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Actuarial soundness under Medicaid block grants and per capita caps

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Proposals to change federal funding for state Medicaid programs from an uncapped matching percentage to block grants or per capita caps have generated significant national attention.

As a result, many Medicaid managed care stakeholders are questioning whether there may also be changes in the actuarial soundness requirements for capitation rates paid to managed care organizations participating in these programs. Capitation expenditures for comprehensive Medicaid managed care programs exceeded $200 billion in fiscal year 2015.[1] Regardless of any statutory or regulatory changes associated with federal funding, actuarially sound capitation rates will remain critical to the long-term viability of Medicaid managed care programs.

There are several plausible scenarios for how actuarial soundness requirements may change under block grants or per capita caps.

The scenario often pondered by Medicaid managed care stakeholders is one where capitation rates no longer have any formal requirement to be actuarially sound, as defined in 42 CFR §438.4(a) and the Actuarial Standard of Practice (ASOP) #49. State Medicaid agencies would have freedom to propose capitation rates without documentation requirements and with potential for reductions attributable to state budget constraints. Health plans would then negotiate with the agencies in an attempt to arrive at mutually agreeable rates. The hope is that the negotiation mechanism and states' desire for stable programs would be sufficient to consistently contract at rates that support an efficient and sustainable program. Such negotiations often occur in programs currently, but contracted rates are still subject to actuarial soundness requirements.

This scenario may or may not include the involvement of actuaries in capitation rate development. States may continue to enlist actuaries to project future benefit and non-benefit costs to inform the starting point for negotiations with health plans. Any capitation work actuaries do perform would still be subject to actuarial soundness requirements under ASOP #49 regardless of the existence of state or federal requirements. States and health plans would simply have the ability to contract at rates that are not actuarially sound.

However, changes in federal funding mechanisms do not necessarily imply changes to federal requirements for how managed care capitation rates are developed, though the oft-accompanying notion of increased state flexibility in program operation raises this possibility. For example, it is possible to require actuarially sound payments to health plans while drawing down federal block grant or per capita cap funding streams. This paper briefly explores the following scenarios:

- Federal actuarial soundness requirements are unchanged.
- Federal actuarial soundness requirements are eliminated, but states add soundness requirements.
- No actuarial soundness requirements remain in effect, but many states continue to incorporate them.

Continuation of federal actuarial soundness requirements under revised federal funding is a plausible scenario.

Actuarial soundness requirements are a well-established component of Medicaid managed care programs, having been in effect since June 2003. Even a full repeal of the Patient Protection and Affordable Care Act (ACA) and the 2016 Medicaid managed care regulations[2] would have only a modest effect on how actuarial soundness is applied in Medicaid managed care programs.

The Medicaid managed care actuarial soundness requirements were implemented through the Balanced Budget Act of 1997 and became effective in June 2003. Prior to that date, capitation

1 "Total Medicaid MCO Spending," *KFF.org*, accessed March 2, 2017, http://kff.org/other/state-indicator/total-medicaid-mco-spending/.

2 See http://www.milliman.com/medicaidmanagedcare/ for a series of white papers on the implications of the 2016 regulation on Medicaid managed care capitation rate development.

rates were required to be below a fee-for-service equivalent Upper Payment Limit (UPL) for the covered population. In the early 2000s, there were several programs that had served the entirety of certain populations under managed care for several years, which limited the value of the UPL requirement because comparable, non-managed care data was quite old or obsolete. The implementation of the actuarial soundness criteria established a more standardized rate methodology along with accountability for the development of capitation rate certifications and documentation.

The existence of actuarial soundness requirements since that time has served Medicaid managed care programs well. The number of such programs and individuals served through them have significantly grown since that time, while in most cases maintaining program sustainability.

Actuarially sound capitation rates have been critical to the growth and success of managed care programs nationwide. Legislators and policy experts will carefully consider potential negative consequences before eliminating this requirement.

Some states may establish their own requirements if federal requirements are eliminated.

States have vested interests in the fiscal stability of health plans serving their citizens. Medicaid health plans already need to meet solvency requirements established by the appropriate state regulating agencies. A critical component of meeting those requirements is the establishment of actuarially sound capitation rates.

If the federal actuarial soundness requirement is removed, state legislators and regulators may get involved to ensure appropriate health plan funding levels are maintained. This process would likely require changes in state legislation because capitation rates are negotiated between Medicaid agencies and health plans. For other lines of business, state regulators review rates that are developed by the health plans themselves.

Many states may continue to develop actuarially sound capitation rates even in the absence of any soundness requirements.

There is significant value in developing capitation rates that are actuarially sound, and this is well-recognized across a wide range of Medicaid managed care stakeholders. There are even programs, such as stand-alone Children's Health Insurance Program (CHIP) arrangements, that have not historically been required to have capitation rates certified as actuarially sound and that have nonetheless utilized actuaries to develop sound rates. In this scenario, Medicaid managed care programs would retain the benefit of actuarially sound rates while significantly reducing the oversight and documentation requirements formalized in the 2016 regulations.

Actuarial soundness principles target rate levels that provide for all reasonable, appropriate, and attainable costs. This is critical to promoting both the efficiency and sustainability of Medicaid managed care programs. Most Medicaid programs involve billions of dollars in revenue annually, and even very small percentage changes can equate to tens of millions of dollars. Using a sound actuarial rate methodology minimizes the risk of significant mismatches, either high or low, between capitation rates and health plan liabilities.

Finally, actuarially sound rates serve as a valuable, unbiased estimation of program costs. Medicaid agencies and health plans face significant pressures to contract at lower or higher rates, respectively. Actuarial soundness requirements reduce the risk of health plan overpayment or underpayment simply because one side has better leverage or negotiation skills.

Changes in federal Medicaid funding may or may not result in changes to federal actuarial soundness requirements for Medicaid managed care capitation rates. Regardless of the outcome, there are invaluable benefits to continuing to utilize sound principles in capitation rate development.

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