NAVIGANT

MEMORANDUM

To: The Bureau of Medical Services (BMS) of West Virginia

From: Colby Schaeffer and Sterling Felsted

Date: May 31, 2019

Subject: Actuarial Response to AHIP's "Assessment of Report on Impacts of West Virginia Medicaid Prescription Drug Carve-Out" Prepared by The Menges Group, April 2019

The purpose of this actuarial memorandum is to provide BMS and other interested parties with a response to The Menges Group's "Assessment of Report on Impacts of West Virginia Medicaid Prescription Drug Carve-Out".

America's Health Insurance Plans (AHIP) engaged The Menges Group (Menges) to review and produce a counter-analysis to Navigant's "Pharmacy Savings Report" for the State of West Virginia Medicaid. As the authors of that actuarial study, we at Navigant appreciate the interest this report has generated and want to ensure the methodology and results are appropriately understood and utilized. Navigant's actuaries consider this especially important as the original report's findings run counter to the conventional stance that managed care arrangements can be expected to produce savings compared to Medicaid Fee-For-Service (FFS) arrangements. In general, we agree that managed care arrangements should be considered as potential cost saving alternatives to FFS, but stress that the impacts of doing so must be considered in light of the different dynamics and circumstances within each state and their Medicaid programs. Furthermore, experience under managed care arrangements should be monitored regularly to ensure that utilization controls are within appropriate levels.

We note that the scope of the original analysis was to ascertain the fiscal impact of the carve-out; Methodologies and assumptions were not modified to achieve any desired target or outcome. Impartiality is critically fundamental to actuarial engagements.

We reaffirm the findings of our original report produced on February 25, 2019 as well as the amended report dated April 2, 2019. As stated on page 5 of our amended report: "*we note that additional analysis could be performed to explain what caused this counterintuitive result, as managed care typically can be expected to result in lower costs than FFS arrangements.*"

We also note that we welcome additional analysis to help explain the findings. However, the Menges report, in its attempt to simultaneously review our report's methodologies and produce its own analysis, merely asserts that Navigant's report "*inaccurately estimated cost savings from West Virginia carving prescription drugs out of its Medicaid managed care program for several reasons.*"

It is not Navigant's intention to respond to or address any and all analyses put forward by the Menges Group, especially any outside of the original scope of the analysis. However, after reviewing the analysis and critiques put forward by the Menges Group, to preserve the integrity and dignity of the original results, Navigant has decided it would be appropriate to (a) address the critical assertions regarding our methodology, and (b) identify potential issues with the methodology the Menges report relies on to determine its own conclusions.

In addressing the assertions made in the Menges Assessment, it's important to note the following context around the report:

1. Menges was retained by AHIP to represent the interests of AHIP's member insurance companies.
2. In order to properly review our methodology, two things are required: data and expertise. To our knowledge, at no point has the Menges Group requested the data we relied on to determine our results. Without the appropriate data, the Menges Group is not in a position to evaluate the appropriateness of the findings.
3. Navigant's report clearly states that "expertise in pharmacy claim costs, actuarial science, and healthcare modeling is required to avoid misinterpretation of the data presented." Based on available public information, no credentialed actuaries assisted in their report. Therefore, the Menges report does not constitute an actuarial opinion.

Navigant's Responses to Critical Assertions from Menges' report

Below is a list of critical assertions made in the Menges report regarding Navigant's methodologies, along with our responses to each:

1. "*[Navigant's Pharmacy Savings Report] inaccurately estimated cost savings from West Virginia carving prescription drugs out of its Medicaid managed care program for several reasons. First, it estimated the change in pharmacy costs using a re-pricing methodology instead of looking at available data regarding the actual change in West Virginia's Medicaid pharmacy costs before and after the carve-out was implemented.*" (page 3)

This assertion is objectively false. While the primary finding presented in our report did rely on a repricing methodology for several reasons, the actuaries performed reasonability checks and sensitivity analysis on several of the model assumptions to ensure the results were reasonable and appropriate to the State's situation. The results of this are described in the "Observations & Considerations" section on pages 8-9 of our report. In contrast, the Menges report presents its own projection and methodologies as the only possible estimate without providing any valid rationale as to why our repricing methodology might be inappropriate or why theirs might be preferred.

2. *"Relying on this re-pricing approach – and only this approach – fails to assess actual 'before vs. after' costs in an accurate and comprehensive manner." (page 4)*

First, as stated above, the re-pricing approach was not the only methodology used. Secondly, the Menges report does not elaborate on why they believe re-pricing does not assess actual cost differences accurately. In fact, it is our contention that re-pricing offers the distinct advantage of controlling for the utilization differences between periods.

3. "*[Navigant's Pharmacy Savings Report] over-estimated the administrative cost savings that would arise by carving prescription drugs out of Medicaid managed care based on faulty tabulations and/or a misunderstanding of MCO administrative expenses.*" (page 3)

Navigant observes that the Menges report purports to estimate how much the MCOs **spend** on administrative costs for pharmacy benefits management activities based on MCOs' administrative cost reporting via financial statements, which we note is self-reported and thus can be subject to distortion.

However, aside from the self-reporting limitations, their report's authors miss the fact that the appropriate metric to determine the **State's** financial impact is rather what the MCOs actually

received from the State as administrative loads for the benefits. The Menges report's assertion therefore represents a misunderstanding of how actuarially determined capitation rates are developed in general, and for West Virginia in particular. MCOs receive administrative loads based on the build-up of the capitation rates, as detailed below. These capitation rates are based on decades of actuarial experience put into practice, then certified by qualified actuaries, and approved by the Centers for Medicare & Medicaid Services (CMS).

Navigant acknowledges that the actuarial certifications may not have been available to the Menges report authors, and therefore the authors might be missing information that would be necessary for them to produce a properly informed assessment. Included in West Virginia's Medicaid MCO rate certifications for the periods in question, the signing actuaries provided administrative expenses to the MCOs as a percentage of the final premium, meaning that a proportion of each capitation payment included provisions for administrative costs, including risk margin. Navigant notes that these percentages did not change from SFY17 to SFY18 so the MCOs did not receive a greater administrative load as a percentage of premium due to the carve-out. This in turn means that the administrative load as a percentage of premium is applicable to the pharmacy portion of the rates. Based on actual administrative cost data from the State, it was determined that the MCOs received administrative costs for pharmacy benefits amounting to 10.5% of pharmacy claims in SFY17, much larger than the '5%' of the '8.4%' of premium (5% x 8.4% = 0.42%) surmised by the Menges report.

4. "*[Navigant's Pharmacy Savings Report] estimated savings from carving out prescription drugs due to reduced Health Insurance Fund (HIF) allocations. We anticipate that the Health Insurance Fund is a mechanism fundamentally designed to draw down additional federal Medicaid matching funds to lower net state fund Medicaid costs, and that reductions in the HIF amounts will have a detrimental state fund impact.*" (pages 3-4), and
"*if [the $11m costs associated with the HIF] does disappear altogether, this presumably has significant damaging consequences in terms of West Virginians having diminished access to health insurance and health care. Simply reducing coverage, if that is what is presumed here, will of course yield savings."* (page 9)

Navigant observes that the Menges report authors stated that they have not researched the details of the HIF. Contrary to the Menges report authors' misunderstanding, the HIF does not provide any additional coverage to Medicaid recipients, nor does it result in additional federal funds to the State's program. Rather, it is an additional **expense**, prescribed by the federal government much like an additional tax, that State Medicaid programs must reimburse MCOs. While most of the HIF is covered by typical FMAP, a significant amount is still considered additional liability to the State. While there have been HIF moratoriums in recent years, during a non-moratorium year the HIF increases under a prescribed index rate and is spread across all for-profit health plans (including MCOs), and all services that those plans cover for State Medicaid programs. It is therefore appropriate to treat HIF-related costs as savings to the State.

5. "*[Navigant's] report does not consider the programmatic impacts of the carve-out policy."* (page 4)

This is correct. As stated in our original actuarial report, Navigant's scope of work for this report focused only on the fiscal impacts of this program change.

6. "M*odest movement in the generic percentage has significant cost implications. This finding demonstrates the need to take drug mix into account in assessing carve-out impacts (which the Pharmacy Savings Report's methodology did not do).*" (page 6)

Recognizing that Navigant did not specifically identify controls based on a simplistic Generics / Brand drug mix between the two periods, the actuaries instead more fully analyzed medication utilization and unit cost by therapeutic class. Re-pricing in this way accounts for price differentials between different drugs more completely than a simple Generic / Brand classification.

After careful review of the criticisms put forward by the Menges report, we find no valid reason to alter or revisit our assumptions, methodologies, or findings in any way.

Concerns Regarding the Methodology use in the Menges Report Calculations

Aside from the assertions made by the Menges Group regarding our methodologies, their report also included calculations of estimates of both claims and administrative costs. While the data cited in the Menges report is not available at this time, based on our understanding we advise caution against reliance on any of the figures presented as we believe there are significant issues with the methodologies used to develop them.

Regarding the estimation of SFY18 pharmacy claims under managed care, the Menges report presumes an arithmetically calculated deterministic result that gives a false sense of certainty and neglects to reflect the true complexities in West Virginia's pharmacy environment. In reality, projected claim costs can vary depending on the methodology and assumptions used. Per Actuarial Standards of Practice, multiple data points should be considered to improve credibility of analysis and ensure volatility is not unduly affecting claims experience or projections. Based on the multi-year analysis used to develop Navigant's report, SFY17 was a statistically low outlier for year-to-year managed care experience, thus necessitating a multi-year approach to avoid inaccuracy and bias caused by sole reliance on a potential statistical outlier. We note that our report applies various projection techniques to estimate that the SFY18 carve-out increased pharmacy claim costs anywhere from $2.5m to $51.6m.

However, while the Menges estimate of an $18m increase is within our stated range of possible financial impacts, we do not consider it credible. The derivation appears to be based on a high-level calculation by the Menges authors that unjustifiably attribute 100% of the increase in per prescription pharmacy cost trends above national averages to the carve-out. This technique is inadequately performed for the following reasons:

1. The use of CY2017 data in total to model additional claim costs as a result of West Virginia's carve-out is problematic as experience for half the year was under managed care arrangements and the other half FFS. There are material differences in utilization and costs between managed care and FFS, and thus sole reliance on that aggregate total in a simple arithmetically calculated data point introduces an inconsistency to their base that is not appropriate.
2. In comparing West Virginia against national trends, Navigant notes that the difference in FFS / managed care mix between West Virginia and national trends has not been recognized (the Menges report states that 67.9% of West Virginia's Medicaid prescription cost was under managed care arrangements, whereas the 'USA Total' figures imply a mix between 71.0% and 71.6% managed care). If the USA Totals were aggregated using this figure, the 'USA Total' comparative trend would be 4.3% instead of 4.1%, which would result in lower claim cost estimates as a result of West Virginia's carve-out.
3. While the comparison of West Virginia's per prescription trends to national trends is not wholly inappropriate, it is an oversimplification to assume that West Virginia's SFY17 to

SFY18 pharmacy trends would have matched the national averages had pharmacy benefits remained under managed care. No experienced health actuary would rely exclusively on a methodology that assumes every State's cost trends match national averages.

4. It is a further oversimplification to assume that the difference between the West Virginia and national per prescription trends is entirely attributable to the carve-out. The Menges report appears to indicate that any differences from the national trend are due solely to the policy change, while there may be other contributing factors that account for additional state versus national differences.
5. Estimating a state-wide cost impact inclusive of FFS by simply dividing out a percentage trend (in which the 8.5% is divided by 0.679) neglects to account for the impact of existing FFS experience. In other words, this assumes that West Virginia's existing FFS costs also matched the national average. No justification is provided for this assumption.
6. Navigant observes that the math presented in their final paragraph on the matter (the first paragraph on page 6) lacks sufficient clarity to determine the validity of their method for translating their assumed 12.5% on half a year of managed care organization (MCO)-paid expenses to an annualized figure.
7. While the Menges report's 'before vs. after' analysis could be a fair starting point to understand the impact of the carve-out, it is inadequate for controlling for the significant utilization and unit cost differences between SFY17 and SFY18. Re-pricing the SFY18 claims experience to control for the significant utilization differences between the two periods is a necessary step that the Menges report authors ignored. Re-pricing allowed Navigant to accurately control for the inconsistencies between periods and isolate the fiscal impact, which is why it was the primary result Navigant presented.

Additionally, the report does not make appropriate considerations for a complex pharmacy environment to control for the difference in utilization mix and therapeutic drug mix. One can observe that the Menges report fails to acknowledge how a Supplemental Security Income (SSI) population, which has a higher risk acuity and greater likelihood of specialty drug usage (therefore lower generic), was only included in the managed care program for the last six months of SFY17.

It is also unclear how the Menges report differentiates between managed care and FFS populations within each year.

Regarding the estimation of administrative costs, we believe our prior statements (under item 3 on pages 2-3 of this document) are sufficient to show that the focus on what the MCOs spend on administrative functions for the pharmacy benefits is inadequate for the purpose of establishing the financial impact to the State.

However, we also note that the Menges report does not present any justification to conclude that less than 5% of those administrative costs are attributable to pharmacy benefit management activities.

Additionally, the following Menges report statement is incorrect:

> *"A crude but reasonable annual net Medicaid administrative savings from the carve-out would be 2% of all MCO administrative costs, which is approximately $3 million annually in West Virginia. We would also assume that roughly a 2% profit margin is built into the capitation rates."*

Industry experts understand that spread pricing (differences in what the MCO or PBM reports as the cost and what the MCO pays the pharmacy) creates additional margin when working with both MCOs and PBMs. In other words, the pharmacy profit margin exceeded 2%.

Conclusion

After careful review, Navigant has determined the critical assertions made by the Menges report to be inadequate and unfounded. We find no reason to modify our report in any way.

Furthermore, we have several concerns of our own regarding the methodologies employed by the Menges Group to estimate both the claim, administrative, and HIF cost components of the financial impact of West Virginia's carve-out. We advise against the reliance of the figures, methodologies, and overall content of the Menges Report. While we do not intend to formally address any and all criticism of our work in the future, we remain available for the Menges Group and other interested parties for questions and clarifications to ensure our findings are used appropriately.

Actuarial Documentation

We, Sterling Felsted and Colby Schaeffer, are employed with the firm Navigant. We are members of the American Academy of Actuaries and Associates of the Society of Actuaries. We meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board. We have been contracted by Lewin to provide actuarial services to the State of West Virginia's Medicaid program and are generally familiar with the data, program, eligibility rules, and benefit provisions. We are qualified to provide and speak to actuarial analysis for this client in the capacity described in this document and are responsible for its contents.

We have relied upon data and information provided by BMS. We did not audit the data, but we reviewed the data for reasonableness and consistency in addition to financial record validation.