Financial Solvency Standards Board Meeting – April 23, 2002
Summary of Comments Received
Regarding The Appropriate Interpretation of Health & Safety Code Section 1375.4(a)(1)

§ 1375.4. Risk-bearing organizations; administrative and financial capacity; report

(a) Every contract between a health care service plan and a risk-bearing organization that is issued, amended, renewed, or delivered in this state on or after July 1, 2000, shall include provisions concerning the following, as to the risk-bearing organization's administrative and financial capacity, which shall be effective as of January 1, 2001:

(1) A requirement that the risk-bearing organization furnish financial information to the health care service plan or the plan's designated agent and meet any other financial requirements that assist the health care service plan in maintaining the financial viability of its arrangements for the provision of health care services in a manner that does not adversely affect the integrity of the contract negotiation process.

Topic I

What is the minimum level of financial information that a risk-bearing organization must disclose to its contracting health plans to assist the health plan in maintaining the financial viability of its arrangements?

Health Plan Comments:	**Provider Comments:**	**Consumer Comments:**
CAHP 1. Quarterly financial statements, including an income statement, balance sheet and cash flow statement. 2. Certified calculation of incurred but not reported claims and a justification of the methodology used to calculate IBNR that includes a retrospective review. 3. Annual audited financial statements, including an income statement, balance sheet and cash flow statement, as well as footnote disclosures. 4. Monthly claims payment timeliness reports and claims aging report. On-site claims audits are also conducted routinely. 5. Deposits or reserves, annual evidence of reinsurance, and/or establishment of a financial guarantee. (These items are the "other financial requirements" that SB 260 permits and that some plans require.) 6. Monthly or regular statements to demonstrate maintenance of any required reserves. 7. Monthly statements if problems are detected.	**CMGA** Organizations must provide contracting health plans audited annual financial statements and quarterly un-audited financial summary information, not specific to a plan. In the instance of the audited annual financial statement, any plan specific information shall be redacted, including applicable footnotes, specific enrollment data, product information, or other data that allow a plan to determine capitation rates or other reimbursement mechanisms. Quarterly un-audited financials would consist of summary information including income and expenses, in a format similar to that previously collected by the DMHC. The un-audited quarterly financial information pertaining to claims payments, tangible net equity (TNE), and working capital, as well as the incurred but not reported (IBNR) methodology might also be provided.	**Consumer Coalition** Health plans and medical groups should be required to make the same level of financial disclosure and suggest that the information that the Department was collecting is the minimum level of financial disclosures to be required.

Health Plan Comments:	Provider Comments:	Consumer Comments:
PacifiCare Oversight of provider financial solvency can best be achieved through an alternative third party collection and review mechanism that will give plans actionable information in managing networks and member access to care. PacifiCare supports the implementation of a centralized data collection system that relies on an external entity to obtain financial data from RBOs, similar to the previous DMHC approved template. This third party entity would measure financial criteria as required by SB 260 and provide summary level compliance information to contracted plans. This approach should allow health plans to collect financial data independently or collectively through a collaborative process, possibly championed through the Industry Collaborative Effort (ICE) Committee. This third party collection entity would contract directly with health plans, with approval of the Department, and would oversee data collection and confidentiality of the information The ability of a health plan to continue to receive financial information directly from providers under certain circumstances should not be precluded, including the need to review detailed financial statements when entering into a new contract with a provider, negotiating a contract renewal, or development of corrective action plan. PacifiCare's standard contracts require risk-bearing organizations to allow review of quarterly balance sheets and income statements, prepared in accordance with Generally Accepted Accounting Principles (GAAP). Additionally, PacifiCare requires review of annual audited financial statements. It is PacifiCare's intention to establish an additional requirement to report IBNR reserves and a historical analysis of the group's success in gauging IBNR. **<u>Additional Information Needed to Facilitate Corrective Action Plan Process</u>** **CAHP** 1. A breakdown of revenue by product or other	**CAPO** RBO should provide contracting health plans with a quarterly statement verifying that the RBO: 1. Is timely paying claims within the meaning of Health and Safety § 1371. 2. Properly estimates IBNR. 3. Maintains a positive current ratio (assets over liabilities), or if negative, a current ratio that is trending upward. The same information should be provided annually with an auditor's verification of its correctness. **CMA** RBO shall submit to each contracting health plan, financial statements related to that specific health plan's contract only. A health plan may review, upon request, the contracting organization's general financial status, provided the following conditions are met: 1. The health plan provides at least ten (10) days prior written notice to perform a review; 2. The review must occur at a time that is acceptable to the organization and during the organization's normal business hours or at such other times as may be mutually agreed upon; 3. The review shall take place at the organization's principle place of business with the appropriate organization representatives present at all times during the review; 4. The information available for review shall be the most recent audited financial statement, provided that any information, which relates to the terms of other health plan contracts be redacted. The review is conducted by a health plan representative with the appropriate financial expertise to certify that the organization meets the plan's financial capacity requirements; 5. The health plan representative is prohibited from taking any information off the premises of the organization's place of business;	

Health Plan Comments:	Provider Comments:	Consumer Comments:
category. 2. A review of claims payment to non-contracting providers indicating the percent of claims paid to these providers. 3. A detailed schedule of assets and liabilities. 4. Audited financials and cash flow statements. 5. A list of creditors. 6. Information on the materiality of risk pool accounts receivable and payable. 7. Information regarding any affiliates or subsidiaries. 8. A detailed schedule of the components of the RBO's general and administrative expenses. **PacifiCare** If an RBO's financial statements were to indicate potential solvency issues, PacifiCare typically require additional information to understand the RBO's business model, organizational structure and source of financial difficulties, including: 1. Estimated percentage of non-contracted claims paid for covered services for most recent quarter. 2. List of payors, along with information regarding their total and percentage of membership. The list could be blind, but would include all payors, including non-HMO payors to provide a complete picture of the group's position relative to plans. 3. Cash flow projections for the next 12 months including management plans for financial turn-around. 4. List of creditors by amount of debt. 5. Information to substantiate risk pool accounts receivable and payable. 6. Description of the legal organization of the group, including board governance, list of Board members, and affiliated companies. 7. Financial information regarding affiliated companies. 8. Information regarding the salaries of the top ten officers. The list may be blind or aggregated. 9. A cash ratio metric that provides information as to the quality of the group's cash ratio.	6. The health plan and its representative shall sign a confidentiality agreement prior to the review of this information prohibiting any further disclosure of the information reviewed, and provides for damages and injunctive relief in the event of an improper disclosure.	

Topic II

What is the meaning of "meet *any other financial requirements* that assist the health care service plan in maintaining the financial viability of its arrangements…?"

Health Plan Comments:	**Provider Comments:**	**Consumer Comments:**
CAHP "Any other financial requirements" include deposits or reserves, annual evidence of reinsurance, and/or establishment of financial guarantees.	**CMGA** This term is extremely broad and should be clarified by regulation. Additional financial requirements should be limited to: information regarding claims timeliness, TNE, IBNR, working capital, and cash liquidity ratios. **CAPO** The emphasis of SB 260 is on that which a health plan is intended to determine rather than strictly on what an RBO is intended to provide. SB 260 was not intended to set minimum financial requirements or ratios for RBOs. Accordingly, "other financial requirements" refers to information that supports a health plan's determination of an RBO's timely claims payment, IBNR calculation, and current ratio.	**Consumer Coalition** Other financial requirements include a consideration of quality of care issues that are often an early warning of financial deterioration.

Topic III

If a health plan cannot secure sufficient financial information from a risk-bearing organization to demonstrate the financial viability of its arrangements, may the health plan continue to contract with that organization on a risk basis?

Health Plan Comments:	**Provider Comments:**	**Consumer Comments:**
CAHP No automatic termination of non-complaint risk-bearing organizations. **PacifiCare** We support corrective action processes for such situations, but would not support a policy that would mandate termination of a business relationship if financial data is not shared between the interested parties. Health plans must be allowed to use certain discretion in selecting and working with contracted providers on a case-by-case basis. Any oversight system that relies on providers reporting required financial data to multiple plans on a routine basis, under threat of enrollment freezes or contract terminations will be burdensome to providers and plans and could result in potential manipulation of the process.	**CMGA** Believes the RBO should be subject to a mutually agreed upon corrective action plan that would remedy the situation. During certain times of the year, a quarterly report may be deficient in one or two of the financial criteria. This may be due to labor problems, flu season, or other temporary or seasonal changes. If the RBO is unwilling to enter into a mutually agreeable corrective action plan, the health plan may consider terminating the contract. In the case of a health plan failing to secure *any* financial information from a risk-bearing organization, the RBO may be subject to breach of contract and the plan should be allowed to terminate the contract, as appropriate. **CAPO** If an RBO provides the three financial statements detailed above and its current ratio is positive or trending appropriately, contracting should continue, but health plans need not continue contracting if the statements are not provided. RBOs failing to meet the criteria must undertake a corrective action plan should such regulations be promulgated by the Department.	**Consumer Coalition** If risk-bearing organizations fail to disclose sufficient financial information to allow their contracting health plans to verify their administrative and financial capacity to accept risk then the delegation of financial responsibility for the delivery of health care services should be discontinued.

Topic IV

What is the meaning of the clause "in a manner that does not adversely affect the integrity of the contract negotiation process?"

Health Plan Comments:	**Provider Comments:**	**Consumer Comments:**
CAHP The phrase "in a manner that does not adversely affect the integrity of the contract negotiation process" was largely left to the Department to interpret during its rulemaking process. When SB 260 was being debated in the Legislature, RBOs were already submitting to health plans the financial information described above. The definition of "Integrity" is important. According to the *Random House/Webster's College Dictionary* (Random House, 1999), integrity is defined as: 1. Uncompromising adherence to moral and ethical principles; soundness of moral character; honesty. 2. The state of being whole or entire: *to preserve the integrity of the empire.* 3. Sound or unimpaired condition. Syn. See Honor. The most apt definition for the use of "integrity" in SB 260 is "honest" or "ethical." The most appropriate interpretation is that SB 260 prohibits disclosure of RBO financial information in a way that would compromise the honesty and ethics of a contract negotiation process. It is ***not*** correct to interpret this phrase in SB 260 as meaning that a disclosure is prohibited merely because it would have ***any*** effect on a negotiation at all. The language also does not prohibit a disclosure simply because it would have an adverse affect on the bargaining power of one of the parties to the negotiation. Likewise, the language does not prohibit a disclosure because it would have an adverse impact on the ***outcome*** of a negotiation for one or the other party. SB 260 protects the ***process***, and prohibits disclosures that would preclude or	**CMGA** This clause means any information that a plan could potentially utilize to determine confidential information including salaries, reimbursement rates, including capitation payments, as well as detailed membership enrollment by product should be withheld. In general, any financial information that allows any plan to estimate the RBO's profitability by Plan or the calculation of average or plan specific capitation rates, particularly without the context of the detailed description of services covered by a specific contract, would be misleading and adversely impact the contracting process. **CAPO** The disclosure of RBO financial data compromises the integrity of contract negotiations. When a health plan knows that an RBO is realizing a profit under a given contract, the plan negotiates "harder" - it grinds the RBO in a way it could not in the absence of that knowledge. **CMA** While not offering a specific definition for the clause "in a manner that does not adversely affect the integrity of the contract negotiation process," CMA believes that the financial disclosures of RBOs to health plans that it proposes under Topic I would not adversely affect the contract negotiation process.	**Consumer Coalition** Mandating the same level of financial disclosures for both health plans and medical groups will ensure the "integrity of the contract negotiation process."

Health Plan Comments:	Provider Comments:	Consumer Comments:
interfere with an honest or ethical negotiation process. An honest and ethical negotiation process means that any policy regarding disclosure cannot interfere with a health plan's ability to determine whether the RBO has the financial and administrative capacity to accept the risk to be assumed under the contract. It means that any policy regarding disclosure cannot interfere with either party's ability to obtain a reasonable level of valid information about the financial condition of the other party in order to protect the economic interests involved. The "manner" of disclosure is also critical. Health plans recognize that certain elements of an RBO's financial information, or a certain level of detail in the financial documents, may compromise the ethical nature of a contract negotiation process. Consequently, health plans do not compel information on the rates that other health plans pay to that RBO or the rates the RBO pays to its employees or contracting and subcontracting physicians. Plan-specific revenue and expense data or information relating to strategic plans is not required in the financial statements disclosed. The balance sheets, cash-flow statements and income statements should reflect overall financial results for the RBO as an organization. Most RBOs disclose financial information pursuant to confidentiality agreements in which the health plan agrees not to share the information with any other party. **PacifiCare** The integrity in contract negotiations must be present for both parties, and that plans and providers must be as forthcoming concerning their financial capacity. The financial status of an RBO is particularly relevant because of the RBO's assumption of financial risk for services delivered to members.		

Health Plan Comments:	Provider Comments:	Consumer Comments:
Placing the following limitations on required disclosures will ensure that the integrity of the contract negotiation process will not be adversely impacted: 1. The financial data shared by an RBO with a health plan should be aggregate financial data that is not health plan specific. 2. The disclosure of financial data should be between the contracted business partners only. We would agree to maintain the confidentiality of sensitive information provided by our business partners and refrain from sharing this information with ancillary providers, specialty groups, or other contracting entities.		