ACAP

The Importance of Maintaining Actuarial Soundness During COVID-19

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About Actuarial Soundness

Actuarial soundness rules for Medicaid payments to managed care organizations (MCOs) assure rates are developed fairly and adequately based on specific criteria. If an MCO's rate is actuarially sound, it means the plan receives proper reimbursement for services provided and populations served. This, in turn, encourages continued participation in Medicaid by MCOs, improving the continuity of coverage and access to care for Medicaid enrollees.

Actuarial soundness is established in section 1903(m)(2)(A)(iii) of the Social Security Act. The Omnibus Reconciliation Act of 1981 required capitated payments to risk-based MCOs to be actuarially sound.

Medicaid rules at 42 CFR §438 define sound capitation rates as providing "for all reasonable, appropriate, and attainable costs that are required under the terms of the contract…for the time period and the population covered." The regulations mandate CMS to review and approve these capitation rates, which must:

- Be developed using actuarially sound standards,
- Be sufficient for populations and services covered within the contract,
- Meet specific requirements on MCOs, PIHPs, and PAHPs as defined in §§438.206, 438.207, and 438.208, and above all,
- Be calculated so that these entities can "reasonably achieve a medical loss ratio …of at least 85 percent for the rate year."

The Importance of Actuarial Soundness During the Pandemic

The unprecedented crisis presented by COVID-19 places an inordinate amount of stress on the entire health care system, including the Medicaid program and the providers and health plans that serve it. Projections by Health Management Associates estimate that nationwide Medicaid enrollment, currently 71 million people, could grow by up to 23 million in 2020.

The anticipated surge in Medicaid enrollment brings into stark relief the need to maintain actuarially sound rates for Medicaid health plans. Far from being a "plan-only" issue, failure to pay actuarially-sound rates has a direct impact on reimbursement rates paid by a plan to its network of providers who deliver benefits to enrollees. If rates are not actuarially sound, plans that are contractually obligated to provide benefits to enrollees must do so at rates that that would force them to dangerously limit access to benefits, curtail provider reimbursements, and remain unpaid for other state-mandated requirements. In such a scenario, providers either accept inadequate payments – a common critique among policymakers who are concerned about Medicaid access – or drop out of the network altogether. Without a robust provider network, enrollees will have difficulties accessing their Medicaid benefits and plans cannot meet minimum access requirements. If enough providers drop out of networks, it is impossible for health plans to deliver benefits – leading to a "death spiral" in a Medicaid managed care program that could force plans to withdraw from participation altogether.

Inadequate rates put managed care organizations in a no-win situation by either forcing them to scrimp on benefits or underpay network providers, which could destabilize the network, limiting access to benefits. This would be detrimental if it were to occur during this pandemic; we need to ensure plans can continue to provide care to the newly eligible Medicaid beneficiaries. That is why actuarial soundness is a critical linchpin for the successful use of managed care organizations in Medicaid.

Threats to Actuarial Soundness During and Prior to the COVID-19 Pandemic

To address the pandemic, nearly all 50 states and U.S. territories have requested 1135 waivers to take advantage of flexibilities allowable only after the President declares an emergency or disaster under the Stafford Act or the National Emergencies Act and the Secretary of HHS declares a public health emergency. These waivers can temporarily waive or change Medicaid, CHIP, and Medicare requirements to guarantee availability of health care goods and services to those enrolled in these health care programs. The waivers also help ensure provider reimbursement and allow provider exemption from sanctions.

Four states have asked CMS to use 1135 authority to waive actuarial soundness. The New York and Minnesota waivers proposed suspension of actuarially sound Medicaid managed care rates for all plans and contracts in 2020 and 2021. New York justified the request by stating that "the State with plans and their actuaries [can] best determine how to [deal with] COVID-19 and its associated requirements regarding cost-sharing, telehealth, and other access requirements will impact plan financial performance." Washington and Wisconsin also requested waivers of actuarial soundness, with the stated goal of protecting small and vulnerable providers, such as behavioral health providers, during the pandemic.

While the Centers for Medicare & Medicaid Services (CMS) has not approved any state's request to waive actuarial soundness using 1135 authority, there are additional avenues for such waivers. CMS released the Healthy Adult Opportunity initiative on January 30, 2020, which would allow states to submit a Section 1115 waiver to implement a block grant or a per capita cap arrangement on particular Medicaid programs. In addition, this guidance encourages states to waive most Medicaid managed care regulations, including actuarial soundness requirements. While states would be expected to maintain actuarially sound rates, they could request a waiver of CMS' review to prove the soundness of rates. It also grants further flexibility for managed care regarding network adequacy, access to care and availability of services. The reduction in federal oversight presents a risk that states would cut payment rates, decrease network adequacy and access to services through this initiative.

In November 2019, Tennessee submitted a waiver amendment to TennCare II, which proposed to convert payments for its Medicaid program to a modified block grant. The amendment also seeks to waive "Federal approval… for actuarially certified capitation rates paid to managed care contractors," which would eliminate any requirement in Tennessee that MCOs rates be actuarially sound. A decision – still pending – by CMS to grant this waiver would impact plans' and providers' capacity to deliver coordinated, affordable, and timely access to quality services. In May 2017, Florida proposed amending its 1115 Managed Medical Assistance waiver to eliminate federal review and approval of certified Medicaid managed care rates. Ultimately, CMS did not approve Florida's actuarial soundness waiver.

Experts anticipate legal challenges to any future CMS approvals under the Healthy Adult Opportunity initiatives.

Conclusion

With mass layoffs brought about by the pandemic, millions of Americans will transition from private insurance coverage to chronically underfunded Medicaid programs. Accordingly, maintaining an actuarially sound rate-setting process is essential to maintaining stable Medicaid managed care programs. The requirement that Medicaid managed care plans receive actuarially-sound capitation rates is intended to ensure that plans can viably cover the needs of Medicaid enrollees and appropriately reimburse providers for their services. Without such assurances, providers' willingness and ability to participate in Medicaid may be seriously jeopardized, and therefore, so may be access to care. Ensuring that Medicaid managed care plan rates are actuarially sound is, therefore, an essential component of a strong, efficient, and effective Medicaid program.

Waiving actuarially sound rates will only place an onerous burden on our nation's safety net at a time where states should engage in fairly compensating their Medicaid health plans. During this epochal pandemic, it is more important than ever to protect health plans and providers' financial livelihoods through actuarially sound capitation rates.