Financial Solvency Standards Board Meeting
January 30, 2019
Meeting Minutes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Jeffrey Conklin, Adventist Health Plan
Dr. Larry deGhetaldi, Palo Alto Medical Foundation
Paul Durr, Sharp HealthCare
John Grgurina, Jr., San Francisco Health Plan
Dr. Jeff Rideout, Integrated Healthcare Association
Shelley Rouillard, Department of Managed Health Care

Department of Managed Health Care (DMHC) Staff Present:
Sarah Ream, Acting General Counsel & Deputy Director of Plan Licensing
Pritika Dutt, Deputy Director, Office of Financial Review
Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations
Michelle Yamanaka, Supervising Examiner, Office of Financial Review

1) Welcome & Introductions

Chairperson John Grgurina called the meeting to order and announced FSSB board member Richard Figueroa had accepted a position with Governor Newsom's Office and would no longer serve on the Board. As a result, the Department would be looking for a new consumer-oriented member. Suggestions or nominations should be sent to Mary Watanabe. Mr. Grgurina then asked the Board members to introduce themselves.

Mr. Grgurina noted Mari Cantwell was unable to attend the meeting so the Department of Health Care Services (DHCS) update would be presented at the next FSSB meeting.

2) Minutes from October 17, 2018 FSSB Meeting

Mr. Grgurina asked if there were any changes to the October 17, 2018, FSSB meeting minutes. The meeting minutes were approved with no changes.

Director Shelley Rouillard acknowledged Kristian Wright for doing an amazing job on the October minutes and for capturing the good discussion.

3) Director's Remarks

Ms. Rouillard provided a brief summary of the Governor's proposed 2019-2020 Budget. She noted the budget assumes continued economic growth of 3.2 percent compared to a historical rate of 5 percent. The budget includes $13.6 billion to pay down debt, including $4 billion in debt reduction, $4.8 billion to build reserves, and $4.8 billion to cover unfunded pension liabilities. The budget also adds to the safety net reserve so

that when there is an economic downturn, CalWORKs and Medi-Cal continue without adverse impact as in prior recessions. Overall, the budget pays off $34.7 billion in debt.

On January 21, 2019, Governor Newsom appointed Kris Perry, a national leader in early childhood policy, to serve as Deputy Secretary of the California Health and Human Services (CHHS) Agency for Early Childhood Development and Senior Advisor to the Governor on Implementation of Early Childhood Development Initiatives. Kris Perry was a former Executive Director of First 5 California.

Ms. Rouillard highlighted the following budget items related to healthcare:

- Increases subsidies for people in the individual market with incomes between 250 to 400 percent of the federal poverty level (FPL) and expands subsidies for those between 400 and 600 percent FPL.
- Provides full-scope Medi-Cal for undocumented individuals up to age 26.
- $50 million to the Office of Statewide Health Planning and Development (OSHPD) for workforce training for mental health care.
- $3.2 billion for Medi-Cal supplemental payment to physicians, dentists and other providers.
- Provides $100 million for the Whole Person Care Pilot programs that provide housing services, and coordinate health, behavioral health and social services in a patient-centered manner.
- Restores the 7 percent cut to In-Home Supportive Services (IHSS) hours.
- Increases CalWORKs grants to 50 percent FPL and also increases Supplemental Security Income/State Supplementary Payment SSI/SSP grants.
- Continues the Department of Social Services (DSS) Continuum of Care program for children in foster care.
- $290 million for grants to community based organizations to provide services during immigration or human trafficking emergency situations when federal funding is unavailable.
- Creates a Governor's Task Force on Brain Health and provides $3 million to support Alzheimer's research programs.
- $30.5 million to expand the California Home Visiting program and Black Infant Health Program.
- Moves Juvenile Justice from the Department of Corrections to the CHHS Agency.

Ms. Rouillard provided an update on the Executive Orders issued by the Governor during his first few days in office:

- Prescription Drug Purchasing. Directs the DHCS to (1) transition all pharmacy services from Medi-Cal managed care to a fee-for-service benefit by January

2021 and (2) review all state purchasing initiatives and consider options for maximizing the state's bargaining power, including the Medi-Cal program, by July 1, 2019. Additionally, the Department of General Services (DGS), in consultation with the California Pharmaceutical Collaborative, will develop a list of drugs that could be prioritized for future bulk purchasing initiatives and submit a report by March 15, 2019.

- Surgeon General. Established the first California Office of the Surgeon General. On January 21, 2019, Governor Newsom appointed Dr. Nadine Burke Harris, a national leader in pediatric medicine, to serve as California's first-ever Surgeon General.
- Letter to President and Congress. The letter, sent January 7, 2019, requested an amendment to federal law to create and allow states to apply for and receive, "Transformation Cost and Universal Coverage Waivers". These waivers would empower California to innovate and begin transformative reforms that provide the path to a single-payer health care system.
- Affordable Housing and Homelessness. Directs DGS and the Department of Housing and Community Development (HCD) to develop screening tools to prioritize affordable housing development on excess state land by March 29, 2019, and to have a selection process by September.

Ms. Rouillard provided an update on other Department activities starting with Senate Bill (SB) 17 and the first Prescription Drug Cost Transparency Report. SB 17 requires health plans and health insurers that file premium rate information with the DMHC or the California Department of Insurance (CDI) to annually report specific information related to the costs of covered prescription drugs.

For measurement year 2017, 25 health plans submitted prescription drug data, including the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the highest year-over-year increase in total annual spending. The data represents prescription drugs obtained through a retail or mail order pharmacy, and does not include drugs administered in a doctor's office or a hospital.

Key findings from the report include:

- Health plans paid nearly $8.7 billion for prescription drugs in 2017, which accounted for 13.1 percent of total health plan premiums.
- Manufacturer drug rebates equaled approximately $915 million or about 10.5 percent of the $8.7 billion spent on prescription drugs.
- Specialty drugs represent only 1.6 percent of all prescription drugs, but accounted for over half of total annual spending on prescription drugs. Conversely, generic drugs represented nearly 90 percent of all prescribed drugs, but only a quarter of the total annual spending on prescription drugs.
- Overall, plans paid over 90 percent of the cost of the 25 Most Costly Drugs across all three categories (generic, brand name and specialty).

The DMHC published the Timely Access Report for measurement year 2017 on December 19, 2018. The report summarizes provider appointment availability data submitted by 35 health plans and 6 behavioral health plans. While there are still some data errors, the data continues to improve each year. As a result, the DMHC was able to compare data across plans and to display data by product line.

The DMHC continues to require health plans to use an external data validator prior to submitting the data to the Department. All of the health plans used a survey methodology to assess provider appointment availability, except Kaiser which used an audit methodology for its internal providers. Kaiser did use the survey methodology for its externally contracted providers.

Key findings from the report include:

- For full service health plans, the percentage of all surveyed providers who had an appointment available within the wait time standards for both urgent and non-urgent appointments ranged from 63 percent to 99 percent. Non-urgent appointments ranged from 70 percent to 99 percent and urgent appointments ranged from 52 percent to 99 percent.
- For behavioral health plans, the percentage of all surveyed behavioral health providers who had an appointment within the wait time standards ranged from 64 percent to 83 percent. Non-urgent appointments ranged from 71 percent to 87 percent and urgent appointments ranged from 57 percent to 80 percent.
- Kaiser Permanente reported that the percentage of all audited providers who had both urgent and non-urgent appointments available was 92 percent. Non-urgent appointments were available 91 percent of the time and urgent appointments were available 98 percent of the time.

Ms. Rouillard provided an update on mergers approved by the DMHC before the end of the year. In November, the DMHC approved the purchase of Aetna, Inc. by CVS. In December, the DMHC approved the purchase of Express Scripts by Cigna and the purchase of DaVita Health Plan by Optum, Inc. The Department's approval of the three mergers included a total of $357 million in community investments for the following activities:

- Over $40 million over three to five years for workforce development, including investments totaling $32.8 million from CVS/Aetna and Cigna/Express Scripts to the Health Professions Education Foundation housed within OSHPD and $8 million from Optum/DaVita for scholarships through the United Health Foundation Diverse Scholars Program for those seeking to become a psychiatrist or psychiatric nurse practitioner in the field of child and adolescent psychiatry.
- $171 million in healthcare infrastructure to improve and expand facilities and create or maintain jobs.

- $66 million in quality improvement activities, including support for the California Quality Collaborative Practice Transformation Initiative and Pay-for-Performance programs.
- $10 million to address social determinants of health.
- $3 million for consumer assistance targeted at seniors and persons with disabilities.
- $4.2 million for opioid prevention and treatment, including stocking naloxone in pharmacies and not requiring prior authorization for naloxone.

Ms. Rouillard stated the Integrated Healthcare Association (IHA) launched the Symphony Provider Directory in early January 2019. The Symphony Provider Directory enables providers to update their information in one place and for health plans to access the data to update their directories with the goal of more up-to-date and accurate information for consumers.

Ms. Rouillard provided an update on the undertakings related to Centene's acquisition of Health Net. The DMHC required Health Net to set aside $55 million to address the problems related to lack of timely and accurate encounter data. In February, Health Net is expected to release a Request for Proposal for a contract to facilitate an industry-wide stakeholder process similar to what Blue Shield did for provider directories. Health Net is planning on a year-long process to develop an industry solution.

Ms. Rouillard provided the following update regarding regulations:

- General Licensure, or Risk, regulation. On January 18, 2019, the DMHC resubmitted the regulation to the Office of Administrative Law (OAL) which has 30 days to review.
- Risk Bearing Organization (RBO) regulation. The second public comment period has closed and the DMHC is reviewing the comments. The regulation will be submitted to OAL shortly.
- Standard Prescription Drug Formulary Template. The DMHC is reviewing the comments and expects to submit the final regulation to OAL by the end of March 2019.
- Cancellations, Rescissions and Non-Renewals. The second, 15-day public comment period closed on January 14, 2019 and the DMHC anticipates submitting the final package to OAL in April 2019.

Discussion

Dr. Jeff Rideout asked if the $100 million in the Governor's budget for affordable housing and homelessness has a connection to the whole person care funding for housing and other housing initiatives in the undertakings the DMHC has required in recent mergers. Ms. Rouillard responded she is not sure how these programs will be structured. However, the DMHC wants to make sure the work is coordinated**.**

Dr. Larry deGhetaldi stated that when looking at health care inflation, pharmacy is the leading cause. However, the greatest inflation is actually not in prescription drugs but the biologics administered in the infusion centers. This information is not included in the prescription drug information the DMHC receives from the plans. In the debate about the fate of 340 B and maintaining access for Medi-Cal patients, it is important to remember the inflation in infusion drugs is the greatest single driver of overall inflation.

Dr. deGhetaldi added he applauds the work on encounter data because the future is in risk-based payments and accurate encounter data is needed.

Paul Durr noted taking on responsibility for drug risk is pretty significant, especially for orphan drugs and new developments. If the medical groups are taking on this risk, it has to be built into the premium at some point. While prescription drugs are a piece of that, what makes providers nervous is the risk associated with the high-cost ones. The orphan drugs, in particular, have the potential to bankrupt groups.

Mr. Grgurina noted his excitement about the changes the Governor is proposing for healthcare. The Board has discussed what Covered California is doing to try to maintain a stable risk pool, while the decisions from the federal government are undermining that effort. The ability to place a mandate and add subsidies for those at 400 to 600 percent FPL is significant. The presentation at the last FSSB meeting showed there were several points added to the rates because of the mandate going away. A state based mandate will improve the rates and adding consumers from 400 to 600 percent FPL to the risk pool will have a very positive effect.

Dr. Rideout stated he was invited to meet with the Centers for Medicare and Medicaid Services (CMS) officials last week, including the Chief of Staff and Secretary Azar. He provided them with an overview of their work on Symphony and the Cost and Quality Atlas. They seemed very impressed with the work California is doing through collaborative solutions and would like to use them as examples for other regions in the country.

Mr. Durr expressed concern for the way the timely access survey is conducted and the way the survey asks about a provider’s availability. In many cases, a nurse practitioner, physician’s assistant, or another physician are available. Additionally, some consideration may need to be given to other types of services, such as urgent care. Although the patient may want a particular physician, if it is urgent, they may need to be seen by other providers within that group.

Dr. deGhetaldi added much of the work by primary care physicians is now virtual work, which can’t really be measured. A patient will be delighted to have a response to an email within a short period of time even if it delays a face-to-face office visit. Ms. Rouillard responded the statute does not allow the DMHC to measure that right now. The DMHC has until 2020 to promulgate the timely access regulations and is working to determine what the standard methodology is that will enable the DMHC to establish a rate of compliance to hold plans accountable for.

In regards to the agenda item on Delta Dental of California's purchase of an interest in Moda, Inc., Ms. Rouillard reminded to Board that its role is to advise the Director on matters of financial solvency affecting the delivery of health care services. The purpose of putting the item on the agenda was to provide the public with an opportunity to provide input, as there has been significant interest in the transaction. While it is not the Board's responsibility to make a decision on the matter, Board members are welcome to provide their perspectives. The DMHC's review is ongoing and the DMHC will consider the comments received during the meeting and a decision will be made at a later date.

4) Federal Update

Sarah Ream, Acting General Counsel and Deputy Director of Plan Licensing, provided an update on activities at the federal level, including one piece of litigation and four regulations.

In the case of Texas v. Azar from the Federal District Court in Fort Worth, Texas, on December 14, 2018, Judge Reed O'Connor held that the Affordable Care Act (ACA) in its entirety is unconstitutional. Judge O'Connor found that reducing the federal penalty to zero effectively means the individual mandate is no longer a tax. Without the tax, the entirety of the ACA must be struck down as an improper exercise of the Constitution's Commerce Clause.

On December 17, 2018, the U.S. Department of Health and Human Services (HHS) issued a statement that Judge O'Connor's ruling is not an injunction against the ACA and that the ACA, for the time being, remains in effect. Likewise, on December 30, 2018, Judge O'Connor issued a final judgement as well as a stay of that judgment, which allows California and the other 16 intervener states to file an appeal of his decision. On January 3, 2019, California and the other intervener states filed notice that they are appealing Judge O'Connor's decision to the Fifth Circuit Court of Appeals. It is likely this case will ultimately go to the Supreme Court. However, the ACA remains in effect for the time being.

Ms. Ream noted on January 17, 2019, CMS issued its annual Notice of Benefit and Payment Parameters for 2020. This is a huge annual proposed federal regulation that covers a variety of topics related to the health insurance marketplaces, from benefits to risk adjustments to cost-sharing parameters. Some notable items include the following:

- The regulation continues to allow states to "silver load" but also invites comments on whether this should be allowed in the future. "Silver loading" is the way some states resolved the elimination of the federal payments for Cost Sharing Reductions (CSRs). The cost of the CSRs was loaded on to the Exchange Silver plan's premiums, which are the benchmark for calculating the tax credits. Silver loading protected people with low incomes from bearing the brunt of premium hikes attributable to the elimination of federal payments for CSRs.
- The proposed regulations also include provisions around prescription drugs, including provisions that appear to have the intent to steer people toward generic

drugs, when they are available. For example, the regulation proposes that health plans could say that if a consumer uses a manufacturer-issued drug coupon for a non-generic drug, the amount of the coupon does not apply to the out-of-pocket maximum.

Ms. Ream provided an update on the proposed Exchange Program Integrity Rule issued by HHS on November 7, 2018. Under current law, federal funds cannot be used for "non-Hyde abortions," an abortion performed for reasons other than the life of the mother, rape or incest. The proposed rule goes a step further and requires health plans to issue two premium bills in separate envelopes or in two e-mails for electronic payments. One bill would be for less than one dollar to cover abortion-related services. The second bill would be the premium for all other services. Concerns have been raised that this rule, if enacted, could cause significant confusion to enrollees when they receive two separate bills. Also, an enrollee could face a potential loss of coverage if the enrollee paid only one of the two bills.

Ms. Ream stated on November 7, 2018, HHS, the Department of Labor, and the Department of Treasury issued the following two interim final rules regarding religious and moral objections to coverage of contraceptives:

- The religious exemption rule would expand the exemption that was previously available primarily to churches and religious institutions to any individual, insurer, or non-governmental employer, including for-profit entities, who may seek an exemption from providing coverage for contraceptive and sterilization services based on religious beliefs.
- The moral exemption rule, which is similar to the religious exemption rule, but more limited in scope. It applies only when an entity or person has a moral exemption or moral objection to providing contraceptive or sterilization services.

Both rules note that state law should not be pre-empted. California has a robust statutory scheme for contraception, so the rules would not directly impact enrollees in fully-insured health plan products. However, they would apply to enrollees in self-insured products. Shortly after the final rules were issued, federal judges in Pennsylvania and California issued preliminary injunctions blocking the rules from going into effect while the litigation regarding the rules is pending.

Ms. Ream discussed the final regulation related to the Interim Final Rules Regarding Third Party Premium Payments. On December 12, 2016, CMS issued an interim final rule barring dialysis facilities from making premium payments for individuals without disclosing to the insurer or health plan that a third-party payment was being made, and obtaining assurance from the insurer or health plan that the third-party payments would be accepted.

After the implementation of guaranteed issue requirements in the individual market, health plans and insurers started seeing third-party premium payments from providers, particularly dialysis centers. For example, the American Kidney Fund, a charity which is largely funded by two large dialysis companies, was paying premiums for commercial

coverage for enrollees with End Stage Renal Disease (ESRD). The health plans' concerns largely center on the fact that the reimbursement rates they pay to dialysis centers are often higher for commercial coverage than for coverage under a government program. Therefore, moving enrollees from government programs to commercial coverage was increasing the cost to the plan. The rules were set to take effect on January 13, 2017, but a federal court in Texas issued a preliminary injunction blocking the rules from taking effect while litigation is pending.

Ms. Ream noted, at the state level, there was proposed legislation related to third-party payments in 2018, which was not enacted. Earlier this week, Assembly Member Wood introduced Assembly Bill (AB) 290 on this subject.

Discussion

Dr. deGhetaldi asked how many Californians are covered by self-insured Employee Retirement Income Security Act (ERISA) sponsored plans and could lose access to reproductive services. Ms. Ream stated she estimated 6 million are covered by self-insured products.

Dr. Rideout asked if the CSR work-around fully mitigated the CSR withdrawal. Ms. Ream responded different states have handled it differently and in California, it is almost a wash. Ms. Rouillard noted it has been a good for consumers. Ms. Ream added if the Federal government says you can't load the CSR offset to the premium for the Exchange Silver products, it would have to be spread across all products, both on and off Exchange, which could impact consumers negatively.

Mr. Grgurina asked if the CSR load to the Silver products happened only in the Exchange, and not to the unsubsidized off-Exchange Silver products. Ms. Ream confirmed that was correct. He noted this actually costs the federal government more because when premiums rates go up, the federal government is paying the full differential for each member that gets a subsidy.

Jeffrey Conklin asked what would happen if someone did not pay the dollar and whether their coverage would be cancelled. He noted this would put the provider and the patient in a really bad place and could be very confusing. Ms. Ream agreed and said it is not clear at this time what would happen.

Dr. deGhetaldi asked if there would be different premium notices by gender. Ms. Ream responded her understanding of the rules is it would be spread across the risk pool for the product. Likely everybody would get a bill for one dollar and another bill for the remainder. She added sending two separate bills could increase costs to health plans, in the hundreds of millions of dollars.

5) Department of Health Care Services Update

Mari Cantwell, Chief Deputy Director, Health Care Programs, DHCS was unable to attend the meeting. As a result, Item 5 was struck from the January 30, 2019 Agenda.

6) Delta Dental of California Purchase of Interest in Moda, Inc.

Sarah Ream, Acting General Counsel and Deputy Director of Plan Licensing provided an overview of Delta Dental of California's proposed purchase of Moda, Inc., an Oregon-based corporation and health insurer.

Delta Dental of California is proposing to purchase a 49 percent interest in Moda, Inc., for the purchase price of $153 million. Delta Dental is a specialized dental plan and has been licensed in California since 1974. They have approximately 25 million California enrollees and approximately $2.65 billion in assets. Delta is a nonprofit, mutual benefit corporation.

Ms. Ream pointed out the difference in California law between a nonprofit mutual benefit corporation and a nonprofit public benefit corporation. A nonprofit public benefit corporation is formed under the Corporations Code to perform any public or charitable purpose. In contrast, a nonprofit mutual benefit corporation, which Delta is, is formed for any lawful purpose. However, often they're formed for the purpose of advancing the mutual benefit of their members or the mutual benefit of those engaged in a profession.

Ms. Ream explained how the organizational structure of Moda, Inc. would change after the proposed transaction. Moda Holdings, LLC, would own a 50.5 percent interest in Moda Partners, Inc., and Delta Dental would own a 49.5 percent interest in Moda Partners, Inc.

Ms. Ream described the DMHC's review of the transaction, specifically whether the transaction would have a material effect on Delta Dental of California's enrollees and how Delta will continue to serve its enrollees, provide services, and work with its contracted providers. The DMHC also looked at how the transaction would impact Delta Dental's administrative capacity and current and future finances.

Ms. Ream addressed the applicability of AB 595 and of Article 11 under the Knox-Keene Act. The DMHC determined AB 595 does not apply to this transaction because the purchase is not a merger, as defined in the statute, since Moda is not a California-licensed plan. Furthermore, Article 11 applies only to restructuring and conversions of nonprofit health plans that have assets subject to a charitable trust. The Department has not found any evidence that Delta has assets subject to a charitable trust.

Ms. Ream said the DMHC's review is nearing completion. The DMHC has received comments and questions about issues outside the Departments authority, such as the premium rates Delta has set, the amount Delta compensates its executives, and whether Delta should be considered a nonprofit entity in California. Since these factors are outside of the DMHC's authority under the Knox-Keene Act, they were not considered in the review of the transaction.

Discussion

Mr. Conklin asked if mutual benefit corporations, such as Delta, are usually nonprofit, noncharitable, but taxable entities. Ms. Ream said she believed so.

Mr. Conklin stated his organization works very closely with Moda. They are a very strong, capable organization in Oregon. His organization has looked closely at the transaction and believe it's a really good thing for Oregonians. He asked what happens if the Department decides it has a concern and whether it would ask Oregon to undo the transaction. Ms. Rouillard stated the Department would not ask the State of Oregon to undo what it's done. The issue with Moda is around its financial stability. They might have to find another buyer or get an infusion of cash in order to be able to operate in other states. Mr. Conklin stated the transaction seemed to be a good opportunity to help stabilize an important insurer in Oregon.

Mr. Michael Johnson commented via phone that he, and other consumer groups, believe Article 11 applies as Delta has declared itself a nonprofit mutual benefit corporation, and noted consumer groups have presented quite a number of indications that it has a charitable trust obligation. When the plan was initially incorporated, it declared it would operate for the benefit of all Californians. It currently has Board members that purport to represent the public, not policy holders. The governing documents do not mention it being organized for the mutual benefit of its policy holders; therefore, it is clear it is organized for the mutual benefit of all Californians. In addition, it has both a state and federal tax exemption as a social welfare organization. So, it has a legal duty as a social welfare organization to operate primarily, or exclusively, for the promotion of social welfare.

Mr. Johnson noted the Attorney General has no authority over the charitable trust obligation of nonprofit organizations that are health plans and the law gives all authority to the DMHC. He stated Article 11 is the lynchpin of the DMHC's authority and if the Department takes the plan's word that they don't have assets subject to a charitable trust obligation, the public is going to get short changed. He said Delta holds over $1.5 billion in reserves and $9 billion in revenue per year.

Mr. Johnson requested that the Department provide a written explanation of the decision and commit to transparency on the Department's decision making authority.

Terri Boughton asked the DMHC to explain why AB 595 does not apply. Ms. Ream said if Delta was being acquired by another entity, AB 595 would apply.

Linda Nguy with Western Center on Law and Poverty stated she agrees Delta Dental holds a charitable trust obligation. She recommended, if the merger is approved, that the DMHC consider undertakings to increase the charitable contributions beyond five percent of its assets to support locally-based, community assistance programs targeting low-income individuals, including the Denti-Cal Program, to improve quality, ensure premium dollars go toward claims and not profits or salaries, and to increase the diversity of network providers and enrollees.

Mike Hankinson, Chief Legal Officer for Delta Dental of California, thanked the Board for taking the time to review the transaction. Delta Dental has an enrollee retention rate of 97.9 percent, which shows people who have dental plans are more proactive about their oral health and the visit their dentist far more often than those without dental plans. Enrollment and retention drives Delta's social welfare purpose of getting people into the dental office where they can take care of their oral health.

Delta Dental is the largest dental carrier in the country with over 28,000 dental providers in California and 37 million enrollees, of which over 25 million are in California. These enrollees come from all manner of groups, including commercial groups, Medicare Alliances, Medicaid programs, Health Exchanges, and Federal Programs such as the Veterans Insurance Program.

Mr. Hankinson stated Delta Dental recognized the dental and health benefit landscape is changing as consumers and purchasers want a one-stop shopping experience where they can acquire a bundled dental and medical plan. In order to fulfill Delta Dental's social purpose and grow enrollment, they needed to find a like-minded medical partner. They found this in Moda, who already has integrated dental and medical plans.

He said this transaction is in line with Delta's commitment to expanding oral health and presents an opportunity to develop analytics in support of how dental coverage can improve overall health outcomes and, ultimately, reduce medical cost. He reiterated Delta Dental's commitment that the transaction will have no adverse impact on Delta Dental's financial solvency and California operations, enrollees and employees, and will not increase premiums as a result of the direct costs incurred in connection with this investment.

7) Dental Medical Loss Ratio

Pritika Dutt, Deputy Director, Office of Financial Review, provided an overview of the dental medical loss ratio (MLR) information for reporting year 2017. AB 1962 requires dental plans offering commercial dental coverage to file MLR information annually. The plans first reported the data in calendar year 2014 and the current data is for reporting year 2017.

Ms. Dutt reviewed the key findings for the 19 plans that offered dental HMO products in 2017:

- Individual market MLR ranged from 19 percent to 84 percent. The average MLR was 52 percent, an increase compared to 43 percent in 2016.
- The small group market MLR ranged from 34 percent to 91 percent, with an average MLR of 55 percent, the same as in 2016.
- The large group market HMO MLR ranged from 48 percent to 78 percent, with an average MLR of 63 percent, the same as 2016.

Ms. Dutt reviewed the key findings for the four plans that offered dental PPO products in 2017:

- The two plans in the individual market reported MLR of 66 percent and 75 percent. The average MLR was 70 percent, an increase compared to 66 percent in 2016.
- For the four plans in the small group market, the MLR ranged from 33 percent to 88 percent. The average MLR was 63 percent, a slight increase compared to 61 percent in 2016.
- For the three plans in the large group market, the MLR ranged from 82 percent to 88 percent. The average MLR was 85 percent, a slight decline from 87 percent in 2016.

Ms. Dutt noted this is the first year there were no single digit MLRs in the dental HMO products. For reporting year 2015 and 2016, the dental MLR was as low as 4 percent and for 2014, the dental MLR was as low as 5 percent.

Ms. Dutt stated there is significant variance between the plans and products the dental plans offer. The premiums can be as low as $3 in some cases. There is also a variety of products depending on how much premium consumers are willing to pay. Some of the big plans have thousands of product designs.

The average administrative cost for the dental plans was 33 percent. Dental plans have the same administrative functions as full service health plans, but the premium amount is significantly lower for dental plans. The average net profit on a consolidated basis was 10 percent for the 19 plans. Two plans had zero profit and two had net losses. Ms. Dutt noted low MLR may not necessarily relate to a high profit.

Ms. Dutt concluded by pointing out the majority of enrollment, about 76 percent, is with plans with loss ratios greater than 70 percent. Only 1.5 percent of the enrollment is with plans with loss ratios below 50 percent.

Discussion

Dr. Rideout stated, as discussed at a prior FSSB meeting, the comparability of this information is really challenging and maybe the best approach is to look at the stability of the groups and to make sure the trends are going in the right direction.

Mr. Durr asked if there was an explanation for the increase in the MLR. Ms. Dutt said the plan’s reporting has improved over the last 4 years which could be a reason for higher MLR.

Dr. deGhetaldi said it would be good to watch MLR trend and profit margin over time. He asked if the average was weighted or a straight average. Ms. Dutt said it was a straight average.

Mr. Conklin asked what the DMHC's role or oversight is in regards to solvency for dental plans. Ms. Dutt responded the DMHC's oversight of dental plans for financial solvency is similar to the medical plans. Plans with net losses are placed on a corrective action plan.

Dr. deGhetaldi stated that it would be interesting to see dental plan data presented in a way that is similar to medical plan data. Dr. Rideout added it would be helpful to see the weighted average by membership across the entire marketplace, since most are in the upper tier, with a much higher medical loss ratio.

Mr. Durr stated it would be helpful to see the average premium by dental HMO and PPO so the data could be easily compared to the loss ratio.

Mr. Grgurina added another way to look at the data is to look at it by exception. The plans that have low MLR and are not profitable would be the ones to analyze and present to the Board. In addition, standard benefit data would be helpful. A $3 premium likely does not cover many services. Ms. Dutt noted there is no MLR requirement for dental plans.

Mr. Durr added there is probably a lot of variability in benefits, which makes it even more complicated when we are looking at the plan data and determining what is being compared. Grouping plans with like benefits would add context as well. Ms. Dutt responded that unlike full service medical plans, there is no standardized benefit requirement in the dental industry.

8) Overview of Management Services Organizations

Bill Barcellona, Senior Vice President for America's Physician Groups (APG), presented a white paper, drafted by APG, on the role Management Services Organizations (MSOs) play in the healthcare delivery system. The white paper discusses how the 200 MSOs in California were organized to help manage the administrative affairs of 300 RBOs, clinics, hospitals, and even health plans.

Mr. Barcelona stated as a provider organization gains enrollment and grows in size and scope, they have to decide whether to build or to buy administrative capability. The independent MSOs provide the administrative infrastructure for functions such as claims payment, utilization management, IT support, care coordination, and population health management. Over the past two decades, these organizations have become more sophisticated and have expanded the number of services they provide. In addition, the market increasingly demands that managed care organizations innovate to make data actionable and empower the treating physician to deliver care more quickly and affordably.

Kathy Hegstrom, CEO of American Medical Management, stated she operates a MSO that was started in 1981 and has been doing MSO-type services since about 1993. They currently manage six RBOs and a hospital that is dual risk. The MSO also works

with a number of county systems and the State, helping with the uninsured programs in those counties.

Ms. Hegstrom shared a story of assisting a large Federally Qualified Health Center (FQHC), developing ways to incentivize primary care providers to do a better job of providing primary care so they could keep their full capitation within their system and use it to enhance their services. They added social workers in the clinics, added transportation, and developed a Promotoras program to assist new Medi-Cal expansion patients in understanding how to use their benefits and to get primary care rather than using the emergency room. The MSO also has provider support teams who go to all of the clinics to help them change their workflow and helped them bring new specialists into the clinics. As a result, the FQHC has tripled their number of Med-Cal lives.

Kimberly Carey, CEO of MedPOINT Management, said she established the company in 1987 with her mother and sister with a focus on Medi-Cal. As the FQHCs wanted to get into Medi-Cal managed care, many did not understand the process. MedPOINT helped the FQHCs and community health centers learn managed care. Today, they manage the largest FQHC network in the nation with 500,000 members and 120 sites throughout Los Angeles County.

Ms. Carey said, with the expansion of Medi-Cal, there were many barriers for patients accessing care. They came into a managed care system where the specialty network had historically been serving moms and babies. MedPOINT helped them build their specialty network of community-based providers. She said now the focus has shifted to social determinants of health and delivering care in the home environment, providing member outreach and case management. Another big shift has been to bring a higher level of quality to Medi-Cal Managed Care patients. This has involved educating providers and their offices on the Healthcare Effectiveness Data and Information Set (HEDIS), the importance of coding, and providing the infrastructure to support quality programs.

Ms. Carey stated compliance has been a hot topic over the last 18 months. MedPOINT Management, like other MSOs, has been challenged by the new focus and has had to increase staff by 25 to 40 percent to address compliance needs. Health plans are auditing physician groups on a daily basis, which is very important, but this has increased the workload on MSOs.

Megan North, CEO of Conifer Health and President of Conifer’s Value-Based Care, said when she started working in a Medicare Advantage program, she was struck by how powerful it was when a physician had the full complement of information about a person. Rather than treating an episode, they were able to help the whole person have better outcomes across the system. At the time, it sounded revolutionary, but today it is accountable care. California has led the county in this approach to health.

Ms. Carey said physicians are inundated with data and measured in many different ways. The MSOs bring leverage to invest in the science of data and information. They can help aggregate large amounts of data from claims and utilization management to

get the right information at the right time so that it can be acted upon in the setting of care. Small organizations can't build it or buy it because it is too expensive so MSOs help them leverage data to create programs and measure the effectiveness of those programs.

Discussion

Dr. Rideout said IHA's Atlas data shows a strong relationship between financial risk-taking, better quality, and lower cost. He asked how MSOs enable, especially smaller entities, to take risk responsibly. His organization is trying to understand the relationship between financial risk assumption and clinical integration. The Atlas Medi-Cal data shows the regions of California that experienced the highest increase in enrollment were not necessarily the ones that had the highest percentage increase in emergency room use. Those regions tended to be in Southern California, especially in Los Angeles and the Inland Empire. There is something within the environment that at least mitigated some of the worst challenges that other parts of the State experienced.

Dr. deGhetaldi said he understands there is tension and a need to find the right balance between allowing MSOs to do their work and the appropriate oversight. The large systems like Kaiser, Sutter and Sharp have their own MSO functions built in and he has spent nearly 40 years in a multi-specialty group that did not need an MSO. He would have predicted at one point, as managed care really took off in the 1980s, that there would be a divergence of performance around value, quality, access, and utilization between the large systems and the independents. However, that did not happen because the MSOs became the virtual structure that enabled independent providers to compete and deliver the same value. He added MSOs are a very important part of the network that creates value for all Californians regardless of where they get care. A primary care doctor can only do so much in the office. The work in the back room is what bends the cost and value curve and the MSOs are part of that solution.

Mr. Durr said although his independent group has the benefit of being part of the Sharp Healthcare System, he understands the value independent providers bring to the community, particularly in serving the Medi-Cal population. Without MSOs, the infrastructure in California would be markedly different and that would be a loss to consumers. He said everyone knows coordinated care is better. The regulations are there for a purpose. However, MSOs provide oversight and allow independent doctors to be more coordinated, which allows them to be competitive against the larger groups.

Mr. Grgurina said he appreciated the opportunity to hear the stories of FQHCs, who are trying to figure out how they can do this on their own. When running an organization, they must consider build versus buy and whether they have the expertise or need to turn to someone else. Mr. Grgurina asked the presenters to talk more about the oversight they have experienced directly from the RBOs.

Ms. Carey responded the entire process regarding corrective action plans (CAPs) and audits has changed as plans are looking at things much differently. Historically, when a CAP was received, they would respond and the CAP would be accepted because a

response was given. During the next audit, the auditor would review the previous issues to ensure they were corrected. Now, there are live audits on site or via Webex. In addition, the RBOs now have a compliance section in their board meetings and a managed care report which covers every health plan's CAP, a response to each health plan's CAP, each deficiency and its cause, and how it has been corrected. The report also includes turnaround times, claims measurements, and a list of the rights to the software systems for every single employee within the MSO.

Ms. North said, historically, the audit process looked at units of work not the processes and whether they were compliant. Now MSOs are starting to see a shift towards a more processed-based review with a focus on data integrity and data quality. The failures over the past couple of years might have been prevented had there been more of a process focus.

There is a heightened sense of awareness of the importance of being knowledgeable and not just delegating to the MSO. Now there is a joint governance process with the leadership of the RBO and the MSO holding the various reporting areas or functional areas accountable. They both review dashboards, daily reporting, and monthly reporting. They are also ensuring there is a separation of duties between the people who are creating those reports and the individuals actually doing the work. All of that is made transparent up to the board with a monthly review of any action and corrective action, if needed.

Ms. North added there is also a cultural shift across the marketplace. Although the board may not agree with some changes, they understand they have to comply. Conifer Health must now provide more of a directive when the board is going in the wrong direction. Less time is spent arguing over a regulation, as opposed to figuring out how to meet the requirement.

Mr. Grgurina noted Ms. Carey had mentioned a dramatic increase in staff due to the increased focus on compliance and asked Ms. Hegstrom and Ms. North if their organizations experienced the same need to increase staffing. Ms. Hegstrom responded in the past couple of months, they have added about 10 staff for compliance-related work. Ms. North said her organization has primarily invested in third-party oversight and experts who are looking at their processes and controls.

Mr. Barcelona noted in the early 2000s, CAPG developed the Standards of Excellence, which was a checklist to help groups learn how to take risk, coordinate care, and deliver superior outcomes. It evolved into six or seven domains over the last decade. Now, APG has developed a Code of Conduct, Compliance and Competency Checklist, which they really tailored toward the Medi-Cal compliance market. The checklists were developed in conjunction with their consultant, Health Management Associates, and are available at the back of the white paper. APG recently started to engage with specific health plans to go through the checklist and to compare it to their compliance programs. Mr. Barcelona noted on February 7, 2019, he would talk to all of the Medi-Cal plans and present the checklist. Part of that compliance is teaching smaller IPAs and smaller

physician practices that when they function in the risk-based world, compliance cannot be off loaded to the MSO.

Dr. deGhetaldi stated the focus tends to be on Medi-Cal and the capitated lives in California. However, Medicare is pushing toward value. The fee-for-service Medicare world is rapidly moving beyond the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) into Alternative Payment Models (APMs) and Accountable Care Organizations (ACOs). Sixty percent of Californians on Medicare are not in Medicare Advantage or any fee-for-service space, and yet underpayments grow each year. He worries the independent physicians are going to bail on Medicare. He asked if the physician groups and small and medium IPAs are looking at Medicare APMs using the MSO infrastructure to provide value and to do that work.

Mr. Barcellona responded that at the association level, they have been tremendously active all over the country and in Washington D.C., in particular, on building administrative capability to function in the APM world. One of the successes the D.C. team has had in the last two years is to get credit for the APM based on the MA population. Originally, when the APM program came out in MACRA, only Medicare could be counted. A lot of groups are exclusively Medicare Advantage and could not count that population to become an APM.

Ms. North said Conifer works with 14 Medicare ACOs outside of California and much more care management is possible in Medicare Advantage. She has seen a movement of more groups wanting to get into MA and out of the advanced payment models.

Ms. Hegstrom added her organization is not managing any Medicare ACOs. Most of their groups, except for the big Medi-Cal one, are very involved in Medicare Advantage. They are working with those practices to help them understand that Medicare Advantage is actually better for the patient, the provider and everyone else if they are using it the right way.

Ms. Rouillard asked the presenters what their role is in ensuring the RBOs or FQHCs are providing appropriate care to Medi-Cal beneficiaries. Ms. Carey responded their role is to give those they contract with data that shows their patient experience. They provide a look at every single provider in the system providing primary care services, including the difference between pediatric and adult care, identifying how many visits that provider has had for his patients compared to specialty visits outside of the primary care practices. They determine if the provider is actually working up to the scope of their license and make sure patients are being seen at the appropriate place. It is their job to provide the data and educate the providers and they provide report cards at the group level. They also sit down with the board of directors and create corrective actions plans for providers to do a better job and have them respond to it.

Ms. North stated it goes back to the information at the point of care and ensuring the physicians have the information about gaps in care and a historical, longitudinal record of what happened in the past to inform how they take the patient forward for appropriate

care. There are also measures around encounter data and other outcomes measures to ensure that appropriate care is being given.

Ms. Rouillard asked the MSOs if they had made any operational changes as a result of everything that happened in the last 18 months. Ms. Hegstrom responded her organization has enhanced their systems to have more capacity to get providers into the system and get claims paid timely. They also created new functionality to handle the high volume, such as auto adjudication for most claims.

Ms. Carey responded she took the easy route and took the most difficult health plan on the planet and found out who they used to review their performance to ensure compliance. She then hired that consultant to go through MedPOINT's entire shop to ensure compliance. They created a reporting team in their own isolated space, with a significant investment in software to improve reporting and to streamline the process. They had previously invested in a program that they owned, but an entire rewrite was required to ensure they were connecting their main software system to their letter writing system throughout the organization. This would ensure no information could be changed. Executive leadership is now involved in all of these processes, decision making and audits.

Ms. Carey said she has been asked on many occasions to be present at audits, which was never asked of her before. Fifty percent of her job has changed and now she is basically a compliance person, but it has paid off.

Ms. North stated, historically, they had taken a detective approach to compliance. The process was to look for defects and then make sure they did not happen again. Conifer is now taking a prevention approach where there are alerts to let them know before something happens, or something could potentially be happening, or if a change is made to a transaction at a time when it is not supposed to.

Mr. Conklin stated he works with two of the MSOs that participated in the meeting and they are MSOs that truly partner. They really help raise the bar for performance on the compliance process through a quality-driven process and better results for the patient. He added the MSOs also bring value in reducing variation. Every health plan has a slightly different way of doing credentialing. If an MSO credentials 5,000 physicians, it reduces the variation.

9) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, provided an update on the financial solvency of RBOs for the quarter ending September 30, 2018:

- 186 RBOs were required to file financial information with the Department and all RBOs are required to file annual reports. For the fiscal year ending in 2019, 14 RBOs filed annual reports and there were 3 non-filers.

- 132 RBOs filed quarterly financial survey reports and 54 RBOs filed compliance statements. Eight RBOs filed monthly financial survey reports as required by their corrective action plans (CAPs).
- 171 of the reporting RBOs reported compliance with the solvency criteria including:
    - 36 RBOs, or 19 percent, were in the Superior category. Two RBOs were on a CAP, but are reporting compliance.
    - 81 RBOs, or 44 percent, were in the Compliant category. Four RBOs were on a CAP, but are reporting compliance, and four RBOs were on the monitor-closely list.
    - 15 RBOs reported non-compliance.
- There were 21 RBOs on a CAP, which represents 11 percent of all RBOs. Of these, 11 of the CAPs continued from the previous quarter and the RBOs are meeting their approved projections. Seven are not meeting their approved projections, and 3 are new corrective action plans received in the third quarter of 2018.
- Of the 21 CAPs, 17 have been approved, 3 are in progress, and 1 CAP has been closed.
- There were 88 RBOs with Medi-Cal enrollment covering approximately 4 million enrollees.
    - The top 20 RBOs served approximately 3 million Medi-Cal lives. Of these, 17 have no financial concerns and 3 were on a CAP.
    - The remaining 68 RBOs served approximately 1 million Medi-Cal lives. Of these, 54 have no financial concerns, 12 were on a CAP, and 2 were on the monitor-closely list.

Ms. Yamanaka stated the Office of Financial Review planned 24 audits for 2018 and the last 9 are in progress. For 2019, the Office of Financial Review has 24 audits planned and 3 of those audits are currently in progress.

Discussion

Dr. Rideout stated, for the RBOs on CAP, if you remove the RBOs that either don't have an MSO or have a wholly-owned MSO, it looks like there's about 14 left. About half of those use the same two MSOs. He asked if this indicates a systemic problem. Ms. Yamanaka said sometimes there is an issue with an MSO, such as a concern with claims processing or staffing, which could impact several RBOs assigned to that MSO. They look at patterns of issues and MSOs.

Dr. deGhetaldi pointed out that it is good to look at the deficiency for the groups on CAP because some of the deficiencies, like working capital, tangible net equity (TNE), or cash-to-claims ratio, are the RBO's responsibility, not the MSO's. However, claims

timeliness would be the responsibility of the MSO.
Dr. deGhetaldi noted there were two RBOs on CAP all four quarters and said it is hard to tell if they are improving or not. He asked how the Department monitors trends for those that continue to be on a CAP. Ms. Yamanaka responded the Department reviews monthly statements to determine if the RBO is improving and has discussions with the RBO. They also monitor whether the RBO is deviating from their approved CAP. Mr. Grgurina added it is not only the DMHC taking a look, but the plans are also monitoring.

10) Health Plan Quarterly Update

Pritika Dutt, Deputy Director, Office of Financial Review, presented the health plan quarterly update for the quarter ending September 30, 2018.

- There were 126 Knox-Keene licensed plans, four more than the prior year.
- On January 3, 2019, there were 7 applications for licensure under review, including 4 full service and 3 specialized.
- Enrollment in full-service plans is 26.35 million lives. Full service plans added approximately 200,000 enrollees compared to September 2017. This is largely driven by commercial enrollment.
- Overall PPO enrollment decreased compared to last year. HMO enrollment increased as it appears more enrollees transitioned to HMO products, which tend to be more cost effective.
- Medi-Cal enrollment decreased by 140,000 lives while Medicare enrollment increased by 100,000 lives.
- There were 27 health plans with 6.2 million lives on the closely-monitored list, an increase from the prior year. Of the 25 full service plans, 9 are restricted licensees with about 157,000 lives. The total enrollment for the two specialized health plans was 128,000.
- There were two TNE deficient plans as of September 30, 2018. Both plans received cash infusions from their parent entities or owner and are now compliant with the TNE requirement.
- There were 22 plans on CAPs and most are a result of findings during the financial examination, including 14 in progress, and 8 pending approval. Most of these are as a result of claims reviews.

Ms. Dutt stated, on average, the Department conducts 47 financial exams annually. For fiscal year 2018-19, there were 24 completed routine examinations, 24 examinations in progress, and 19 planned.

Discussion

Dr. Rideout noted there were five Medi-Cal Plans with about five million enrollees on the closely-monitored list. This is about half of the total Medi-Cal enrollment of 10.45 million, which is concerning. He asked if Ms. Dutt could give any more explanation for this. Ms.

Dutt said she can't identify the plans, but it could be due to claims processing issues related to a claims system conversion or a downward trend in their financial status.

Dr. deGhetaldi said revenue-per-member is now less than expenses and plans are dipping into reserves. In addition, the proposed public charge rules are leading to a decline in Medi-Cal enrollment, which is adding further pressure. Mr. Grgurina responded there are only a few areas in the state seeing minor increases in Medi-Cal enrollment, with most areas seeing a decline. This is due to a combination of reasons. The economy is doing well, so people are working more and getting paid more, which puts them outside of the Medi-Cal income range. He also noted individuals in the lower income ranges are leaving the State.

11) Public Comment on Matters not on the Agenda

Mr. Grgurina asked for public comment on items not on the agenda. There was no public comment.

12) Agenda Items for Future Meetings

Mr. Grgurina asked for agenda items for future meetings, and noted Dr. deGhetaldi requested the financial summary for the Medi-Cal plans to be presented at the next meeting.

13) Closing Remarks/Next Steps

The meeting was adjourned at 12:48 p.m.