

## Managed Care Organizations

Effective date: 12/30/11

Pursuant to the authority vested in the Commissioner of Health by section 4403(2) of the Public Health Law, 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 filing with the Department of State, to read as follows:

Subdivision (b) of section 98-1.11 is amended to read as follows:

(b) No funds [the aggregate of which involves five percent or more of the MCO's admitted assets at last year-end] shall be transferred or loaned from the MCO article 44 business to any other business, function or contractor of the MCO, or to any subsidiary or member of the MCO's holding company system or to any member or stockholder [over the course of a single calendar year,] without the prior approval of the commissioner and, except in the case of a PHSP, HIV SNP<sub>2</sub> [or] PCPCP[,], or MLTC, the superintendent.

Repayment of any such approved loans, to the extent required, shall be made in accordance with schedules approved by the superintendent and commissioner. Any such transfers or loans shall require a certification by the MCO that such transfer or loan is in compliance with and does not violate any provision of any applicable law or regulation.

(1) No such transfer or loan shall be approved if the net worth of the MCO after the transfer or loan would fall below 12.5 percent of its annual net premium income, and all such transfers and loans must be accompanied by projections submitted by the MCO showing that its net worth shall continue to meet or exceed 12.5 percent of annual net

premium income for two calendar years following the transfer or loan.

(2) Notwithstanding the provisions of paragraph (1) of this subdivision, no such proposed transfer or loan made by any MCO that received seventy-five percent or more of its net premium income from the New York State Medicaid, Family Health Plus, and Child Health Plus programs during the last calendar year shall be approved if the net worth of the MCO after such transfer or loan would fall below 15 percent of its annual net premium revenue, and all such transfers and loans must be accompanied by projections submitted by the MCO showing that its net worth shall continue to meet or exceed 15 percent of annual net premium revenue for two calendar years following the transfer or loan. In order to ensure the availability of quality health services for an enrolled population, the commissioner may waive the provisions of this paragraph should the proposed transfer of funds or loan be used to purchase a controlling interest, or a substantial portion of the assets, of a MCO certified to operate under Article 44 of the Public Health Law.

Subdivision (e) of section 98-1.11 is amended to read as follows:

(e) (1) Except for a PCPCP, a certified operating MCO, or an MCO that is initially commencing operations, shall maintain a reserve, to be designated as the contingent reserve [which must be equal to five percent of its annual net premium income].

(i) The contingent reserve for an HMO, PHSP or HIV SNP shall be equal to and shall not exceed:

[(i)] (a) 5 percent of net premium income for the first calendar year subsequent to the effective date of this Subpart;

[(ii)] (b) 6.5 percent of net premium income for the second calendar year subsequent;

[(iii)] (c) 7.5 percent of net premium income for the third calendar year subsequent;

[(iv)] (d) 8.5 percent of net premium income for the fourth calendar year subsequent;

[(v)] (e) 9.5 percent of net premium income for the fifth calendar year subsequent;

[(vi)] (f) 10.5 percent of net premium income for the sixth calendar year subsequent;

[(vii)] (g) 11.5 percent of net premium income for the seventh calendar year subsequent;

[(viii)] (h) 12.5 percent of net premium income for calendar years thereafter.

(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 programs shall be:

(a) 7.25 percent of net premium income for 2011;

(b) 7.25 percent of net premium income for 2012;

(c) 8.25 percent of net premium income for 2013;

(d) 9.25 percent of net premium income for 2014;

(e) 10.25 percent of net premium income for 2015;

(f) 11.25 percent of net premium income for 2016;

(g) 12.25 percent of net premium income for 2017;

(h) 12.5 percent of net premium income for calendar years after 2017.

The provisions of this subparagraph shall not apply to HMOs and PHSPs beginning operations in 2011 or after.

(iii) 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 amendments to §98-1.11(b) and §98-1.11(e) specify criteria to be used to evaluate requests for approval of asset transfers and loans proposed by MCOs and allows implementation of certain provisions of the SFY 2012 budget and the Medicaid Redesign Team Proposal #6 by temporarily reducing the contingent reserve requirements applied to premium revenues from the Medicaid Managed Care (MMC), Family Health Plus (FHP) and HIV Special Needs Plan (SNP) programs.

### **Needs and Benefits:**

§98-1.11(b) - Current regulation requires that the Department of Health (DOH) and State Insurance Department (SID), as applicable, must approve any asset transfers or loans of 5% or more of the MCOs admitted assets but fails to stipulate the criteria for approving such transactions. Both agencies follow a policy of approving a transfer or loan only

when the net worth of the plan after the transaction would be equal to or greater than 12.5% of annual premium revenue, or 5% for Managed Long Term Care (MLTC) plans. The 12.5% threshold was selected to coincide with the maximum contingent reserve established under §98-1.11(e)(1), which begins at 5% of premium revenue and increase by 1% per year until the maximum 12.5% standard is reached. The revision to §98-1.11(b) establishes this criteria for approval in regulation, applies the same criteria to all plans, including MLTC plans, and requires approval for any asset transfer or loan rather than only those that exceed 5% of admitted assets.

The revised regulation also establishes a higher standard for approval of asset transfers or loans made by MCOs that receive 75% or more of their annual premium revenue from managed care programs sponsored by NYS: Medicaid, Family Health Plus and Child Health Plus. The regulation would allow approval of asset transfers or loans only if the net worth of the MCO after the transaction would be equal to or greater than 15% of annual premium revenue. The Commissioner would have the authority, however, to waive the latter provision when the purpose of the asset transfer or loan is for the purchase of another MCO or a controlling interest thereof, that the Commissioner finds is in the public interest.

MCOs would also be required to submit financial projections showing that their net worth would continue to meet or exceed 12.5% or 15% of premium revenue, as applicable, for two calendar years following the transfer or loan.

§98-1.11(e) - The approved SFY 2012 NYS Budget incorporates a proposal from the Medicaid Redesign Team that reduces the allocation of surplus in the premium rates of MMC, FHP and HIV SNP managed care plans from 3% to 1% effective April 1, 2011, resulting in savings to the Medicaid program of approximately \$188 million (federal and state shares combined). The actuarial firm employed by DOH, Mercer Consulting, which must certify the actuarial soundness of the premium rates to CMS, has determined the reduction in surplus allocation will require the lowering of the contingent reserve requirement specified in §98-1.11(e)(1) from the current 10.5% to 7.25% of premium revenue in order to maintain the actuarial soundness of the premium rates. The revision to 98-1.11(e) will allow DOH to reduce the surplus allocation in the mainstream Medicaid and FHP, and HIV SNP 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 SID 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:**

There were minimal alternative standards considered. Revisions to §98-1.11(b) in part codifies current policy in evaluating requests for approval for asset transfers or loans. Removal of the 5% threshold before approval is required for asset transfers or loans is consistent with the desire of DOH and SID to ensure MCO financial reserve levels do not fall below regulatory requirements via unregulated financial transactions.

Revisions to §98-1.11(e) are needed to implement provisions of SFY 2012 budget.

**Federal Standards:**

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

**Compliance Schedule:**

Revisions to §98-1.11(b) would apply to MCOs immediately upon adoption. Revisions to §98-1.11(e) would be retroactive to January 1, 2011, once adopted.

**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.state.ny.us](mailto:REGSQNA@health.state.ny.us)

## **Regulatory Flexibility Analysis for Small Businesses and Local Governments**

### **Effect of Rule:**

Companies affected by the proposed regulation include all MCOs certified under Article 44 of the Public Health Law. Inasmuch as most of these companies are not independently owned and operated and employ more than 100 individuals, they do not fall within the definition of "small business" found in section 102(8) of the State Administrative Procedure Act. No local governments will be affected.

### **Compliance Requirements:**

The amended regulation would not impose additional reporting, recordkeeping or other requirements on small businesses or local governments since the provisions contained therein apply only to MCOs authorized to do business in New York State and regulated by the NYS Health and Insurance Departments.

### **Professional Services:**

There are no professional services that will need to be provided by small businesses or local government as a result of the amended regulation.

### **Compliance Costs:**

The amended regulation would not impose any new reporting, recordkeeping or other requirements on small businesses or local governments.

**Economic and Technical Feasibility:**

There are no compliance requirements for small businesses or local governments.

**Minimizing Adverse Impacts:**

The amendment will have no adverse impact on small businesses or local governments since the provisions contained therein apply only to regulated MCOs authorized to do business in New York State.

**Small Business and Local Government Participation:**

As the amendments have no impact on small businesses or local governments, no input was sought from these entities.

## **Rural Area Flexibility Analysis**

### **Types and Estimated Number of Rural Areas:**

Companies affected by the proposed regulation include all Managed Care Organizations (MCOs) certified under Article 44 of the Public Health law. The companies affected by this regulation do business in certain "rural areas" as defined under section 102(1) of the State Administrative Procedure Act, although none do so exclusively or have a significant portion of their business in rural areas. Some of the home offices of these companies may lie within rural areas. Further, companies may establish new office facilities and/or relocate in the future depending on their requirements and needs.

### **Reporting, Recordkeeping and Other Compliance Requirements:**

None of the compliance requirements are significantly different from requirements presently contained in Part 98 and none pertain exclusively to rural areas. The amendments should not impose any significant additional paperwork, recordkeeping or compliance requirements upon any regulated party.

### **Costs:**

The amended regulation imposes no additional compliance costs on MCOs or state and local governments.

**Minimizing Adverse Impact:**

The proposed regulation applies to all MCOs certified under Article 44 to do business in New York State, including rural areas. It does not impose any adverse impacts unique to rural areas.

**Rural Area Participation:**

In developing the amended regulation, the Health Department conducted outreach to regulated managed care organizations authorized to do business throughout New York State, including those located or domiciled in rural areas.

## **Job Impact Statement**

### **Nature of Impact:**

The Health Department finds that these amendments will have no adverse impact on jobs and employment opportunities.

### **Categories and Numbers Affected:**

Not Applicable.

### **Regions of Adverse Impact:**

No region in New York should experience an adverse impact on jobs and employment opportunities.

### **Minimizing Adverse Impact:**

The Health Department finds that these amendments will have no adverse impact on jobs and employment opportunities.

## **Emergency Justification**

The SFY 2012 NYS Budget effective April 1, 2011 incorporates a proposal from the Medicaid Redesign Team (MRT Proposal #6) that reduces the allocation of surplus in the premium rates of Medicaid, Family Health Plus (FHP) and HIV SNP managed care plans from 3% to 1%, resulting in savings to the Medicaid program of approximately \$188 million. The actuarial firm employed by DOH, Mercer Consulting, which must certify the actuarial soundness of the premium rates to CMS, has determined the reduction in surplus allocation will require the lowering of the contingent reserve requirement specified in §98-1.11(e)(1) from the current 10.5% to 7.25% of premium revenue in order to maintain the actuarial soundness of the premium rates. The SFY 2012 Article VII budget bill gives DOH the authority to adopt regulations on an emergency basis to implement provisions of the SFY 2012 budget. The amendments to 98-1.11(e) will allow DOH to reduce the surplus allocation in the mainstream Medicaid, FHP and HIV SNP premium rates consistent with the approved SFY 2012 budget.

In light of the amendments to 98-1.11(e), revisions to 98-1.11(b) are needed to clarify in regulation the criteria used to evaluate transfers of assets or loans proposed by managed care organizations regulated by Part 98 that heretofore have been linked in policy to the contingent reserve requirement specified in §98-1.11(e).