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State of Texas

Health and Human Services Commission

Medicaid Managed Care
STAR+Plus Program Rate Setting

State Fiscal Year 2008

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I. Introduction

The Texas Health and Human Services Commission (HHSC) retained Deloitte Consulting to develop the state fiscal year 2008 (SFY08: September 1, 2007 through August 31, 2008) capitation rates (rates) for managed care organizations (MCOs) participating in the Texas Medicaid STAR+Plus program. We have worked closely with HHSC in developing these rates. This report presents the rating methodology and assumptions used in this rate development, as well as our certification of these rates.

MCOs participating in STAR+Plus are paid a monthly capitation rate per member to provide long-term care and certain acute care services to enrolled members. The long-term care services that are provided by the MCOs include Primary Home Care (PHC), Day Activity and Health Services (DAHS), and Community-based Alternatives (CBA). Acute care services that are provided by the MCOs include physician, outpatient hospital, lab/radiology, as well as other services. Non-psychiatric hospital inpatient facility services and prescription drugs are provided by the State via FFS, as are Nursing Facility (NF) LTC services after four months of institutionalization.

Medicaid pays for the LTC for both eligibility categories. Medicaid also pays for the acute care of Medicaid-only eligibles, whereas Medicare pays for the acute care of persons eligible for both Medicare and Medicaid (Dual Eligible). Within each of these two eligibility categories there are three eligibility classes (a.k.a. risk groups). The following identifies these risk groups and describes the types of associated services:

- NF – for members that must be institutionalized and cannot, therefore, benefit from home and community-based care;
- CBA – for persons age 21 and older who would qualify for NF care but elect to stay in their home and receive services such as:
  - Personal Assistance Services
    - Assistance to the participant including assistance with the performance of the activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment.
    - The level of assistance provided is determined by the participant's needs for assistance and the plans of care.
    - Personal assistance services may include the provision of nursing tasks delegated by an RN in accordance with state rules promulgated by the Texas Board of Nurse Examiners.
  - Adaptive Aids and Medical Supplies
    - Devices, controls, or medically necessary supplies which enable persons with functional impairments to perform activities of daily living or control the environment in which they live.
  - Adult Foster Care
    - A 24-hour living arrangement in an enrolled foster home for persons who, because of physical or mental limitations, are unable to continue residing in their own homes.
    - Services may include meal preparation, housekeeping, personal care, help with activities of daily living, supervision, and the provision of or arrangement of transportation.
  - Assisted Living/Residential Care Services
    - A 24-hour living arrangement in licensed personal care facilities in which personal care, home management, escort, social and recreational activities, twenty-four hour supervision, supervision of, assistance with, and direct administration of medications, and the provision or arrangement of transportation are provided.

        - Under the CBA, personal care facilities may contract to provide services in three distinct types of living arrangements:
            - Assisted Living apartments.
            - Residential Care apartments, or
            - Residential Care non-apartment settings.
    - Emergency Response Services
        - An electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community.
        - In an emergency, the participant can press a call button to signal for help.
        - The electronic monitoring system, which has a 24-hour, seven-day-a-week capability, helps insure that the appropriate persons or service agency respond to an alarm call from the participant.
    - Minor Home Modifications
        - Services that assess the need for, arrange for, and provide modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security and accessibility.
    - Nursing Services
        - Includes, but is not limited to, the assessment and evaluation of health problems and the direct delivery of nursing tasks, providing treatments and health care procedures ordered by a physician and/or required by standards of professional practice or state law, delegation of nursing tasks to unlicensed persons according to state rules promulgated by the Texas Board of Nurse Examiners, developing the health care plan, and teaching individuals about proper health maintenance.
    - Occupational Therapy
        - The full range of activities provided by an occupational therapist, or a licensed occupational therapy assistant under the direction of a licensed occupational therapist, within the scope of his state licensure.
    - Physical Therapy
        - The full range of activities provided by a physical therapist or a licensed physical therapy assistant, under the direction of a licensed physical therapist, within the scope of his state licensure.
    - Respite Care
        - Temporary relief to persons caring for functionally impaired adults in community settings other than AFC homes or AL/RC facilities.
        - Respite services are provided on an in-home basis and out-of-home basis and are limited to 30 days per IPC year.
        - Room and board is included in the waiver payment for out-of-home settings.
    - Speech and/or Language Pathology Therapy
        - The full range of activities provided by speech and language pathologists under the scope of their state licensure.
- Other Community Care (OCC) services – namely:
    - PHC (e.g. primary home care services, family care services, and community attendant services), as well as
    - DAHS
        - Adult day care including nursing services, physical rehabilitation services, nutrition/food service, and other supportive services (e.g. community interaction, cultural enrichment, educational or recreational activities, and other social activities).
        - Transportation to/from approved therapies.

Enrollment in an MCO is required for most Medicaid eligibles. This includes Supplemental Security Income (SSI) eligibles age 21 years and over, CBA clients, and, clients entering a NF. SSI eligibles under age 21 years may chose to enroll in an MCO on a voluntary basis.

Since institutionalized members are ultimately disenrolled from the STAR+Plus managed care program, only four risk groups are ultimately developed. They are:

- Medicaid-only OCC (Acute Care and Long-term Care - PHC, DAHS, and NF);
- Medicaid-only CBA (Acute Care and Long-term Care - CBA);
- Dual Eligible OCC (Long-term Care only - PHC, DAHS, and NF); and
- Dual Eligible CBA (Long-term Care only - CBA).

II. Overview of the Rate Setting Methodology

The actuarial approach we used to develop the SFY08 STAR+Plus managed care capitation rates incorporates the following components:

- Base period claims costs
- Trend in health care costs
- Programmatic changes
- Anticipated managed care savings
- Provision for administrative expense, risk and contingency margin

The risk groups (or rating populations) used in the analysis are as follows:

- Medicaid-only – OCC
- Medicaid-only – CBA
- Dual Eligible – OCC
- Dual Eligible – CBA

For each of the risk groups we have separately determined the appropriate rates for acute care services and long-term care services. The summarized acute care service categories used in the analysis include the following:

- Inpatient Hospital Psychiatric Services
- Outpatient Hospital
- Primary Care Physician
- Specialist Physician
- Non-Physician Professional Services
- Other Professional Services
- Behavioral Health Services
- Home Health Services
- Emergency Room Services
- Ambulance Services
- Lab, X-ray and Radiology Services
- Medical Supplies
- EPSDT Medical Services
- Hearing Services

The long-term care services used in the analysis include the following:

- Personal Assistance Services (PAS)
- Respite Care
- Skilled Nursing
- Personal Emergency Response Systems
- Consumer Directed – PAS
- Adult Foster Care
- Assisted Living/Residential Care

- Minor Home Modifications
- Adaptive Aids/Medical Supplies
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Home Delivered Meals
- Transition Assistance Services

Services specifically excluded from the analysis include:

- Prescription Drugs
- Dental and Orthodontia Services

Base Period Claims Costs

The actuarial methodology used to develop the SFY08 STAR+Plus MCO capitation rates relies on both State FFS and MCO claim experience. The managed care program has existed in the Harris County SDA since 2000. As of February 1, 2007, the State expanded the STAR+Plus managed care program to include the following SDAs:

- Bexar – Contiguous Counties
- Harris – Contiguous Counties
- Nueces – Contiguous Counties
- Travis – Contiguous Counties

Since meaningful FFS claims experience for Harris County is no longer available, historical claims experience for each MCO was analyzed to develop the base period (SFY05) claim cost estimates for this area. Other plan expenditures such as capitation payments, reinsurance costs and administrative expenses were added to the claims component in order to project the total Harris County SDA SFY08 cost under the managed care program.

State FFS acute care claims experience during SFY04 and LTC claims experience during SFY05 was used for each of the four expansion regions. Not all FFS claims and member months are applicable to HMO rate setting. Further, coverage limits and parameters of the FFS program differ from that required for HMO coverage for some services. Adjustments to the FFS claims and exposures to account for these items were made. Specifics regarding the adjustments are described in this document.

Ultimately, the Harris County/Contiguous experience was combined to reflect a single region.

In developing these rates, we have relied on the following data sources as provided by HHSC, the participating MCOs, and the agency's External Quality Review Organization (EQRO):

Managed Care Program Information

- Monthly enrollment by risk group for each MCO in Harris County. This includes historical enrollment since September 2004 and a projection of future enrollment through August 2008. These projections were prepared by HHSC System Forecasting staff.
- Encounter data reports by risk group and service category for each MCO with claims incurred for the period September 2004 through August 2005 and paid between September 2004 and November 2005. These reports include monthly paid claims by month of service.

- Financial Statistical Reports (FSR) for each participating MCO for SFY04 and SFY05. The FSRs contain detailed information reported by the MCOs including monthly enrollment, revenue, incurred claims, and administrative expenses.
- MCO encounter claim assessment provided by the agency's EQRO vendor.

State Fee-For-Service Data

- Monthly eligibility and claims experience for the Medicaid FFS program.
- Claim lag data representing monthly paid claims by month of service, which were used to establish completion factors to project incurred claims.
- Retroactive eligibility periods for each Medicaid FFS client. We removed these member months and the corresponding claims from the base data used to develop the capitation rates.
- We used STAR+Plus eligibility criteria to identify the Medicaid FFS clients eligible for the STAR+Plus program. Only the member months and claims for these eligibles were included in our analysis.

Other Information

- Current (SFY07) capitation rates by risk group and service category for each MCO.
- Information regarding recent changes in covered services and provider reimbursement under the Medicaid program.

Although the above data was reviewed for reasonableness, Deloitte Consulting did not audit the data. Deloitte Consulting did receive managed care program information and state fee-for-service data for SFY06. However, upon review of this data we identified unusual trends, which lead us to believe data could be missing. It is our actuarial judgment that the SFY04 and SFY05 data is more reliable and this is the data we used.

Trend in Health Care Costs

Having derived claim cost rates for SFY05, we applied trends to project the corresponding claim costs for SFY08. Trend factors were agreed upon by Texas and the MCO's. Deloitte Consulting did not believe these trend factors appeared unreasonable. These factors are described in more detail in Section III.

Programmatic Changes

The claim cost rates thus obtained for SFY08 were then adjusted for the following items:

- The Legislature had previously required a 1.1% cost reduction across-the-board for LTC services. Thus, the LTC rates had been reduced by 1.1% to reflect this mandate. That 1.1% reduction was reinstated for SFY06. The LTC rates for SFY08 reflect this reinstatement.
- The claim cost rates have been increased to reflect the cost of other services. These other services include capitation payments, care coordination, reinsurance premiums, and cost settlements.
- Recent legislative changes to provider reimbursement have been incorporated as well. These represent adjustments for:
  - Restoration of rates for prior rate reductions for professional services
  - State Teaching Rate Increase
  - PT/OT/ST Rate Increase
  - Physician Drugs Rate Decrease

- Ambulance Rate Increase
- LTC Attendant Care Rate Increase
- LTC Provider Rate Increase
- NF Provider Rate Increase
- Cap to Qualify for CBA
- Frew Unit Cost < 21
- Frew Unit Cost >= 21
- Frew Utilization < 21

Anticipated Managed Care Savings

Managed care adjustments account for variations in the health care delivery patterns between managed care and FFS. Typically, MCOs strive to facilitate the use of lower cost services in place of higher cost services, such as inpatient facilities. When FFS data is used as the base data, it is appropriate to adjust these historical results to reflect anticipated savings from managed care.

Provision for Administrative Expense, Risk and Contingency Margin

Exhibit C displays the detail involved in the adjustments for the costs of other services and exclusions. SFY08 capitation rates include a fixed $50.00 PMPM provisions for administrative expense, risk and contingency margin. This margin consists of:

- A fixed $50.00, which is intended to account for:
  - Premium tax of 1.75% of the capitation rate,
  - Provision for risk margin representing approximately 1.6% across all rate cells, and
  - A load for administrative (or non-benefit) expenses of approximately 7.4% across all rate cells.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the SFY08 STAR+Plus rate setting process. We have classified each adjustment based on the point in the rate setting process where the adjustment has been applied; namely, an adjustment to the base data, trend, programmatic changes, managed care adjustment, or administrative adjustment.

Base Data Adjustments

IBNP Adjustments

In order to account for any claims that may still be outstanding in the FFS data we used Incurred But Not Paid (IBNP) adjustments to complete the data. For Harris County, the IBNP adjustments are based on information received from Texas. For all other service areas, we calculated completion factors for acute care services using standard actuarial techniques and the LTC IBNP adjustments are based on information received from Texas. The following table shows the IBNP adjustments.

Type of Service	Non-Harris County	Harris County
AC IP Hosp	1.0005	1.0710
AC OP Hosp	1.0007	1.0710
AC Phys/Other	1.0030	1.0710
LTC	0.9997	1.0641

Large Claim Adjustments

In order to smooth any potential volatility as a result of an abnormal distribution of catastrophic claims in the experience period medical claims greater than $100,000 were reviewed. The number of members with these claims was prevalent mostly within the Medicaid Only OCC risk group. An analysis was performed to redistribute claims in excess of $100,000 evenly based on membership. As a result of this analysis, the following table highlights the adjustment factors applied to each service area.

Service Area	Adjustment Factor
Bexar Service Area	0.999
Nueces Service Area	1.008
Travis Service Area	1.007
Harris Contiguous	0.980

Attendant Care / Enhanced Payments

The legislature required that the State make available enhanced payments to providers that utilize attendants. The FFS data included the enhanced payments, however the existing STAR+Plus program in Harris County received these payments off line. We applied the following factors to the Harris County rates based on the amounts paid in other areas.

Risk Group	Harris County Adjustment Factor
Medicaid Only OCC	1.026
Medicaid Only CBA	1.002
Dual Eligible OCC	1.019
Dual Eligible CBA	1.002

CBA Area Factors

For the Medicaid Only CBA and Dual Eligible CBA risk groups, the FFS data was not credible at a service area level. In order to account for this, area factors were developed using all CBA data. The "manual rate" assumed was the aggregate FFS PMPM for the appropriate risk group (Medicaid Only CBA or Dual Eligible CBA) across all service areas. The area factor was then applied with 50% credibility. The following table outlines the final factor used to adjust CBA data for Medicaid Only and Dual Eligible members.

Service Area	CBA Adjustment Factor
Bexar Service Area	1.024
Nueces Service Area	0.998
Travis Service Area	1.031
Harris Contiguous	1.021

Long Term Care Rate Restoration

The legislature previously mandated a 1.1% reduction to long term care service costs, but then reinstated the reduction in SSFY06. The base data costs for long term care reflect this adjustment.

Long Term Care PMPM Adjustments

Care coordination, functional assessment and four months of nursing facility coverage are considered long term care service costs under STAR+Plus. We have added these costs to our base data for rate calculation.

Service Area	AC-Non IP	LTC-CC	LTC-Assess	NF Services
Medicaid Only OCC	n/a	$ 16.35	$ 1.99	$ 2.91
Medicaid Only CBA	n/a	$ 16.49	$ 60.84	$ 42.44
Dual Eligible OCC	$ 33.48	$ 16.06	$ 1.99	$ 3.99
Dual Eligible CBA	$ 52.02	$ 16.11	$ 60.84	$ 45.92

Trend

Enrollment Trend Rates

The Medicaid Only trend rates shown below were calculated using expected disabled and blind caseload trends as developed by Texas. The Dual Eligible trend rates shown below were calculated using expected aged and Medicare related caseload trends as developed by Texas. The trending period corresponds to enrollment that will be effective for the period September 1, 2007 through August 31, 2008.

Eligibility Category	FY04 - FY05	FY05 - FY06	FY06 - FY07	FY07 - FY08
Medicaid Only	8.42%	8.40%	7.24%	6.80%
Dual Eligible	0.88%	1.55%	1.48%	1.20%

Medical Trend Factors

The rating methodology uses assumed trend factors to adjust the base period claims cost to the projection period. The factors used in this analysis reflect a combination of utilization and unit cost trend components. The trends used to project claim costs to SFY08 were calculated using FFS data and the expected impact of future budget allocations. These expected trends have been discussed with Texas personnel.

Service Area / Risk Group	Type of Service	Trend
All	AC IP Hosp	2.20%
All	AC OP Hosp	5.25%
All	AC Phys/Other	5.25%
All	LTC	5.25%

The trends reflect per member per month cost changes including changes due to utilization, mix of services, and unit cost changes. We also considered the fact that budget allocation increases must also address expected increases in enrollment. The trending period corresponds to rates that will be effective for the period September 1, 2007 through August 31, 2008.

Programmatic Changes

Provider Reimbursement Adjustment Factors

Effective September 1, 2003, the State implemented a 2.5% reduction in reimbursement rates payable to most Medicaid providers. This reduction did not apply to children's hospitals, Federally Qualified Health Centers and Rural Health Clinics. We have assumed that no further revision to provider reimbursement rates will occur for SFY08. Therefore, the Provider Reimbursement Adjustment Factor is 1.0.

First Four Months of CBA

When the eligibility status of a STAR+Plus member changes from OCC to CBA, there is a four month lag until the CBA capitation payments begin. We reviewed the fee-for service (FFS) data for members with a change in eligibility status from OCC to CBA, and we calculated adjustments to move their costs for the first four months of CBA eligibility (remove from CBA; add to OCC). We applied the following factors to the non-Harris County rates.

Risk Group	AC Non-IP	LTC
Medicaid Only OCC	1.001	1.029
Medicaid Only CBA	0.995	1.000
Dual Eligible OCC	1.001	1.029
Dual Eligible CBA	0.995	1.000

Inpatient Psychiatric Providers

All inpatient facility costs are excluded from the rates, with the exception of inpatient psychiatric providers. Services for inpatient psychiatric providers are included in the calculation of the rates, however, and include a 22% managed care savings adjustment in the expansion areas. Harris county's rate does not have the 22% managed care savings factor applied, since the rate is not based on FFS data, thus already reflecting managed care savings.

Managed Care Savings Assumptions

The following shows the managed care savings assumptions used in the rate setting. We based the savings on market conditions to represent targets for a well-managed HMO.

	AC - IP		AC OP Hosp		AC Phys/Other							
Risk Group	Non-Pschy	Pschy	ER	Non-ER	Phy PCP	Phy Spec	Non-Phy	Amb	Home Hlth	Behav Hlth	Other Other	LTC LTC
Non-Harris Medicaid Only OCC	22.0%	22.0%	15.0%	15.0%	0.0%	0.0%	15.0%	15.0%	15.0%	15.0%	15.0%	10.0%
Non-Harris Medicaid Only CBA	22.0%	22.0%	15.0%	15.0%	0.0%	0.0%	15.0%	15.0%	15.0%	15.0%	15.0%	10.0%
Non-Harris Dual Eligible OCC	22.0%	22.0%	15.0%	15.0%	0.0%	0.0%	15.0%	15.0%	15.0%	15.0%	15.0%	10.0%
Non-Harris Dual Eligible CBA	22.0%	22.0%	15.0%	15.0%	0.0%	0.0%	15.0%	15.0%	15.0%	15.0%	15.0%	10.0%
Harris County Medicaid Only OCC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Harris County Medicaid Only CBA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Harris County Dual Eligible OCC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Harris County Dual Eligible CBA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Administrative Adjustments

Risk Adjustment

Under the STAR program, the state adjusts the acute care rates based on an analysis using the Chronic Illness and Disablity Payment System (CDPS) risk adjustment methodology. The risk adjustment mechanism is intended to better align reimbursement with risk (or costs) and to be cost-neutral.

Since this adjustment is based on the health risk of members enrolling within an MCO historically, this adjustment cannot be made until sufficient credible experience exists under the STAR+Plus Expansion program. Because the capitation rate in Harris County has been blended with the counties contiguous to Harris County, it is not appropriate to base this adjustment on the historical managed care experience within Harris County only.

Third Party Liability (TPL)

Third Party Liability collections were compiled by the State for the populations in the STAR+Plus expansion program. These amounts were insignificant so no TPL adjustment was made.

Investment Income Adjustments

An adjustment was made to account for potential investment income due to timing of capitation payments. An assumption of 4.375% interest rate for a period of 1.48 months was used to develop the investment income factor of 0.9947.

Administrative Fees and Risk Margin

The rating methodology includes an explicit provision for administrative expenses. SFY08 capitation rates include a fixed $50.00 PMPM provisions for administrative expense, risk and contingency margin. This amount is intended to provide for all administrative-related services performed by the MCO. Additionally, this amount also includes a risk and contingency margin equal to 1.6% of the total capitation rate.

IV. Summary of Final Rates

The table below presents a summary of the SFY08 STAR+Plus rates.

Service Area / Risk Group	9/07 - 8/08 Estimated Member Months	9/07 - 8/08 Capitation Rates
Bexar Medicaid Only OCC	287,582	$ 462.72
Bexar Medicaid Only CBA	5,458	$ 3,138.64
Bexar Dual Eligible OCC	266,464	$ 270.37
Bexar Dual Eligible CBA	20,977	$ 1,931.47
Nueces Medicaid Only OCC	118,034	$ 533.57
Nueces Medicaid Only CBA	2,353	$ 3,062.58
Nueces Dual Eligible OCC	118,633	$ 337.13
Nueces Dual Eligible CBA	12,858	$ 1,887.61
Travis Medicaid Only OCC	111,530	$ 419.60
Travis Medicaid Only CBA	1,943	$ 3,158.71
Travis Dual Eligible OCC	97,881	$ 238.63
Travis Dual Eligible CBA	10,710	$ 1,942.90
Harris County/Contiguous Medicaid On	463,464	$ 557.90
Harris County/Contiguous Medicaid On	13,893	$ 2,782.46
Harris County/Contiguous Dual Eligible	437,147	$ 206.31
Harris County/Contiguous Dual Eligible	33,783	$ 1,639.80

Statistical error and uncertainty are inherent in any rate development process. The final managed care rates represent a “best estimate” of the anticipated cost to provide services during SFY08 for the populations to be covered. The State offers these rates on a “take it or leave it” basis. In general, these rates are intended to provide sufficient margin so that insolvency is not a significant risk for an appropriately managed MCO, while also mitigating the risk that the capitation revenue received by an MCO is not so large that the State is at risk of paying too much for the provision of health care for eligible recipients. These best estimate rates are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. MCOs are advised that the use of these rates may not be appropriate for their particular circumstance, and Deloitte Consulting disclaims any responsibility for the use of these rates by MCOs for any purpose. Deloitte Consulting recommends that any MCO considering contracting with the HHSC should analyze its own projected medical expense, administrative expense, and any other premium requirements for comparison to these rates before deciding whether to contract with the HHSC.

V. Actuarial Certification of SFY08 STAR+Plus MCO Capitation Rates

I, Steven N. Wander, am a Principal with Deloitte Consulting, LLP. 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.

The Texas Health and Human Services Commission (HHSC) retained Deloitte Consulting to assist in the development of the managed care rate-setting methodology, assumptions and resulting capitation rates, as well as to provide the actuarial certification required under the Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.6(c) for SFY08.

I certify that the SFY08 MCO capitation rates developed by HHSC and Deloitte Consulting satisfy the following:

- The capitation rates have been developed in accordance with generally accepted actuarial principals and practices;
- The capitation rates are appropriate for the populations and services covered under the managed care contract; and
- The capitation rates are actuarially sound as defined in the regulations.

In developing these capitation rates I have relied on historical claim experience data and program information provided to us by HHSC. I have reviewed the data for reasonableness but have not audited the data.

Rates developed by Deloitte Consulting are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. Deloitte Consulting has developed these rates on behalf of the HHSC to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable law and regulations. MCOs are advised that the use of these rates may not be appropriate for their particular circumstance, and Deloitte Consulting disclaims any responsibility for the use of these rates by MCOs for any purpose. Deloitte Consulting recommends that any MCO considering contracting with the HHSC should analyze its own projected medical expense, administrative expense, and any other premium requirements for comparison to these rates before deciding whether to contract with the HHSC. Use of these rates for any purpose beyond that stated may not be appropriate.

Steven N. Wander, F.S.A., M.A.A.A.