September 1, 2011, HHSC requires MCOs to pay Federally Qualified Health Centers (FQHCs) the full encounter rate.

The attached exhibit presents a summary of the derivation of the rating adjustment factors.

FY2012 STAR Health Rating Analysis
Provider Reimbursement Adjustments
Estimates Based on FY2010 STAR Health Encounter Data

Provider Reimbursement Adjustment Factor

Fee Schedule Changes	119,614
Vision and Hearing Screening	167,303
2% Provider Rate Reduction - 9/1 + additional 2/1	-2,420,781
OP Imaging Fee Schedule	-1,004,036
Legislative Reductions	-4,173,290
FQHC Wrap Payment	550,774
Overall Provider Reimbursement Change	-6,760,415
FY2010 Total Claims	211,975,445
Rate Adjustment Factor	-3.19 %

DRG Rebasing Adjustment Factor

Estimated FY2010 Impact*	-947,668
FY2010 Total Claims	211,975,445
Rate Adjustment Factor	-0.45 %

* From HHSC. Assumed to become effective 11/1/2011.