

Pursuant to the authority vested in the Commissioner of Health by section 4403(2) of the Public Health Law, subparagraph (ii) of paragraph (1) of subdivision (e) of section 98-1.11 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon publication of the Notice of Adoption in the New York State Register, to read as follows:

Subparagraph (ii) of paragraph (1) of subdivision (e) of section 98-1.11 is amended to read as follows:

(ii) Notwithstanding the provisions of subparagraph (i) above, the contingent reserve applicable to net premium income generated from the Medicaid managed care[,Family Health Plus,] and HIV SNP[, and HARPs] programs shall be:

- (a) 7.25 percent of net premium income for 2011;
- (b) 7.25 percent of net premium income for 2012;
- (c) 7.25 percent of net premium income for 2013;
- (d) 7.25 percent of net premium income for 2014;
- (e) 7.25 percent of net premium income for 2015;
- (f) [8.25] 7.25 percent of net premium income for 2016;
- (g) [9.25] 7.25 percent of net premium income for 2017;
- (h) [10.25] 7.25 percent of net premium income for 2018;
- (i) [11.25] 8.25 percent of net premium income for 2019;
- (j) [12.5] 9.25 percent of net premium income for 2020;
- (k) [12.5] 10.25 percent of net premium income for 2021; [calendar years after 2020.]
- (l) 11.25 percent of net premium income for 2022;

(m) 12.5 percent of net premium income for 2023.

(n) 12.5 percent of net premium income for calendar years after 2023.

The provisions of this subparagraph shall not apply to HMOs and PHSPs beginning operations in 201[1]6 or after.

New Subparagraph (iii) of paragraph (1) of subdivision (e) of section 98-1.11 is added to read as follows:

(iii) The contingent reserve applicable to net premium income generated from the Health and Recovery Plans (HARPs) shall be the same percentages listed in subparagraph (ii), except that for years 2015, 2016 and 2017 the applicable contingent reserve shall be 5.0 percent of net premium income.

[(iii)](iv) Upon an HMO, PHSP or HIV SNP reaching its maximum contingent reserve of 12.5 percent of its net premium income for a calendar year, it must continue to maintain its contingent reserve at this level thereafter. Such contingent reserve requirement shall be deemed to have been met if the net worth of the HMO, PHSP or HIV SNP, based upon admitted assets, equals or exceeds the applicable contingent reserve requirement for such calendar year.

Regulatory Impact Statement

Statutory Authority:

Public Health Law section 4403(2) states the Commissioner may adopt and amend rules and regulations pursuant to the state administrative procedures act to effectuate the purposes and provisions of Article 44, which governs the certification and operational requirements of Managed Care Organizations (MCOs).

Legislative Objectives:

10 NYCRR 98 was extensively amended in 2005 to further implement the provisions of Article 44 of the Public Health Law. The proposed amendment to §98-1.11(e) continues the Medicaid Redesign Team Proposal #6 (2% reduction in Medicaid premium rates) by temporarily reducing the contingent reserve requirements applied to premium revenues from the Medicaid Managed Care (MMC) and HIV Special Needs Plan (SNP) programs. Consistent with the MRT #1458 and the carve-in of populations and benefits into Managed Care, the Health and Recovery Plans (HARPs) started October 1, 2015. The contingent reserve requirement for HARPs was reduced to 5% for 2015, 2016 and 2017 to ease plan transitions, and to assure that the coordination and provision of services are not jeopardized. The Department believes that temporarily relaxing the contingent reserve requirement to 5% for the HARPs assures that the Managed Care Plans are not financially harmed by coordinating benefits and providing services to such a vulnerable population.

Needs and Benefits:

The approved SFY 2011-2012 and SFY 2012-2013 NYS Budgets incorporated a proposal from the Medicaid Redesign Team that reduced the premium rates of MMC and

HIV SNP managed care plans by 2%. This was accomplished by lowering the rate component for surplus/reserves from 3% to 1% effective April 1, 2011.

The actuarial firm employed by the Department of Health (DOH), Mercer Consulting, must certify the actuarial soundness of the premium rates to Centers for Medicare and Medicaid Services (CMS). Mercer determined that reducing the rate component for surplus/reserves by 2% would result in rates that were not actuarially sound, as such rates would be insufficient to support the contingent reserve requirement specified in §98-1.11(e)(1). As a result, Mercer recommended that the contingent reserve requirement for Medicaid product lines be reduced from 10.5% to 7.25% of premium revenue. This change was implemented in regulations promulgated on an emergency basis effective July 7, 2011 and adopted permanently on February 15, 2012.

The new revision to 98-1.11(e) maintains the 7.25% contingent reserve requirement through calendar year 2018. This will permit DOH to maintain the 2% reduction in the premium rates and allow Mercer to certify the actuarial soundness of the premium rates to CMS.

Costs:

The amended regulation imposes no compliance costs on state or local governments. There will be no additional costs incurred by the Health Department or by the MCOs.

Local Government Mandates:

The regulation imposes no new programs, services, duties or responsibilities on any county, city, town, village, school district, fire district or other special district.

Paperwork:

Paperwork associated with filings to DOH or Department of Financial Services should be minimal and would be no more substantial than the current regulation.

Duplication:

These regulations do not duplicate, overlap, or conflict with existing State and federal regulations.

Alternatives:

Revisions to §98-1.11(e) are needed to ensure the actuarial soundness of Medicaid Managed Care premium rates. No alternatives were considered since Medicaid premium rates are set by the State actuary and with built in profits of 1% which is not sufficient to accommodate reserve increases without jeopardizing soundness of the rates.

Federal Standards:

The rule does not exceed any minimum standards of the Federal government for the same or similar subject area.

Compliance Schedule:

Managed care organizations should be able to comply with the proposed regulations upon publication of the Notice of Adoption.

Contact Person:

Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
Corning Tower Building, Rm. 2438
Empire State Plaza
Albany, New York 12237
(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.ny.gov

STATEMENT IN LIEU OF REGULATORY FLEXIBILITY ANALYSIS

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

STATEMENT IN LIEU OF RURAL AREA FLEXIBILITY ANALYSIS

No rural area flexibility analysis is required pursuant to section 202-bb(4)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse impact on facilities in rural areas, and it does not impose reporting, record keeping or other compliance requirements on facilities in rural areas.

STATEMENT IN LIEU OF JOB IMPACT STATEMENT

A Job Impact Statement for these amendments is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.