

## Capital Adequacy (E) Task Force

### RBC Proposal Form

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Capital Adequacy (E) Task Force  | <input checked="" type="checkbox"/> Health RBC (E) Working Group | <input type="checkbox"/> Life RBC (E) Working Group  |
| <input type="checkbox"/> Catastrophe Risk (E) Subgroup    | <input type="checkbox"/> Investment RBC (E) Working Group        | <input type="checkbox"/> SMI RBC (E) Subgroup        |
| <input type="checkbox"/> C3 Phase II/ AG43 (E/A) Subgroup | <input type="checkbox"/> P/C RBC (E) Working Group               | <input type="checkbox"/> Stress Testing (E) Subgroup |

<p style="text-align: right;"><b>DATE:</b> <u>11-24-2015</u></p> <p><b>CONTACT PERSON:</b> <u>Crystal Brown</u></p> <p><b>TELEPHONE:</b> <u>816-783-8146</u></p> <p><b>EMAIL ADDRESS:</b> <u>cbrown@naic.org</u></p> <p><b>ON BEHALF OF:</b> <u>Health RBC (E) Working Group</u></p> <p><b>NAME:</b> <u>Patrick McNaughton</u></p> <p><b>TITLE:</b> <u>Chief Financial Examiner/Chair</u></p> <p><b>AFFILIATION:</b> <u>WA Office of Insurance Commissioner</u></p> <p><b>ADDRESS:</b> <u>PO Box 40255</u> <u>Olympia, WA 98504-0255</u></p>	<p style="text-align: center;"><b><u>FOR NAIC USE ONLY</u></b></p> <hr/> <p>Agenda Item # <u>2015-27-H</u></p> <p>Year <u>2015 &amp; 2016</u></p> <hr/> <p style="text-align: center;"><b><u>DISPOSITION</u></b></p> <p><input checked="" type="checkbox"/> ADOPTED <u>Jan. 25, 2016</u></p> <p><input type="checkbox"/> REJECTED _____</p> <p><input type="checkbox"/> DEFERRED TO _____</p> <p><input type="checkbox"/> REFERRED TO OTHER NAIC GROUP _____</p> <p><input checked="" type="checkbox"/> EXPOSED <u>Jan. 8, 2016</u></p> <p><input type="checkbox"/> OTHER (SPECIFY) _____</p>
--	---

#### IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Health RBC Blanks  | <input type="checkbox"/> Property/Casualty RBC Blanks | <input type="checkbox"/> Life RBC Instructions              |
| <input type="checkbox"/> Fraternal RBC Blanks                                       | <input type="checkbox"/> Health RBC Instructions      | <input type="checkbox"/> Property/Casualty RBC Instructions |
| <input type="checkbox"/> Life RBC Blanks  | <input type="checkbox"/> Fraternal RBC Instructions   |   |
| <input checked="" type="checkbox"/> OTHER <u>Health RBC Guidance for 2015</u> _____ |   |   |

#### DESCRIPTION OF CHANGE(S)

Guidance for the treatment of Medicaid Pass-Through Payments for 2015 reporting if the payment qualifies as a subcapitated payment.

#### REASON OR JUSTIFICATION FOR CHANGE \*\*

Develop guidance for the 2015 reporting of Medicaid Pass-Through Payments if the payment qualifies as a subcapitated payment by including the payment under Category 3 – Capitations for a Managed Care Credit.

#### Additional Staff Comments:

12-9-15 cgb – The HRBC WG exposed the proposal with modifications to the instructions for a 30 day comment period with comments due back on Jan. 8, 2016.

1-25-16 cgb – AHIP submitted comments on the proposed guidance to change the reference of “subcapitation” within the parenthetical to “capitation.” The WG agreed to the modification and to add additional language “as defined by the health RBC formula” after “capitation” in the parenthetical. The Working Group adopted the guidance on the 1-25-16 call for YE-2015 reporting.

6-22-16 cgb The HRBCWG agreed to use the guidance in proposal 2015-27-H for 2016 reporting as a result of the withdrawal of proposal 2015-26-H.

\*\* This section must be completed on all forms.

Revised 11-2013

## UNDERWRITING RISK – MANAGED CARE CREDIT

XR017

The effect of managed care arrangements on the variability of underwriting results is the fundamental difference between health entities and pure indemnity carriers. The managed care credit is used to reduce the RBC requirement for experience fluctuations. It is important to understand that the managed care credit is based on the reduction in uncertainty about future claims payments, not on any reduction in the actual level of cost. Those managed care arrangements that have the greatest reduction in the uncertainty of claim payments receive the greatest credit, while those that have less effect on the predictability of claims payments engender less of a discount.

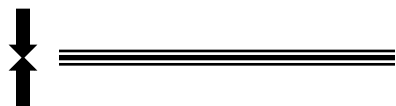
There are currently five levels of managed care that are used in the formula, other than for Medicare Part D Coverage, although in the future as new managed care arrangements evolve, the number of categories may increase or new arrangements may be added to the existing categories. The managed care categories are:

- \* Category 0 – Arrangements not Included in Other Categories
- \* Category 1 – Contractual Fee Payments
- \* Category 2 – Bonus / Withhold Arrangements
- \* Category 3 – Capitation
- \* Category 4 – Non-Contingent Expenses and Aggregate Cost Arrangements and Certain PSO Capitated Arrangements

For Medicare Part D Coverage, the reduction in uncertainty comes from two federal supports. The reinsurance coverage is optional in that a plan sponsor may elect to participate in the Part D Payment Demonstration. The risk corridor protection is expected to have less impact after the first few years. To allow flexibility within the RBC formula, Lines (10) through (13) will be used to give credit for the programs in which the plan sponsor participates. While all PDPs will have formularies and may utilize other methods to reduce uncertainty, for the near future, no other managed care credits are allowed for this coverage.

The managed care credit is based on the percentage of paid claims that fall into each of these categories. Total claims payments are allocated among these managed care “buckets” to determine the weighted average discount, which is then used to reduce the Underwriting Risk-Experience Fluctuation RBC. Paid claims are used instead of incurred claims due to the variability of reserves (unpaid claims) in incurred claim amounts and the difficulty in allocating reserves (unpaid claims) by managed care category. Medicaid pass-through payments that meet the Centers for Medicare and Medicaid Services (CMS) definition (included below) as subcapitations under Category 3 (if they qualify as a capitation, as defined by the health RBC formula) may be considered for the 60% managed care adjustment.

In some instances, claim payments may fit into more than one category. If that occurs, enter the claim payments into the highest applicable category. CLAIM PAYMENTS CAN ONLY BE ENTERED INTO ONE OF THESE CATEGORIES! The total of the claim payments reported in the Managed Care Credit Calculation page should equal the total year’s paid claims.



**Detail Eliminated To Conserve Space**



Definition of Pass-Through Payments (Defined by CMS in section 4 of the 2016 Medicaid Managed Care Rate Development Guide)

A pass-through payment is any of the following things:

i. any amount that the state requires a managed care plan to pay providers for something other than:

(a) a specific service or benefit provided;

(b) an alternative provider payment methodology, which is consistent with previously issued guidance on integrated care models;

(c) a quality incentive payment;

(d) a subcapitated payment arrangement for a specific set of services;

(e) Graduate Medical Education (GME) payments; or

(f) Federally Qualified Health Center (FOHC) or Rural Health Clinic (RHC) wrap around payments.

ii. any amount added by the State, or any amount required by the State to be added, to the payments from the plans to the providers that is not included in the contracted payments rates between the plans and the providers for a health care service, benefit or something listed in items (a) through (f) above.