

Actuarial services

Mercer Government Ready for next. Together.

Since 1985, we've worked alongside state and territorial partners to design practical, sustainable solutions that strengthen programs and improve outcomes.

State, county, and local governments face numerous challenges as they work to continue providing quality health care to more people while dealing with tightly constrained budgets and changing federal policy prompting strategic yet rapid implementation efforts. Budget crises, increasing coverage losses, escalating health care expenditures, challenges with splintered and less-than-optimal health care delivery systems, and escalating demands for health plan oversight and accountability are some issues that present unique obstacles to each state and require innovative solutions.

As a result of new federal policies, the landscape of government-sponsored health care programs is changing significantly. This is evidenced by the implementation of the One Big Beautiful Bill Act (OBBBA) of 2025 that includes new administrative requirements and conditions on eligibility for Medicaid and the Health Insurance Market Places. These new policies are changing the delivery and financing of health care in the United States and include such topics as long-term care programs, Home- and Community-Based Services (HCBS), health home models, accountable care organizations, and increased focus on health insurance exchanges and duals integration by the Centers for Medicare and Medicaid Services (CMS).



Mercer Government provides consulting assistance built on actuarial knowledge, consulting experience, and the creativity to develop comprehensive solutions for its clients. The OBBBA's provisions have created new complexities that will increase the demand for actuarial expertise that Mercer is well-positioned to assist clients on a variety of topics ranging from traditional capitated rate setting to program development and compliance with these new health care delivery models and federal provisions.

Mercer's actuarial consultants have assisted with a variety of issues, including:

- Actuarially sound capitation rates and rate ranges, with CMS rate approval
- Risk adjustment for capitation rates
- Creative alternatives for full-risk and partial-risk contracting, including stop loss, reinsurance, and risk corridors
- Cost effectiveness and budget neutrality analysis for 1915(b), 1915(c), and 1115 waivers
- Managed long-term care capitated rate setting
- Health home reimbursement analysis
- Accountable Care Organization (ACO) shared-savings target development
- Financial analysis related to duals integration projects involving Medicaid and Medicare funding
- Actuarial analysis to support the development of state exchange programs as well as the basic health plan option
- Cost evaluation of expansion populations, including the expansion of Medicaid coverage under PPACA
- Focused data-driven efficiency studies related to health plan management of emergency room utilization and potentially preventative inpatient admissions, as well as management of pharmacy
- Health plan reviews for compliance and efficiency benchmarking
- Financial impact of legislative changes and legislative testimony
- Policy and program strategy, design, and development
- Technical assistance sessions, including contract/rate negotiations with health plans
- Primary Care Case Management program enhancement strategy
- Identification of efficient provider networks



Case study



Situation

As state-managed care programs have become reliant on managed care financial and encounter data as sources for rate-setting calculations, questions have been raised as to how the resulting rates reflect the concept of value-based purchasing, which is a key tenet of many states' purchasing strategies. To address these concerns, Mercer has performed medical efficiency analyses, using program encounter data, when developing Medicaid managed care capitation rates. Managed care organization (MCO) historical data are used as a base. If the historical MCO program experience contains evidence of inefficient medical management, efficiency adjustments are used to set appropriate rates. This approach ensures that using MCO historical experience does not result in cost-plus rate-setting. State Medicaid programs can demand optimal and achievable value from their contracted MCOs.



Challenge

Action is needed to make our health care system more efficient and to ensure more consistent delivery of high-quality care while improving patient safety and decreasing costs. As one of the largest groups of health care purchasers, states play an important role in identifying opportunities for implementing successful cost-containment strategies and enhancing efficiencies in the delivery of care, which can free up dollars for other state priorities such as focused alignment with federal health care policy changes. By emphasizing care provision in physician offices and other community settings, patient safety is also improved by avoiding escalations of manageable chronic conditions and preventing hospitalizations or unnecessary emergency room visits.

Mercer's medical efficiency analyses focus on drivers of health care costs and support value-based purchasing approaches that are consistent with a prudent purchasing strategy. These analyses are predicated on national guidelines/best practices and supported by national literature reviews and health services research. The underlying methodology was developed by an expert panel consisting of physicians, nurses, and pharmacists with managed care experience. Through this process, Mercer applies clinical expertise to various data-driven/analytical approaches using the managed care program encounter data to identify unnecessary health care expenditures that can be addressed through improved efficiencies and care management processes.



Action

Low acuity non-emergent (LANE) emergency room analysis

Emergency room visits are expensive, costing two to three times as much as visits in a physician's office. Research published by the American Journal of Managed Care indicates that up to 60% of ER visits in the United States remain non-urgent and potentially unnecessary.¹ Mercer's LANE analysis employs a subset of ICD-10 codes, which research indicates can be representative of instances in which an ER visit could have been avoided had effective outreach, care coordination, and access to preventive care been available. Based on industry best practices and supporting literature, Mercer developed a data-analytic procedure to identify low to moderate acuity diagnosis codes that could potentially be avoided. Some examples of conditions included in this type of analysis are fever, headache, cough, rash, and removal of sutures.

Potentially preventable admissions (PPA) inpatient analysis

Many hospitalizations represent ambulatory care failures. According to the National Institute of Health (NIH), approximately 20–35% of all unplanned hospitalizations are thought to be avoidable if complications are handled well in primary care.² Mercer's PPA analysis identifies inpatient admissions that could have been avoided in the managed care programs through high-quality outpatient care and/or reflect conditions that could be less severe and not warrant an inpatient level of care if treated early and appropriately. These are identified through claims data using criteria from the AHRQ's Guide to Prevention Quality Indicators and Pediatric Data Indicators, with additional filters applied to better understand MCOs' ability to prevent the admissions in the Medicaid environment.



Results

As a result of these clinically informed, data-driven analyses, Mercer actuaries have incorporated medical efficiency adjustments into the development of actuarially sound capitation rate ranges. These adjustments, based on sound clinical input, have reduced the MCO capitation rates to reflect clinical medical efficiency targets, even after factoring in the offset of expected increases in physician and other outpatient costs. The results vary by state, but the following ranges should help inform the magnitude of each measure:

- LANE adjustments: typically 5%–10% of total ER costs
- PPA adjustments: typically 3%–5% of total inpatient hospital costs

1 Uscher-Pines, L., J. Pines, A. Kellermann, E. Gillen, & A. Mehrotra. 2013. "Emergency Department Visits for Nonurgent Conditions: Systematic Literature Review." *The American Journal of Managed Care* 19(1):47–59

2 Purdey, S, and A Huntley. "Predicting and preventing avoidable hospital admissions: a review." *The journal of the Royal College of Physicians of Edinburgh* vol. 43,4 (2013): 340-4. doi:10.4997/jrcpe.2013.415

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