SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

CIVIL DIVISION

DISTRICT OF COLUMBIA,
Department of Insurance, Securities and Banking,

Petitioner,

v.

D.C. CHARTERED HEALTH PLAN, INC.,

Respondent.

Civil Action No. 2012-8227
Judge Melvin R. Wright
Next Event: Status Hearing
August 21, 2013 at 9:30 a.m.

SUPPLEMENT TO D.C. HEALTHCARE SYSTEMS, INC.'S MEMORANDUM IN OPPOSITION TO MOTION TO APPROVE SETTLEMENT AGREEMENT

DCHSI submits this supplemental opposition brief to address two matters that have come to DCHSI's attention since it filed its opposition brief ("Opp. Brief") on August 9, 2013.

I. The Towers Watson Report

On Tuesday, August 13, 2013, four days after DCHSI filed its opposition to the Rehabilitator's motion to approve the subject settlement agreement, the Rehabilitator provided DCHSI with a two-month-old consulting actuarial report prepared by Towers Watson Pennsylvania, Inc., dated June 11, 2013 ("TW Report") (Ex. A hereto). Just days before DCHSI's opposition brief was due, the Rehabilitator offered to produce the TW Report, but only subject to a range of unjustifiable limitations on its use. DCHSI did not accept those conditions because they were not legally supportable, and the Rehabilitator produced the report without limitation on August 13.

The TW Report is stark proof that the Rehabilitator's proposed settlement is unreasonable and should not be approved. The TW Report examines *only one* of numerous categories of the District's underpayments to Chartered and breaches of contract, and concludes that, *as to that one category alone relating to only twenty-two months out of a five-year contract*, the District owes Chartered over $51.4 million. *See* TW Report (Ex. A) at 5-10. The report also shows that

the District and its retained rate-setting actuary, Mercer, ignored significant information repeatedly provided by Chartered, as well as information in DHCF's possession, and engaged in a pattern of actuarially unsound and inadequate rate setting that caused the capital depletion that drove Chartered into rehabilitation. *See id*. at 29–32.

Based on the TW Report and Chartered's financial statements, DCHSI's own experts have prepared an analysis (attached at Exhibit B) showing that, even without information sufficient to calculate all categories of the District's underpayments, Chartered is entitled to retrospective rate adjustments *exceeding $82 million*. DCHSI submits the TW Report, and DCHSI's corresponding financial analysis, as critical, supplemental information relevant to the Rehabilitator's motion and DCHSI's Opposition. DCHSI will be prepared to explain further the details of the TW Report and its own expert's analysis in Court, including through expert testimony, when the merits of the settlement ultimately are addressed or in any subsequent briefing on the issue following discovery.[1]

As to the lone category of underpayment examined in the TW Report – addressing the same subject and time period at issue in the Retrospective Claim the Rehabilitator filed on February 22, 2013 for $51.2 million against the District (which claim Towers Watson has valued higher, at $51.45 million) – the TW Report examines the adequacy of the rates the District paid to Chartered by "construct[ing] a summary of revenue and benefits incurred by population and calendar month for the period of August 1, 2010 to April 30, 2012 ('Observation Period') using data files that were provided to [Towers Watson] by Chartered." TW Report at 3. The analysis starts after the District transferred the 774 Population to Medicaid, and examines the actuarial

[1] The scope of the scheduled August 21, 2013 status hearing remains uncertain. DCHSI has requested that the Court either reject the proposed settlement agreement based on its facial defects, or use the status hearing to set a schedule that would allow for focused discovery after which DCHSI's experts would have approximately 60 days to evaluate the discovery, then final post-discovery briefing and a final hearing on the proposed settlement. The Rehabilitator has requested that the status hearing serve as the final hearing on approval of the settlement with no further briefing and no time for focused discovery. Given this uncertainty, out of an abundance of caution, DCHSI submits its supplemental memorandum and its attachments.

soundness of the District's rates for the 774 Population, the 775 Population, and the pre-existing Medicaid population (termed the Legacy Population). Based on this analysis, and informed by the governing federal regulations as well as CMS and actuarial guidance (*see id.* at 3-4), Towers Watson made a number of important conclusions about the unsound rates set by DHCF and Mercer:

> 1. Chartered's losses began to emerge in early 2011 and accumulated to $51.5 million during the Observation Period.[2]
>
> 2. **Capitation rates** in place during the Observation Period for the 774 and 775 Populations ***were not actuarially sound***.
>
> 3. **Capitation rates** in place during the Observation Period for the Legacy Population ***were not actuarially sound***.
>
> 4. Key Contract requirements were not met [by the District].
>
> 5. **Applying actuarially sound capitation rates retroactively would reduce Chartered's losses by $47.2 million**.[3]

TW Report at 5 (emphases and footnotes added); *see also* TW Report at 9.

The TW Report provides abundant details that support the inescapable conclusions that (1) the District, by breaching its obligations under the DHCF Contract, engineered the very financial problems that the District then used to justify this rehabilitation proceeding and (2) the proposed settlement falls preposterously short of reasonable**.** *See, e.g.*, TW Report at 5-10 (detailing the actuarial unsoundness of the capitation rates paid by the District to Chartered and documenting one aspect of the large, cumulative losses to Chartered attributable to these inadequacies).

In addition to the single underpayment category that Towers Watson calculated, the District also underpaid Chartered in *seven other significant categories*:

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[2] Chartered's losses in fact began to escalate in 2010 due to the transfer of the 774 population and the impact of other actuarially unsound rates.

[3] That is, if the District had selected the "target level" recommended by Mercer, whose rates were the product of an improper analysis and the exclusion of important data, virtually the entire "loss" experienced by Chartered would have disappeared. *See* TW Report at 5.

1. Actuarially unsound rates under the Alliance program from July 2010 through July 2011. This is the subject matter and period at issue in the Rehabilitator's "Alliance Claim," in which the Rehabilitator showed that the District owes Chartered an additional $9,086,929 (plus interest). *See* Opp. Brief at 8.

2. Actuarially unsound rates for certain dental benefits that DHCF imposed on Chartered, but for which the District did not pay from January 2011 through November 2012. This is the subject matter and period at issue in the Rehabilitator's "Dental Crown Claim," in which the Rehabilitator showed that the District owes Chartered an additional $2.2 million (plus interest). *Id.*

3. Actuarially unsound rates for the Alliance program for the period August 2011 through December 2011 (subsequent to the period addressed in the Alliance Claim). The TW Report does not address such underpayments and the Rehabilitator has not asserted any right to recover them (but proposes to release them in the proposed settlement). *See* TW Report at 1-2. The Alliance program in particular requires comprehensive retrospective adjustments because, as described in the TW Report, Director Turnage of the DHCF admitted in an April 4, 2011 letter to the Mayor that Mr. Turnage's predecessors had directed Mercer, the District's rate-setting actuary, "to set the MCO [Managed Care Organization, e.g., Chartered] rates for the Alliance **below** the lowest level considered actuarially sound." TW Report at 31. Mr. Turnage further admitted that the goal was to use Medicaid funds (70% of which are paid by the federal government) "to offset predicted Alliance losses," but that this did not work and the MCOs such as Chartered consequently were injured in two ways. *Id*. First, because "members with higher health care costs" were transferred into the Medicaid program, "the expected margins on the Medicaid side have not materialized."[4] Second, "both MCOs have experienced substantial losses on their Alliance business." *Id.*

[4] These margins failed to materialize, of course, due to the increased costs imposed due to the 774 and 775 Populations, and because the District set unsound rates.

4. Actuarially unsound rates, not otherwise claimed, for the year ended December 31, 2012, both in the Alliance program (the full calendar year) and the Medicaid program (May 2012 through year end). The TW Report does not address such underpayments and the Rehabilitator has not asserted any right to recover them (but proposes to release them in the proposed settlement). *See* TW Report at 1-2. DCHSI does not possess the information necessary to calculate these amounts with precision, but notes that both the Rehabilitator and Towers Watson have stated that the District undoubtedly improperly set these rates too low. *See* TW Report at 34-35; Settlement Agreement at Recital K. As an estimate of the District's underpayments in this category, DCHSI's expert assumed a 4% underpayment rate, conservative when compared to the 8.2% underpayment rate for the prior period.[5]

5. Actuarially unsound rates for January 1, 2013 until the end of the contract period, April 30, 2013, for both the Alliance program and the Medicaid program. The TW Report does not address such underpayments and the Rehabilitator has not asserted any right to recover them (but proposes to release them in the proposed settlement). *See* TW Report at 1-2. Both the Rehabilitator and Towers Watson also have stated that rates undoubtedly were too low in this period (*see* TW Report at 34-35; Settlement Agreement at Recital K, and DCHSI's expert again applied a conservative 4% underpayment assumption for his calculations.

6. Actuarially unsound rates prior to the period addressed in the Rehabilitator's asserted Alliance Claim, i.e., from May 1, 2008 through June 2010 ("Early Alliance Retrospective Period"). The Rehabilitator has not asserted any right to recover these amounts (but proposes to release them in the proposed settlement). *See* TW Report at 1-2. Given the extent of the District's demonstrably and admittedly improper rate settings – and the particular admissions of Mr. Turnage concerning DHCF's intentional setting of actuarially unsound rates in this time period – it would be imprudent to release a claim for this period without investigation.

[5] The underpayment percentage was calculated by dividing Tower Watson's figure for the shortfall from an actuarially sound "target" payment ($47.2 million) by the total premium for the period ($574.8 million).

DCHSI's expert was unable to estimate any value for these claims, but will do so once the Rehabilitator makes the necessary information available.

7. Actuarially unsound rates for the Medicaid program prior to the period addressed in the Retrospective Claim and the TW Report, i.e., from May 1, 2008 through July 31, 2010 ("Early Medicaid Retrospective Period"). The TW Report does not address such underpayments and the Rehabilitator has not asserted any right to recover them (but proposes to release them in the proposed settlement). *See* Report at 1-2. Given the extent of the District's demonstrably and admittedly improper rate settings, it would be imprudent to release a claim for this period without investigation. DCHSI's expert was unable to estimate any value for these claims, but will do so once the Rehabilitator makes the necessary information available.

Even beyond these medical expense related payment deficiencies, it appears that the District has underpaid Chartered's administrative expenses, further contributing to Chartered's District-engineered losses. Before the District implemented the 2% premium tax, it had determined that the actuarially sound non-medical rate load was 13.5%, composed of 11.5% for administration and 2% for profit. During 2010, the District began to impose a 2% premium tax, which necessarily affected what would constitute an actuarially sound non-medical rate. As the TW Report makes clear, rates are actuarially sound only if the "projected premiums ... provide for all reasonable, appropriate and attainable costs, *including ... any state-mandated assessments and taxes*." (emphasis added) TW Report at 25 (quoting *Actuarial Certification of Rates for Medicaid Managed Care Programs*). After the imposition of the premium tax, however, the District did not adjust Chartered's non-medical rate load (and at the same time imposed a host of new, costly administrative burdens on Chartered and the other MCOs). Thus, the District's view of actuarially sound administrative rates is based on funny math: 11.5% + 2% = 11.5%.

DCHSI's expert, Drew Joyce, using the best data available to DCHSI without the benefit of discovery, has estimated what the impact of most of these categories would be on Chartered's financial statements as of year ends 2011 and 2012, and as of March 31, 2013, assuming the District had honored its obligation to pay retrospectively adjusted rates with respect to several –

but still not all – of the underpayment categories set forth above (Ex. B hereto). Mr. Joyce relied on the newly-produced TW Report and Chartered's financial statements. A full understanding of the extent of the additional underpayments is necessary due to the District's pattern of setting actuarially unsound rates and repeated breaches of contract, and the near certainty that the rates set for Alliance after July 2011 and for Medicaid after April 2012, also were unsound; in fact, both the Rehabilitator and Towers Watson have agreed that the rates in these more recent periods were unsound, but neither quantified the amount of the underpayment. *See* TW Report at 34-35; Settlement Agreement at Recital K.

In an attempt to estimate the value of underpayments for Alliance after July 2011 and for Medicaid after April 2012, Mr. Joyce first calculated that the District fell short of paying actuarially sound rates by 8.3% during the Observation Period (i.e., July 2010 through April 30, 2013). *See* footnote 5, above. For sake of analysis, Mr. Joyce used a conservative factor (4%) to estimate the extent to which the District fell short of paying actuarially sound rates to Chartered during the post-Observation Period as to Medicaid, and for periods after July 2011 (when the Rehabilitator's Alliance Claim cuts off) as to Alliance.

Although Mr. Joyce could not calculate the extent of the underpayments for the above periods with precision because he lacked access to information held by Chartered and/or the Rehabilitator, Mr. Joyce concludes that Chartered's total adjusted capital and surplus as of December 31, 2012 should have been $37.2 million, an amount that would have precluded Chartered's rehabilitation. He further concludes that Chartered's total adjusted capital and surplus as of March 31, 2013 should have been $22.3 million.[6] *See* Ex. B.

In short, the TW Report articulates an analysis of the District's misconduct that, when extrapolated to fewer than all categories of underpayment examined (as Mr. Joyce was

[6] The estimated capital as of March 31, 2013 (again, a partial estimate because some losses cannot yet be calculated) reflects an approximately $12 million reduction of assets due to Cardinal Bank having taken possession of certain collateral during the first quarter of 2013. Of course, that collateral was taken because of an event of default – Chartered's liquidation – that would not have occurred but for the District's misconduct.

constrained to do), demonstrates that Chartered was solvent and not a proper subject of rehabilitation. Indeed, DCHSI's analysis is conservative and necessarily incomplete, and evaluation of the comprehensive records is likely to show that, but for the District's underpayments, Chartered would have had well more than adequate capital. As such, the District, whether through negligence or willful bad faith, wrongfully engineered Chartered's liquidation when, had the District honored the DHCF Contract, Chartered would have been operating at a reasonable profit. In the face of these facts, which flow directly and necessarily from the report of the Rehabilitator's own expert and Chartered's audited financial statements, *the Rehabilitator's proposal to forgive over $30 million of the District's debt* – debt which is contractually-triggered and mathematically-certain under the DHCF Contract – is a blatant breach of duty and should not be countenanced.

Leaving tens of millions of dollars on the table, while asking providers and other creditors to suffer reduced recoveries, is wrong. And, this wrong is magnified when the Rehabilitator at the same time is suing DCHSI and its owner – and attempting in the process to collect millions in fees for himself and his professionals – for sums DCHSI could not conceivably owe if the District satisfied its contractual obligations, which would leave Chartered with surplus capital.

II. <u>The Final Rector Associates Report</u>

Attached as Exhibit 2 to DCHSI's opposition brief was a November 27, 2012 order of the DISB adopting the report of Rector Associates (attached thereto) as its own finding and order. Counsel to the Rehabilitator has brought to DCHSI's attention that DCHSI attached a draft of the Rector Report and not the final, signed version that DISB in fact adopted as its finding and order. DCHSI regrets its inadvertent error and, to correct the record, attaches as Exhibit C hereto the DISB Order with the correct, final version of the Rector Report. So that the record is clear, DCHSI notes that the only change between the initially-submitted draft and final version (Ex. C) was that limited language was added to one paragraph of the final report at page 4; no language was deleted. The changed paragraph in its final form reads (added language italicized):

> Based on our analysis, *we believe that the determination of whether the contract is a retrospectively rated contract in accordance with statutory accounting principles is a very close question. The relevant statutory accounting principles, as described herein, do not specifically address the relevant facts and Contract language, which is unclear with respect to the manner in which rate adjustments are made. Despite the lack of clarity in the relevant Contract language*, we believe the relevant language supports DC Chartered's position that the Contract is a retrospectively rated contract and that DC Chartered's claim for additional premium payments is an asset in accordance with SSAP No. 66. In other words, we believe that it is reasonable to interpret the Contract to expect that DC Chartered could receive premium adjustments based on DC Chartered's loss experience relating to the Contract, including loss experience resulting from changes to the terms of the Contract.

The final Rector Report maintains the all-important conclusion that (1) "the [DHCF] Contract is a retrospectively rated contract [and Chartered] should take into account its *entire* loss experience to determine its final policy premium, not just the loss experience resulting from the transfer of the 774 and 775 populations from the Alliance Program to [Medicaid]." Rector Report (Ex. C) at 4. As such, the non-material difference between the two versions has no impact on DCHSI's argument or the expert opinion of Drew Joyce.

III. Conclusion

The Rehabilitator's own expert report makes it unmistakably clear that the District improperly brought about what should have been an entirely unnecessary rehabilitation proceeding by deliberately underpaying Chartered in the amount of at least $82 million, and

likely quite more. The motion to approve the proposed settlement agreement should be rejected outright as facially inadequate to protect the interests of Chartered's creditors and its shareholder and residuary beneficiary. In the alternative, a schedule should be set to permit discovery, evaluation of the discovery, supplemental briefing and a hearing on the merits, including the presentation of evidence.

Dated: August 16, 2013

Respectfully submitted,

_____/s/_____

David Killalea (DC Bar 418724)
John Ray (DC Bar 214353)
Manatt, Phelps & Phillips, LLP
700 12th Street, NW, Suite 1100
Washington, DC 20005-4075
Tel. (202) 585-6500
Fax. (202) 585-6600

J. Jonathan Schraub
Sands Anderson PC
1497 Chain Bridge Road, Suite 202
McLean, VA 22101
(703) 893-3600

Counsel for DCHSI

CERTIFICATE OF SERVICE

I hereby certify that on this 16th day of August, 2013, a copy of the foregoing was filed and served by email upon:

Prashant K. Khetan, Esquire
Troutman Sanders, LLP
401 9th Street, NW, Suite 1000
Washington, D.C. 20004
prashant.khetan@troutmansanders.com

David Herzog
Faegre Baker Daniels LLP
300 N. Meridian Street, Suite 2700
Indianapolis, IN 46204-1750
David.Herzog@faegrebd.com

William P. White, Commissioner
c/o Stephanie Schmelz, Senior Counsel,
DISB, Office of the General Counsel
810 First St., NE, Suite 701
Washington, D.C. 20002
stephanie.schmelz@dc.gov

Daniel Watkins, Esquire
Special Deputy to the Rehabilitator
1050 K Street NW, Suite 400
Washington, D.C. 20001
danwatkins@sunflower.com

Charles T. Richardson, Esquire
Faegre Baker Daniels LLP
1050 K Street NW, Suite 400
Washington, D.C. 20001
crichardson@faegrebd.com

E. Louise R. Phillips
Stephane J. Latour
Assistant Attorney General
441 Fourth Street, N.W., 650N
Washington, D.C. 20001
louise.phillips@dc.gov
stephane.latour@dc.gov

Stacy Anderson
Assistant Attorney General
441 Fourth Street, N.W., 650N
Washington, D.C. 20001
stacy.anderson2@dc.gov

Donna Murasky
Deputy Solicitor General
441 Fourth Street, N.W.
Washington, D.C. 20001
donna.murasky@dc.gov

Courtesy Copies to:

Joseph D. Edmondson, Jr.
Foley & Lardner LLP
3000 K Street, NW, Suite 600
Washington, D.C. 20007
jedmondson@foley.com

_____/s/_____
Adam Riedel

EXHIBIT A

DC Chartered Health Plan

Review of Capitation Rate Adequacy

June 11, 2013

TOWERS WATSON

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Section 1: Background and Scope

This document has been prepared by Towers Watson Pennsylvania, Inc. ("Towers Watson" or "we") for D.C. Chartered Health Plan ("Chartered"), a Medicaid managed care organization ("MCO") involving reimbursements it received for its Medicaid and Alliance Programs. Our work has been performed in accordance with our engagement letter dated March 1, 2013.

The sole intended use of this document is to provide support for settlement discussions on behalf of Chartered with the District of Columbia (the "District") Department of Health Care Finance ("DHCF"). It is not suitable for any other purpose and may not be used for any other purpose or in any proceedings. This report and the information contained herein are provided to Chartered solely for the intended purpose, and may not be referenced or distributed to any other party, and distribution or disclosure to any other party is restricted by the limitations given in Section 6 of this document.

This report is considered a statement of actuarial opinion under the guidelines promulgated by the American Academy of Actuaries. The consulting actuary of Towers Watson who developed this report, Vincent L. Bodnar, is a member of the American Academy of Actuaries and meets the Qualifications Standards of the American Academy of Actuaries to render the opinion contained herein.

Towers Watson has performed the work assigned and has prepared this document in conformity with its intended utilization by a person(s) technically competent in the areas addressed and for the stated purposes only. Judgments as to the information contained in this report should be made only after studying the report (including appendices) in its entirety. The results presented in this report are based on data supplied to Towers Watson and are subject to the reliances and limitations set forth in Section 6.

DHCF contracted with Chartered to provide medical insurance coverage under Medicaid to individuals classified as temporary aid to needy families ("TANF") under the District of Columbia Healthy Families Program ("DCHFP") for a five-year period starting May 1, 2008. The contract required Chartered to provide coverage to enrollees in the program that are assigned to Chartered. Chartered is reimbursed by DHCF on a capitated rate basis plus direct "kick payments" (amounts paid to Chartered for each birth that occurs in the covered population). Capitation rates were set by DHCF, generally on an annual basis.

As allowed by the Patient Protection and Affordable Health Care Act ("ACA"), the District expanded Medicaid eligibility to include childless adults at or below 133% of the Federal poverty level, (the "774 Population") effective July 2010. The District further expanded eligibility to include childless adults at or below 200% of the Federal poverty level (the "775 Population") effective December 2010.

Mercer Government Human Services Consulting ("Mercer"), working on behalf of DHCF, developed the capitation rates for at least three rating periods (contract periods) for the contract. As required for Medicaid programs, Mercer developed certifications that rates were actuarially sound for each of the

contract periods ("Certifications"). Reed Smith has asked us to review the following three such Certifications:

1. 2010 Certification: Dated June 22, 2010. Establishes capitation rates for the contract period of July 1, 2010 through April 30, 2011.

2. 2011 Certification: Dated July 8, 2011. Establishes capitation rates for the contract period of August 1, 2011 through April 30, 2012.

3. 2012 Certification: Dated May 1, 2012. Establishes capitation rates for the contract period of May 1, 2012 through April 30, 2013.

We have been asked to review these three Certifications, as well as other documentation provided by Chartered. In particular, we have been asked to review how the Certifications considered available data and the experience of the three distinct populations covered by Charter. These are the 774 Population, the 775 Population and the remaining population ("Legacy Population").

Section 2 provides an Executive Summary of our analysis. Section 3 outlines the applicable requirements for developing actuarial certifications. Section 4 provides a summary of our review of key communications. In Section 5, we provide our conclusions regarding the Certifications. Our reliances and limitations are provided in Section 6. Appendices A and B provide additional detail on our analysis. The data we considered in our review is listed in Appendix C.

It is important to note that we have only had access to the certifications and the data books from Mercer. As of this date, we have not had discussions with Mercer to obtain additional insight into its approach and methodology; this report is therefore based on the documentation that has been made available to us.

Section 2: Executive Summary

Summary of Review Approach

Our review consisted of the following steps:

1. We constructed a summary of revenue and benefits incurred by population and calendar month for the period of August 1, 2010 to April 30, 2012 ("Observation Period") using data files that were provided to us by Chartered. Using this summary, we prepared a calculation of losses (benefits plus expense load less net revenue) that occurred during the Observation Period.

2. We reviewed and summarized the requirements that are applicable to Medicaid managed care rate certifications, as well as Actuarial Standards of Practice, which are applicable to all actuarial work products. The key items reviewed include:

    a. Federal regulation. *Code of Federal Regulations Title 42, Chapter V, § 438.6(c)* is entitled *Payments under risk contracts* (the "*Regulation*"). It provides the requirements for establishing capitation payments for Medicaid enrollees to MCOs that cover them.

    b. CMS Checklist. This is entitled *Appendix A. PAHP, PIHP and MCO Contracts, Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03* (the "*Checklist*"). It is published by the Centers for Medicare and Medicaid Services ("CMS") and provides detailed instructions to a CMS Regional Office ("RO") for determining if a set of proposed capitation rates meet the requirements of the *Regulation*.

    c. The Contract. DC Chartered Health Plan, Inc. entered into Contract No. DCHC-2008-D-5052 with the Government of the District of Columbia, Office of Contracting and Procurement on behalf of the Department of Health Medical Assistance Administration to provide healthcare services to its Medicaid eligible population enrolled in DCHFP and its DC Health Care Alliance program (the "Contract").

    d. Actuarial Standards of Practice ("ASOPs"). These are a series of standards that are binding on accredited actuaries who are members of the American Academy of Actuaries.

e. Health Practice Note 2005-1. This document is entitled *Actuarial Certification of Rates for Medicaid Managed Care Programs* (the "*Practice Note*"). It represents non-binding guidance to actuaries practicing in this area and was developed by the Medicaid Rate Certification Work Group of the American Academy of Actuaries (the "Working Group").

f. CMS Letter. This is a letter dated January 14, 2011 from the Chair of the Working Group to Camille Dobson, Technical Director, Division of State Demonstrations, Waiver, and Managed Care at CMS responding to questions from CMS on the rate-setting checklist (the "*CMS Letter*").

3. We reviewed the three Certifications described in the prior section and other communications pertaining to this matter that were provided to us by Chartered. A partial listing of the material reviewed is shown in Appendix C. We independently assessed the methods and data considerations as described in the Certifications.

4. We summarized our conclusions as stated in the remainder of this section of this document. Our conclusions were made upon consideration of the reviews that are described above and in more detail in the remainder of this document.

Conclusions

We have the following conclusions as a result of the review described above:

1. Chartered's losses began to emerge in early 2011 and accumulated to $51.5 million during the Observation Period.

2. Capitation rates in place during the Observation Period for the 774 and 775 Populations were not actuarially sound.

3. Capitation rates in place during the Observation Period for the Legacy Population were not actuarially sound.

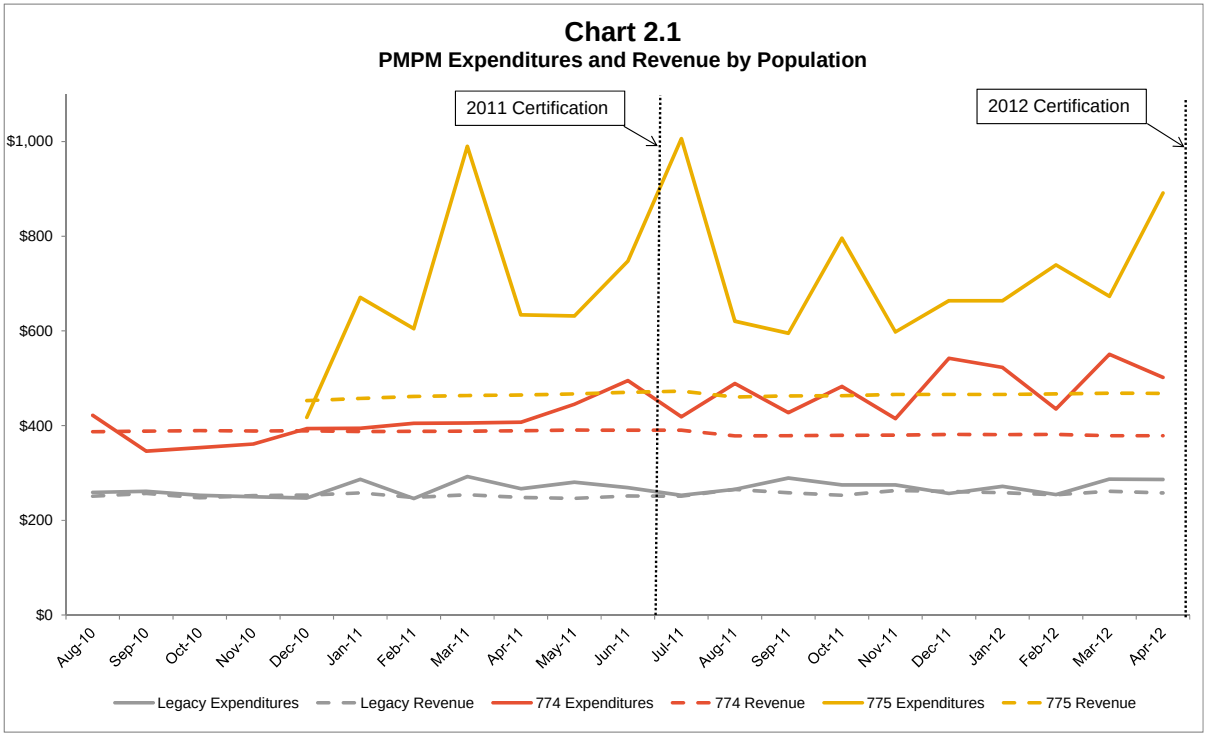
4. Key Contract requirements regarding rates and payments were not met.

5. Applying actuarially sound capitation rates retroactively would reduce Chartered's losses by $47.2 million.

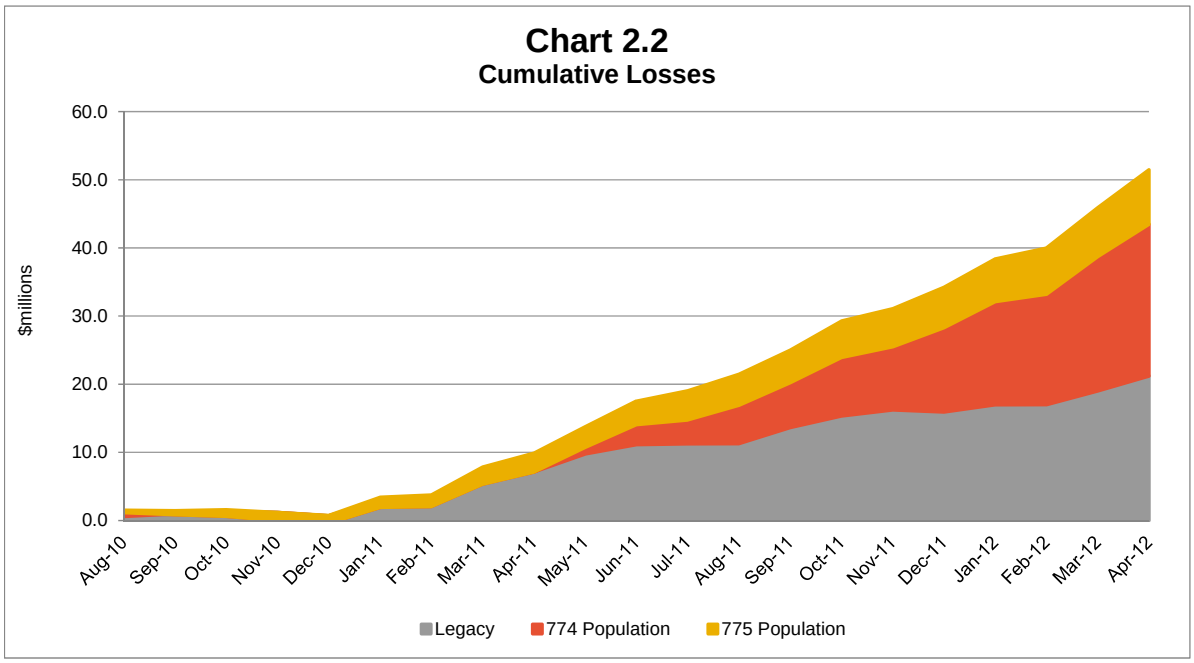
Each of our conclusions is discussed in more detail in the remainder of this section. The remainder of our report provides additional support.

1. Chartered's losses began to emerge in early 2011 and accumulated to $51.5 million during the Observation Period

a. Chartered's losses began to occur in January 2011 for the Legacy and 775 Populations and in May 2011 for the 774 Population. With few exceptions, monthly losses persisted throughout the remainder of the Observation Period for all three Populations. This pattern, which is illustrated on a per-member-per-month ("PMPM") basis in the following chart, demonstrates that there was a consistent inadequacy of capitation rates from early 2011. For the purposes of this analysis, expenditures are defined as the benefits incurred by the Populations, plus an administrative load of 13.4% (suggested by Mercer in the 2012 Certification).



b. Chartered incurred $51.5 million in losses from inadequate capitation rates during the Observation Period. The breakdown is $21.7, $21.8 and $8.0 million from the Legacy, 774 and 775 Populations, respectively. This breakdown of losses by category is illustrated in the following chart.



The calculations supporting the figures shown in the above two charts are provided in Appendix A.

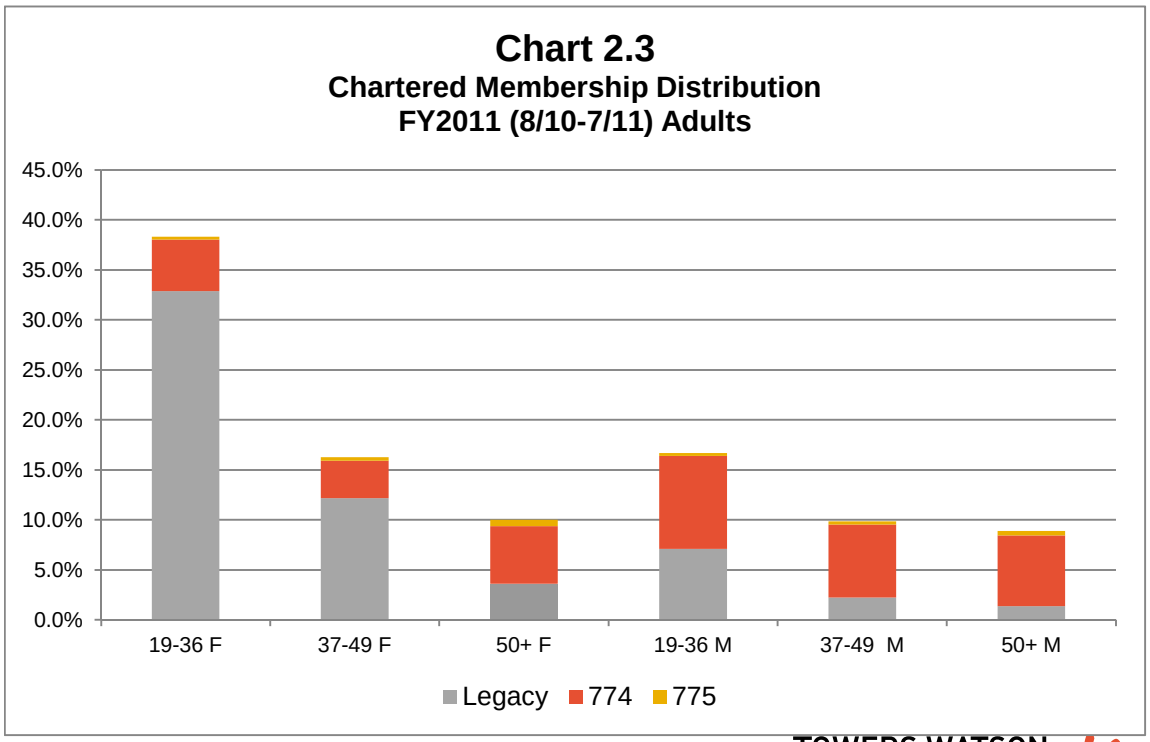
2. *Capitation rates in place during the Observation Period for the 774 and 775 Populations were not actuarially sound*

a. Chartered's losses arising from inadequate capitation rates for the 774 and the 775 Populations were 14.8% and 59.4% of revenue, respectively, during the Observation Period. The 774 and 775 losses were proportionally much greater than the 5.2% loss that arose from the Legacy Population. Notwithstanding requirements that it do so, the significantly higher average costs demonstrate that Mercer should have established separate capitation rate schedules for these two populations.

b. Applicable federal regulation and standard actuarial practices require the establishment of separate rates for the 774 and 775 Populations, unless justification is provided for not doing so. Mercer never suggested separate rates for the 774 Population and delayed such a suggestion for the 775 Population until the 2012 Certification.

c. We did not find evidence that Mercer attempted to obtain credible experience data for or separately review recent emerging experience data for either the 774 or 775 Populations prior to the 775 Population was separately rated in the 2012 Certification. We did not find evidence that Mercer considered several efforts made by Chartered to demonstrate such emerging experience. Mercer did not disclose the lack of data used to adequately rate the new Populations as is required when any such unresolved concerns could have a material effect on the actuarial work product.

The Populations have quite different profiles. Chart 2.3 shows the distribution of Chartered's Medicaid adult population by rate cell. The adults in the Legacy Population are primarily younger females. There are proportionately fewer adult males in each age grouping. The incoming 774 Population is primarily male and older. We do not see evidence that Mercer considered the differences in enrollment for these Populations.



d. The rate-setting process requires states to make "Special populations' adjustments" when there are changes in the population between the time of the data exposure period and the time for which the capitation rates are applicable. We do not see evidence that this was done. Item AA 3.3 of the CMS checklist states:

> *The State should use adjustments* [to historic base data]*...to develop rates for new populations....The State should document why they believe the rates are adequate for these particular new populations.*

e. The rate setting process requires that adjustments are to be made when there are anticipated changes in the general health of the population between the time of the data exposure period and the time for which the capitation rates are applicable. Item AA 3.12 of the CMS checklist states:

> *The State must document that utilization and cost assumptions are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk-sharing or other appropriate cost-neutral methods.*

We do not see evidence that Mercer performed this analysis or documented it as required, neither when the new populations were added nor when Chartered raised concerns about the higher costs for the new Populations, and in particular the 775 Population.

3. *Capitation rates in place during the Observation Period for the Legacy Population were not actuarially sound*

The DHCF imposed capitation rates that were below "target rates" during the Observation Period. In all three Certifications, Mercer recommends a range of capitation rates that surround a set of "target rates". Mercer explains that "the lower bound of the rate range represents a rate for a very efficient MCO." Mercer provides no guidance to the DHCF on how to determine if a particular MCO is efficient. The DHCF went on to impose rates that were between the lower bound and target rates during the first rating period and that were at the lower bound during the second rating period. Of the $21.7 million of losses arising from inadequate capitation rates for the Legacy Population, $17.4 million is attributable to the DHCF imposing rates below target rates (see Table 2.4 below). The calculations supporting the figures shown are provided in Appendix B.

Table 2.4

Legacy Population Revenue at Various Rate Levels ($ 000)

	Associated Revenue	Difference from Actual
August 1, 2010 – July 31, 2011		
Lower bound rates	223,073	-8,008
Target rates	236,466	5,385
Upper bound rates	248,279	17,198
Rates imposed by DHCF	231,081	
August 1, 2011 – April 30, 2012		
Lower bound rates	180,177	0
Target rates	192,180	12,003
Upper bound rates	198,710	18,532
Rates imposed by DHCF	180,177	
Total Observation Period		
Lower bound rates	403,250	-8,008
Target rates	428,646	17,388
Upper bound rates	446,988	35,731
Rates imposed by DHCF	411,258	

We believe that rates below the target rates for the Legacy population were not actuarially sound rates for Chartered for the following reasons, all of which, per established actuarial guidance, should be considered when setting rates:

- There was no negotiated bid process as capitation rates were imposed by the DHCF.
- The high degree of uncertainty of the incoming new Populations, due to the lack of data considered, means that a decreased margin in overall rates presented additional unanticipated financial risk to Chartered.
- Chartered's financial condition as a single-state, mono-line MCO reporting adverse experience on its DCHFP block should be considered in setting actuarially sound rates.

4. Key Contract requirements regarding rates and payments were not met

The Contract contains specific requirements regarding rates and payments.

a. Payments to Contractor [Chartered] are required to be actuarially sound in accordance with federal regulation (Section G.1.6). Based on our review, we do not believe the capitation rates were actuarially sound.

b. The Contract contains requirements for the annual review of the capitation rates, i.e., *...will take into account factors such as inflation, significant changes in the demographic characteristics of the member population, or the disproportionate enrollment selection of Contractor by members in certain rate cohorts* (Section B.3.2).

The influx of the 774 and 775 Populations represents both a significant change in the demographic characteristics and disproportionate enrollment which were not adequately taken into account in setting rates during the Observation Period.

c. Contract changes resulting in increased costs are subject to equitable adjustment ... *The Contracting Officer may... make changes in the contract within the general scope hereof. If such change causes an increase or decrease in the cost of performance of this contract, or in the time required for performance, an equitable adjustment shall be made.* (Section 15 of Amendment J.5).

The 774 and 775 Populations caused a significant increase in the cost of performance.

5. Applying actuarially sound capitation rates retroactively would reduce Chartered's losses by $47.2 million.

Applying actuarially sound rates retroactively would reduce Chartered's losses. Applying the target level recommended by Mercer for the Legacy Population would eliminate $17.4 million of the losses. Calculating and applying actuarially sound rates for the 774 and 775 Populations would eliminate $29.8 million of the losses.

Section 3: Requirements for Actuarial Rate Certifications

Introduction

This section presents excerpts from regulations, regulatory guidance and professional guidance documents that are relevant to our review. The elements that are presented here focus on the following areas of requirements and guidance:

- Basic parameters for the establishment of actuarially sound capitation rates;
- Establishment of rating cells;
- Data considerations; and
- Retroactive and interim capitation rate adjustments.

The key items presented here include:

- Federal regulation. *Code of Federal Regulations Title 42, Chapter V, § 438.6(c)* is entitled *Payments under risk contracts* (the "*Regulation*"). It provides the requirements for establishing capitation payments for Medicaid enrollees to MCOs that cover them.

- CMS Checklist. This is entitled *Appendix A. PAHP, PIHP and MCO Contracts, Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03* (the "*Checklist*"). It is published by the Centers for Medicare and Medicaid Services ("CMS") and provides detailed instructions to a CMS Regional Office ("RO") for determining if a set of proposed capitation rates meet the requirements of the *Regulation*.

- The Contract. DC Chartered Health Plan, Inc. entered into Contract No. DCHC-2008-D-5052 with the Government of the District of Columbia, Office of Contracting and Procurement on behalf of the Department of Health Medical Assistance Administration to provide healthcare services to its Medicaid eligible population enrolled in DCHFP and its DC Health Care Alliance program. It contains provisions related to the establishment of capitation rates, as well as adjustments to those rates.

- Actuarial Standards of Practice ("ASOPs"). These are a series of standards that are binding on accredited actuaries who are members of the American Academy of Actuaries.

- Health Practice Note 2005-1. This document is entitled *Actuarial Certification of Rates for Medicaid Managed Care Programs* (the "*Practice Note*"). It represents non-binding guidance

to actuaries practicing in this area and was developed by the Medicaid Rate Certification Work Group of the American Academy of Actuaries (the "Working Group").

- CMS letter. This is a letter dated January 14, 2011 from the Chair of the Working Group to Camille Dobson, Technical Director, Division of State Demonstrations, Waiver, and Managed Care at CMS responding to questions from CMS on the rate-setting checklist (the "CMS Letter").

- GAO Report. The United States Government Accountability Office ("GAO") Report to Congressional Committees—Medicaid Managed Care: CMS Oversight of States' Rate Setting Needs Improvement, dated August 4, 2010. This report provides commentary on the oversight provided by CMS, as well as recommendations.

The items are listed in the order of relative priority of compliance. Actuaries are required to comply with laws and regulations, then to follow the binding ASOPs. Although laws and regulations take precedence, if they compel an actuary to deviate from the ASOPs, the actuary is required to disclose the deviation. Finally, the *Practice Note* and the *CMS Letter* represent non-binding, but relevant, guidance.

Summary of Relevant Requirements and Standards

The following is a summary of our understanding of the requirements and standards relevant to our review:

With respect to establishing the appropriate level of capitation rates, an actuary that has been engaged by a state should consider the issues listed below.

- Capitation rates should be adequate. This means that the rates should:
    - cover "reasonable, appropriate and attainable" costs;
    - provide for appropriate administrative expenses and profit and risk margins;
    - consider the quality of the data;
    - consider the ability or inability of the participating MCOs to negotiate rates (contain more margin where the ability is constrained); and
    - consider the financial condition of the MCOs (single-state, mono-line MCOs require more margin to cover overhead costs).

- Capitation rates must be appropriate for the population to be covered, including new populations not previously covered.

- Capitation rates should be developed independent of state budget pressures.

- Capitation rate cells should vary by eligibility category. This is required by the Regulation. Actuarial standards confirm that risk classifications are prudent when they are related to expected outcomes, produce reasonable results and are consistent with usual and customary practices.

- Capitation rates should be adjusted, even retroactively, for programmatic changes. Programmatic changes include changes in eligibility requirements.

- Capitation rates can be adjusted for unforeseen differences in anticipated medical trend inflation.

- When capitation rates are changed, a new or amended rate certification is desirable when such a change is material.

- Source data used to calculate capitation rates are subject to the following requirements:

    - The data must come from the Medicaid population or be appropriately adjusted.

    - Where Medicaid population data is not available, other reliable data sources can be used. Acceptable alternative sources include data from other low-income health insurance programs.

    - The data must be recent and free from material omission. Recent data should be adjusted to consider incurred but not reported claims if applicable.

    - The actuary should consider all available data, including MCO financial reports and financial statements.

    - The data should be adjusted for differences between the population that comprise the historical data and the population to be covered.

    - The actuary has an obligation to review and judge the quality of the data used. If the data is inadequate or defective, he should obtain different data or decline to complete the assignment. The actuary's judgment about the data quality and its possible effects on his work product should be communicated along with his work product.

The following sub-sections of this report provide excerpts from the sources we reviewed that support our understanding of requirements and standards as summarized above.

Federal Regulation

The stated purpose of the Certifications prepared by Mercer is to demonstrate compliance with the *Regulation*. The primary purpose of the Regulation is to require that capitation rates proposed by the RO be actuarially sound. The term is defined in § 438.6(c)(1)(i) as follows:

> *Actuarially sound capitation rates means capitation rates that—*
>
> > *(A) Have been developed in accordance with generally accepted actuarial principles and practices;*
> >
> > *(B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and*
> >
> > *(C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.*

In addition, § 438.6(c)(2)(i) states that:

> *All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.*

Furthermore, the *Regulation* requires the following in § 438.6(c)(3):

> *Requirements for actuarially sound rates. In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:*
>
> > *(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.*
> >
> > *(ii) Adjustments made to smooth data and adjustments to account for factors such as medical trend inflation, incomplete data, MCO, PIHP, or PAHP administration (subject to the limits in paragraph (c)(4)(ii) of this section), and utilization;*
> >
> > *(iii) Rate cells specific to the enrolled population, by—*
> >
> > > *(A) Eligibility category;*
> > > *(B) Age;*
> > > *(C) Gender;*
> > > *(D) Locality/region; and*

(E) Risk adjustments based on diagnosis or health status (if used).

(iv) Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

CMS Checklist

According to the preamble of the *Checklist*, its stated purpose is as follows:

> *This checklist is a tool for [CMS Regional Offices ("ROs")] for use in approving rates under [the Regulation] for all capitated Medicaid managed care programs…excluding PACE capitated programs.*

The Checklist is divided into "Item Numbers". Items that contain elements that are relevant to one of the areas of focus are as follows:

- Item AA.1.0. Asks for an indication as to whether the proposed rates are new or if they represent an adjustment to existing rates:

  Rate Development or Update

  __ *The State is developing a new rate...*
  __ *The State is adjusting rates approved under [the Regulation]…*

- Item AA.1.1. Requires an actuarial certification that rates are actuarially sound. The definition of actuarially sound is identical to that described in the *Regulation*:

  Actuarial certification - The State must provide the actuarial certification of the capitation rates and payments under the contract. All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound. Actuarially sound capitation rates means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices, are appropriate for the populations to be covered, and the services to be furnished under the contract; and the Actuary must submit a certification, as meeting the requirements of the regulation, by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board.

- Item AA.1.7. Provides guidance on rate modifications:

  Rate Modifications - This section is for use if the State updates or amends rates set under the [Regulation]. The State has made program and rate changes that have affected the cost and utilization under the contract. The value and effect of these programmatic service changes on the rates should be documented. Adjustments for changes in the program structure or to reflect Medical trend inflation are made…The adjustments include but are not limited to:

  - *Medical cost and utilization trend inflation factors are based on historical medical State-specific costs or a national/regional medical market basket applicable to the state and population. Justification for the predictability of the inflation rates is given regardless of the source. Differentiation of trend rates is documented (i.e., differences in the trend by service categories, eligibility category, etc.). All trend factors and assumptions are explained and documented…*

  - *Programmatic changes include additions and deletions to the contractor's benefit package, changes in the eligible population, or other programmatic changes in the managed care program…made after the last set of rates were set and outlined in the regulation. The State may adjust for those changes if the adjustment is made only once (e.g., if the State projected the effect of a change in the last rate setting, then they must back out that projection before applying an adjustment for the actual policy effect)*

  CMS allows rate changes (regardless of whether they are reductions or augmentations) and provides [Federal Financial Participation ("FFP")] in such changes as long as the changes are implemented through either a formal contract amendment or a multi-period contract and continue to meet all applicable statute provisions and regulations. If rate changes are implemented through a contract amendment, the amendment must receive approval by the RO before FFP in any higher payment amounts may be awarded. If the rate change is an anticipated development in a multi-year process, it must also be reviewed by the RO, consistent with guidelines for multi-year contracts.

- Item AA.2.0. Describes data that are acceptable for rate setting:

  Base Year Utilization and Cost Data - The State must provide documentation and an assurance that all payment rates are:

  - *based only upon services covered under the State Plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration)*

- *Provided under the contract to Medicaid-eligible individuals.*

**In setting actuarially sound capitation rates, the State must apply the following element or explain why it is not applicable: Base utilization and cost data that are derived from the Medicaid population or if not, are adjusted to make them comparable to the Medicaid population. The base data used were recent and are free from material omission.*

Base data for both utilization and cost are defined and relevant to the Medicaid population (i.e., the database is appropriate for setting rates for the given Medicaid population). States without recent [Fee-for-service ("FFS")] history and no validated encounter data will need to develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the have the highest degree of reliability, subject to RO approval.

Examples of acceptable databases on which to base utilization assumptions are: Medicaid FFS databases, Medicaid managed care encounter data, State employees health insurance databases, and low-income health insurance program databases. Note: Some states have implemented financial reporting requirements of the health plans which can be used as a data source in conjunction with encounter data and would improve on some of the shortcomings of these other specific databases used for utilization purposes. For example, some states now require the submission of financial reports to supplement encounter data by providing cost data. It would also be permissible for the State to supplement the encounter data by using FFS cost data. The State could use the cost and utilization data from a Medicaid FFS database and would not need to supplement the data with plan financial information.

Note: The CMS RO may approve other sources not listed here based upon the reasonableness of the given data source. The overall intent of these reporting requirements is to collect the same information that is available in the encounter data, but in a more complete and accurate reflection of the true cost of services. Utilization data is appropriate to the Medicaid population and the base data was reviewed by the State for similarity with the covered Medicaid population. That is, if the utilization assumptions are not derived from recent Medicaid experience, the State should explain and document the source of assumptions and why the assumptions are appropriate to the Medicaid population covered by these proposed rates.

Service cost assumptions are appropriate for a Medicaid program and the base data was reviewed by the State for similarity with the Medicaid program's current costs…

The term "appropriate" means specific to the population for which the payment rate is intended. This requirement applies to individuals who have health care costs that are much higher than the average. Appropriate for the populations covered means that

the rates are based upon specific populations, by eligibility category, age, gender, locality, and other distinctions decided by the State. Appropriate to the services to be covered means that the rates must be based upon the State plan services to be provided under the contract…

- Item AA.3.0. Describes adjustments that are to be made to data for the purpose of rate setting:

  Adjustments to the Base Year Data - The State made adjustments to the base period to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are predictable for the covered Medicaid population.

  All regulatorily referenced adjustments are listed in 3.1 through 3.14….

  Note: The CMS RO must review all changes for appropriateness to the data selected by the State (e.g., if the State is using encounter data, then adjustments for FFS changes may not be appropriate). Some adjustments are mandatory. They are noted as such.

- Item AA.3.3. States that adjustments are to be made when there are changes in the population between the time of the data exposure period and the time for which the capitation rates are applicable:

  Special populations' adjustments - Specific health needs adjustments are made to make the populations more comparable. The State may make this adjustment only if the population has changed since the utilization data tape was produced (e.g., the FFS population has significantly more high-cost refugees) or the base population is different than the current Medicaid population (e.g., the State is using the State employees health insurance data). The State should use adjustments such as these to develop rates for new populations (e.g., SCHIP eligibles or 1115 expansion eligibles). The State should document why they believe the rates are adequate for these particular new populations.

- Item AA.3.12. States that adjustments are to be made when there are anticipated changes in the general health of the population between the time of the data exposure period and the time for which the capitation rates are applicable:

  Utilization and Cost Assumptions – The State must document that the utilization and cost data assumptions for a voluntary program were analyzed and adjusted to ensure that they are appropriate for the populations to be covered if a healthier or sicker population voluntarily chooses to enroll (compared to the population data on which the rates are set). The State must document that utilization and cost assumptions that are

appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk-sharing or other appropriate cost-neutral methods.

Note: this analysis is needed whenever the population enrolled in the managed care program is different than the data for which the rates were set…

- Item AA.3.14. States that adjustments are to be made when the data is recent to reflect the lag time between the date of service and date of payment:

  Incomplete Data Adjustment – The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the Actuary must calculate an estimate of the services ultimate value after all claims have been reported. Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. Documentation of assumptions and estimates is required for this adjustment.

- Items AA.4.0 – 4.4. Require the establishment of rate category groupings:

  Establish Rate Category Groupings (All portions of subsection AA.4 are mandatory) -- The State has created rate cells specific to the enrolled population. The rate category groupings were made to construct rates more predictable for future Medicaid populations' rate setting. The number of categories should relate to the contracting method. Rate cells need to be grouped together based upon predictability so entities do not have incentives to market and to enroll one group over another. Multiple rate cells should be used whenever the average costs of a group of beneficiaries greatly differ from another group and that group can be easily identified. Note: The State must document that similar cost categories are grouped together to improve predictability. For example, rate cells may be combined if there is an insufficient number of enrollees in any one category to have statistical validity.

  Age - Age Categories are defined. If not, justification for the predictability of the methodology used is given.

  Gender -Gender Categories are defined. If not, justification for the predictability of the methodology used is given

Locality/Region - Locality/region Categories are defined. If not, justification for the predictability of the methodology used is given

Eligibility Categories - Eligibility Categories are defined. If not, justification for the predictability of the methodology used is given.

The Contract

The Contract between the District and Chartered contains several sections related to establishing and updating capitation rates.

G.1 Payments

Section G.1.6 of the Contract also specifically required rates to adhere to § 438.6(c)(2)(i).

G.1.6 Actuarially Sound

In accordance with 42 C.F.R. §438.6(c)(2)(i), payments to Contractor must be actuarially sound.

B.3 Rate Adjustment

Section B.3 of the Contract provides the requirements for rate adjustments.

B.3.1 In the event that the District, pursuant to the Changes Clause of the Standard Contract Provisions, adds, deletes or changes any services to be covered by the Contractor under DCHFP or the Alliance Program, the District will review the effect of the change and equitably adjust the capitation rate (either upwards or downwards) if appropriate. In the event a capitation rate adjustment needs to be made prospectively, an actuarial calculation will be made by the District to determine the increase or decrease in the total cost of care from the instituted change. If required, the adjusted rate will be applied by the District. Contractor may request a review of the program with assumptions discussed with Contractor's change if it believes the program change is not equitable; the District will not unreasonably withhold such a review.

B.3.2 No later than twelve (12) months after the date of Contract Award and annually thereafter, the District will conduct an actuarial review of the capitation rates in effect to determine the actuarial soundness of the rates paid to the Contractors. The actuarial review will be based upon the rates offered by Contractor and will take into account factors such as inflation, significant changes in the demographic characteristics of the member population, or the disproportionate enrollment selection of Contractor by members in certain rate cohorts.

B.3.3 This actuarial review of the capitation rates may result in an annual adjustment, either increase or decrease, to the capitation rates. The District and Contractor shall negotiate the

actual amount of the adjustment; however, the negotiated adjustment shall be actuarially sound in accordance with 42 C.F.R §438.6(c).

B.3.4 The annual adjustment shall be effective as of the first day of the option period to which the adjusted capitation rate applies. If the District and Contractor have not completed negotiations for the adjusted capitation rate by the first day of the affected option period, Contractor shall continue to perform under the contract at the rates in effect for the preceding contract period. All negotiations shall be concluded by the end of the third month of the option period. If, by the end of the third month of the option period, the Contracting Officer and the Contractor fail to reach agreement, the Contracting Officer shall determine the annual adjustment and the Contractor shall perform the Contract with payment based on the annual adjustment determined by the Contracting Officer. Any dispute regarding the annual adjustment shall be subject to the Disputes Provision of the Standard Contract Clauses.

Changes Clause of the Standard Contracts Provision

The Standard Contracts Provision, which is Attachment J.5 of the Contract, contains the following clause.

15 Changes: The Contracting Officer may, at any time, by written order, and without notice to the surety, if any, make changes in the contract within the general scope hereof. If such change causes an increase or decrease in the cost of performance of this contract, or in the time required for performance, an equitable adjustment shall be made. Any claim for adjustment under this paragraph must be asserted within ten (10) days from the date the change is offered; provided, however, that the Contracting Officer, if he or she determines that the facts justify such action, may receive, consider and adjust any such claim asserted at any time prior to the date of final settlement of the contract. If the parties fail to agree upon the adjustment to be made, the dispute shall be determined as provided in the Disputes clause at Section 18. Nothing in this clause shall excuse the Contractor from proceeding with the contract as changed.

This clause gives the District the right to make changes to the Contract, such as expanding eligibility to include the 774 and 775 Populations. It also gives the Contractor, Chartered, the right to make a claim for an equitable adjustment.

Actuarial Standards of Practice

The ASOPs are binding on actuaries when providing actuarial advice and services. The following elements of the ASOPs cover the areas of focus of this review.

ASOP No. 23, Data Quality

This ASOP ("ASOP 23") gives guidance to actuaries in the areas of selecting, reviewing and using data that underlie an actuarial work product. It also gives guidance on placing reliance on data provided by others and in making disclosures about data quality.

ASOP 23, Section 3.7 provides guidance on the usage of data:

> *Use of Data – Because data that are completely accurate, appropriate, and comprehensive are frequently not available, the actuary should make a professional judgment about which of the following is applicable:*
>
> a. *the data are of sufficient quality to perform the analysis;*
>
> b. *the data require enhancement before the analysis can be performed, and it is practical to obtain additional or corrected data that will allow the analysis to be performed;*
>
> c. *judgmental adjustments or assumptions can be applied to the data that allow the actuary to perform the analysis. If the actuary judges that the use of the data, even with adjustments and assumptions applied, may cause the results to be highly uncertain or contain a material bias, the actuary may choose to complete the assignment, but should disclose the potential existence of the uncertainty or bias, and, if reasonably determinable, their nature and potential magnitude;*
>
> d. *if the actuary believes that the data are likely to contain material defects, the actuary should determine, if practical, the nature and extent of any checking, verification, or auditing that may have been performed on the data. Then, if, in the actuary's professional judgment, a more extensive review is needed, the actuary should arrange for such a review prior to completing the assignment; or*
>
> e. *if, in the actuary's professional judgment, the data are so inadequate that the data cannot be used to satisfy the purpose of the analysis, then the actuary should obtain different data or decline to complete the assignment.*

ASOP 23, Section 4.1 provides guidance on disclosures about the data used:

> *Communication and Disclosure – When issuing communications under this standard, the actuary should comply with ASOP No. 41. In addition, the actuary should disclose the following items:*
>
> a. *the source(s) of the data;*
>
> b. *whether the actuary reviewed the data and, if not, any resulting limitations on the use of the actuarial work product;*
>
> c. *the extent of the actuary's reliance on data and other information relevant to the use of data supplied by others;*
>
> d. *any material judgmental adjustments or assumptions that the actuary applied to the data, or are known by the actuary to have been applied to the data, to allow the actuary to perform the analysis;*

e. *any limitations on the use of the actuarial work product due to uncertainty about the quality of the data;*

f. *any unresolved concerns the actuary may have about the data that could have a material effect on the actuarial work product;*

g. *(1) the existence of results that are highly uncertain or have a potentially material bias of which the actuary is aware due to the quality of the data; and (2) the nature and potential magnitude of such uncertainty or bias, if they can be reasonably determined;*

h. *the disclosure in ASOP No. 41, section 4.2, if any material assumption or method was prescribed by applicable law (statutes, regulations, and other legally binding authority);*

i. *the disclosure in ASOP No. 41, section 4.3, if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and*

j. *the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.*

ASOP No. 12, Risk Classification

This ASOP ("ASOP 12") provides guidance to actuaries when performing professional services with respect to designing risk classification systems. Relevant sections are as follows:

- *3.2.1 Relationship of Risk Characteristics and Expected Outcomes — The actuary should select risk characteristics that are related to expected outcomes. A relationship between a risk characteristic and an expected outcome, such as cost, is demonstrated if it can be shown that the variation in actual or reasonably anticipated experience correlates to the risk characteristic. In demonstrating a relationship, the actuary may use relevant information from any reliable source, including statistical or other mathematical analysis of available data. The actuary may also use clinical experience and expert opinion.*

  Rates within a risk classification system would be considered equitable if differences in rates reflect material differences in expected cost for risk characteristics. In the context of rates, the word fair is often used in place of the word equitable….

  Sometimes it is appropriate for the actuary to make inferences without specific demonstration. For example, it might be necessary to demonstrate that persons with seriously impaired, uncorrected vision would represent higher risks as operators of motor vehicles.

- *3.2.2 Causality — While the actuary should select risk characteristics that are related to expected outcomes, it is not necessary for the actuary to establish a cause and effect relationship between the risk characteristic and the expected outcome in order to use a specific risk characteristic.*

- *3.2.3 Objectivity — The actuary should select risk characteristics that are capable of being objectively determined. A risk characteristic is objectively determinable if it is based on readily verifiable observable facts that cannot be easily manipulated…*

- *3.2.6 Industry Practices — When selecting risk characteristics, the actuary should consider usual and customary risk classification practices for the type of [insurance program] under consideration.*

- *3.3.4 Reasonableness of Results – When establishing risk classes, the actuary should consider the reasonableness of the results that proceed from the intended use of the risk classes (for example, the consistency of the patterns of rates, values, or factors among risk classes).*

Health Practice Note

As previously discussed, we acknowledge that a practice note is intended to provide nonbinding guidance to actuaries practicing in this field. Although it does not have the binding authority of an ASOP, it is helpful in providing insights into common industry practices.

The preamble of the *Practice Note* states:

> *The purpose of this practice note is to provide nonbinding guidance to the actuary when certifying rates or rate ranges as meeting the requirements of [the Regulation] for capitated Medicaid managed care programs.*

Page 7 and 8 describes issues that should be taken into consideration when a state establishes actuarially sound rates:

> *The above discussion of "actuarial soundness" involves knowledge concerning the health benefit plan's expected costs. An actuary working on behalf of a state Medicaid agency to form an opinion concerning the "actuarial soundness" of rates offered to MCOs would not normally have MCO-specific knowledge like that of the actuary working on behalf of the MCO. A workable assessment of "actuarial soundness" for certifications performed on behalf of state Medicaid agencies would usually take into account the following:*
>
> 1. *The data available to develop rates for populations with current coverage…*
>
> 2. *The types of rate negotiation methods that may be in use by states…*
>
> 3. *The financial condition and operations of participating MCOs:*
>
>   - *Some MCOs may be Medicaid-only and one-state-only, with no other lines of business or states over which to allocate certain administrative costs. In contrast, some MCOs may have other lines of business (Medicare Advantage, commercial group, and commercial individual) or other states' Medicaid business.*

The *Practice Note* proposed the following definition of Actuarial Soundness on pages 8 and 9:

> *Actuarial Soundness—Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital.*

The *Practice Note* defines a phrase used in the above definition on page 9 as follows:

> *The words "reasonable, appropriate, and attainable" clarify that the costs of the Medicaid benefit plan do not normally encompass the level of all possible costs that any MCO might incur, but only such costs as are reasonable, appropriate, and attainable for the Medicaid program. In addition, all expected costs directly related to the Medicaid benefit plan would normally be included.*

The following excerpt from pages 11 and 12 discusses rate adequacy as a component of actuarial soundness:

> *Rate adequacy is a component of "actuarial soundness." …*
>
> *Rate adequacy for Medicaid would normally mean that rates calculated and paid by a state Medicaid agency are likely to cover the costs of the program. The actuary working for the state may only have access to publicly available financial information about the health plans that contract with the state.*
>
> *It is generally difficult to set any specific administrative targets, either in percentage of capitation or amount per member per month (PMPM), without knowledge of the specific environment in each state – including such items as populations covered, services covered, medical costs, access to health care, and other factors.*
>
> *The same concept applies to profit/risk levels. It is generally difficult to specify a precise value, and this practice note makes no attempt to do so. However, there would usually be appropriate profit/risk margins included in the capitation rates.*

The *Practice Note* offers the following commentary on interplay between state budgets and requirements for actuarially sound rates on page 12:

> *In times of economic downturn, state budgets may exert pressure on rates that must be certified as "actuarially sound." This pressure can build as program expenditures are capped, yet "actuarially sound" rates are usually independently determined. In rate-setting, there is*

normally a range of reasonable assumptions. Budgetary constraints may influence the selection of certain assumptions toward the low end of the range. However, the actuary would usually be prudent to select assumptions that are individually reasonable and appropriate when deriving the final premium rates.

The following discussion on the actuarial soundness by rating cell is found on page 12:

Section 438.6(c)(2) requires "all payments" to be "actuarially sound." Pages 40998–40999 of the "Comments and Response" section specifically state that "all payments" refers to individual rate cells. CMS appears to be looking for the certification of "actuarial soundness" to apply to each individual rate cell.

CMS also specifies requirements concerning the establishment of rate cells. Section 438.6(c)(3)(iii) requires states to establish rate cells by eligibility category, age, gender, region and risk adjustment (or explain why any of these factors is not applicable). Section AA.4.0 of the checklist indicates that the key principle is that rate cells should be developed "whenever the average [which we interpret as "expected"] costs of a group of beneficiaries greatly differ from another group and that group can be easily identified."

CMS expects that rates will usually be developed for appropriate rate cells, taking into account the credibility of the data for each rate cell. Where sufficient data are unavailable to establish a rate for a particular cell, the rate would normally be developed based on blended data from that cell and an adjacent cell. Further, separate rate cells would usually be established only where there is a meaningful difference in expected per capita costs.

Page 15 includes the following statement about the *Checklist*:

The [Checklist] is a general document and probably does not cover every circumstance the actuary may encounter. Should the actuary think it appropriate to deviate from the guidance provided in the checklist, he or she would usually be prudent to describe and explain the deviation.

Page 16 references the *Checklist* and contains a discussion on data selection when typical sources are not available:

Section AA.2.0 — Base-Year Utilization and Cost Data. This section states, "States without recent FFS history and no validated encounter data will need to develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the highest degree of reliability, subject to RO approval."

Comment: The actuary should consider ASOP #23 (Data Quality) in the development of the base-year data. Generally, the actuary would consider all available data, including the Medicaid FFS data, Medicaid managed care encounter data, Medicaid managed care financial reports and Medicaid MCO financial statements. The actuary typically would compare data

sources for reasonableness and check for material differences when determining the preferred source(s) for the base-period data.

The checklist refers to several data sources CMS would consider appropriate. The actuary typically would consider these data sources as well as the most recent available data that, in the actuary's professional judgment, appear to be reliable and well-suited to the assignment. The checklist acknowledges that there are instances where the commonly used data sources are unavailable.

CMS Letter

Pages 6 and 7 of the CMS Letter contain the following discussion about retroactive rate adjustments. The questions from CMS are in bold. The Working Group's responses follow in non-bold:

When are retroactive rate increases appropriate/inappropriate?

If the state or actuary (working for a state or health plan) becomes aware of a significant omission or error in the original rate development due, for example, to missing data, miscalculation, or misinterpretation of the application of the contract between the state and the health plan, a retroactive rate adjustment should be considered. Federal or state mandated benefit or fee schedule changes that are determined to have bearing on the capitation rates are additional examples of situations to be considered for retroactive rate adjustments.

Should we require a new rate certification, if it is still within the [acceptable timeframe]?

A new or amended certification is likely desirable for documentation purposes, although it can be costly to the state. Thus some level of materiality of the change should be considered.

GAO Report

The GAO Report, which was issued in August 2010, noted several concerns regarding expanded Medicaid eligibility, data quality, actuarial soundness, and the ability of CMS to provide consistent oversight. It also noted that federal regulations do not provide standards regarding the type or age of data or for the reasonableness of rates. The GAO reviewed 28 CMS Medicaid managed care rate-setting files. DCHPF rates for the period May 2008 to April 2009, which Mercer certified, was one of the files reviewed.

The GAO Report noted that ACA would greatly expand eligibility for Medicaid perhaps by 18 million, making CMS oversight even more critical.

With the passage of the Patient Protection and Affordable Care Act (PPACA) in March 2010, states will expand coverage under the Medicaid program to an estimated 18 million additional people. Expansions of Medicaid are likely to increase the number of people enrolled in and

> *amount of spending for managed care, making effective federal oversight of this large and complex component of the Medicaid program particularly critical.* (Page 1).

It expressed concern about data quality generally, but especially with respect to the expanded eligibility to ***new populations which states may not have experience servicing and may have no data on which to base rates.***

> *However, CMS needs to ensure that all states' rate setting complies with all of the actuarial soundness requirements and needs to have safeguards in place to ensure that states' data quality efforts are sufficient. Improvements to CMS's oversight of states' rate setting will become increasingly important as coverage under Medicaid expands to new populations for which states may not have experience serving, and may have no data on which to base rates.* (page 19)

> *CMS also does not have sufficient efforts in place to ensure the quality of the data states used to set rates, relying on assurances from states without considering any other available information on the quality of the data used. By relying on assurances alone, the agency risks reimbursing states for rates that may be inflated or inadequate.* (page 19)

The GAO Report noted issues with the federal regulations themselves.

> *The (federal) regulations do not include standards for the type, amount, or age of the data that states may use in setting rates. The regulations also do not include standards for the reasonableness or adequacy of rates. In the preamble to the final rule, CMS noted that health plans were better able to determine the reasonableness and adequacy of rates when deciding whether to contract with the State.* (page 5)

It also noted issues with respect to the inconsistency in CMS oversight due to variations in practices by the various regional offices.

Section 4: Review of Key Communications

This section provides a brief overview of the history and contents of key communications related to the capitation rates that were in place during the Observation Period, as well as our comments. Our comments are based on our current understanding of events and based on the information that has been made available to us as of the date of this document.

Summary of Key Communications

- April 30, 2008: Start of five-year contract.

- May 25, 2010: Communication of potential issues. Chartered notifies the District via letter of concerns with regard to the proposed transfer of approximately 35,000 Alliance members to Medicaid retroactive to May 1, 2010. The concerns in the letter were among those initially raised in a meeting that preceded the letter.

  While the District ultimately decides not to make the transfer retroactive, it is important to note that the letter documents Chartered's concerns about increased pharmacy costs for the incoming population:

  > *Additionally, this program change will eliminate any potential assistance from the Patient Assistance Pharmacy Programs for these members, thus increasing pharmacy cost related to the requirement to provide expensive medically necessary specialty medications.*

- June 22, 2010: 2010 Certification. Mercer Actuarial Certification for Contract Period July 1, 2010 through April 30, 2011 is issued. We note the following:

  - Mercer primarily uses financial and encounter data from 8/1/08-7/31/09 (there is a 30% weighting to 8/1/07-7/31/08 for inpatient). This data does not include experience from the 774 or 775 Populations.

  - The Certification discusses an expansion in eligibility criteria that will take effect on July 1, 2010, to include the 774 Population. Mercer recommends a new age banding structure to the capitation rates to consider that the 774 Population is older than the Legacy Population on average.

  - There is no evidence that Mercer attempted to obtain experience data or consider that experience might be otherwise different for the 774 Population.

- There is no discussion about the 775 Population or the appropriateness of the capitation rates for this Population.

- Mercer states that the rates include a load for administration, profit/contingencies and assessments of approximately 13.5%.

- The rates are presented in the form of rate ranges that are +/-5% around what it describes as a "Target rate". This is disclosed as follows:

  Mercer developed actuarially sound rate ranges for the District to use in rate negotiations with the MCOs. Mercer specifically priced the upper and lower bound of the rate ranges by varying the assumptions outlined above. Mercer varied the trend assumptions and the financial data adjustments to account for different levels of managed care efficiency and potential risk selection. The resulting rate range was approximately +/- 5% around the Target rate. As a result, the lower bound of the rate range represents a rate for a very efficient MCO and the upper bound represents the least amount of efficiency the District is willing to purchase. The final contract rates will be selected by the District in contracting with the MCOs.

- July 1, 2010: First eligibility change. The 774 Population becomes eligible for the DC Healthy Families Program ("DCHFP") and begins to enroll with Chartered.

- August 4, 2010: GAO Report is issued. The GAO Report documents concerns about CMS oversight and the rate setting process.

- December 1, 2010: Second eligibility change. The 775 Population becomes eligible for the DCHFP and begins to enroll with Chartered. We were not provided with any evidence that Mercer reviewed its rate certification to ensure that the previously certified rates were appropriate for the 775 Population.

- February 9, 2011: First notification. Chartered notifies the District via letter that the 774 and 775 Populations were significantly more costly than the Legacy Population. We were not provided with any evidence that Mercer reviewed its rate certification to ensure that the previously certified rates were still appropriate for the 774 and 775 Population in response to this notification.

  The letter states, in part:

  The escalation in cost is driven in part by an extraordinary increase in the volume of HIV spectrum drugs… The $27.01 expense for these medications for the 774/5 groups is almost equal to the entire pharmacy cost of $27.10 for the legacy population, which includes HIV drugs.

- April 4, 2011: DHCF acknowledges issues. In Wayne Turnage's letter to the Mayor he acknowledges issues related to unstable MCO rates for both Medicaid and Alliance.

  *Previous agency leadership directed Mercer to set the MCO rates for the Alliance **below** the lowest level considered actuarially sound. The goal was to use higher rates on the Medicaid side to offset predicted Alliance losses. However, Medicaid expansion brought former Alliance members with higher health care costs into the Medicaid program and the expected margins on the Medicaid side have not materialized. Further both MCOs have experienced substantial losses on their Alliance business.*

- April 20, 2011: Mercer Data Book. Mercer issues the *DCHFP Data Book for Rates Effective July 1, 2011*. It is intended to be the basis for capitation rates for the following fiscal year. It does not include any data for the 774 or 775 Populations.

- June 2, 2011: Second notification. Chartered met with DHCF to discuss the emerging experience and increased costs of the 774 and 775 Populations. Chartered requested a follow up meeting with DHCF to develop a plan to address this issue. We were not provided with any evidence that Mercer reviewed its rate certification to ensure that the previously certified rates were still appropriate for the 774 and 775 Population in response to this notification.

- July 8, 2011: 2011 Certification. Mercer Actuarial Certification for Contract Period August 1, 2011 through April 30, 2012 is issued. We note the following:

  - Mercer primarily uses financial and encounter data from 8/1/09-7/31/10 (there is a 30% weighting to 8/1/08-7/31/09 for inpatient).

  - With respect to the 774 and 775 Populations, Mercer indicated that it reviewed data on these Populations for the period 7/1/10-12/31/10. We note that this would have included very little data on either Population (six months for the 774 Population and only one month for 775). Based on this review, Mercer believed that a reduction in the capitation rates was justified. This review was not provided to us.

  - Mercer states that the rates include a load for administration, profit/contingencies and assessments of approximately 13.5%.

  - Rates are presented in the form of rate ranges that are +/-6% around what it describes as a "Target rate". Disclosure language about this range is identical to that used in the 2010 Certification.

- September 30, 2011: Third notification. Chartered notifies the District via letter as a follow-up to a regular monthly meeting with Lisa Truitt, that in part:

  Chartered's experience with the 774 and 775 populations has continued to show that their pharmacy utilization will greatly exceed anything experienced by Chartered in the past and presents a serious, adverse financial exposure, and Chartered needs your assistance to help resolve this matter.

- May 1, 2012: 2012 Certification. Mercer Actuarial Certification for Contract Period May 1, 2012 through April 30, 2013 is issued. We note the following:

  - Mercer primarily uses financial and encounter data from 8/1/10-7/31/11 (there is a 30% weighting to 8/1/09-7/31/10 for inpatient).

  - Although data on the 774 and 775 Populations are considered for the 8/1/2010 to 7/31/2010 period, Mercer does not appear to include more recent, poorer experience on the 774 Population. In addition, the data from the 8/1/2009 to 7/31/2010 period for inpatient only includes at most one month of data for the 774 Population and none from the 775 Population.

  - Mercer creates a separate set of rate schedules with significantly higher rates for the 775 Population, but does not create a separate set of rates for the 774 Population.

  - Mercer states that the rates include a load for administration, profit/contingencies and assessments of approximately 13.4%.

  - Rates are presented in the form of rate ranges that are +/-5% for the Legacy and 774 Population and +/-4% for the 775 Population. Disclosure language about this range is similar to the prior two Certifications:

    Mercer developed actuarially sound rate ranges for the District to use in rate negotiations with the MCOs. Mercer specifically priced the upper and lower bound of the rate ranges by varying the assumptions outlined above. Mercer varied the trend assumptions and the financial data adjustments to account for different levels of managed care efficiency and potential risk selection. As a result, the lower bound of the rate range represents a rate for a very efficient MCO and the upper bound represents the least amount of efficiency the District is willing to purchase. The final contract rates will be selected by the District in contracting with the MCOs.

Section 5: Conclusions

Based on the information that has been provided to us to date, Towers Watson has a number of conclusions regarding Mercer's Certifications. We provide general conclusions that are applicable to all three Certifications and then additional conclusions that are specific to each of the three Certifications.

General Conclusions

We have the following general conclusions that are pertinent to all three Certifications:

- Appropriateness of data. As described in ASOP No. 23, Data Quality, actuaries are responsible for making a professional judgment regarding the quality of the data used and whether it is appropriate for its intended use in the analysis.

  We did not find evidence that Mercer attempted to obtain credible experience data for or separately review recent emerging experience data for either the 774 or 775 Populations until the 775 Population was separately rated in the 2012 Certification. We note that experience data specific to these Populations would have been available from the DHCF, which provided most coverage to them prior to their becoming eligible for Medicaid. (Pharmacy benefits, including treatments for HIV/AIDS, were provided under other programs.) Mercer could have obtained information on the demographics of the new populations from the District since the District maintained eligibility data.

  We note that recent emerging experience for these two Populations could have been extracted from more recent encounter or financial data or could have been requested from the MCO's directly.

  We note that none of Chartered's attempts to communicate concerns or adverse experience with the two Populations appear, nor the DHCF's own acknowledgement of such experience, seems to have been considered by Mercer.

  We expected additional disclosure from Mercer concerning the lack of data used to adequately rate the new populations. The actuary is required to disclose if there are any unresolved concerns related to the information that could have a material effect on the actuarial work product (ASOP No. 23). We did not see any such additional disclosure.

- Risk classification. The *Checklist* and the *Practice Note* discuss the need to establish separate rate schedules if there is a significant difference in expected costs.

We consider the 774 and 775 Populations to be new eligibility categories. We understand from the *Checklist* and the *Practice Note* that, if an eligibility category is not used as a factor in establishing rate schedules, the actuary is required to explain why. We did not find any such explanations. Furthermore, we were not provided with any evidence that Mercer re-assessed the appropriateness of its prior Certifications in reaction to multiple notifications that adverse experience was emerging for the two new Populations.

- Adequacy of capitation rates. A critical part of actuarial soundness is an expectation that capitation rates will be adequate. This expectation should consider several factors, such as the nature of the bid process, the degree of uncertainty in the program and the financial condition of the MCOs for which they are intended. In all three Certifications, Mercer recommends a range of capitation rates that surround a set of "target rates". Mercer explains that "the lower bound of the rate range represents a rate for a very efficient MCO." Mercer provides no guidance to the DHCF on how to determine if a particular MCO is efficient. The DHCF went on to impose rates that were between the lower bound and target rates during the first rating period and at the lower bound during the second rating period of the Observation Period.

We believe that rates below the target rates for the Legacy population were not actuarially sound rates for Chartered for the following reasons, all of which should be considered per established actuarial guidance, when setting rates:

- There was no negotiated bid process as capitation rates were imposed by the DHCF.
- The high degree of uncertainty of the incoming new Populations, due to lack of data considered, means that an decreased margin in overall rates presented additional unexpected financial risk to Chartered.

Additional Conclusions Specific to the 2010 Certification

- Appropriateness of rates for two new Populations. Actuarial rate certifications are made for the populations to be covered and the services to be furnished (emphasis added). The 2010 Certification mentions the incoming 774 Population. By not creating separate rate schedules for this Population, there is an implicit assumption that the 774 Population has the same risk profile as the Legacy Population. The Certification is silent with respect to the 775 Population.

  Mercer does not disclose that it does not have experience data specific to the new population, does not address whether the 774 Population should have a separate rate schedule, and does not disclose that it has any unresolved concerns related to the lack of information that could have a material effect on the actuarial work product (ASOP No. 23.).

  The rates covered by the 2010 Certification are later applied to the 775 Population when it becomes eligible in December 2010. This Population does not appear to have been contemplated in the 2010 Certification and thus the capitation rates would not have been

appropriate for them. Mercer should have provided additional documentation when eligibility was expanded to include the 775 Population if the rates were appropriate for them.

Additional Conclusions Specific to the 2011 Certification

- Consideration of emerging experience. Mercer reviews experience through December of 2010 that is specific to the 774 and 775 Population. This experience includes just the first month of exposure for the 775 Population and six months of exposure for the 774 Population. Mercer determines that rates need to be reduced as a result of including the new Populations. This analysis is not provided and is not described in any detail in the Certification.

  Between the time of the 2010 and 2011 Certifications, Chartered communicated to the DHCF on at least three occasions that experience for the new Populations was emerging adversely. Mercer does not mention this in the 2011 Certification and does not appear to consider this information.

Additional Conclusions Specific to the 2012 Certification

- Consideration of emerging experience. Mercer reviews experience through July 2011 and determines that there is a need for a separate rate schedule for the 775 Population. It does not determine that there is a similar need for the 774 Population.

  Between the time of the 2011 and 2012 Certifications, Chartered communicated to the DHCF on at least one occasion that experience for both of the new Populations continued to emerge adversely. Mercer does not mention this in the 2012 Certification and does not appear to consider this information.

Section 6: Reliances and Limitations

The usage, interpretation and distribution of this report and its content are subject to the reliances and limitations described below.

Reliances

In developing this report, Towers Watson relied on information provided by Chartered. We reviewed the information for reasonableness, but did not independently audit it. This information includes, but is not limited to, the information shown in Appendix C.

We relied on the following publicly available information:

- *Appendix A. PAHP, PIHP and MCO Contracts, Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03*, published by the Centers for Medicare and Medicaid Services
- *Actuarial Standard of Practice No. 12: Risk Classification (for All Practice Areas)*, published by the American Academy of Actuaries
- *Actuarial Standard of Practice No. 23: Data Quality*, published by the American Academy of Actuaries
- *Health Practice Note 2005-1: Actuarial Certification of Rates for Medicaid Managed Care Programs*, published by the American Academy of Actuaries
- Letter dated January 14, 2011 from the Chair of the Working Group to Camille Dobson, Technical Director, Division of State Demonstrations, Waiver, and Managed Care at CMS, published by the American Academy of Actuaries.
- The United States Government Accountability Office ("GAO") Report to Congressional Committees—*Medicaid Managed Care: CMS Oversight of States' Rate Setting Needs Improvement*, dated August 4, 2010.

Limitations

This report is subject to the following limitations:

- In accordance with a scope of work dated March 1, 2013, this report has been prepared for Chartered for its use in settlement discussions in the matter cited in the Scope section of this

report. It is not suitable for any other purpose and may not be used for any other purpose or in any proceedings.

- This report is not to be referenced or distributed to any other party without Towers Watson's prior written consent, except that copies of the report may be provided to those involved in settlement discussions in this matter for the limited purposes described above provided that:
    - the recipient agrees neither to reference nor distribute the report to any party other than those involved in the settlement discussions and to place no reliance on the report or information contained therein, or related thereto, that would result in the creation of any duty or liability by us to the recipient
    - Each recipient understands that such RECIPIENT IS DEEMED TO HAVE ACCEPTED THESE TERMS AND CONDITIONS by retaining a copy of this report.
- Towers Watson has performed the work assigned and has prepared this report in conformity with its intended utilization by a person(s) technically competent in the areas addressed and for the stated purposes only. Judgments as to the data contained in the report should be made only after studying the report (including appendices) in its entirety. Furthermore, members of the Towers Watson staff are available to explain and/or amplify any matters presented herein, and it is assumed that the user of this report will seek such explanation and/or amplification as to any matter in question.
- This report has been prepared as of May 31, 2013. No account has been taken of any changes beyond this date.
- Towers Watson is not providing legal advice.

Right to Amend

We reserve the right to amend or supplement the conclusions in this report if and when new data or information becomes available.

Appendix A: Calculation of Losses

This appendix describes how we prepared our calculation of losses in the graphs in Section 2. There are four sets of tables, with each set containing a separate table for each population. Version A is Legacy, version B is 774, version C is 775 and version D is the total.

The tables are organized as follows:

- A.1: Detailed Benefit Dollars and PMPM, Excluding Expense Provision
- A.2: Detailed Revenue Dollars and PMPM
- A.3: Summary of Benefits, Total Expenditures and Revenue
- A.4: Calculation of Monthly Loss and Cumulative Loss

Each set of tables is followed by a description of the development of the columns. Following the tables is a listing of the sources uses to develop each set of tables.

Table A.1

TABLE A.1-A
Benefits PMPM for the Legacy Population ($000's)

			Benefits Dollars									Benefits PMPM								
Year	Month	Enrollment	Medical	Rx	PCP	MH	Dental	Other	Reins	Adj	Total	Medical	Rx	PCP	MH	Dental	Other	Reins	Adj	Total
2010	Aug	74,119	11,456	1,715	1,278	486	1,330	0	0	349	16,615	154.57	23.14	17.24	6.56	17.95	0.00	0.00	4.70	224.16
	Sep	74,651	11,638	1,819	1,283	490	1,340	0	0	328	16,898	155.90	24.37	17.19	6.56	17.96	0.00	0.00	4.40	226.37
	Oct	75,846	11,452	1,809	637	496	1,360	0	0	841	16,597	151.00	23.85	8.40	6.55	17.94	0.00	0.00	11.09	218.82
	Nov	76,923	11,625	1,865	645	503	1,380	0	0	615	16,632	151.12	24.25	8.38	6.54	17.94	0.00	0.00	7.99	216.22
	Dec	76,959	11,607	1,929	566	502	1,380	0	0	494	16,478	150.81	25.06	7.35	6.52	17.93	0.00	0.00	6.42	214.11
2011	Jan	77,361	14,050	1,911	557	504	1,386	0	0	791	19,198	181.61	24.70	7.20	6.51	17.91	0.00	0.00	10.22	248.16
	Feb	77,314	11,512	1,887	568	504	1,385	0	0	615	16,471	148.90	24.41	7.35	6.52	17.91	0.00	0.00	7.95	213.03
	Mar	77,606	13,927	2,230	538	505	1,389	0	0	1,054	19,644	179.46	28.74	6.93	6.51	17.90	0.00	0.00	13.58	253.12
	Apr	77,626	12,526	2,083	553	505	1,389	0	0	876	17,933	161.37	26.84	7.12	6.50	17.90	0.00	0.00	11.29	231.02
	May	77,171	13,346	2,150	552	502	1,381	0	0	810	18,740	172.95	27.86	7.15	6.50	17.90	0.00	0.00	10.49	242.84
	Jun	76,814	12,544	1,993	596	499	1,375	0	0	883	17,889	163.31	25.94	7.75	6.49	17.90	0.00	0.00	11.50	232.89
	Jul	76,661	11,808	1,821	594	497	1,372	0	0	681	16,773	154.03	23.75	7.75	6.48	17.89	0.00	0.00	8.88	218.79
	Aug	76,722	12,751	2,060	596	536	1,306	455	-64	0	17,640	166.20	26.85	7.77	6.99	17.02	5.93	(0.83)	0.00	229.92
	Sep	76,579	14,266	2,074	604	535	1,303	454	-64	0	19,172	186.29	27.08	7.89	6.98	17.02	5.93	(0.83)	0.00	250.36
	Oct	76,893	13,212	2,241	606	537	1,309	456	-64	0	18,296	171.82	29.14	7.88	6.98	17.02	5.93	(0.83)	0.00	237.94
	Nov	77,280	13,319	2,196	610	540	1,315	458	-64	0	18,374	172.34	28.42	7.89	6.98	17.02	5.93	(0.83)	0.00	237.76
	Dec	77,136	12,172	2,124	611	538	1,313	457	-64	0	17,151	157.80	27.54	7.92	6.98	17.02	5.93	(0.83)	0.00	222.35
2012	Jan	77,244	12,967	2,368	613	539	1,314	446	-82	0	18,164	167.87	30.66	7.93	6.98	17.01	5.77	(1.07)	0.00	235.15
	Feb	77,431	11,949	2,258	615	540	1,318	447	-83	0	17,044	154.32	29.16	7.94	6.98	17.02	5.77	(1.07)	0.00	220.12
	Mar	78,269	14,150	2,443	622	546	1,332	452	-83	0	19,460	180.78	31.21	7.94	6.97	17.01	5.77	(1.07)	0.00	248.63
	Apr	78,070	14,058	2,422	620	545	1,330	451	-83	0	19,343	180.07	31.03	7.94	6.98	17.04	5.77	(1.07)	0.00	247.76

TABLE A.1-B
Benefits PMPM for the 774 Population ($000's)

			Benefits Dollars									Benefits PMPM								
Year	Month	Enrollment	Medical	Rx	PCP	MH	Dental	Other	Reins	Adj	Total	Medical	Rx	PCP	MH	Dental	Other	Reins	Adj	Total
2010	Aug	16,736	4,908	762	28	90	193	0	0	128	6,110	293.25	45.54	1.68	5.38	11.55	0.00	0.00	7.66	365.06
	Sep	16,335	3,705	787	29	88	189	0	0	95	4,893	226.83	48.20	1.77	5.37	11.56	0.00	0.00	5.82	299.53
	Oct	16,561	3,561	936	31	89	192	0	0	257	5,066	215.03	56.52	1.90	5.36	11.57	0.00	0.00	15.51	305.89
	Nov	16,936	3,738	1,040	35	91	196	0	0	196	5,295	220.69	61.42	2.07	5.36	11.57	0.00	0.00	11.55	312.66
	Dec	17,195	4,204	1,162	31	92	199	0	0	176	5,863	244.48	67.58	1.77	5.36	11.57	0.00	0.00	10.23	340.98
2011	Jan	17,755	4,295	1,189	30	95	205	0	0	250	6,064	241.89	66.99	1.70	5.35	11.56	0.00	0.00	14.07	341.55
	Feb	17,870	4,536	1,163	32	95	207	0	0	234	6,267	253.81	65.09	1.78	5.34	11.56	0.00	0.00	13.09	350.68
	Mar	18,375	4,317	1,446	33	98	213	0	0	346	6,452	234.92	78.70	1.79	5.34	11.57	0.00	0.00	18.83	351.15
	Apr	18,502	4,474	1,385	34	99	214	0	0	319	6,525	241.80	74.85	1.86	5.34	11.57	0.00	0.00	17.23	352.65
	May	18,499	5,105	1,368	37	99	214	0	0	308	7,131	275.97	73.97	1.99	5.33	11.59	0.00	0.00	16.66	385.50
	Jun	18,819	5,788	1,521	40	100	218	0	0	398	8,065	307.56	80.83	2.11	5.33	11.58	0.00	0.00	21.16	428.57
	Jul	18,993	4,806	1,436	42	101	220	0	0	280	6,884	253.03	75.62	2.19	5.33	11.58	0.00	0.00	14.72	362.46
	Aug	19,250	5,960	1,650	43	139	257	114	-16	0	8,147	309.59	85.69	2.26	7.21	13.37	5.93	(0.83)	0.00	423.21
	Sep	19,355	4,960	1,666	44	139	259	115	-16	0	7,167	256.27	86.06	2.28	7.20	13.38	5.93	(0.83)	0.00	370.28
	Oct	19,464	5,992	1,601	45	140	261	115	-16	0	8,137	307.83	82.26	2.31	7.18	13.39	5.93	(0.83)	0.00	418.07
	Nov	19,647	4,864	1,643	46	141	263	116	-16	0	7,056	247.56	83.61	2.32	7.18	13.40	5.93	(0.83)	0.00	359.16
	Dec	19,393	6,858	1,701	45	139	260	115	-16	0	9,102	353.62	87.73	2.33	7.16	13.41	5.93	(0.83)	0.00	469.36
2012	Jan	19,532	6,445	1,859	46	140	262	113	-21	0	8,843	329.95	95.18	2.33	7.17	13.41	5.77	(1.07)	0.00	452.75
	Feb	19,583	5,050	1,790	46	140	263	113	-21	0	7,381	257.88	91.40	2.34	7.17	13.42	5.77	(1.07)	0.00	376.92
	Mar	20,486	7,238	1,962	47	147	274	118	-22	0	9,766	353.33	95.78	2.31	7.17	13.39	5.77	(1.07)	0.00	476.69
	Apr	20,748	6,558	1,888	47	149	278	120	-22	0	9,017	316.07	90.98	2.28	7.17	13.39	5.77	(1.07)	0.00	434.59

TABLE A.1-C
Benefits PMPM for the 775 Population ($000's)

			Benefits Dollars									Benefits PMPM								
Year	Month	Enrollment	Medical	Rx	PCP	MH	Dental	Other	Reins	Adj	Total	Medical	Rx	PCP	MH	Dental	Other	Reins	Adj	Total
2010	Aug	113	260	55	0	0	2	0	0	13	330	2,303.28	485.64	2.18	4.32	18.61	0.00	0.00	110.75	2,924.78
	Sep	146	194	60	0	1	3	0	0	24	282	1,329.41	410.74	2.26	4.33	18.66	0.00	0.00	166.03	1,931.44
	Oct	175	280	75	0	1	3	0	0	17	376	1,598.17	427.09	2.01	4.39	18.74	0.00	0.00	95.62	2,146.01
	Nov	202	210	74	0	1	4	0	0	18	307	1,038.86	366.61	2.18	4.37	18.69	0.00	0.00	89.66	1,520.37
	Dec	1,527	370	140	2	7	29	0	0	4	552	242.51	91.96	1.43	4.31	18.77	0.00	0.00	2.43	361.41
2011	Jan	1,513	647	164	2	7	28	0	0	30	879	427.73	108.50	1.32	4.30	18.80	0.00	0.00	20.08	580.73
	Feb	1,511	518	206	2	6	28	0	0	29	791	343.15	136.45	1.57	4.30	18.84	0.00	0.00	19.46	523.76
	Mar	1,532	1,016	234	2	7	29	0	0	25	1,313	663.20	153.02	1.53	4.31	18.86	0.00	0.00	16.43	857.35
	Apr	1,536	537	240	2	7	29	0	0	28	843	349.60	156.02	1.50	4.30	18.88	0.00	0.00	18.48	548.78
	May	1,529	512	241	3	7	29	0	0	45	836	334.82	157.89	1.65	4.28	18.92	0.00	0.00	29.42	546.98
	Jun	1,549	675	255	3	7	29	0	0	34	1,003	435.75	164.82	1.80	4.26	18.99	0.00	0.00	21.74	647.37
	Jul	1,590	1,065	249	3	7	30	0	0	31	1,385	670.09	156.50	1.99	4.27	19.02	0.00	0.00	19.36	871.23
	Aug	1,635	572	262	3	7	26	10	-1	0	878	349.69	160.41	2.01	4.37	15.62	5.93	(0.83)	0.00	537.20
	Sep	1,685	545	277	4	7	26	10	-1	0	868	323.62	164.38	2.12	4.35	15.65	5.93	(0.83)	0.00	515.21
	Oct	1,711	814	318	3	7	27	10	-1	0	1,179	475.98	186.03	2.03	4.35	15.65	5.93	(0.83)	0.00	689.12
	Nov	1,743	516	339	4	8	27	10	-1	0	903	296.07	194.54	2.08	4.32	15.69	5.93	(0.83)	0.00	517.80
	Dec	1,755	578	384	4	8	28	10	-1	0	1,009	329.07	218.60	2.08	4.32	15.71	5.93	(0.83)	0.00	574.87
2012	Jan	1,795	668	315	4	8	28	10	-2	0	1,032	372.19	175.73	2.29	4.31	15.69	5.77	(1.07)	0.00	574.92
	Feb	1,824	849	270	4	8	29	11	-2	0	1,168	465.32	148.15	2.26	4.31	15.70	5.77	(1.07)	0.00	640.44
	Mar	1,910	719	342	4	8	30	11	-2	0	1,113	376.51	179.30	2.34	4.30	15.70	5.77	(1.07)	0.00	582.85
	Apr	1,944	1,129	320	4	8	31	11	-2	0	1,501	580.51	164.54	2.31	4.29	15.69	5.77	(1.07)	0.00	772.05

Development of Table A.1

The following describes the development of the columns in the above tables.

1. Enrollment: This column represents the monthly enrollment for the time periods underlying the retrospective premium claim calculated by Chartered. The source for this column is described in the "Sources for Table A.1" section later in this appendix.

2. Benefit Dollars, Medical through Reins: These columns represent the benefits paid by Chartered for the respective type of service, and come from, or are developed from, various sources as described in the "Sources for Table A.1" section later in this appendix.

3. Benefit Dollars – Adj: This column represents the adjustment to the detailed data necessary to tie to the total benefits underlying the retrospective premium claim calculated by Chartered, as described in more detail in the "Sources for Table A.1" section later in this appendix.

4. Benefit Dollars - Total: This column represents the total benefits paid by Chartered for the time periods underlying the retrospective premium claim, and is calculated as the sum of "Medical" through "Adj" columns.

5. Benefits PMPM: These columns represent the amounts, per member per month, and are calculated as respective "Dollars" divided by "Enrollment".

Table A.2

TABLE A.2-A
Development of Revenue PMPM for the Legacy Population ($000's)

			Estimated Revenue Dollars			Estimated Revenue PMPM		
Year	Month	Enrollment	Capitation	Kick Payment	Total Revenue	Capitation	Kick Payment	Total Revenue
2010	Aug	74,119	16,132	2,469	18,601	217.65	33.31	250.96
	Sep	74,651	16,236	2,909	19,145	217.49	38.97	256.46
	Oct	75,846	16,494	2,285	18,779	217.47	30.12	247.59
	Nov	76,923	16,715	2,673	19,388	217.29	34.75	252.04
	Dec	76,959	16,709	2,791	19,499	217.11	36.26	253.37
2011	Jan	77,361	16,801	3,146	19,947	217.18	40.66	257.84
	Feb	77,314	16,781	2,415	19,196	217.05	31.24	248.29
	Mar	77,606	16,851	2,867	19,718	217.14	36.95	254.08
	Apr	77,626	16,855	2,415	19,270	217.13	31.11	248.24
	May	77,171	16,746	2,267	19,013	216.99	29.38	246.37
	Jun	76,814	16,652	2,643	19,296	216.79	34.41	251.20
	Jul	76,661	16,602	2,626	19,229	216.56	34.26	250.83
	Aug	76,722	17,043	3,303	20,346	222.14	43.05	265.19
	Sep	76,579	16,999	2,781	19,780	221.98	36.31	258.29
	Oct	76,893	17,057	2,375	19,432	221.82	30.89	252.71
	Nov	77,280	17,151	3,168	20,319	221.93	41.00	262.93
	Dec	77,136	17,115	3,005	20,120	221.88	38.96	260.84
2012	Jan	77,244	17,143	2,785	19,928	221.94	36.05	257.99
	Feb	77,431	17,188	2,465	19,653	221.98	31.84	253.82
	Mar	78,269	17,399	3,060	20,458	222.29	39.09	261.39
	Apr	78,070	17,356	2,785	20,141	222.31	35.68	257.98

TABLE A.2-B
Development of Revenue PMPM for the 774 Population ($000's)

			Estimated Revenue Dollars			Estimated Revenue PMPM		
Year	Month	Enrollment	Capitation	Kick Payment	Total Revenue	Capitation	Kick Payment	Total Revenue
2010	Aug	16,736	6,480	0	6,480	387.17	0.00	387.17
	Sep	16,335	6,340	0	6,340	388.10	0.00	388.10
	Oct	16,561	6,452	0	6,452	389.58	0.00	389.58
	Nov	16,936	6,580	0	6,580	388.55	0.00	388.55
	Dec	17,195	6,692	0	6,692	389.19	0.00	389.19
2011	Jan	17,755	6,882	0	6,882	387.60	0.00	387.60
	Feb	17,870	6,931	0	6,931	387.87	0.00	387.87
	Mar	18,375	7,138	0	7,138	388.46	0.00	388.46
	Apr	18,502	7,197	0	7,197	389.00	0.00	389.00
	May	18,499	7,225	0	7,225	390.56	0.00	390.56
	Jun	18,819	7,343	0	7,343	390.20	0.00	390.20
	Jul	18,993	7,412	0	7,412	390.23	0.00	390.23
	Aug	19,250	7,281	0	7,281	378.22	0.00	378.22
	Sep	19,355	7,328	0	7,328	378.63	0.00	378.63
	Oct	19,464	7,382	0	7,382	379.28	0.00	379.28
	Nov	19,647	7,464	0	7,464	379.92	0.00	379.92
	Dec	19,393	7,394	0	7,394	381.28	0.00	381.28
2012	Jan	19,532	7,444	0	7,444	381.10	0.00	381.10
	Feb	19,583	7,468	0	7,468	381.37	0.00	381.37
	Mar	20,486	7,760	0	7,760	378.81	0.00	378.81
	Apr	20,748	7,858	0	7,858	378.75	0.00	378.75

Development of Table A.2

The following describes the development of the columns in the above tables.

1. Enrollment: This column comes from Table 3.1.

2. Revenue Dollars

    a. Cap and Kick Payment: These values represent the amount paid to Chartered for the time periods underlying the retrospective premium claim, and come from, or are developed from, various sources as described in the "Sources for Table A.2" section later in this appendix.

    b. Total Revenue: This column represents the total amount paid to Chartered for the time periods underlying the retrospective premium claim, and is calculated as the sum of the "Cap" and "Kick Payment" columns.

3. Estimated Revenue PMPM: These columns represent the amounts, per member per month, and are calculated as respective "Dollars" divided by "Enrollment".

Table A.3

TABLE A.3-A
Benefits, Expenditures and Revenue for the Legacy Population ($000's)

			Benefits		Expenditures		Total Revenue	
Year	Month	Enrollment	Total $	PMPM	Total $	PMPM	Total $	PMPM
2010	Aug	74,119	16,615	224.16	19,186	258.85	18,601	250.96
	Sep	74,651	16,898	226.37	19,513	261.39	19,145	256.46
	Oct	75,846	16,597	218.82	19,165	252.68	18,779	247.59
	Nov	76,923	16,632	216.22	19,206	249.68	19,388	252.04
	Dec	76,959	16,478	214.11	19,027	247.24	19,499	253.37
2011	Jan	77,361	19,198	248.16	22,169	286.56	19,947	257.84
	Feb	77,314	16,471	213.03	19,019	246.00	19,196	248.29
	Mar	77,606	19,644	253.12	22,683	292.29	19,718	254.08
	Apr	77,626	17,933	231.02	20,708	266.77	19,270	248.24
	May	77,171	18,740	242.84	21,640	280.42	19,013	246.37
	Jun	76,814	17,889	232.89	20,658	268.93	19,296	251.20
	Jul	76,661	16,773	218.79	19,368	252.64	19,229	250.83
	Aug	76,722	17,640	229.92	20,370	265.50	20,346	265.19
	Sep	76,579	19,172	250.36	22,139	289.10	19,780	258.29
	Oct	76,893	18,296	237.94	21,127	274.76	19,432	252.71
	Nov	77,280	18,374	237.76	21,217	274.55	20,319	262.93
	Dec	77,136	17,151	222.35	19,805	256.76	20,120	260.84
2012	Jan	77,244	18,164	235.15	20,974	271.53	19,928	257.99
	Feb	77,431	17,044	220.12	19,682	254.18	19,653	253.82
	Mar	78,269	19,460	248.63	22,471	287.10	20,458	261.39
	Apr	78,070	19,343	247.76	22,336	286.10	20,141	257.98

TABLE A.3-B
Benefits, Expenditures and Revenue for the 774 Population ($000's)

			Benefits		Expenditures		Total Revenue	
Year	Month	Enrollment	Total $	PMPM	Total $	PMPM	Total $	PMPM
2010	Aug	16,736	6,110	365.06	7,055	421.55	6,480	387.17
	Sep	16,335	4,893	299.53	5,650	345.88	6,340	388.10
	Oct	16,561	5,066	305.89	5,850	353.22	6,452	389.58
	Nov	16,936	5,295	312.66	6,115	361.04	6,580	388.55
	Dec	17,195	5,863	340.98	6,770	393.75	6,692	389.19
2011	Jan	17,755	6,064	341.55	7,003	394.40	6,882	387.60
	Feb	17,870	6,267	350.68	7,236	404.94	6,931	387.87
	Mar	18,375	6,452	351.15	7,451	405.49	7,138	388.46
	Apr	18,502	6,525	352.65	7,534	407.22	7,197	389.00
	May	18,499	7,131	385.50	8,235	445.15	7,225	390.56
	Jun	18,819	8,065	428.57	9,313	494.88	7,343	390.20
	Jul	18,993	6,884	362.46	7,949	418.55	7,412	390.23
	Aug	19,250	8,147	423.21	9,407	488.70	7,281	378.22
	Sep	19,355	7,167	370.28	8,276	427.58	7,328	378.63
	Oct	19,464	8,137	418.07	9,396	482.76	7,382	379.28
	Nov	19,647	7,056	359.16	8,148	414.73	7,464	379.92
	Dec	19,393	9,102	469.36	10,511	541.98	7,394	381.28
2012	Jan	19,532	8,843	452.75	10,211	522.81	7,444	381.10
	Feb	19,583	7,381	376.92	8,523	435.24	7,468	381.37
	Mar	20,486	9,766	476.69	11,277	550.45	7,760	378.81
	Apr	20,748	9,017	434.59	10,412	501.84	7,858	378.75

TABLE A.3-C
Benefits, Expenditures and Revenue for the 775 Population ($000's)

			Benefits		Expenditures		Total Revenue	
Year	Month	Enrollment	Total $	PMPM	Total $	PMPM	Total $	PMPM
2010	Aug	113	330	2,924.78	382	3,377.34	55	488.80
	Sep	146	282	1,931.44	326	2,230.30	69	469.76
	Oct	175	376	2,146.01	434	2,478.07	80	457.06
	Nov	202	307	1,520.37	355	1,755.62	92	453.89
	Dec	1,527	552	361.41	637	417.33	692	452.87
2011	Jan	1,513	879	580.73	1,015	670.59	692	457.34
	Feb	1,511	791	523.76	914	604.81	697	461.41
	Mar	1,532	1,313	857.35	1,517	990.01	710	463.36
	Apr	1,536	843	548.78	973	633.70	714	464.68
	May	1,529	836	546.98	966	631.61	714	467.02
	Jun	1,549	1,003	647.37	1,158	747.54	729	470.50
	Jul	1,590	1,385	871.23	1,600	1,006.04	751	472.60
	Aug	1,635	878	537.20	1,014	620.32	753	460.47
	Sep	1,685	868	515.21	1,002	594.93	780	462.69
	Oct	1,711	1,179	689.12	1,362	795.75	792	463.07
	Nov	1,743	903	517.80	1,042	597.92	812	465.68
	Dec	1,755	1,009	574.87	1,165	663.82	818	465.88
2012	Jan	1,795	1,032	574.92	1,192	663.88	836	465.77
	Feb	1,824	1,168	640.44	1,349	739.54	852	466.87
	Mar	1,910	1,113	582.85	1,286	673.04	895	468.39
	Apr	1,944	1,501	772.05	1,733	891.52	910	468.28

Development of Table A.3

1. Enrollment: This column comes from Table 3.1.

2. Benefits Dollars: This column comes from Table 3.1.

3. Benefits PMPM: This column comes from Table 3.1, but can also be calculated as “Benefit Dollars” divided by “Enrollment”.

4. Expenditure Dollars: This column represents the estimated cost to Chartered of providing the benefits, in terms of benefits paid plus a provision for expenses, and is calculated as “Benefit Dollars” divided by (1 minus 13.4%).

    a. The 13.4% accounts for administration, profit/contingencies and assessments, per Mercer's May 1, 2012 Actuarial Certification.

    b. It is consistent with DC Chartered's development of the retrospective premium claim amount.

    c. Note that the June 22, 2010 and July 8, 2011 Actuarial Certifications used approximately 13.5%.

5. Expenditures PMPM: This column represents the per member per month estimated cost to Chartered, and is calculated as “Expenditure Dollars” divided by “Enrollment”.

6. Total Revenue Dollars: This column comes from Table 3.2.

7. Total Revenue PMPM: This column comes from Table 3.2, but can also be calculated as “Total Revenue Dollars” divided by “Enrollment”.

Table A.4

TABLE A.4-A
Cumulative Losses by Month for the Legacy Population ($000's)

Year	Month	Enrollment	Expenditures	Total Revenue	Loss	Loss as % of Revenue	Cumulative Loss
2010	Aug	74,119	19,186	18,601	585	3.1%	585
	Sep	74,651	19,513	19,145	368	1.9%	953
	Oct	75,846	19,165	18,779	386	2.1%	1,339
	Nov	76,923	19,206	19,388	-182	-0.9%	1,157
	Dec	76,959	19,027	19,499	-472	-2.4%	685
2011	Jan	77,361	22,169	19,947	2,222	11.1%	2,908
	Feb	77,314	19,019	19,196	-177	-0.9%	2,730
	Mar	77,606	22,683	19,718	2,965	15.0%	5,695
	Apr	77,626	20,708	19,270	1,438	7.5%	7,133
	May	77,171	21,640	19,013	2,627	13.8%	9,760
	Jun	76,814	20,658	19,296	1,362	7.1%	11,122
	Jul	76,661	19,368	19,229	139	0.7%	11,261
	Aug	76,722	20,370	20,346	23	0.1%	11,285
	Sep	76,579	22,139	19,780	2,359	11.9%	13,644
	Oct	76,893	21,127	19,432	1,695	8.7%	15,339
	Nov	77,280	21,217	20,319	898	4.4%	16,237
	Dec	77,136	19,805	20,120	-315	-1.6%	15,922
2012	Jan	77,244	20,974	19,928	1,046	5.2%	16,968
	Feb	77,431	19,682	19,653	28	0.1%	16,996
	Mar	78,269	22,471	20,458	2,013	9.8%	19,009
	Apr	78,070	22,336	20,141	2,195	10.9%	21,204
Total		1,614,675	432,462	411,258	21,204	5.2%	

TABLE A.4-B
Cumulative Losses by Month for the 774 Population ($000's)

Year	Month	Enrollment	Expenditures	Total Revenue	Loss	Loss as % of Revenue	Cumulative Loss
2010	Aug	16,736	7,055	6,480	575	8.9%	575
	Sep	16,335	5,650	6,340	-690	-10.9%	-114
	Oct	16,561	5,850	6,452	-602	-9.3%	-717
	Nov	16,936	6,115	6,580	-466	-7.1%	-1,183
	Dec	17,195	6,770	6,692	78	1.2%	-1,104
2011	Jan	17,755	7,003	6,882	121	1.8%	-983
	Feb	17,870	7,236	6,931	305	4.4%	-678
	Mar	18,375	7,451	7,138	313	4.4%	-365
	Apr	18,502	7,534	7,197	337	4.7%	-28
	May	18,499	8,235	7,225	1,010	14.0%	981
	Jun	18,819	9,313	7,343	1,970	26.8%	2,952
	Jul	18,993	7,949	7,412	538	7.3%	3,489
	Aug	19,250	9,407	7,281	2,127	29.2%	5,616
	Sep	19,355	8,276	7,328	947	12.9%	6,563
	Oct	19,464	9,396	7,382	2,014	27.3%	8,578
	Nov	19,647	8,148	7,464	684	9.2%	9,262
	Dec	19,393	10,511	7,394	3,117	42.1%	12,378
2012	Jan	19,532	10,211	7,444	2,768	37.2%	15,146
	Feb	19,583	8,523	7,468	1,055	14.1%	16,201
	Mar	20,486	11,277	7,760	3,516	45.3%	19,717
	Apr	20,748	10,412	7,858	2,554	32.5%	22,271
Total		390,034	172,323	150,052	22,271	14.8%	

TABLE A.4-C
Cumulative Losses by Month for the 775 Population ($000's)

Year	Month	Enrollment	Expenditures	Total Revenue	Loss	Loss as % of Revenue	Cumulative Loss
2010	Aug	113	382	55	326	590.9%	326
	Sep	146	326	69	257	374.8%	583
	Oct	175	434	80	354	442.2%	937
	Nov	202	355	92	263	286.8%	1,200
	Dec	1,527	637	692	-54	-7.8%	1,146
2011	Jan	1,513	1,015	692	323	46.6%	1,468
	Feb	1,511	914	697	217	31.1%	1,685
	Mar	1,532	1,517	710	807	113.7%	2,492
	Apr	1,536	973	714	260	36.4%	2,752
	May	1,529	966	714	252	35.2%	3,003
	Jun	1,549	1,158	729	429	58.9%	3,432
	Jul	1,590	1,600	751	848	112.9%	4,281
	Aug	1,635	1,014	753	261	34.7%	4,542
	Sep	1,685	1,002	780	223	28.6%	4,765
	Oct	1,711	1,362	792	569	71.8%	5,334
	Nov	1,743	1,042	812	230	28.4%	5,564
	Dec	1,755	1,165	818	347	42.5%	5,912
2012	Jan	1,795	1,192	836	356	42.5%	6,267
	Feb	1,824	1,349	852	497	58.4%	6,765
	Mar	1,910	1,286	895	391	43.7%	7,156
	Apr	1,944	1,733	910	823	90.4%	7,978
Total		28,925	21,419	13,441	7,978	59.4%	

TABLE A.4-D
Cumulative Losses by Month for the Total Population ($000's)

Year	Month	Enrollment	Expenditures	Total Revenue	Loss	Loss as % of Revenue	Cumulative Loss
2010	Aug	90,968	26,622	25,136	1,486	5.9%	1,486
	Sep	91,132	25,489	25,553	-64	-0.3%	1,422
	Oct	92,582	25,448	25,311	138	0.5%	1,560
	Nov	94,061	25,675	26,060	-385	-1.5%	1,175
	Dec	95,681	26,435	26,883	-448	-1.7%	727
2011	Jan	96,629	30,186	27,520	2,665	9.7%	3,393
	Feb	96,695	27,169	26,825	344	1.3%	3,737
	Mar	97,513	31,651	27,566	4,084	14.8%	7,821
	Apr	97,664	29,216	27,181	2,035	7.5%	9,856
	May	97,199	30,841	26,952	3,889	14.4%	13,745
	Jun	97,182	31,129	27,368	3,761	13.7%	17,506
	Jul	97,244	28,917	27,392	1,525	5.6%	19,031
	Aug	97,607	30,791	28,380	2,411	8.5%	21,443
	Sep	97,619	31,417	27,888	3,529	12.7%	24,972
	Oct	98,068	31,885	27,606	4,279	15.5%	29,251
	Nov	98,670	30,407	28,595	1,813	6.3%	31,063
	Dec	98,284	31,481	28,332	3,149	11.1%	34,212
2012	Jan	98,571	32,377	28,208	4,169	14.8%	38,381
	Feb	98,838	29,554	27,973	1,581	5.7%	39,962
	Mar	100,665	35,033	29,113	5,920	20.3%	45,882
	Apr	100,762	34,481	28,909	5,572	19.3%	51,454
Total		2,033,634	626,204	574,751	51,454	9.0%	

Development of Table A.4

1. Enrollment: This column comes from Table A.1.

2. Expenditures: This column comes from Table A.3.

3. Total Revenue: This column comes from Table A.3.

4. Loss: This column is calculated as “Expenditures” minus “Total Revenue”.

5. Percent of Revenue: This column represents the monthly loss as a percent of revenue and is calculated as ‘Loss” divided by “Total Revenue”

6. Cumulative Loss: This column represents the cumulative loss over time and is calculated as the prior month’s cumulative loss plus the current month’s loss.

Note that Table A.4 includes a total, which is the sum of the three population tables.

Sources for Table A.1

The following describes the sources for the columns in Table A.1 other than those calculations already documented earlier in this appendix.

1. Enrollment: These values come from the "Grid" tab in the [Phcy Claim 11.16.12 Doug DCMC MED-Surg cost by Aidcode Segment-Run Nov 2012 (3).xlsx] file.

2. Benefit Dollars

    a. Medical: These values come from the "Grid" tab in the [Phcy Claim 11.16.12 Doug DCMC MED-Surg cost by Aidcode Segment-Run Nov 2012 (3).xlsx] file.

    b. Rx: These values come from the "Sheet 1" tab in the [Phcy Claim 11.12.12 Doug DCMC RX cost by Aidcode Segment-Run Nov 2012-July 2010 added.xlsx] file.

    c. PCP: These values come from the [Cap Pmts PCP 11 15 12 CAP WITH PHYSICIAN PAYMENTS JULY 2010 TO DECEMBER 2011 Revised 12.12.12.xlsx] file as follows.

        i. The "ALL DCMC MEM JUL10 TO DEC11" tab is the source of the time period 8/2010 – 12/2011.

        ii. The "Sheet2" tab is the source of the time period 1/2012 – 4/2012.

        iii. In order to split out the three populations, the field "aidcode" is used. Population 774 is assumed to be "aidcode" 774 and population 775 is assumed to be "aidcode" 775. All other "aidcode" values are assumed to be the Legacy population.

    d. MH: These values come from two sources, and are calculated as follows:

        i. The 774 and Legacy populations are combined in one file, [DCHFP Legacy-Final Reports Template_12042012 Filed 12.07.12.xls]. The tabs are "Report #1 - Expenses-FY11" and "Report #1 - Expenses-FY12".

            1. The "Inpatient Hospital - Mental Health", "Outpatient Hospital - Mental Health" and "Physician - Mental Health" rows are added together to calculate total mental health cost.

            2. The cost is split into the 774 and Legacy populations and allocated by month using monthly enrollment by rate cohort.

ii. The 775 population is from the file [DCHFP 775- Final Reports Template_12042012 Filed 12.07.12.xls]. The tabs are “Report #1 - Expenses-FY11” and “Report #1 - Expenses-FY12”.

1. The “Inpatient Hospital - Mental Health”, “Outpatient Hospital - Mental Health” and “Physician - Mental Health” rows are added together to calculate total mental health cost.

2. The cost is allocated by month using monthly enrollment by rate cohort.

e. Dental: These values come from two sources, and are calculated as follows:

i. The 774 and Legacy populations are combined in one file, [DCHFP Legacy-Final Reports Template_12042012 Filed 12.07.12.xls]. The tabs are “Report #1 - Expenses-FY11” and “Report #1 - Expenses-FY12”.

1. The cost is split into the 774 and Legacy populations and allocated by month using monthly enrollment by rate cohort.

ii. The 775 population is from the “Report #1 - Expenses-FY11” and “Report #1 - Expenses-FY12” tabs in the [DCHFP 775- Final Reports Template_12042012 Filed 12.07.12.xls] file.

1. The cost is allocated by month using monthly enrollment by rate cohort.

f. Other: The values in this column come from the “Summation” tab in the [Phcy Claim Through 04.30.12 Updated 12.11.12.xlsx] file.

i. The average PMPM from the 8/1/11 – 12/31/11 time period is assumed for every month in that time period. The PMPM is multiplied by that month’s enrollment to calculate the dollars.

ii. The average PMPM from the 1/1/12 – 4/30/12 time period is assumed for every month in that time period. The PMPM is multiplied by that month’s enrollment to calculate the dollars.

g. Reins: The values in this column come from the “Summation” tab in the [Phcy Claim Through 04.30.12 Updated 12.11.12.xlsx] file.

i. The average PMPM from the 8/1/11 – 12/31/11 time period is assumed for every month in that time period. The PMPM is multiplied by that month's enrollment to calculate the dollars.

ii. The average PMPM from the 1/1/12 – 4/30/12 time period is assumed for every month in that time period. The PMPM is multiplied by that month's enrollment to calculate the dollars.

h. Adj: These values are backed into by taking the total by month from the lag tables (described below) and subtracting out the sum of the "Medical" through "Dental" columns. This is done because of a disconnect between the two data sources prior to August 2011, and is approximately 2-5% per month.

(i) The lag table files are [DCHFP Legacy- Final Reports Template_12042012 Filed 12.07.12.xls] for the Legacy and 774 population combined, and [DCHFP 775- Final Reports Template_12042012 Filed 12.07.12.xls] for the 775 population.

(ii) In each of these files, there are six different lag triangles by type of service. They are found on tabs "Report #4 - Lags Inpatient", "Report #4 - Lags Outpatient", "Report #4 - Lags Mental Health", "Report #4 - Lags Physician", "Report #4 - Lags Pharmacy" and "Report #4 - Lags Other".

(iii) The sum of the "Medical" through "Dental" columns is used to allocate the adjustment between the 774 and Legacy populations.

Sources for Table A.2

The following describes the sources for the columns in Table A.3 other than those calculations already documented earlier in this appendix.

1. Revenue Dollars

a. Cap: This column represents the gross capitated revenue paid to Chartered for the time periods underlying the retrospective premium claim, and comes from file [Phcy Claim Through 04.30.12 Updated 12.11.12.xlsx].

i. The "Gross Cap Revenue" PMPM for each rate cohort is assumed for every month in that time period. E.g.: For all members in the Female 19-36 rate cohort, the gross cap revenue is $266.27 for each month in the time period 8/1/11 – 12/31/11

ii. The PMPM is multiplied by that month's enrollment to calculate the dollars. This is done at the rate cohort level.

b. Kick Payment: This column represents additional revenue in the form of birth "kick" payments paid to Chartered for the time periods underlying the retrospective premium claim. The source of this revenue is the file [Birth Receipts 7 1 10 - 04 30 12 Edget 12.06.12.xlsx]. The tab name is "Sheet1".

i. The "NewBorn" payments are included as revenue in the <1 Male & Female rate cohort for the Legacy population.

ii. The "NewMother" payments are included as revenue in the Female 19-36 rate cohort for the Legacy population.

Appendix B: Rate Comparisons for Legacy Population

Table B.1 compares Chartered's actual capitation rates versus the rates Mercer provided in the Certifications for the Legacy Population. We compare the associated revenue under each rate set and show the difference from Chartered's actual rates for three time periods are shown:

- August 1, 2010 through July 31, 2011
- August 1, 2011 through April 30, 2012
- August 1, 2010 through April 30, 2012 (Total)

We do not have comparable data for later time periods.

TABLE B.1
Comparison of Actual Revenue (PMPM) to Actuarial Certification Rates (PMPM)—Legacy Population

August 1, 2010 Through July 31, 2011

		7/1/10 - 4/30/11 Contract Period				Chartered Rates as Percent of:		
Age/Sex Cell	Enrollment	Bottom of Range	Target	Top of Range	Chartered Rates*	Bottom of Range	Target	Top of Range
< 1 Year, Male and Female	41,353	304.18	326.53	348.79	305.43	100.4%	93.5%	87.6%
1 - 12 Years, Male and Female	391,671	134.87	143.42	150.75	135.43	100.4%	94.4%	89.8%
13-18 Years, Female	83,328	164.90	174.54	182.46	165.58	100.4%	94.9%	90.7%
13-18 Years, Male	73,232	146.27	154.41	161.32	146.87	100.4%	95.1%	91.0%
19 - 36 Years, Female	182,389	266.04	279.90	292.03	281.04	105.6%	100.4%	96.2%
19 - 36 Years, Male	39,419	146.27	157.27	167.69	161.38	110.3%	102.6%	96.2%
37 - 49 Years, Female	67,630	415.85	435.93	453.86	436.77	105.0%	100.2%	96.2%
37 - 49 Years, Male	12,373	268.38	281.08	292.45	281.44	104.9%	100.1%	96.2%
50+ Years, Female	19,992	610.53	685.33	736.83	709.09	116.1%	103.5%	96.2%
50+ Years, Male	7,664	508.78	571.11	614.03	590.90	116.1%	103.5%	96.2%
Infant Month of Birth	2,526	4,285.43	4,455.14	4,667.53	4,302.99	100.4%	96.6%	92.2%
Mother's Month of Delivery	2,468	8,328.04	8,669.25	9,068.03	8,362.17	100.4%	96.5%	92.2%
Total	919,051	242.72	257.29	270.15	251.43	103.6%	97.7%	93.1%
Associated Revenue		223,072,648	236,465,625	248,278,707	231,080,513			
Difference from Actual		(8,007,865)	5,385,113	17,198,194	-			

August 1, 2011 Through April 30, 2012

		8/1/11 - 4/30/12 Contract Period				Chartered Rates as Percent of:		
Age/Sex Cell	Enrollment	Bottom of Range	Target	Top of Range	Chartered Rates*	Bottom of Range	Target	Top of Range
< 1 Year, Male and Female	31,857	298.32	317.58	329.04	298.32	100.0%	93.9%	90.7%
1 - 12 Years, Male and Female	299,372	145.17	154.97	160.10	145.17	100.0%	93.7%	90.7%
13-18 Years, Female	61,710	180.21	192.23	199.09	180.21	100.0%	93.7%	90.5%
13-18 Years, Male	53,826	154.78	164.14	170.13	154.78	100.0%	94.3%	91.0%
19 - 36 Years, Female	139,105	266.27	285.58	294.80	266.27	100.0%	93.2%	90.3%
19 - 36 Years, Male	30,013	170.47	181.41	187.91	170.47	100.0%	94.0%	90.7%
37 - 49 Years, Female	49,619	477.94	512.15	529.07	477.94	100.0%	93.3%	90.3%
37 - 49 Years, Male	9,565	295.31	314.81	325.69	295.31	100.0%	93.8%	90.7%
50+ Years, Female	14,666	716.84	771.02	796.82	716.84	100.0%	93.0%	90.0%
50+ Years, Male	5,891	479.70	511.65	527.59	479.70	100.0%	93.8%	90.9%
Infant Month of Birth	1,963	4,598.05	4,797.21	4,980.20	4,598.05	100.0%	95.8%	92.3%
Mother's Month of Delivery	1,873	8,916.90	9,417.54	9,754.00	8,916.90	100.0%	94.7%	91.4%
Total	695,624	259.02	276.27	285.66	259.02	100.0%	93.8%	90.7%
Associated Revenue		180,177,124	192,180,016	198,709,561	180,177,124			
Difference from Actual		-	12,002,891	18,532,437	-			

Total: August 1, 2010 Through April 30, 2012

		Weighted Average			Weighted Average	Chartered Rates as Percent of:		
Age/Sex Cell	Enrollment	Bottom of Range	Target	Top of Range	Chartered Rates*	Bottom of Range	Target	Top of Range
< 1 Year, Male and Female	73,210	301.63	322.64	340.20	302.34	100.2%	93.7%	88.9%
1 - 12 Years, Male and Female	691,043	139.33	148.42	154.80	139.65	100.2%	94.1%	90.2%
13-18 Years, Female	145,038	171.41	182.07	189.54	171.80	100.2%	94.4%	90.6%
13-18 Years, Male	127,058	149.88	158.53	165.05	150.22	100.2%	94.8%	91.0%
19 - 36 Years, Female	321,494	266.14	282.36	293.23	274.65	103.2%	97.3%	93.7%
19 - 36 Years, Male	69,432	156.73	167.70	176.43	165.31	105.5%	98.6%	93.7%
37 - 49 Years, Female	117,249	442.13	468.19	485.69	454.19	102.7%	97.0%	93.5%
37 - 49 Years, Male	21,938	280.12	295.79	306.94	287.49	102.6%	97.2%	93.7%
50+ Years, Female	34,658	655.52	721.59	762.22	712.37	108.7%	98.7%	93.5%
50+ Years, Male	13,555	496.14	545.27	576.46	542.57	109.4%	99.5%	94.1%
Infant Month of Birth	4,489	4,422.14	4,604.72	4,804.26	4,432.02	100.2%	96.2%	92.3%
Mother's Month of Delivery	4,341	8,582.11	8,992.11	9,364.00	8,601.52	100.2%	95.7%	91.9%
Total	1,614,675	249.74	265.47	276.83	254.70	102.0%	95.9%	92.0%
Associated Revenue		403,249,772	428,645,641	446,988,268	411,257,637			
Difference from Actual		(8,007,865)	17,388,004	35,730,631	-			

Appendix C: Data Sources

Towers Watson relied on electronic versions of the following documents that were provided by Chartered at the direction of Reed Smith. We have presumed that these documents have not been corrupted in any way.

Data Sources
Contract No. DCHC-2008-D-5052, Sections B, G.1, J.5
1-11-13-Chartered-Court-Package.pdf
10-19-12 Chartered Rehab Petition and Order - Signed.pdf
AAA Letter.pdf
DC Chartered Limited Scope Exam.PDF
DCCHP Claim to CO.pdf
Draft updated Claim w attach 012813.pdf
Mercer 2010-6-22.pdf
Mercer Actuarial Certification Letter_070811.pdf
Mercer _ActuarialRates_05_11_12.pdf
Millenium Pharmacy Claim Retrospective Adjustment_Final.pdf
Pharmacy Claim Memo 12 13 12.pdf
Pharmacy Claim Memo Att A.pdf
Pharmacy Claim Memo Att B.xlsx
Pharmacy Costs Charts.pdf
Primary Driver.docx
ReedSmith to Turnage 072012.pdf
Alliance Exhibit A - Turnage Letter to Chartered.pdf
Alliance Exhibit B - Chartered's Spreadsheet.pdf
Alliance Exhibit C - Snapshot of Capitation Payments.pdf
Alliance Exhibit D - AAA Letter.pdf
Chartered - Alliance Claim Letter to DHCF (Updated).docx
Standard Contract Provisions.pdf
Phcy Claim Through 04.30.12 Updated 12.11.12.xlsx
Birth Receipts 7 1 10 - 04 30 12 Edget 12.06.12.xlsx
Cap Pmts PCP 11 15 12 CAP WITH PHYSICIAN PAYMENTS JULY 2010 TO DECEMBER 2011 Revised 12.12.12.xlsx
Capitation Rates 11.15.12 Edget NON PCP PMPM.xlsx
DCHFP 775- Final Reports Template_12042012 Filed 12.07.12.xls

DCHFP Alliance - Final Reports Template_12042012 Filed 12.07.12.xls
DCHFP Legacy- Final Reports Template_12042012 Filed 12.07.12.xls
Phcy Claim 11.12.12 Doug DCMC RX cost by Aidcode Segment-Run Nov 2012-July 2010 added.xlsx
Phcy Claim 11.16.12 Doug DCMC MED-Surg cost by Aidcode Segment-Run Nov 2012 (3).xlsx
Phcy Claim Through 04.30.12 Updated 12.11.12.xlsx
Premium Capitation Rates 10.10.12 James Updated 12.11.12.xlsx
Reinsurance premiums and recoveries since Jan 2005 12.10.12.xlsx
DCHFP Data Book_042011.pdf
Master lag report-Oct 2009-Apr 30th 2013-RunDate05152013.xls
Master lag 03.31.13 run 04.10.13.xls

In addition, we received the following documents at a meeting on February 5, 2013:

- Issues at DHCF Memo from Wayne Turnage dated April 4, 2011
- Rate Setting Presentation for District Council dated June 24, 2011
- Email exchange between William White and Wayne Turnage dated January 24, 2013
- Pharmacy PMPM graph 1/2010 to 10/2012

EXHIBIT B

DC Chartered Health Plan, Inc., Summary of Statutory Equity
Adjusted For Known Receivables (for dates and programs indicated)
Prepared by HMO Affiliates, LLC, Drew Joyce, August 15, 2013

	March 31, 2013	12/31/2012	12/31/2011
Total Capital and Surplus (Deficit) (per audits at 12/31/11 & 12/31/12 and 3/31/13 Quarterly Statement filed with DISB) [1]	(28,205,753)	(9,757,167)	5,949,445
Add estimated additional receivables (see calculation below)	49,031,336	45,415,136	25,818,468
(Deduct) interest due to providers [2]	(3,531,046)	(3,441,046)	(2,186,446)
Eliminate Premium Deficiency Reserve	5,000,000	5,000,000	-
Retrospective Claim for 5/08-6/10 (Alliance)	TBD	TBD	TBD
Total Capital and Surplus With Illustrated Adjustments	22,294,536	37,216,922	29,581,466
Additional Receivables			
Retrospective Claim (8/2010-4/2012, per TW Report)	51,454,000	51,454,000	34,212,000
Alliance Claim (7/2010-7/2011, per asserted claim)	9,086,929	9,086,929	9,086,929
Dental Crown Claim (per asserted claim)	2,200,000	2,200,000	
Claims calculated by Receiver	62,740,929	62,740,929	43,298,929
Additional Underpayments Unasserted (Est.)			
Retrospective Claim for Alliance 8/11-12/31/11 [3]	860,000	860,000	860,000
Retrospective Claim @ 12/31/12 (Medicaid 5/12-12/12, Alliance full year 2012) [3]	11,300,000	11,300,000	-
Retrospective Claim for 1/13-3/31/13 (Medicaid and Alliance) [3]	3,600,000	-	-
Early Alliance Retrospective Claim (5/08-6/10) [4]	TBD	TBD	TBD
Early Medicaid Retrospective Claim (5/08-7/2010) [4]	TBD	TBD	TBD
Estimated Interest @2.5% [2]	3,531,046	3,441,046	2,186,446
Total District underpayments	82,031,975	78,341,975	46,345,375
Receivable per audit report	(32,000,000)	(32,000,000)	(20,000,000)
Additional Premium Receivable	50,031,975	46,341,975	26,345,375
Less 2% premium tax on additional premium receivable	1,000,640	926,840	526,908
Additional Receivable	49,031,336	45,415,136	25,818,468

[1] Equity at 12/31/2012 & 12/31/2011 not reduced for the net $12,200,294 taken by Cardinal Bank on 5/17/13; 3/31/13 reduced for that amount

[2] Estimated interest payments are calculated as additional receivables times 2.5%. This calculation was entered as an additional expense and recovery for Chartered.

[3] Retrospective claim for 5/1/12-4/30/13 assumes value of unsound rate setting equaled 4% of premium for the Medicaid and Alliance population, compared to 8.3% in prior periods. Amount illustrated is as of 3/31/13.

[4] These claims cannot be calculated without additional information from Chartered.

EXHIBIT C

Government of the District of Columbia
Department of Insurance, Securities and Banking

William P. White
Acting Commissioner

BEFORE THE INSURANCE COMMISSIONER OF THE DISTRICT OF COLUMBIA

Re: Report on Limited Scope Financial Examination of
DC Chartered Health Plan Inc. – NAIC #95748

ORDER

A Limited Scope Financial Examination of the above referenced company ("the Company") has been conducted by the District of Columbia Department of Insurance, Securities and Banking ("Department").

It is hereby ordered on this 27th of November 2012, that the attached limited scope financial examination report be adopted and filed as an official record of this Department.

Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, this Order is considered a final administrative decision and may be appealed pursuant to Section 31-4332 of the D.C. Official Code.

Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, within 30 days of the issuance of the adopted report, the Company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related order.

Pursuant to Section 31-1404(e)(1) of the D.C. Official Code, the Department will continue to hold the content of the report as private and confidential information for a period of 10 days from the date of this Order.

William P. White
Commissioner

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

REPORT ON LIMITED SCOPE EXAMINATION

OF

DC CHARTERED HEALTH PLAN, INC.

NAIC #95748

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SALUTATION

Washington, D.C.
November 8, 2012

Honorable William P. White
Commissioner
Department of Insurance, Securities and Banking
Government of the District of Columbia
810 First Street, NE, Suite 701
Washington, D.C. 20002

Dear Commissioner White:

In accordance with the provisions of the District of Columbia Official Code Title 31, Chapter 14 (Law on Examinations), we have conducted a limited scope examination of certain activities of

DC CHARTERED HEALTH PLAN, INC. – NAIC #95748

hereinafter referred to as the "Company", or "DC Chartered", and the following Report on Examination is submitted. The Company is a licensed District of Columbia Medicaid Managed Care Organization ("MCO") that operates exclusively in the District of Columbia. The Company was organized and commenced business in 1986.

BACKGROUND

On February 25, 2008, DC Chartered entered into Contract DCHC-2008-D-5052 (the "Contract") with the District of Columbia Office of Contracting and Procurement ("DCOCP") to provide healthcare services to the Medicaid eligible population enrolled in the District of Columbia Healthy Families Program ("DCHFP") and to the Alliance eligible population enrolled in the DC Health Care Alliance Program ("Alliance Program"). The Contract is administered by the District of Columbia Department of Healthcare Finance ("DHCF") (formerly known as the Medical Assistance Administration).

In July 2010, the DHCF required the transfer of a population of former members of the Alliance Program to the DCHFP. That population, referred to as the "774 population", consisted of childless adults who had incomes at or below 133% of the federal poverty level.

In December 2010, the DHCF required the transfer of an additional population of former members of the Alliance Program to the DCHFP. That population, referred to as the "775 population", consisted of childless adults who had incomes at or below 200% of the federal poverty level.

The effect of the transfers was to provide increased benefit coverage, particularly pharmacy benefit coverage, to the 774/775 populations than was made available under the Alliance Program.

Pursuant to the Contract, the DHCF conducts an annual actuarial review of the Contract's capitation rates and establishes capitation rates for the 12-month period commencing each August 1. After the July and December, 2010 transfers of the 774 and 775 populations from the Alliance Program to the DCHFP, the DHCF conducted its actuarial review and established capitation rates for the August 1, 2011 – July 31, 2012 time period.

On November 30, 2011, the Company filed a claim with the Contracting Officer of the DCOCP for payment of $25,771,117. The Company contended that rate adjustments made by the DHCF after the 774/775 populations were added to the DCHFP were not actuarially sound, as required by the Contract, and resulted in losses to the Company.[1] The Contracting Officer failed to issue a decision within 120 days of receipt of the claim; thus, the claim was deemed denied as of March 29, 2012.

On April 9, 2012, the Company filed an appeal of the Contracting Officer's denial of its November 30, 2011 claim with the District of Columbia Contract Appeals Board ("Appeals Board"). Under the appeal, the Company is seeking:

> (1) a review of the capitation rate decision and the applicable assumptions as the rate chosen by the District is not actuarially sound or equitable, (2) a review of the annual

[1] The claim consisted of payments of approximately $13,665,419 for losses experienced by DC Chartered from August 1, 2010 to October 31, 2011and $12,105,699 for the losses DC Chartered projected it would experience for the period between November 1, 2011 and April 30, 2012.

adjustment to the rates and the applicable assumptions as the adjustment is not actuarially sound or equitable, (3) an adjustment to the capitated rate to make such rates actuarially sound; and in the alternative, (4) an equitable adjustment to the capitated rate due to significant increases in actual pharmacy benefit costs. [2]

In the specific counts of the appeal, the Company alleges breach of contract and an equitable adjustment due to the DHCF's failure to compensate the Company for its increased cost of performance due to changed circumstances. The Company seeks, among other things, payment of $25,771,117, plus accrued interest and reasonable attorneys' fees and costs. It is our understanding that a date has not been set for a ruling by the Appeals Board.

In the Company's Annual Statement as of December 31, 2011 (due March 1, 2012), the Company did not record a receivable for the $25,771,117 claim. However, in the Company's Quarterly Statement as of June 30, 2012 (due August 15, 2012), the Company established an accrued retrospective premium receivable ("premium receivable") of $24,060,016.[3]

In meetings and communications with the District of Columbia Department of Insurance, Securities and Banking ("DISB"), the Company and its consultants have contended that the Contract is a retrospectively rated contract, as defined in Statement of Statutory Accounting Principles No. 66 – Retrospectively Rated Contracts ("SSAP 66") of the NAIC *Accounting Practices and Procedures Manual*. As a result, the Company believes the amount it claims is due under the Contract represents an admitted asset under statutory accounting principles.

SCOPE OF EXAMINATION

Pursuant to the Memorandum of Understanding between Rector & Associates, Inc. and the DISB with respect to this limited scope examination, the scope of the examination is to review the information surrounding the inclusion of amounts in the financial statement related to DC Chartered's interpretation of the Medicaid contract as a retrospectively rated contact and the establishment of an asset in the financial statement as a result of the currently pending action with the Appeals Board. Should the conclusion be that the establishment of an asset is appropriate, the DISB does not need a determination as to whether the amount established by DC Chartered is appropriate given the circumstances.

The following materials were reviewed in the performance of the limited scope examination:

- Contract No. DCHC-2008-D-5052 (Medicaid Services contract between DCOCP and DC Chartered), and related attachments
- April 9, 2012 DC Chartered Appeal to the Appeals Board

[2] Based on the remedies sought by DC Chartered in the appeal, it is not clear whether the Appeals Board might award DC Chartered only a portion of its $25,771,117 claim if the Appeals Board finds in favor of DC Chartered on only certain of its requested remedies.

[3] Please note that we have been unable to determine why the Company recorded a receivable of $24,060,016, vs. the $25,771,117 claim that it filed with the Contracting Officer of the DCOCP and that it is claiming on appeal.

- Annual Statement as of December 31, 2011 and Quarterly Statement as of June 30, 2012 for DC Chartered
- District of Columbia Statutes and Regulations
- NAIC *Accounting Practices and Procedures Manual* (as of March 2012)
- Position papers titled "Accounting and Reporting for Pharmacy Retrospective Equitable Capitation Rate Adjustment (Retrospective Equitable Adjustment) for Costs Incurred" prepared on behalf of the Company by Millennium Consulting Services, LLC dated June 2012 ("June Position Paper") and July 2012 ("July Position Paper")
- Various electronic communications between the DISB and the Company related to discussion of the statutory accounting treatment of the premium receivable

In addition to the listed documents, several telephone conferences were held with members of the DISB to discuss matters relevant to the assessment of the Company's statutory accounting treatment of the receivable.

SUMMARY FINDINGS

Based on our analysis, we believe that the determination of whether the Contract is a retrospectively rated contract in accordance with statutory accounting principles is a very close question. The relevant statutory accounting principles, as described herein, do not specifically address the relevant facts and the Contract language, which is unclear with respect to the manner in which rate adjustments are made. Despite the lack of clarity in the relevant Contract language, we believe the relevant language supports DC Chartered's position that the Contract is a retrospectively rated contract and that DC Chartered's claim for additional premium payments is an asset in accordance with SSAP No. 66. In other words, we believe that it is reasonable to interpret the Contract to expect that DC Chartered could receive premium adjustments based on DC Chartered's loss experience relating to the Contract, including loss experience resulting from changes to the terms of the Contract.

It is important to point out that when DC Chartered takes the position that the Contract is a retrospectively rated contract, it should take into account its *entire* loss experience to determine its final policy premium, not just the loss experience resulting from the transfer of the 774 and 775 populations from the Alliance Program to the DCHFP. SSAP No. 66 makes clear that a retrospectively rated contract's final policy premium is calculated based on the loss experience of the insured during the term of the policy, not just the loss experience resulting from a contract change or a particular set of benefits.

Finally, as previously indicated, we were not asked as part of this limited scope examination to determine whether the amount of the premium receivable established by DC Chartered in its Quarterly Statement as of June 30, 2012 is appropriate. However, it is important to note that even if a reporting entity correctly admits an asset for statutory accounting purposes, the entity still must determine whether the asset is "impaired." Pursuant to statutory accounting principles, if it is probable that an impairment has occurred and the impairment can be measured, the asset must be reduced to its impaired value.

ANALYSIS

Relevant Statements of Statutory Accounting Principles

SSAP No. 66 defines a retrospectively-rated contract as follows:

> A retrospectively rated contract is one which has the final policy premium calculated based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy) and the stipulated formula set forth in the policy or a formula required by law.

In addition, SSAP No. 66 provides that:

> Amounts due from insureds and amounts due to insureds under retrospectively rated contracts meet the definitions of assets and liabilities as set forth in *SSAP No. 4—Assets and Nonadmitted Assets* and *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets* (SSAP No. 5R), respectively.

DC Chartered's Position on Premium Receivable

DC Chartered's analysis of the methodology behind its establishment of the premium receivable is described in the Position Papers and claim. DC Chartered's argument is two-fold:

- *Capitation Rate Retrospective Adjustment Due To Contract Change* -- First, DC Chartered appears to assert that when the DHCF transferred the 774 and 775 populations from the Alliance Program to the DCHFP in July 2010 and December 2010, respectively, the DHCF changed the services to be covered under the Contract. According to DC Chartered, this change should have triggered a retrospective upward adjustment to the Contract's capitation rate for the time period commencing on the dates of the transfers of the 774 and 775 populations.

- *Annual Capitation Rate Adjustment* -- Second, DC Chartered asserts that when the DHCF conducted its actuarial review and established capitation rates for the August 1, 2011 – July 31, 2012 time period, the DHCF should have taken into account the July 2010 and December 2010 transfers of the 774 and 775 populations from the Alliance Program to the DCHFP. Accordingly, DC Chartered believes that the capitation rates commencing on August 1, 2011 should have been adjusted upward to take into account the transfers of the 774 and 775 populations.

Capitation Rate Retrospective Adjustment Due To Contract Change

Contract Provisions. Section B.3.1 of the Contract states, in part:

> In the event that the District, pursuant to the Changes Clause of the Standard Contract Provisions, adds, deletes, or changes any services to be covered by the Contractor under

> DCHFP or the Alliance Program the District will review the effect of the change and equitably adjust the capitation rate (either upward or downwards) if appropriate.…
>
> The "Changes Clause" referenced in Section B.3.1 of the Contract states, in part:
>
> The Contracting Officer may, at any time, by written order, and without notice to the surety, if any, make changes in the contract within the general scope hereof. If such change causes an increase or decrease in the cost of performance of this contract, or in the time required for performance, an equitable adjustment shall be made.…

When read in conjunction with each other, these two sections of the Contract seem to require that if the Contract is changed to add, delete or change services covered by DC Chartered, the DHCF must review the effect of the change and equitably adjust the capitation rate.

As previously indicated, the Contract requires DC Chartered to provide healthcare services to the Medicaid eligible population enrolled in DCHFP and to Alliance Program members. In July 2010 and December 2010, the DHCF required the transfer of the 774 population and 775 population, respectively, of Alliance Program members to the DCHFP. It is our understanding that DC Chartered's position is that pursuant to Section B.3.1, these transfers resulted in a change to the Contract because the transfers added or changed the services to be covered by the Contract.

It could be argued that the DHCF *did not* add or change services to be covered by the Contract. Instead, the DHCF only transferred individuals who were already covered under the Contract from one category (Alliance Program members) to another category (DCHFP enrollees). Transferring individuals between categories of covered enrollees may not add or change services that were covered by the Contract since the same individuals were covered by the Contract both before and after the transfer.

However, DC Chartered claims in its appeal that the 774 and 775 populations previously were not eligible for pharmacy benefits that DCHFP enrollees are eligible to receive through the Medicaid managed care program. As a result, these populations received pharmacy benefits through the Alliance Program which were significantly more restrictive than the benefits DC Chartered was required to provide these populations after they were transferred to the DCHFP.

Based on our understanding of the effect of the 774 and 775 population transfers on the benefits DC Chartered was required to provide, it appears that DC Chartered was required to provide additional services in the form of increased pharmacy benefits. DC Chartered then argues that this change should have triggered a retrospective upward adjustment to the Contract's capitation rate for the time period commencing on the dates of the transfers of the 774 and 775 populations (July 1, 2010 and December 10, 2010, respectively).

Analysis of SSAP and Contract Provisions. As previously indicated, SSAP No. 66 defines a retrospectively-rated contract as a contract that has:

- A final policy premium calculated based on the loss experience of the insured during the term of the policy; and

- A stipulated formula set forth in the policy or a formula required by law.

First, the DHCF's review of the effect of the Contract changes can be viewed as determining the "final policy premium calculated based on the loss experience of the insured during the term of the policy." In addition, the DHCF's equitable adjustment of the capitation rate can be viewed as "the stipulated formula set forth in the policy".

We recognize that simply requiring the DHCF to equitably adjust the capitation rate, if appropriate, is not the type of "stipulated formula" that normally is found in a retrospectively rated contract. However, it seems appropriate that in this type of contract, the "stipulated formula" is limited to determining the appropriate equitable adjustment to the capitation rate, rather than including a specific formula for changes in the capitated rate.

In addition, DC Chartered's July Position Paper points out that:

> The District's courts define an equitable adjustment as 'the difference between what it would have reasonably cost to perform the work as originally required and what it reasonably cost to perform the work as changed.' (Page 3, July Position Paper.)

Although rudimentary, the courts have essentially defined an equitable adjustment as the following "formula":

> Equitable Adjustment = Cost to perform work as changed +/- Cost of work as originally required

The DHCF's decision to redefine the 774/775 populations by transferring them from the Alliance Program to the DCHFP arguably triggered the Changes Clause and, accordingly, required the DHCF to assess the impact of the change and equitably adjust DC Chartered's capitation rate. In effect, the change created a liability for DHCF and an asset (premium receivable) for DC Chartered.

Annual Capitation Rate Adjustment

Contract Provisions. Sections B.3.2 and B.3.3 of the Contract provide:

> B.3.2 No later than twelve (12) months after the date of the Contract Award and annually thereafter, the District will conduct an actuarial review of the capitation rates in effect to determine the actuarial soundness of the rates paid to the Contractors. The actuarial review will be based upon the rates offered by Contractor and will take into account factors such as inflation, significant changes in the demographic characteristics of the member population, or the disproportionate enrollment selection of Contractor by members in certain rate cohorts.

B.3.3 This actuarial review of the capitation rates may result in an annual adjustment, either increase or decrease, to the capitation rates. The District and Contractor shall negotiate the actual amount of the adjustment; however, the negotiated adjustment shall be actuarially sound in accordance with 42 C.F.R. 438.6(c).

Pursuant to these sections, the DHCF is required to review DC Chartered's capitation rates on an annual basis to determine if the rates are actuarially sound by taking into account, among other things, DC Chartered's loss experience.

DC Chartered argues that when the DHCF conducted its actuarial review and established capitation rates for the August 1, 2011 – July 31, 2012 time period, the DHCF should have taken into account the July 2010 and December 2010 transfers of the 774 and 775 populations from the Alliance Program to the DCHFP. Accordingly, DC Chartered argues that the capitation rates commencing on August 1, 2011 should have been adjusted upward to take into account the transfers of the 774 and 775 populations.

Analysis of SSAP and Contract Provisions. As previously indicated, SSAP No. 66 defines a retrospectively-rated contract as a contract that has:

- A final policy premium calculated based on the loss experience of the insured during the term of the policy; and

- A stipulated formula set forth in the policy or a formula required by law.

First, the DHCF's review of DC Chartered's capitation rates can be viewed as determining the "final policy premium calculated based on the loss experience of the insured during the term of the policy."

In addition, Sections B.3.2 and B.3.3 require that any changes to the capitation rate be actuarially sound, which is defined to be actuarial soundness in accordance with 42 C.F.R. 438.6(c). 42 C.F.R. 438.6(c) defines actuarially sound capitation rates to be rates that are:

- Developed in accordance with generally accepted actuarial principles and practices;
- Appropriate for the populations to be covered and the services to be furnished; and
- Certified by an actuary who meets the standards of the American Academy of Actuaries and uses practice standards established by the Actuarial Standards Board.

We recognize that simply requiring the DHCF to take into account actuarial soundness in determining capitation rates is not the type of "stipulated formula" that normally is found in a retrospectively rated contract. However, it is generally understood that actuarial principles and practices include the use of formulas to determine appropriate capitation rates.

Based on this analysis, we believe it is appropriate to consider the Contract to be a retrospectively rated contract due to the DHCF's required annual review of capitation rates in accordance with Sections B.3.2 and B.3.3. We note that if the DHCF failed to perform the required annual review or, alternatively, performed the review and failed to establish actuarially

sound rates, the amount of the deficiency in the capitated rates would be a liability for the DHCF and an asset (premium receivable) for DC Chartered.

Determination of Retrospective Rate for Entire Contract

As previously indicated, the scope of our examination was limited to reviewing DC Chartered's interpretation of the Medicaid contract as a retrospectively rated contact and determining whether it was appropriate for DC Chartered to establish the premium receivable as an asset in its financial statements. Based on our analysis, we have found that relevant Contract language supports DC Chartered's position that the Contract is a retrospectively rated contract and that the premium receivable can be considered an asset in accordance with SSAP No. 66.

At the same time, it is important to point out that when DC Chartered takes the position that the Contract is a retrospectively rated contract, it should take into account its *entire* loss experience to determine its final policy premium, not just the loss experience resulting from the transfer of the 774 and 775 populations from the Alliance Program to the DCHFP. SSAP No. 66 makes clear that a retrospectively rated contract's final policy premium is calculated based on the loss experience of the insured during the term of the policy, not just the loss experience resulting from a contract change or a particular set of benefits.

In addition, we noted that the Contract states that the retrospective capitation rate adjustment could result in a downward adjustment, as described in Section B.3.1, and that the annual rate review could result in a decrease in the capitation rate, as described in Section B.3.3. In other words, the Contract language envisions that it might be necessary for DC Chartered to record a liability due to, as an example, a required premium refund to the DHCF.

Additional Considerations

We were not asked as part of this limited scope examination to determine whether the amount established by DC Chartered in its Quarterly Statement as of June 30, 2012 is appropriate. However, we believe the DISB should be aware of other statutory accounting guidance that might impact the amount of the accrued retrospective premium that could be considered to be impaired.

SSAP No. 5R requires reporting entities to perform an on-going assessment as to the possible impairment to assets. In other words, even if a reporting entity correctly admits an asset for statutory accounting purposes, the entity still must determine whether the asset is "impaired."

SSAP No. 5R defines an impairment of an asset as an existing condition, situation, or set of circumstances involving uncertainty as to a possible loss that ultimately will be resolved when one or more future events occur or fail to occur. In addition, three definitions are used to assess whether an asset is impaired:

a. Probable – The future event or events are likely to occur;

b. Reasonably Possible – The chance of the future event or events occurring is more than remote but less than probable;
c. Remote – The chance of the future event or events occurring is slight.

If it is probable that an impairment has occurred and the impairment can be measured, the asset must be reduced to its impaired value.

RECOMMENDATION

As previously noted in this Report, the Contract language does not set out a stipulated formula that is to be used to determine retrospective and annual premium adjustments or directly define what types of changes to DCHFP or the Alliance Program result in the addition, deletion or change in services to be covered by a contractor such as DC Chartered.

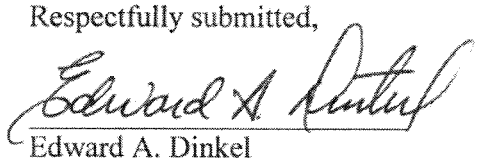
Accordingly, we recommend that to the extent possible, DC Chartered with the DCOCP and the DHCF develop language in their contracts to define and clarify a formula for calculating premium and capitation rate adjustments and the circumstances under which services are added, deleted, or changed. Clarifying the contract language will provide accurate calculation of any receivable/payable incurred under the contracts due to retrospective and annual premium adjustments.

SIGNATURES

In addition to the undersigned, the following examiners representing the District of Columbia Department of Insurance, Securities and Banking participated in certain phases of this examination:

Sarah W. Schroeder
Neil K. Rector

Respectfully submitted,



Edward A. Dinkel
Rector & Associates, Inc.

Under the Supervision of,

Nathaniel Kevin Brown, CFE, CPA
Chief Financial Examiner
District of Columbia Department of Insurance,
Securities and Banking