Financial Solvency Standards Board Meeting
April 19, 2017
Meeting Minutes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Jeffrey Conklin, Adventist Health Plan
Dr. Larry de Ghetaldi, The Palo Alto Medical Foundation
Paul Durr, Sharp Community Medical Group
John Grgurina, Jr., San Francisco Health Plan
Betsy Imholz, Consumers Union
Shelley Rouillard, Department of Managed Health Care
Amy Yao, Blue Shield of California

Department of Managed Health Care (DMHC) Staff Present:
Steven Babich, Supervising Examiner, Office of Financial Review
Pritika Dutt, Deputy Director, Office of Financial Review
Shuzhi Qin, Supervising Examiner, Office of Financial Review
Wayne Thomas, Chief Life Actuary, Office of Financial Review
Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations
Michelle Yamanaka, Supervising Examiner, Office of Financial Review

Department of Health Care Services (DHCS) Staff Present:
Sarah Brooks, Deputy Director, Health Care Delivery System
Lindy Harrington, Deputy Director, Health Care Financing

1) Welcome & Introductions - Agenda

Board Chair Betsy Imholz, Consumers Union, called the meeting to order and asked each of the Board members to introduce themselves.

2) Minutes from January 18, 2017 FSSB Meeting

Ms. Imholz asked if there were any changes to the January 18, 2017 FSSB meeting minutes. Meeting minutes were approved without objection.

3) Director's Remarks

DMHC Director Shelley Rouillard provided an update on the Timely Access Report for measurement year 2015 released in February. This was the first year the plans used a standardized methodology to measure compliance with the timely access standards. Unfortunately, there were many data errors and the Department was unable to

determine if the plans are actually providing timely access to health care services. Since the report was released, the Department has held many meetings with the plans and extensive guidance was provided to the plans. For measurement year 2016 and 2017, the plans are required to use an external vendor to conduct a quality assurance review and validate the data before it is submitted on March 31. Ms. Rouillard said she was encouraged by the commitment the plans have shown to improving their data and is optimistic the next report will be able to evaluate the plan's responsibility to provide timely access.

Ms. Rouillard provided an update on the undertakings associated with the recent health plan mergers. Blue Shield's acquisition of Care1st was approved in October 2015 and included $50 million in undertakings to improve provider directories. The Department is actively engaged in this effort to create an industry solution to the problem of inaccurate provider directories. She added despite significant efforts to update provider information, it seems a response rate of approximately 30 percent is the norm, and that is unacceptable.

Ms. Rouillard explained Blue Shield has set up an advisory committee with broad stakeholder representation, including health plans, providers, consumer advocates, Covered California and the Department of Health Care Services (DHCS), to develop criteria for a provider data utility in the cloud. Additionally, a data definitions work group developed specifications, which go beyond the provider directory standards the Department released at the end of the year, but are not inconsistent with the standards. The next step is to identify an organization to own, build and manage the provider data utility.

Ms. Rouillard said DMHC intends to convene a stakeholder meeting in the next couple of months to provide an update on the work of the Advisory Committee and to seek broader stakeholder input. She encouraged the plans and provider groups to commit to working with the Department on an industry solution and to engage in the process set up through the Blue Shield undertakings.

Ms. Rouillard also provided an update on the undertakings associated with Centene's purchase of Health Net, which included funding for consumer assistance programs to improve health outcomes and strengthen the infrastructure of the Medi-Cal delivery system. The undertakings also include an investment of $75 million in California's healthcare infrastructure, which may include investments in encounter data, telehealth, electronic health care technology, implementing value based payment programs, and other system changes to improve quality. Health Net has convened the consumer assistance work group and plans to make initial grants this summer. The infrastructure investment committee is still being formed and will meet later this year.

Ms. Rouillard stated there are two other mergers under the Department's review, Anthem's acquisition of Cigna and Aetna's acquisition of Humana. However, the U.S. District Count disapproved both mergers earlier in the year and as far as the Department is concerned, these are over.

Ms. Rouillard highlighted a few provisions in the market stabilization rule recently released by the Centers for Medicare and Medicaid Services (CMS), including:

- Reduces the open enrollment period to six weeks, from November 1 to December 15. States would be able to maintain a longer open enrollment, which in California would run from November 1 to January 31 for 2018.
- Increases the de minimis variation in actuarial value for middle levels of coverage, from plus or minus 2 percent to plus 2 percent to minus 4 percent. For a silver plan with a target actuarial value of 70 percent, the actuarial value could range from 66 percent to 72 percent.
- Allows some bronze plans to have an actuarial value variation of plus five or minus four percentage points. A bronze plan could have an actuarial value between 56 and 65 percent.
- Makes changes to special enrollment periods, including giving state-based exchanges flexibility to implement pre-enrollment verification.
- Limits the ability of exchange enrollees to change metal tiers during open enrollment.
- Permits states to allow health plans to attribute initial premium payments to any past-due premium payments or premium amounts owed, if permitted by state law. DMHC believes the guaranteed issue provision in California would prohibit this provision.

Ms. Rouillard concluded by stating that while there is a lot of uncertainty, there is an opportunity for bipartisan improvements to the Affordable Care Act (ACA). The DMHC will continue to assist consumers, enforce the law, and support the programs that have expanded coverage to over 5 million people under the ACA.

4) Department of Health Care Services Update

Sarah Brooks, Deputy Director, Health Care Delivery System, DHCS, provided an update on the required access assessment for Medi-Cal Managed Care (MMC) beneficiaries. The DHCS has convened an advisory committee to solicit feedback on the design of the access assessment, which is due to CMS in April. The focus of the assessment is access to primary care, specialty care, and facilities. The assessment will be conducted by the DHCS' external quality review organization (EQRO), Health Services Advisory Group, once it is approved by CMS.

Ms. Brooks also provided an update on the 274 Provider File, otherwise known as the Managed Care Provider File, which is an automated system the plans use to submit their provider network data to DHCS on a monthly basis. The automated system screens the data up front and will reject any data that is not accurate. This will allow DHCS to have a monthly file that indicates how many providers are in the network for the different health plans, including the levels of delegation. The file also contains

information about panel status, location, and languages spoken. The file went live in February, and 17 of the 22 plans are now reporting their data to DHCS, with the remaining plans complying with the new process soon.

Discussion

Dr. Larry de Ghetaldi asked if it will be possible to determine the percent of Medi-Cal beneficiaries who are linked to a Primary Care Physician (PCP) in California. Ms. Brooks replied MMC beneficiaries either choose or are assigned to a PCP within 30 days of enrollment.

Ms. Rouillard asked if the Provider File will be used for the provider directories or to the fee-for-service provider file. Ms. Brooks said it does not link directly to the directories or with the fee-for-service provider file. However, they use the provider file to strengthen and compare the information in their data management system and provider directories.

Amy Yao asked about the data quality of the Provider File given the challenges with the accuracy of provider directories. Ms. Brooks said the automation has led to improvements in the quality of the data and they are looking at ways to continue to make improvements.

Ms. Yao also asked if the DHCS reports information back to the plans after the data quality checks are run. Ms. Brooks said the files are rejected and sent back to the plans with a report of what needs to be corrected.

Dr. de Ghetaldi asked if DHCS will know the number of patients paneled with each PCP and the full time equivalent (FTE) status. Ms. Brooks responded they will have that information.

Paul Durr asked if the Provider File looks at all practicing providers, which Ms. Brooks confirmed.

Presentation

Lindy Harrington, Deputy Director, Healthcare Financing, DHCS, provided an update on the implementation of the Medicaid Managed Care Final Rule and its financial implications. Ms. Harrington explained the first impact, which will begin in the 2017-18 fiscal year, is prospective rate setting. While DHCS has historically set base rates prospectively, they have continued to make adjustments one to two years later once enrollment and the impact to the plan was known. These adjustments included financing for hospitals, pass-through payments from the federal government, or other supplemental financing. The Final Rule now requires 100 percent prospective payment, meaning there is a single opportunity to submit a rate package for everything that is known at that time. This will require the DHCS to play catch up since they have historically been two years behind, resulting in two and a half years of rate setting in a single rate year.

The DHCS has worked closely with health plans and hospitals and plans to submit the final rate package to CMS for 2015-2016 at the end of April, the 2016-17 rate package by the end of June, and the 2017-18 rate package by the end of December.

Discussion

John Grgurina stated this is incredibly complex and the changes were not requested but were instead imposed. The managed care rates are billions of dollars and the plans are very nervous.

Ms. Yao asked who will develop the rates. Ms. Harrington replied, depending on the delivery system model, it will either be Mercer or DHCS's internal actuaries. Ms. Yao inquired about the processes in place to ensure the health plans will be able to provide sufficient input. Ms. Harrington answered the DHCS has already initiated conversations with health plans, which will continue as they move forward.

5) AB 72 Implementation Update

Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations, presented an update on the implementation of Assembly Bill (AB) 72. Ms. Watanabe explained that the DMHC is focused on the first implementation activity, which is the filing due from the plans on July 1, 2017. The purpose of this presentation is to solicit comments from the Board and from the public regarding that filing.

Ms. Watanabe highlighted the key provisions of AB 72 that begin July 1, 2017, including:

- Prohibits surprise balance billing
- Establishes a default reimbursement rate for non-contracting providers, which is the greater of 125 percent of Medicare or the Average Contracted Rate (ACR)
- Preserves out-of-network benefits with written consent

Ms. Watanabe indicated by July 1, 2017, the plans and delegated entities are required to submit data to the Department on their average contracted rate in each geographic region. In addition, the plans and delegated entities will need to file their methodology and policies and procedures for how they calculated their average contracted rate. The DMHC is anticipating filings from over 400 entities.

Ms. Watanabe presented an example of the template which will be used to submit data to the DMHC. She stated the Department is looking for input on whether this is the information that should be collected. The DMHC has contracted with an external vendor to help establish a secure portal to collect the data and statisticians and actuaries will be providing consultative services to advise the Department on the development of a standardized methodology.

Ms. Watanabe reviewed the additional requirements of AB 72. By September 1, 2017, the DMHC is required to develop an Independent Dispute Resolution Process (IDRP) for providers who want to dispute the default reimbursement rate. By January 1, 2019, the DMHC will be working on a regulation package that will define a standardized methodology for calculating the average contracted rate. The Department is also working with the health plans on additional reporting requirements for the annual network filing to assess the impact of AB 72 on contracting and network adequacy.

Ms. Watanabe said, in addition to input on the template, the Department is looking for feedback on where to set the threshold, or cut point, for services most frequently subject to Health and Safety Code Section 1371.9. Some suggestions include 5 or more claims, 10 percent or 80 percent of services or claims paid to noncontracted providers, or greater than 50 percent. In addition, the Department is looking for input on the right metric, such as claims, services or number of people.

Discussion

Dr. de Ghetaldi asked what regions would be used since different regions have different Medicare rates. Ms. Watanabe said the standardized methodology will need to define the regions beginning in 2019. However, for the July 1 filing, it will be up to each plan to determine how it divides the state and the filing will include a cross-walk.

Dr. de Ghetaldi inquired about the consideration of inflation. Ms. Watanabe explained that there will be no inflation adjustment for 2017, but in 2018, the 2015 rates will be adjusted based on the Consumer Price Index (CPI). Dr. de Ghetaldi suggested the CPI used in 2018 should reflective three years of CPI adjustments.

Dr. De Ghetaldi stated that the rates paid at large hospitals with many complex anesthesia services will vary greatly from a small hospital with low risk anesthesia services. He asked if plans will be given the discretion as to how to account for this variation in their calculation of average contracted rate. Ms. Watanabe said for 2017 and 2018, it will be up to each plan to decide how to calculate the average contracted rate until the Department creates a standard methodology in 2019. She added that how the weighting to account for the volume of claims is applied could significantly change the average contracted rate.

Ms. Yao asked how the plans will report payments to capitated providers. Ms. Watanabe responded the delegated entities who pay claims are also required to report information to the DMHC.

Mr. Durr said the delegated entities will have the same issue since they have sub-capitated arrangements. He added they normally value them at a fee schedule rate.

Ms. Yao said one thing to consider down the road is the impact of payment reform, such as value-based or bundled payments, and how these will be considered when defining

rates. Ms. Rouillard asked if this information could be obtained from encounter data rather than looking at claims. Ms. Yao said it is a possibility, but encounter data is poorer quality and not complete.

Mr. Grgurina suggested focusing on the services where this happens most frequently and where there is a real issue rather than asking for everything. He added the amount of information the plans might need to submit is concerning.

Ms. Watanabe asked what the right metric should be - claims, encounters or services - and whether it made a difference. Ms. Yao recommended focusing on the most common procedures that patients receive in-network. She added that collecting the contract rate is very complex as there are many variations. Mr. Grgurina suggested focusing on claims, not services, since claims are more definitive and are an indication of a service and encounter data doesn't include an amount paid for a service.

Ms. Rouillard asked for input on defining the most common services. Ms. Yao said actuaries tend to look at volume by number of services per 1,000 enrollees, for example. Dr. de Ghetaldi suggested volume of Current Procedural Terminology (CPT) and dollar amount. Jeffrey Conklin recommended collecting data on claims and encounters, with a two-step test driven by both dollars and volume.

Bill Barcellona, CAPG, stated AB 72 applies to non-emergent services and facilities so that primarily means anesthesiology, radiology and pathology. For a typical delegated payer group, payments to noncontracted providers for these services represents less than one percent of the hundreds of thousands of claims paid each year. Looking at what was paid in 2015 should be easy once you filter out emergency claims, which is the majority, and claims for non-contracted facilities.

Mr. Barcellona shared his support for the DMHC's approach of collecting data for the most frequently encountered or paid circumstances. He suggested using Medicare fee-for-service schedule equivalencies to address encounters and bundled payments. He also recommended using the Medicare regions because the floor is Medicare fee-for-service.

Dr. De Ghetaldi asked Mr. Barcellona if he was referring to the nine Medicare regions in 2015 or the 30 Medicare regions used in 2017. Mr. Barcellona stated the bill requires using the 2015 Medicare regions because the comparison is to the 2015 average contracted rate.

Stacey Wittorff, California Medical Association (CMA), expressed concern about the guidance the DMHC intends to provide the plans with regard to their average contracted rate submissions due in July. Without clear guidance, Ms. Wittorff said the plans will be able to manipulate their rate data to skew the average contracted rates. An average contracted rate that does not reflect total claims volume will grossly distort the market.

Ms. Wittorff said the CMA is aware of instances where plans have used AB 72 as a weapon against physicians, refusing to negotiate contract terms, offering take it or leave it contract renewals at severe rate reductions, and closing their panels entirely, even to hospital based physicians. She added not giving guidance to the plans will result in distorted average contracted rates and will result in narrower networks, decreased access for patients, decreased market stability for hospital services, and a high number of claims going to IDRP. CMA requests that the DMHC issue guidance to the plans clarifying that the average contracted rates must reflect total claim volume.

Wendy Soe, California Association of Health Plans (CAHP), thanked the DMHC for creating the draft template, which reflects early feedback provided to the Department. The plans appreciate the flexibility to define the average contracted rate in the initial filing. Ms. Soe encouraged the Department to move up the timeline for stakeholder engagement so plans will have time to prepare the data for the July 1 filing.

Tam Ma, Health Access California, stated they were one of the co-sponsors of AB 72 and they are very pleased this bill has finally come into law and consumers are finally protected from balance billing. She said she hopes plans and providers will get the word out to consumers that they should not be balance billed.

Ms. Ma thanked the DMHC for its work implementing the bill and stated some of the comments made at the meeting indicate there is a misunderstanding about what the law actually requires. Ms. Imholz asked if there would be a forum to review the requirements of the law in order to have a common understanding of the requirements. Ms. Watanabe replied there continues to be substantial informal stakeholder engagement and there will be a broader stakeholder meeting in June to solicit input on the standardized average contracted rate methodology.

Nicole Atkins, Cigna Healthcare, asked if plans will be able to add information to the template to capture specialty provider types. Ms. Watanabe said the reporting entities can insert additional columns to capture the various contracting arrangements. Ms. Atkins added there are times where the psychiatrist in a facility might be out-of-network so the plan is also looking at behavioral health claims.

6) Large Group Aggregate Rates

Ms. Watanabe provided an update on the large group rate information submitted by the health plans on October 1, 2016 as required by Senate Bill (SB) 546. SB 546 requires large group health plans to file aggregate rate information with the DMHC annually, and requires the DMHC to annually conduct a public meeting to permit public discussion regarding changes in rates in the large group market. The public meeting was held on February 1, 2017, in San Francisco and approximately 600 people attended the meeting. Ms. Watanabe stated it was an emotional meeting where over 50 people provided public comments on the impact of the rising costs of health care, housing costs, teacher shortages and the cost of pharmaceuticals.

Ms. Watanabe reviewed the key findings from the October 1, 2016 filing, including:

- 23 health plans filed large group rate information, including 7 statewide plans, 9 regional plans, 2 cross-border plans, and 5 In-Home Supportive Services (IHSS) plans.
- There were 7.6 million enrollees in over 13,000 renewing groups.
- Since IHSS rates are set by the county and did not change in 2016, they were excluded from the report. In addition, cross-border plans provide emergency services only so they also were excluded.
- The unadjusted average rate increase was 3.9 percent. Plans also reported an adjusted average rate increase of 4.3 percent, which adjusts for changes in benefits, cost sharing, networks, geographic rating area or average age.
- Kaiser has the majority of large group enrollment with 5 million enrollees, or 63 percent of the large group market. Kaiser also had the lowest rate increase of 3.1 percent.
- The majority of employer groups, about 79 percent, and the majority of covered lives, 88 percent, are enrolled in an HMO and experienced the lowest average rate increase of 3.7 percent.
- Two plans, Anthem Blue Cross and Blue Shield, offer a PPO product, which had the highest average premium rate increase.
- The majority of renewing groups were rated using a combination of both community and experience rating. Plans tended to use experience rating for larger groups with over 500 employees. Community rated groups tend to have higher premiums.
- Approximately 95 percent of employees are in a plan with an actuarial value of 80 percent or more.
- Medical and pharmacy trends have seen double trend growth in the last decade. However, most plans projected a slight decrease in medical trend and modest increases in pharmacy trends.

Ms. Watanabe noted the large group rate filings can be found on the DMHC's recently updated rate review website.

Discussion

Mr. Grgurina commented that while pharmacy trend is down from 2016, it continues to climb dramatically each year. If a portion of the plan's health care expense is growing at 8 to 10 percent year over year, that's an issue and one that everyone is looking at.

Mr. Conklin requested clarification on the definition of a large group and whether this was only for fully insured large group not self-funded. Wayne Thomas, Chief Actuary,

DMHC, stated large group is 100 or more employees as of January 2016. Mr. Thomas confirmed this data pertains to fully insured large group coverage. Mr. Conklin asked if the Department had a sense of what proportion of employers with more than 100 employees are fully insured because his sense is the majority are self-insured. Ms. Watanabe responded the DMHC does not regulate self-insured plans. However, there are some reports that include information about market distribution that might give some insight into the percentage of the large group market that is self-insured.

7) Dental Medical Loss Ratio Update

Pritika Dutt, Deputy Director, Office of Financial Review, provided an overview of the dental medical loss ratio (MLR) data for calendar year 2015. Assembly Bill (AB) 1962 requires health plans offering commercial dental coverage to file an annual MLR report with the DMHC. The dental MLR data is intended to be used by the Legislature in adopting a MLR standard, which will take effect no later than January 1, 2018.

Ms. Dutt reviewed the key findings from the 2015 data:

- Nineteen dental plans offered dental HMO (DHMO) products to approximately 2.9 million enrollees.
- The DHMO individual market MLR ranged from 10 percent to 77 percent, with an average MLR of 46 percent.
- The DHMO small group market MLR ranged from 4 percent to 116 percent, with an average of 55 percent.
- DHMO large group market MLR ranged from 50 percent to 78 percent, with an average of 65 percent.
- Four plans offered dental PPO (DPPO) products to approximately 3.3 million enrollees.
- One plan offered a DPPO product in the individual market and reported a MLR of 77 percent.
- The DPPO small group market MLR ranged from 31 percent to 86 percent, with an average MLR of 64 percent.
- The DPPO large group market MLR ranged from 81 percent to 90 percent, with an average MLR of 86 percent.
- The average MLR on a consolidated basis for the 19 plans was 60 percent.
- The average administrative cost ratio was 42 percent.
- The average net profit on a consolidated basis was four percent. However, six plans reported net losses in 2015, similar to 2014.

Ms. Dutt stated overall the results for 2015 were consistent with 2014. Unlike the full service health plans, there are no essential benefit requirements for dental plans. Within

each market there are a variety of dental products available with varying premiums. She noted the administrative cost ratios are much higher for dental plans when compared to full service health plans because dental plans are responsible for many of the similar functions such as claims processing and accounting and financial services, but the premiums are much lower than full service health plans. The average dental plan premium ranges from $4 to $76 per month. If the Legislature decides to enact a dental MLR requirement, it will likely result in reducing the options available to consumers.

Discussion

Mr. Conklin asked how the average MLR is calculated and its relation to profit. Shuzhi Qin, Supervising Examiner, Office of Financial Review, explained the plans report MLR, not the plan's net income, and the regulations do not define administrative cost. Therefore, the DMHC uses Generally Accepted Accounting Principles (GAAP) to calculate the net profit and administrative cost.

Ms. Imholz asked which factors might have caused the increase in MLR from 2014 to 2015. Ms. Qin responded DHMO and DPPO markets should be considered separately because the DPPO market has a small number of plans so if one exits the market, the ratios will change. In 2014, there were two plans in the individual DPPO market but by the end of 2015, there was only one plan. In the DHMO market, it is more difficult to determine why the ratios changed because the MLR for some plans increased while others decreased.

Ms. Imholz said for those that are familiar with the medical MLR, the dental MLRs seem especially low and while it is a different product and market, it is important for consumers to get value in their product. She asked Ms. Qin if she believed California has a robust marketplace for consumers. Ms. Qin said it is a very competitive market and consumers have many affordable options, especially with DHMOs.

Mr. Grgurina noted the majority, nearly three-quarters, of the membership is in the plans with higher MLRs. He said the concern about pushing towards any particular MLR is the potential for fewer options for consumers.

Mr. Durr expressed his concern about the negative profit margins experienced by the plans where the majority of the enrollment membership is found.

Ms. Yao inquired about the recommendation to the Legislature. Ms. Rouillard clarified the DMHC is not making a recommendation to the Legislature. Rather, the information is being made available and it will be up to the Legislature to decide if they want to pursue legislation to set a dental MLR.

Jeff Album, Vice President of Public Affairs, Delta Dental of California, stated using MLR as a metric to measure dental care is like using inches, feet or miles to measure the volume of gasoline – it doesn't calculate to anything of value. A low dental MLR says

nothing about the value to the patient; only that it is a very low cost product. A product with a $5 monthly premium is about as low as you can go and yet, the product still has fixed costs. The $5 has to cover language assistance, timely access, claims processing and provider directory accuracy. It also has to pay brokers, who won't sell the product unless the plan pays them 10 to 20 points.

Mr. Album said his plan has a DHMO and DPPO offered through Covered California with the same benefits. The DHMO costs $13 per person per month with a 56 percent MLR. The DPPO cost $58 per person per month with a much higher MLR of 68 to 69 percent. The dental plans have to meet the same requirements as a medical plan but with a much lower premium. Mr. Album added there are about 90,000 children enrolled in the Covered California DHMO product. If there was a MLR requirement of 75 percent, the premium would nearly double to $23, the plan would not offer any additional benefits, and the dentist would be paid more than they asked for to provide the same amount of care.

8) Financial Summary of Medi-Cal Managed Care Plans

Ms. Dutt shared key trends from the Financial Summary of Medi-Cal Managed Care Plans for the quarter ending December 31, 2016. The report highlights enrollment, financial metrics, and claims payment deficiency information for Local Initiatives (LIs), County Organized Health Systems (COHS), and Non-Governmental Medi-Cal Plans (NGMs) with greater than 50 percent Medi-Cal lives.

Local Initiative Health Plans:

- From December 2015 to December 2016, enrollment increased by 368,000 lives, or eight percent. Total Medi-Cal enrollment in LIs increased by 82 percent from 2013 to 2016 as a result of the Medicaid coverage expansion.
- Almost all LIs reported positive net income in December 2016 and for the last five quarters. There was a decrease in net income for some LI plans, likely due to the decrease in Medicaid coverage expansion rates that began in July 2015 and again in July 2016.
- San Francisco Health Plan reported a net loss of $184,000 for the December 2016 quarter. However, the plan has a positive net income of $1 million for the year and meets the tangible net equity (TNE) requirement.
- All LIs reported over 300 percent of the required TNE, with reported TNE ranging from 313 percent to 996 percent of required TNE.
- The liquid TNE, or cash on hand, ranged from negative 1,821 percent to 420 percent.

County Organized Health Systems:

- From December 2015 to December 2016, enrollment increased by 34,000 lives, or nearly two percent. Total Medi-Cal enrollment in COHS increased by 65 percent from 2013 to 2016.
- Almost all COHS plans reported positive income for December 2016 and the last five quarters.
- The Health Plan of San Mateo reported a net loss of $46 million due to adjustments to net income as a result of over-payments on rates.
- All COHS reported over 700 percent of required TNE, with reported TNE ranging from 700 percent to 1,478 percent.
- The liquid TNE ranged from 264 percent to 1,058 percent.

Non-Governmental Medi-Cal Plans:

- From December 2015 to December 2016, enrollment increased by 157,000 lives, or eight percent. Total Medi-Cal enrollment for NGMs increased by 67 percent from 2013 to 2016.
- Almost all NGM plans reported positive net income for December 2016 and the last five quarters.
- Molina Healthcare reported a net loss of $300,000 for the quarter. However, the plan has a positive net income of $38 million for the year.
- All NGMs reported over 200 percent of required TNE, with TNE ranging from 250 percent to 1,010 percent.
- The liquid TNE ranged from negative 71 percent to 908 percent.

Ms. Dutt noted the rates paid by DHCS for the Medicaid expansion population were relatively high in 2014 and 2015. However, the plans have seen a decline in rates in the last year and it is expected that the plan’s excess amounts will decrease in future quarters. Ms. Dutt concluded LIs, COHS, and NGM plans are relatively financially stable.

Discussion

Dr. de Ghetaldi stated this was the first year of famine and while the Health Plan of San Mateo may be an anomaly, it will be important to closely watch for erosion and to make sure TNE remains strong.

Dr. de Ghetaldi noted many primary care doctors are asked by distraught Medi-Cal and Covered California enrollees if they are going to lose coverage if the Affordable Care Act (ACA) is repealed. If providers knew the Medi-Cal aid codes for the expansion

population, they could let patients know if they are at risk for losing coverage. He added patients are desperate to receive services out of fear they will lose their Medi-Cal coverage, yet many are not at risk.

Ms. Yao asked if Cal MediConnect is included in the report. Ms. Dutt answered it is included because it qualifies as Medi-Cal enrollment.

Ms. Yao also asked for additional information about Molina's slight loss in net income for the quarter. Ms. Dutt said Molina saw an increase in their medical expenses for the quarter that caused a net loss. She clarified it does not appear to be related to actual revenue.

Mr. Durr asked if there was information on the total eligible Medi-Cal population to determine if the two to four percent growth is consistent with the growth of the eligible populations. Ms. Dutt said she can provide the information to him.

Mr. Durr expressed surprise at the TNE levels that are over 1,000 percent. The for-profit plans are paying dividends or sending money to their shareholders and the county plans are likely saving for the future. However, it raises the question of whether providers are being paid enough to take care of the patient population if TNE levels are that high.

Mr. Grgurina responded, based on his experience at San Francisco Health Plan, that with 150,000 patients they have nearly $600 million in annual premiums. A TNE of $11 million equates to one week's worth of premium. His board, which is made up of providers, hospital representatives, and city representatives, is targeting two months of premium revenue to protect the plan from declining Medi-Cal rates and to be self-sustainable. Unlike other plans, they cannot go out and generate capital. For San Francisco Health Plan, once they reach two months of premium revenue, they go to their board and financing committee to discuss how to improve services. They are currently passing $15 million on to providers through their Practice Improvement Project to improve Healthcare Effectiveness Data and Information Set (HEDIS) measures and third next available appointment times. They are planning to go back to the board to request $15 million for hospitals to improve services to their members. He concluded by saying there isn't a scientific study that says a certain percentage of TNE is the right amount. Each plan calculates TNE differently based on their relationship with providers.

9) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, provided an update on the financial solvency of Risk-Bearing Organizations (RBOs) for the quarter ending December 31, 2016:

- 180 RBOs were required to file annual reports. Of those, 25 RBOs have filed and the remaining 155 reports are due by the end of May.

- 130 of the 180 RBOs file quarterly financial survey reports and the remaining 50 RBOs with less than 10,000 lives file statements attesting that all of the financial solvency criteria have been met.
- Three RBOs file monthly financial survey reports as part of a corrective action plan (CAP).
- 175 of the 180 RBOs reported compliance with the solvency criteria.
    - 23 RBOs were in the Superior category, 13 fewer than the previous quarter.
    - 102 RBOs, or 56 percent, were in the Compliant category, of which 7 RBOs are currently on a CAP and 8 RBOs are on the monitor-closely list.
- 5 RBOs reported non-compliance.
- 12 RBOs are on a CAP, of which 4 are new and 8 RBOs are continuing from the previous quarter and are all meeting their approved CAPs.
- 3 RBOs, Verity Medical Foundation, WellCare, Incorporated, and Bright Health Physicians, completed their CAPs.

Ms. Yamanaka stated the Office of Financial Review has 24 audits scheduled for 2017, six of which are currently in progress.

10) Health Plan Quarterly Update

Steven Babich, Supervising Examiner, Office of Financial Review, presented the highlights of the health plan quarterly update:

- As of March 20, 2016, there were 74 full-service health plans and a total of 122 Knox-Keene licensed plans, the same as the previous year.
- Enrollment in full-service plans is 25.96 million lives.
- There are 16 plans on the closely-monitored list, which is decrease from the 22 plans that were on the list last year.
- There are three TNE-deficient plans, one full-service and two specialized plans.
- There are 28 plans on CAPs, mostly due to routine financial examinations and claims findings.

Discussion

Ms. Imholz asked if the increase in commercial enrollment was primarily in EPOs or PPOs. Mr. Babich said the financial statements do not distinguish between the two so he could not say.

11) Public Comment on Matters not on the Agenda

Ms. Imholz asked for public comments on items not on the agenda. There were none.

12) Agenda Items for Future Meetings

Ms. Imholz asked if there were any agenda items for future meetings. She suggested discussing the Covered California rate increases, which will be made public on July 18.

Ms. Yao suggested adding an agenda item to continue the discussion about AB 72.

Dr. de Ghetaldi suggested a discussion regarding risk adjustment transfers. He also asked to add an item to the agenda to discuss Medicare Advantage. Ms. Rouillard informed him the DMHC does not regulate Medicare Advantage plans so the information the Department has may be limited.

Mr. Grgurina requested continuing to include the Director’s remarks and an update from DHCS.

13) Closing Remarks/Next Steps

The meeting was adjourned at 12:37 p.m.