Financial Solvency Standards Board Meeting
September 9, 2015
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Edward Cymerys, Healthcare Consultant
Jacob Furgatch, Premier Health Plan, Coast Healthcare Management
Dr. Larry de Ghetaldi, The Palo Alto Medical Foundation
Betsy Imholz, Consumers Union
Dave Meadows, Liberty Dental Plan
Ann Pumpian, Chairperson, Sharp HealthCare
Shelley Rouillard, Department of Managed Health Care
Dr. Rick Shinto, Alternate, InnovaCare Health, Inc.

Department of Managed Health Care (DMHC) Staff Present:
Stephen Babich, Supervising Examiner, Office of Financial Review
Marta Green, Chief Deputy Director
Deborah Haddad, Attorney, Office of Plan Licensing
Kristene Mapile, Assistance Chief Counsel, Office of Plan Licensing
Gil Riojas, Deputy Director, 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, Healthcare Delivery Systems

1) Welcome & Introductions- Agenda

Chairperson Ann Pumpian called the meeting to order and welcomed attendees.

2) Minutes from June 17, 2015 FSSB Meeting

Dr. Rick Shinto made a motion to approve the June 17th FSSB meeting minutes. Edward Cymerys seconded the motion. Meeting minutes were approved with no opposition.

3) Director's Remarks

Director Shelley Rouillard provided an update on the Department's review of the acquisition of Care1st Health Plan by Blue Shield of California. In addition to holding a public meeting on June 8th, the Department commissioned an independent, fair market analysis of the purchase price and expects the final report any day. The Department

has been doing extensive research on non-profit organizations and charitable asset obligations as well as continuing to meet with stakeholders and receive public comment on the transaction.

Ms. Rouillard stated that it is not known when a final announcement of the Department's decision will be made. She acknowledged the staff from the Office of Plan Licensing, Office of Legal Services and the Office of Financial review for their thorough review of the transaction.

Ms. Rouillard provided an update on SB 260 (Monning), the bill to require County Organized Health Systems (COHS) to be licensed by DMHC. The bill failed in the Assembly, which means the two million Medi-Cal beneficiaries enrolled in those plans will not have the same consumer protections of the Knox-Keene Act as other Medi-Cal beneficiaries who are in plans licensed by the Department.

Ms. Rouillard provided an update on the 2016 rate review process. The Department received 24 filings for individual and small group products with an effective date of January 1, 2016. Seventeen of the 24 filings are Covered California products, including 12 individual products and five small group products. The rate review process is expected to be completed by October 1.

Ms. Rouillard reviewed the changes for 2016, including:

- The average rate increase for Covered California's individual market is 4.3 percent, with a range of a decrease of 19 percent to a six percent increase.
- The rates in the small group market increased by an average of 4.5 percent, with a range of a decrease of four percent to an increase of 23 percent.
- Rate changes varied by region. In Northern California, rates increased an average of seven percent compared to a two percent increase in Southern California.
- Rate increases were as high as 44 percent in Monterey County (Region 9), while rates in Los Angeles County decreased 13 percent.
- The significant rate increases are in areas where there has been significant provider consolidation and the rate decreases are in areas where there is more competition.
- The major drivers of rate changes were:
    - A projected increase in medical costs by an average of 6.2 percent
    - Expansion of provider networks in Northern California.
    - Increased administrative expenses related to the Affordable Care Act (ACA) requirements to transfer data to the Centers for Medicare and Medicaid Services (CMS).
    - General administrative expenses or costs related to health care reform.

Ms. Rouillard reviewed the reinsurance payments and risk adjustment transfers by plan for 2014. The ACA Transitional Reinsurance Program helps to keep premiums stable and affordable for consumers by protecting health plans from high cost claims. In 2014, the reimbursement was 100 percent over the attachment point of $45,000. In 2015, the reimbursement rate was 80 percent over the attachment point of $70,000. In 2016, the plans are paying a higher percentage of the claims because the attachment point increases to $90,000 and the reimbursement rate decreases to 50 percent. This decrease in reimbursement could force plans to raise their premiums.

Ms. Rouillard explained the Permanent Risk Adjustment Program, which protects consumers' access to a range of affordable coverage options by reducing incentives to insure only healthy individuals. In addition, the Temporary Risk Corridors Program keeps claims affordable and stable by mitigating the uncertainty in claims cost during the first three years of the Exchange marketplaces.

Discussion

Betsy Imholz with Consumers Union stated that they contract with the Department to review rates and one of the things they are seeing is medical trend issue. She added that pentup demand should be receding so they are looking closely to see if the plans are backing out the costs of pent-up demand. In addition, the individuals seem to be healthier than previously expected. Ms. Imholz asked if the Department has access to the consulting reports so the assumptions could be validated with data about the health of the population in California.

Gil Riojas, Deputy Director of the Office of Financial Review, responded that the actuaries probably received the reports.

Ms. Pumpian asked about the variation in rates across regions and asked if the proposed rates are pushing everyone towards the median or making it a wider range.

Ms. Rouillard responded that the range depends on the area and the age of the person, but the rates are within about $100.

Dr. Larry de Ghetaldi asked if rates are going up in regions where there was an inadequate network of providers.

Ms. Rouillard replied that all of the networks are adequate based on the Department's review, but the public may think they are not adequate if their particular doctor is not in the network.

4) DMHC Strategic Plan

Ms. Rouillard reviewed the Department's five-year strategic plan, including the new mission statement, core values, goals and strategies. The strategic plan was developed with input from external stakeholders, employees, and other agencies, such as Covered California and the Department of Health Care Services (DHCS). The plan has been in development since January 2014 and was initiated as a result of significant growth at

the Department and changes in the health care system due to the ACA. Since September 2011, the number of staff has grown from 334 to 442 positions and the annual budget has increased from $56 million to $70 million.

Discussion

Dr. Shinto complimented the Department on doing a great job on the plan. He asked if there are any other Boards that advise the Department. He said he wasn't sure the FSSB is helping the Department to merge the mission and the goals to ensure a stable healthcare delivery system. The Board is focused on the financial part but could use their knowledge of healthcare and medical trends to protect consumer health care rights too.

Ms. Rouillard responded there are no other Boards that advise the Department in an official capacity. The Department meets informally with the plans, provider groups and consumer groups. However, the FSSB is the only one in statute and its dedicated purpose is to advise on financial matters. The Department has broadened the topics discussed at the meetings because it is the only formal public forum to get feedback.

Mr. Cymerys asked if the Department had considered adding affordability to the mission statement.

Ms. Rouillard said affordability is a key factor in the stability of the healthcare system and there is a lot that the Department does to monitor affordability.

Ms. Imholz said she is very excited about the strategic plan and the reinvigoration and refocusing of the Department. She encouraged the Department to raise the public visibility about what the Department is doing to look at affordability and consumer protection. She also asked for more information about the Data Analytics Unit.

Marta Green, Chief Deputy Director, responded that the Department is in the planning phase of what the Data Analytics Unit will look like, but is working to fill two positions. The Department is doing an assessment of all of the data it collects and how best to warehouse it. Ms. Green also serves on the Health and Human Services Agency Data Governance Work Group and is starting to look at how the Department can better leverage data from sister departments to monitor plan performance.

Dr. De Ghetaldi stated that access is a component of service and suggested including consumer satisfaction as a goal. He also encouraged the Department to measure its progress in meeting the goals where it is possible and to be transparent over the next five years about the progress. He added that it would be a good idea to work towards standardization in quality reporting with the Office of the Patient Advocate (OPA), CMS and others who are reporting on the healthcare delivery system.

Beth Abbott, Director of OPA, stated they would release their report card on October 8. Next year, they are taking over the Medicare report card using CMS data and an element to measure total cost of care in medical groups. The goal is to work toward consumers that make choices based on quality and cost.

5) Alameda Alliance for Health Update

Mark Abernathy, appointed conservator of the Alameda Alliance for Health, provided an update on the plan, including the following:

- Tangible Net Equity (TNE) was over 350 percent as of the end of June and 400 percent at the end of July.
- At the end of June, cash reserves were $349 million. However, $140 million will need to be returned to DHCS for the Medi-Cal expansion.
- Working capital ratio is 1.2 and the required ratio is 1.0.
- Capital spending for the last fiscal year was $1.3 million compared to $6.9 million in 2013 and $9.8 million in 2014.
- The new IT system went live on September 1 and there are no red flags.
- Claims payment levels are steady and compliant with processing time frames. Most claims are paid within 17 to 20 days from the date of receipt.
- The new call center went live at the same time as the claims systems with very little disruption. The abandonment rate at the end of August was less than five percent and 80 percent of calls were answered in 30 seconds.
- Operational functionality is improved and the plan will continue to focus on improving Healthcare Effectiveness Data and Information Set (HEDIS) scores, case management and disease management to control cost.
- The plan hired several senior staff and is close to filling several other positions.

Mr. Abernathy reviewed the status of the corrective action plan and the milestones for returning the plan to local control.

In closing, Mr. Abernathy thanked the staff at DMHC and DHCS for working with the plan and the conservator. Both were patient and compassionate with the plan's Board of Governors.

Discussion

Jacob Furgatch asked if the $349 million in cash reserves included the $140 million that has to be returned to DHCS and if that would impact the TNE.

Mr. Abernathy stated that the $349 million included the $140 million that would be returned to DHCS, but the TNE would stay the same because they had anticipated the payable to DHCS all year long.

Mr. Furgatch asked what the "tracking favorably" status means.

Mr. Abernathy responded it means not compliant in all of the measures.

Dr. Shinto expressed concern that the plan had done a great job of building the IT infrastructure, but was concerned that without a Chief Medical Officer (CMO), the plan wouldn't be able to keep the medical contracting and network in place.

Mr. Abernathy replied that the interim CMO is in place and is working on both quality and medical management until a new CMO is in place. He added that the plan was very patient and provider friendly, but there wasn't a strong medical management function at the plan. The plan has since made improvements in medical management.

Ms. Imholz asked if the plan had done any testing on the consumer experience and encouraged the plan to hear what the enrollees are saying.

Mr. Abernathy said the plan has done secret calls to make sure enrollees can get through to the call center and the plan is following up on complaints.

Dr. De Ghetaldi stated that a wise Chief Financial Officer (CFO) always focuses on quality so focusing on HEDIS is important. He expressed concern that the plan's Medical Loss Ratio (MLR) was 40 percent and asked if it was sustainable.

Mr. Abernathy responded that he believes it is sustainable, but there is still room for the plan to improve. The plan will need to focus case management activities on the six percent of the population that is driving approximately 75 percent of the costs.

6a) Mergers and Acquisitions

Grant Cattaneo, with Cattaneo & Stroud, Inc., provided an overview of the impact of the proposed mergers and acquisitions on HMO enrollment. Cattaneo & Stroud has been collecting data on medical groups that do business with HMOs in California and each March they compare that data to the financial statements for the plans regulated by DMHC.

Mr. Cattaneo said the analysis focuses only on commercial HMO enrollment, including 46 HMO plans regulated by DMHC and one plan under DHCS. It does not include PPO, Medicare supplement, or any out-of-state lives. There are about 20.8 million lives in these plans, including commercial, Medicare and Medi-Cal.

Mr. Cattaneo stated that once the data was collected, they looked at the impact of the proposed mergers and acquisitions, including:

- Blue Shield acquiring Care1st
- Aetna acquiring Humana
- Blue Cross acquiring Cigna
- Centene (California Health and Wellness) acquiring Health Net

The proposed acquisitions would have the following impact on HMO enrollment:

- HMO enrollment is already highly concentrated for commercial and Medicare and the proposed acquisitions would slightly increase the concentration.
- There would be no impact to Medi-Cal.
- The number of competing plans would be reduced in a large number of counties in California. The impact of the specific acquisitions is as follows:
    - The acquisition of Cigna by Blue Cross would reduce the competitiveness in 31 counties;
    - The acquisition of Humana by Aetna reduces the competitiveness in eight counties; and
    - The rumored merger of United Healthcare, Aetna and Humana would reduce competitiveness in 27 counties.

Discussion

Mr. Cymerys asked what the implications are for provider groups, buyers and employers since PPOs are another alternative.

Mr. Cattaneo reiterated that the impact to individuals, employers, government and medical groups is reduced competitiveness. He added that the impact on PPO business is unknown because it is difficult to collect the data from the California Department of Insurance (CDI).

Mr. Furgatch asked if the Cal MediConnect members were included.

Mr. Cattaneo responded that they were included. He said that there is additional information on their website, including definitions for each category and the programs that are included in the analysis.

Dr. De Ghetaldi asked if Mr. Cattaneo thought more healthcare systems and providers will get into the insurance business, similar to the health system in San Diego.

Mr. Cattaneo said there are 14 restricted license plans in operation as of March 2015 and there are four or five pending. Restricted license plans are looking to get both the professional and the facility side of the dollar without going through the process of selling to individuals and employers.

Mr. Cymerys asked if the website contained information about the number of plan choices in each county.

Mr. Cattaneo replied there is information on the website and a link to where health plans do business by county and lines of business.

Ms. Imholz stated that from a consumer perspective, some choice is helpful in keeping costs down and yet in the rate filings, there is variation between regions. Some of this is due to provider concentration. She asked if Mr. Cattaneo thought providers would get into the insurance business in the future since there is some vertical and horizontal consolidation in the provider world.

Ms. Pumpian asked Mr. Cattaneo if he would recommend that the Department set a specified time frame for reporting so there could be a better understanding of the impact of the changes.

Mr. Cattaneo responded that it would be helpful if all of the agencies collected data at the same time and the plans submitted complete data.

Bill Barcelona with the California Association of Physician Groups (CAPG) submitted a letter to Director Rouillard and the Board proposing that the Department consider undertakings to help consumers navigate the healthcare system and make informed choices. CAPG recommended funding two proposals. The first proposal would be an all-payer claims database and the second proposal is a multi-plan online provider directory.

Anthony Wright, Executive Director of Health Access California, thanked the Board and the Department for looking holistically at the impact of the proposed mergers on the market. He expressed concern about the reduction in consumer choice and competition as a result of consolidation. He said that there is also a secondary competitive effect if the only way to get a competitive rate from providers is to have big insurers. This creates very high barriers to entry for smaller insurers and new entrants to the market, which is generally encouraged.

Mr. Wright encouraged the Board to look at anti-trust or competitiveness strain and the practices of the insurers involved in the mergers. Entities should not be allowed to get bigger unless they get better, especially with regard to some of the basic consumer protections.

6b) Mergers and Acquisitions

Gil Riojas, Deputy Director of the Office of Financial Review, discussed the Office of Financial Review's process for reviewing mergers and acquisitions. The primary focus is to ensure the transaction does not have any adverse impact to the Knox-Keene license. The Office reviews the:

- Impact to TNE, working capital, operations and claims payment.
- Organization structure pre- and post-transaction to understand who will hold control.
- Financing of the transaction and the impact to the plan's financial stability.
- Financial statements and any assumptions to developing pro formas.

Mr. Riojas provided examples of undertakings from past mergers, including:

- Requiring the plan to maintain certain thresholds going forward.
- Prohibiting the distribution of dividends or assets if TNE or working capital requirements are not met.
- Required periodic filing of financial statements by the parent company.
- Required a material modification if the plan moves certain functions out of California.

Kristene Mapile, Assistant Chief Counsel with the Office of Plan Licensing, discussed the Office of Plan Licensing's process for reviewing merger and acquisition filings and the timeframes associated with the Department's review.

The plan must first file a notice of material modification and the DMHC has 20 business days to issue an order of postponement or identify any deficiencies in the filing. The plan then has 30 days to respond. Once the comment period is over, the Department will issue an order either approving or denying the notice.

The Office of Plan Licensing's review includes the review of:

- Documents filed pursuant to the transaction.
- The applicability of Article 11 to the extent that the plan is a non-profit and has held or currently holds assets in a charitable trust.
- Changes to the organization or corporate structure.
- Administrative capacity changes.
- Provider network or service area expansion changes.
- Changes to benefits and coverage as described in the Evidence of Coverage (EOC).

Ms. Mapile added that the Department has held public meetings prior to issuing an order approving or denying the transaction to gather additional information that should be considered in the review of the transaction and undertakings.

Ms. Mapile also provided examples of undertakings from past mergers. In the PacifiCare merger with United Healthcare, the Department required the plan to maintain its organization and administrative capacity in California, unless prior approval was given by the Department. This included maintaining organizational functions such as clinical decision making, prior authorization, referrals, grievance system, independent medical review, underwriting and provider disputes in California.

Discussion

Mr. Cymerys asked if the Department looked closely to ensure the undertakings were followed.

Ms. Mapile said the Department does a subsequent review to ensure the undertakings were followed and there was a team that monitored compliance with the undertakings. Currently, the Department has a system that provides an alert when a plan responds to an undertaking.

Mr. Riojas added that this is also part of the audit process.

Ms. Imholz asked if the Attorney General's Office is involved in the review of these transactions.

Ms. Rouillard responded the Department would be talking to them. She also said there would be public meetings on each of the mergers at times yet to be determined.

Mr. Furgatch stated it is important to make sure the critical processes that are important to consumers remain in California. It is also important to look at what things should remain in place for several years post-transaction.

Ms. Pumpian asked if the Department looks at the impact to the network since some plans have relationships that are narrower than others.

Ms. Mapile responded that the Department reviews any changes to the provider network and provider contracts. Some of the provider contracts are written in a way that is broad and includes affiliates, but the Department is looking at these contracts too and their assignability.

7) Center for Medicare and Medicaid Services (CMS) Proposed Rules on Medicaid Managed Care

Sarah Brooks, Deputy Director of Healthcare Delivery Systems at DHCS, provided an overview of the proposed rulemaking that CMS issued on June 1, 2015 for a 60-day comment period. This was the first issuance of guidance from CMS related to managed care since 2002, and is an indication that the country is moving towards a managed care model. Ms. Brooks stated that one in three Californians are now on Medi-Cal, with about 80 percent, or close to 10 million individuals, enrolled in managed care plans.

Ms. Brooks said DHCS submitted comments on July 24, 2015, which are posted on the Department's website. Unlike other CMS regulations that focus on a specific area, these proposed rules are a complete overhaul of the regulations, including access, quality, financial payments, and other issues.

The Department's comments focused on four key issues:

1. Flexibility on the timeline for implementing the regulations. Implementation will likely happen in the beginning part of 2016.
2. Enrollment of all providers through one system. In Medi-Cal there are two systems, fee-for-service and managed care. The managed care plans credential their providers and the Department credentials the fee-for-service providers. The CMS rule requires all providers to enroll through the same system, including the nearly 400,000 In-Home Supportive Services (IHSS) providers and other providers not currently approved through that system. This requirement would significantly limit the ability to expand networks to accommodate the growing Medi-Cal population.
3. Encounter data. Currently, the health plans report monthly encounter data. The CMS proposed rules would tie Federal reimbursement for the Medi-Cal program to encounter data. While the Department believes in strong, robust encounter data to understand what is happening in the program, there is concern about how this requirement would be imposed and how funding would be allocated.
4. Financing payments. CMS is proposing to eliminate the use of certified rate ranges and instead require approval of each individual managed care plan's rate. The Department does not believe that one rate can be actuarially sound, and would have significant negative impact to the Department's costs, resources and ability to structure rates in a way that is flexible to meet the needs of the populations and health plans. The Department suggested that CMS allow states to have a range, with an upper and lower bound of five percent outside the range.

Ms. Brooks stated that the CMS proposed rules are aligned with the majority of the efforts in California so there were not as many concerns as other states.

Discussion:

Dr. De Ghetaldi asked if the managed care plans will continue to have flexibility around incentivizing permanent value, quality and service.

Ms. Brooks responded they are incentivized and required. The rule has a structure of looking at value-based purchasing and payments and implements several rules around that concept. She added that the proposed rule would supplement what is already being done in California.

Dr. De Ghetaldi asked if the Federally Qualified Health Centers (FQHCs) and the cost-based reimbursement are threatened in any way.

Ms. Brooks responded that there is continued support for the FQHCs and she does not believe that was addressed in the proposed rules.

8) Timely Access Reporting

Deborah Haddad, Senior Attorney in the Office of Plan Licensing, reviewed the timely access requirements and stakeholder engagement process.

Ms. Haddad stated that Section 1367.03 of the Health and Safety Code directed the Department to adopt regulations to ensure that the health plans are complying with timely access standards, including:

- Telephone triage 24 hours a day, 7 days a week.
- Limits on the amount of time it can take to speak to a customer service representative.
- Plans must monitor network compliance and investigate and correct any deficiencies.
- Access to interpreter services.
- Compliance with time frames for appointments, including:
    - Urgent care services that do not require prior authorization within 48 hours;
    - Primary Care Provider (PCP) appointment within 10 business days;
    - Specialty care physician appointment within 15 business days;
    - Non-physician mental health provider appointment within 10 business days; and
    - Ancillary care within 15 business days.

Historically, the plans have used different methods for measuring compliance with the timely access standards. However, SB 964 gives the Department the authority to standardize the methodology for measuring timely access, which will allow for comparison across counties and plans. In addition, the Department is required to post a report summarizing the findings on its website by December 1 of each year.
The plans reported measurement year 2014 data on March 31, 2015. The results will be included in the December 1, 2015 report. Measurement year 2014 was the first year that plans utilized the standard methodology for reporting. While the plans were not required to use the standardized methodology since it was developed prior to SB 964, approximately 80 percent of the plans selected the standard methodology. The plans will all be required to use the standard methodology for measurement year 2015.

Ms. Haddad said there are two methodologies the plans may use. The first is a survey, which is a prospective review to assess the next available appointment. The second method is the audit, which looks at when an appointment was requested and when it took place. The Department will survey the plans in early 2016 to assess their readiness to transition from a survey methodology to an audit methodology.

Ms. Haddad discussed the recent stakeholder process to solicit feedback on the timely access project. The Department held four meetings with plans, providers and consumer advocates. Representatives from DHCS and OPA also participated in the meetings. In addition to stakeholder meetings, the Department continues to provide ongoing training and outreach to plans on the differences between the survey and audit methodology.

Discussion:

Ms. Pumpian asked to what extent consumer and provider complaints are incorporated into measuring timely access. She added that the plans may have an adequate number of providers but if those providers do not accept patients transferring from an emergency room to their care, it is like not having access.

Ms. Haddad responded the regulations require the Department to look at patterns of practice and complaints and this information is taken into account in measuring compliance. While this information is not part of the plan's compliance rate, the Department will discuss trends with the plan and followup as needed.

Ms. Brooks thanked the Department for including DHCS staff in the stakeholder meetings and said they look forward to the partnership to continue to improve access and timely access measurement.

Mr. Wright said that the timely access information is very important to consumers, particularly with the conversation about narrow networks and access in Medi-Cal. He added that Health Access and other consumer groups would be submitting a letter to the Department regarding reporting and look forward to seeing the December 1 report.

9) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Examiner in the Office of Financial Review, provided an update on the financial reporting for Risk Bearing Organizations (RBOs) for the quarter ending June 30, 2015:

- 50 of the 178 Risk Bearing Organizations (RBOs) submitted compliance statements attesting to their compliance with all solvency requirements. The remaining 128 RBOs filed quarterly survey reports.
- 32 RBOs are in the superior category.
- 89 RBOs are reporting compliance.
- Four RBOs are on the monitor closely list.
- Seven RBOs are reporting noncompliance.
- There has been an increase in the number of RBOs with a corrective action plan compared to the first and second quarter of 2015. There are seven new plans with corrective action plans, primarily due to noncompliance with TNE requirements and timely payment of claims.

- The top 20 RBOs have more than 50 percent of Medi-Cal enrollment with approximately 2.7 million Medi-Cal lives; three of these RBOs have a corrective action plan and one is on the Monitor Closely list.
- The remaining 63 RBOs have approximately 971,000 Medi-Cal lives; four of these RBOs have a corrective action plan and one is on the Monitor Closely list.

Discussion:

Ms. Pumpian asked if plans that have historically been on the Monitor Closely list move into a corrective action plan or if they correct themselves.

Ms. Yamanaka replied they typically correct themselves because the Department asks additional questions about how they will maintain compliance with the solvency criteria.

Mr. Furgatch stated the Medi-Cal expansion funding was a nice, unexpected cure for some of the RBOS, but as the state adjusted payments to the plans the plans adjusted payments to providers. He recommended monitoring the Medi-Cal exclusive or Medi-Cal heavy plans as the plans potentially face cuts in Medi-Cal expansion payments in the coming year.

Ms. Imholz asked how the increase in the number of noncompliant plans compares to prior years.

Ms. Yamanaka responded the number of corrective action plans has decreased over the years, but it varies by quarter. If there are trends or concerns, the plan will be placed on the Monitor Closely list and will be asked more questions. She added they are seeing an increase in corrective action plans for timely payment of claims as plans are converting to ICD-10.

10) Health Plan Quarterly Update

Stephen Babich, Supervising Examiner in the Office of Financial Review, provided an update on the financial status of the health plans for the quarter ending June 30, 2015:

- The Medi-Cal plans are performing better and only one plan is on the Monitor Closely list.
- There are 20 plans overall on the Monitor Closely list, which is down slightly from the prior quarter. Half of those are Medicare Advantage plans.
- There are no TNE-deficient plans.
- Full service lives continue to increase to 28 million, evenly split between commercial and government.

Discussion:

Dr. De Ghetaldi asked how many undocumented children would be added to Medi-Cal in the next year.

Mr. Wright responded an estimated 170,000 children are expected to be enrolled under the expansion of income eligible children into Medi-Cal regardless of immigration status. This is estimated to start in May 2016. He added that there is an affirmation in the budget to cover undocumented immigrants with deferred action immigration status in Medi-Cal. It is estimated that this could be approximately 180,000 individuals.

Mr. Furgatch asked if restricted license plans were included in the count for full service plans.

Mr. Babach responded that approximately 2.7 million lives are in plan-to-plan arrangements between the full service plans and the restricted license plans. Single lives are approximately 25.3 million. Currently, there are 71 full service licensees and 17 restricted licensees. There are one or two more restricted licensees under review that will go live next year, but most are Medicare Advantage plans.

Ms. Rouillard added that the Department is also seeing some restricted license plans convert to full service plans, like Scripps.

Mr. Furgatch stated that this is a different business model that may require more scrutiny at some point.

Mr. Babich agreed and said it is more taxing on staff to monitor restricted license plans.

11) 2016 FSSB Meeting Dates

Ms. Pumpian reviewed the proposed meeting dates for 2016 and asked if there were any concerns. There were none.

The next meeting is scheduled for December 9, 2015, followed by March 16, 2016.

12) Public Comment on Matters not on the Agenda

Ms. Pumpian asked for public comment on items not on the agenda.

Deepa Prasad, Vice President of Managed care for the California Hospital Association, raised a concern regarding the transition of the Department's provider complaint system. The Association's members are concerned that the complaints filed under the old system would not migrate to the new system. Ms. Prasad asked if there was a new process to resubmit or follow up on claims submitted in the old system.

Ms. Rouillard responded that the Department would follow up with Ms. Prasad.

13) Agenda Items for Future Meetings

There were no suggestions for future agenda items.

14) Closing Remarks/Next Steps

The meeting was adjourned at 12:42 p.m.