FINANCIAL SOLVENCY STANDARDS BOARD MEETING

July 20, 2010

Department of Managed Health Care

DEPARTMENT OF Managed Health Care

Plan Overview

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DFO Ongoing Financial Monitoring

- Financial review of applications for licensure and post-licensure changes
  - 111 Knox-Keene Health Plans (57 Full Service Plans)
  - 20 million enrollees in full service plans
  - 1.8 million PPO enrollees (DMHC only)

- Financial requirements:
  - Restricted Deposit
  - Tangible Net Equity (TNE)
  - Sufficient funds to pay claims
  - Liquidity and Solvency of plans
  - Sufficient Internal Control for Accurate Reporting

- Financial examinations (routine, non-routine, MRMIB. Claims and PDR)

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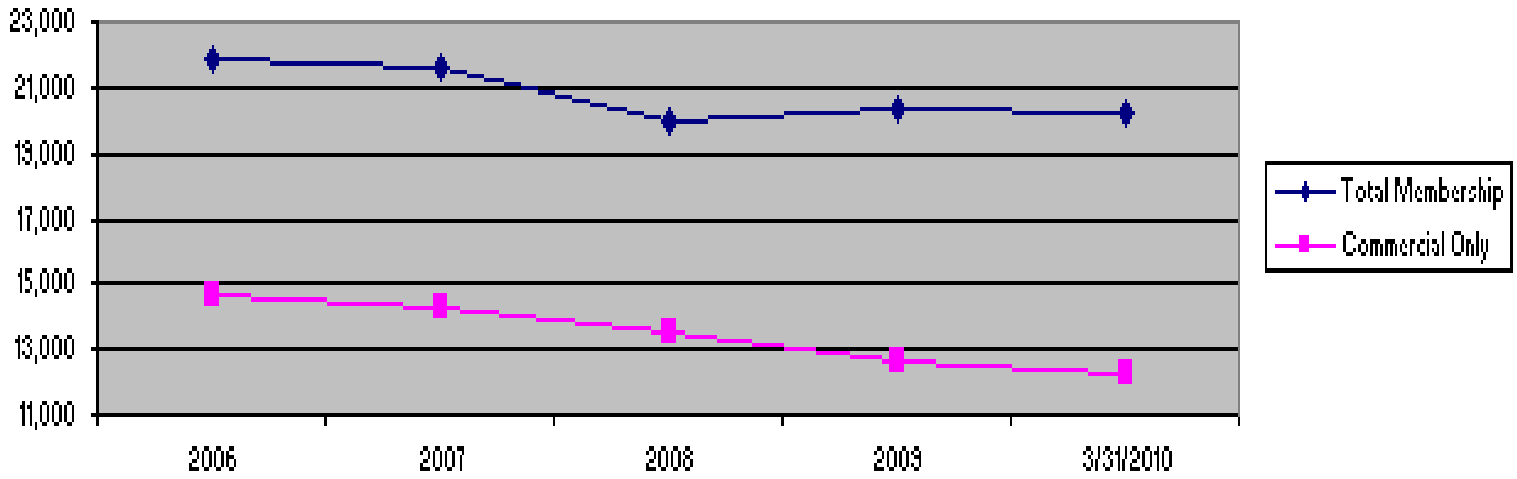
DMHC Full Service Plan Enrollment Changes

(In Thousands)

	2006	2007	2008	2009	3/31/2010	% of Change from 2008
Total Membership	21,822	21,618	19,980	20,382	20,277	1.48%
Commercial Only	14,721	14,249	13,533	12,609	12,300	-9.11%

Note: Total Enrollment includes all type of membership net of Plan-to-Plan enrollment.



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DMHC Full Service Plan
Enrollment Changes (In Thousands)

	2006	2007	2008	2009	3/31/2010
Total Membership	21,822	21,618	21,115	20,382	20,277
% Change from 2006		-0.94%	-3.24%	-6.60%	-7.08%
Commercial Only	14,721	14,249	13,533	12,609	12,300
% Change from 2006		-3.20%	-8.07%	-14.35%	-16.44%
Note: Total Enrollment includes all type of membership net of Plan-to-Plan enrollment.					

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Various Factors to Determine Ongoing Financial Viability of Health Plans

- Required TNE
- Liquidity and solvency ratios
- Income trend
- Cash flow trend
- Net Profit Margin
- Member Months (Enrollment) trend….

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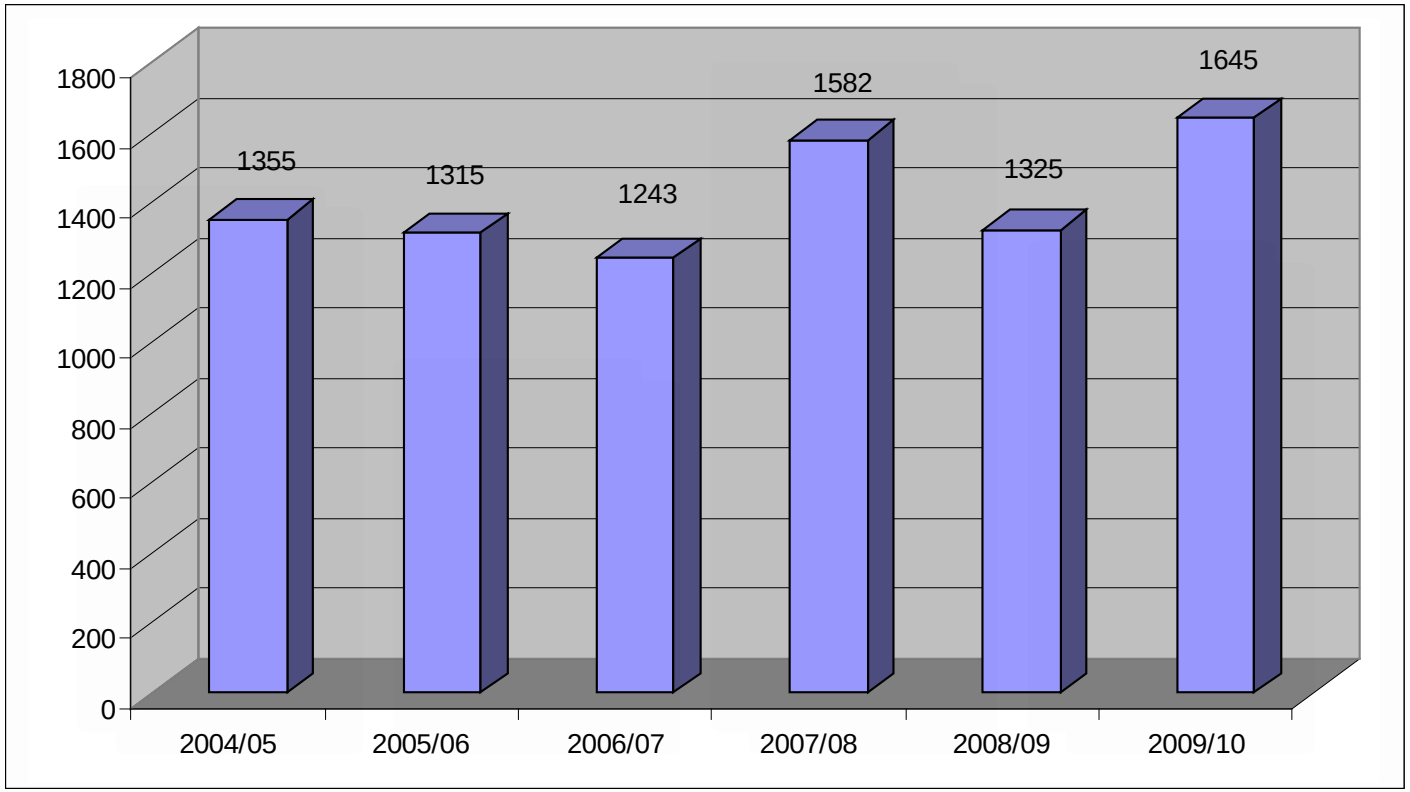
DFO: Financial Statements Reviewed (July 1-June30)



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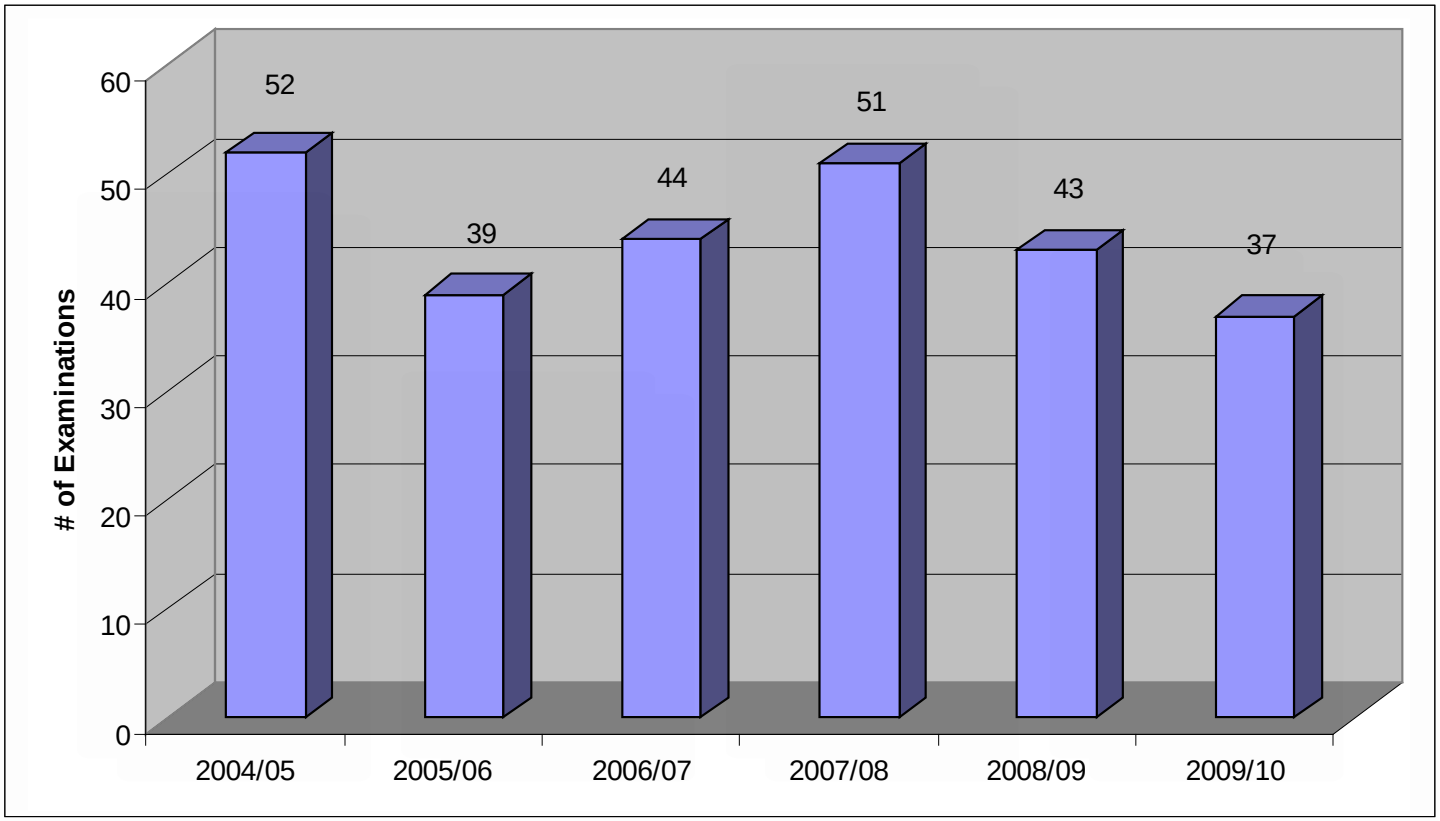
DFO: Examinations Completed (July 1-June30)



Including routine, non-routine and MRMIB examinations.

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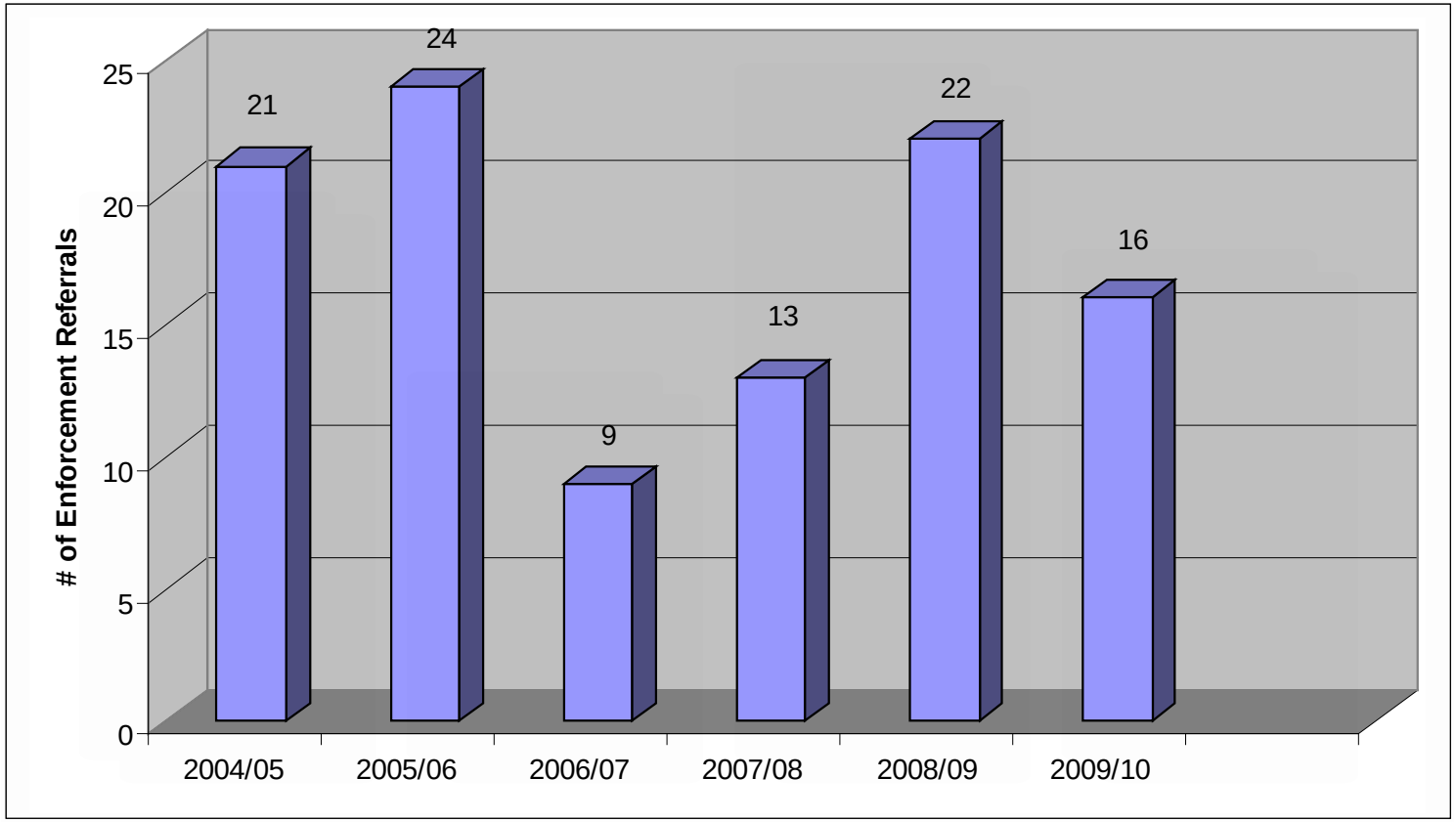
DFO: Enforcement Referrals (July 1-June30)



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Provider Overview

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RBO Reporting

- In Q1 2005 there were 166 RBOs reporting financial surveys.
- In Q1 2010, there were 156 RBOs reporting. The decrease is attributable to the RBOs being absorbed by larger RBOs or health plans, or the RBOs converted back to a “capitated provider” status.
- The number of RBOs filing Compliance Statements has remained relatively stable at 42 RBOs.

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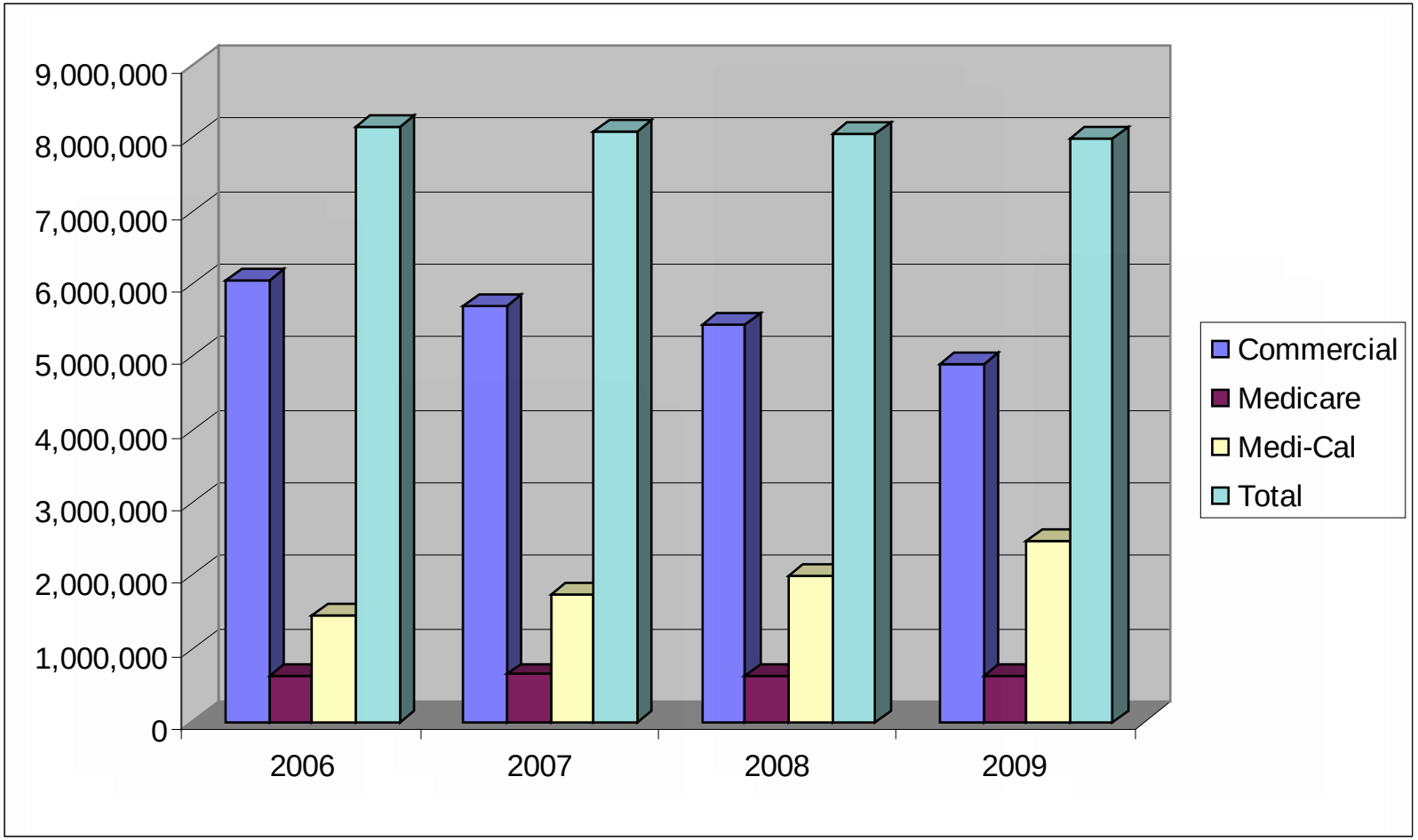
Total Medical Group Enrollment by Business Type



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Required Solvency Criteria for Risk Bearing Organizations:

- Positive Tangible Net Equity
- Positive Working Capital
- Minimum Cash-to-Claims Ratio (minimum 0.75 requirement)
- 95% Claims Timeliness
- Positive response to whether the RBO estimates and documents their IBNR claims liability (on a monthly basis), and
- Positive response that the RBOs IBNR estimate is reflected as an accrual on the financial survey reports

- All RBOs required to submit annual audited financial statement

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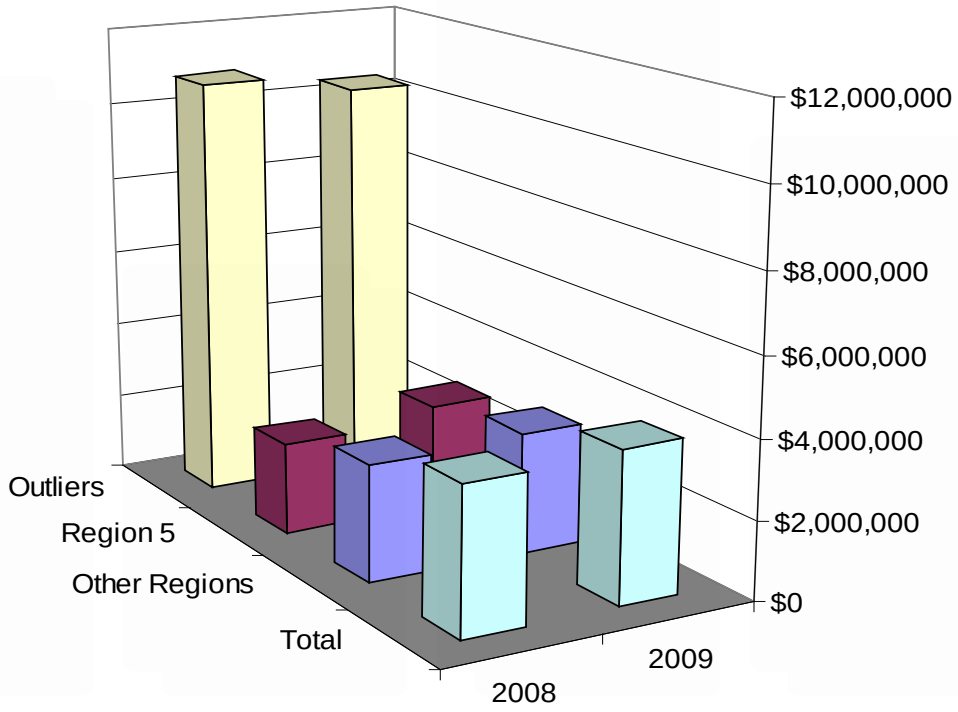
Claims Payable and IBNR



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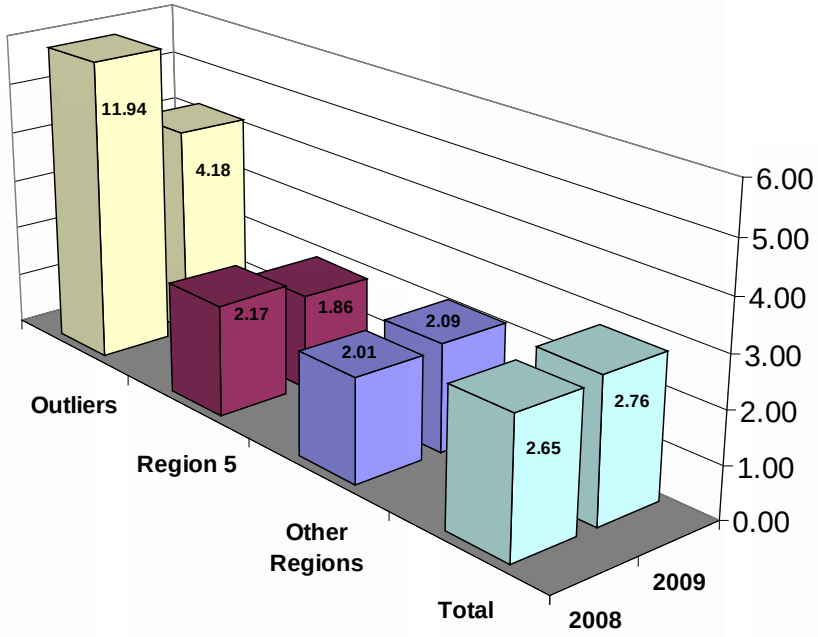
Cash to Claims Ratio



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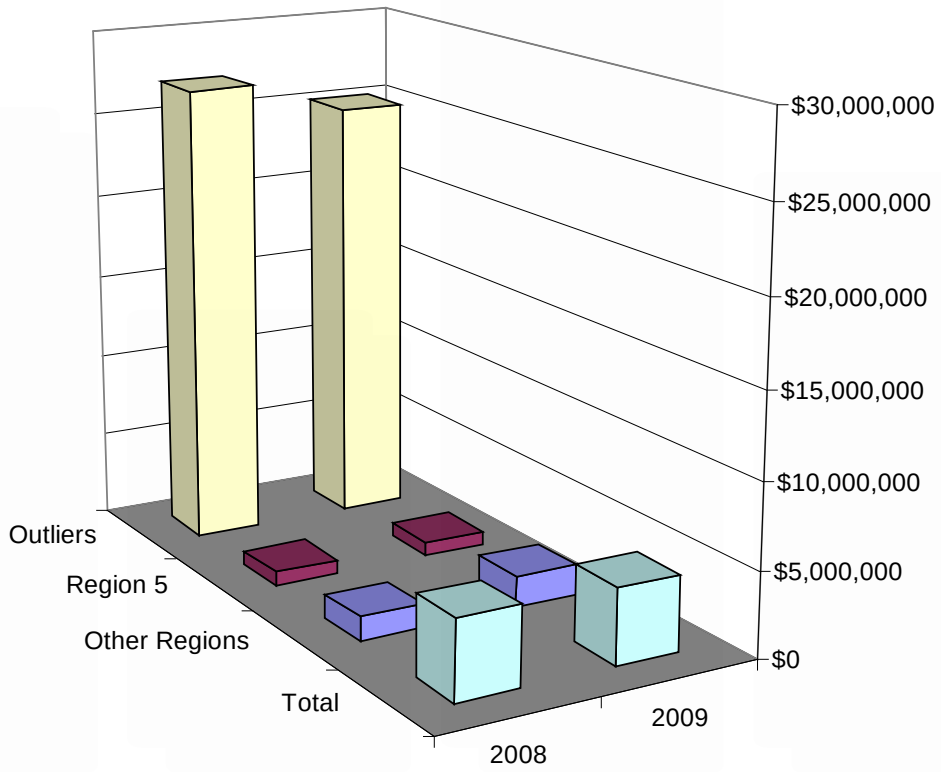
Average Working Capital



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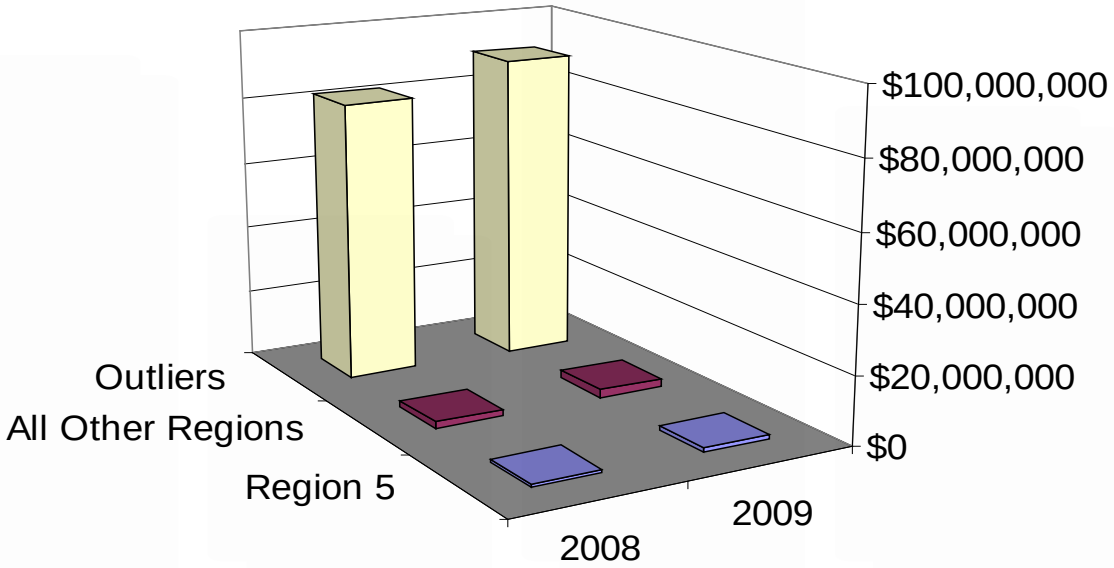

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Corrective Action Plan (CAP) Status

The number of CAPs have decreased since 2006.

As of March 31, 2010, the Department is monitoring 21 corrective action plans.

- 8 CAPs were in process (the CAP development stage).
- 13 CAPs were approved and being closely monitored.

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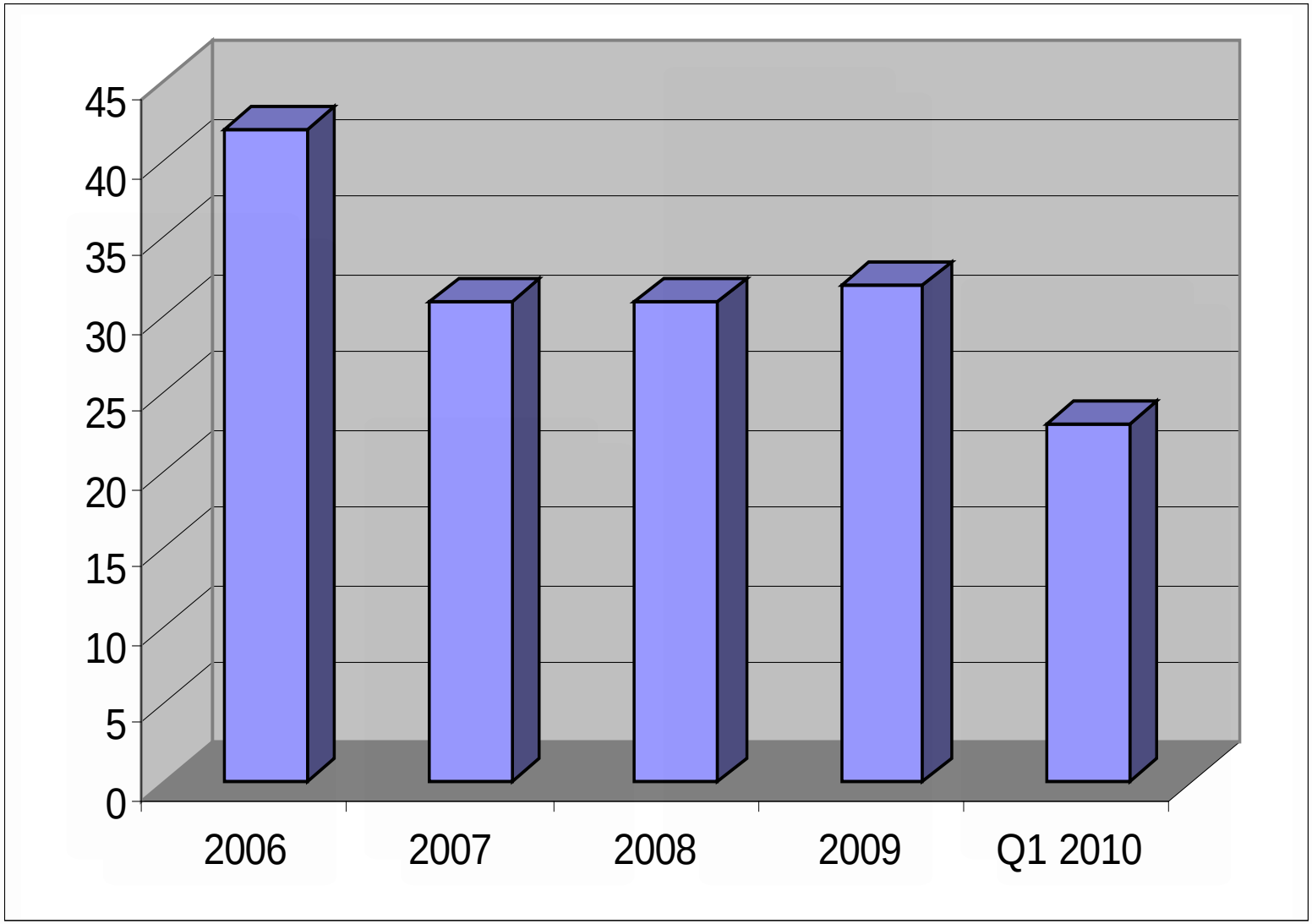
Total RBO Corrective Action Plans



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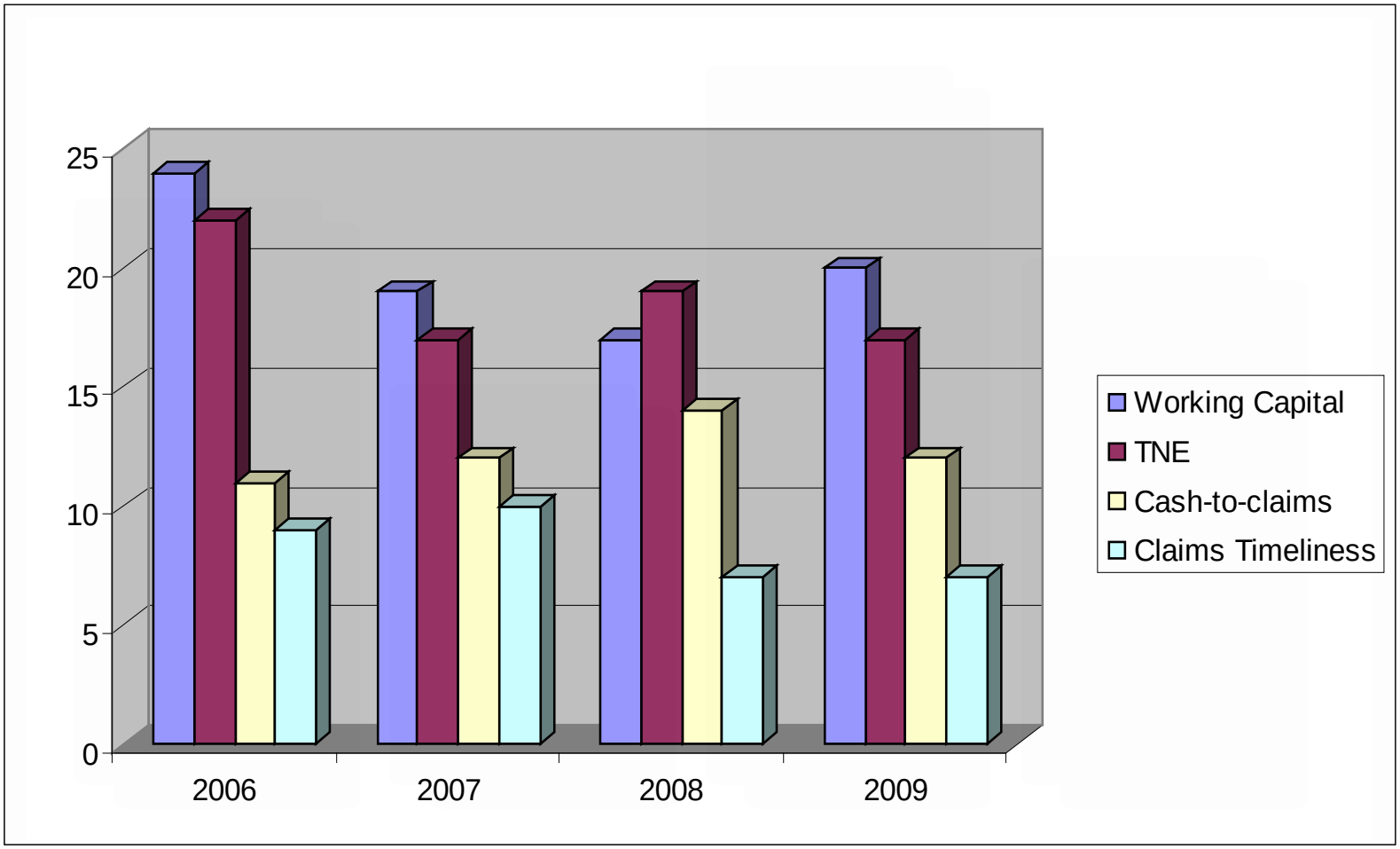
Criteria Deficiencies Monitored in the CAPs



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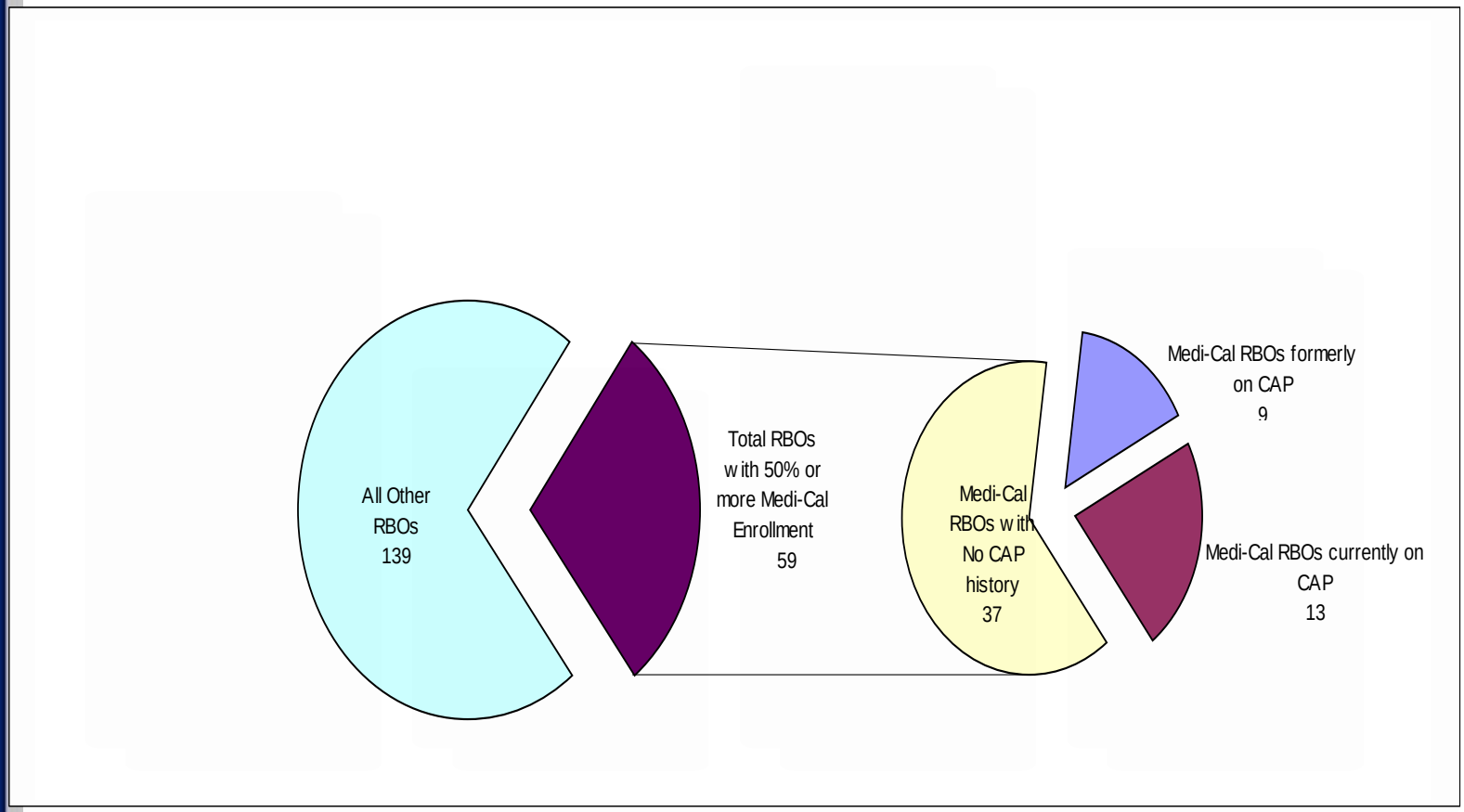
Current History of RBOs with over 50 % Medi-Cal Enrollment



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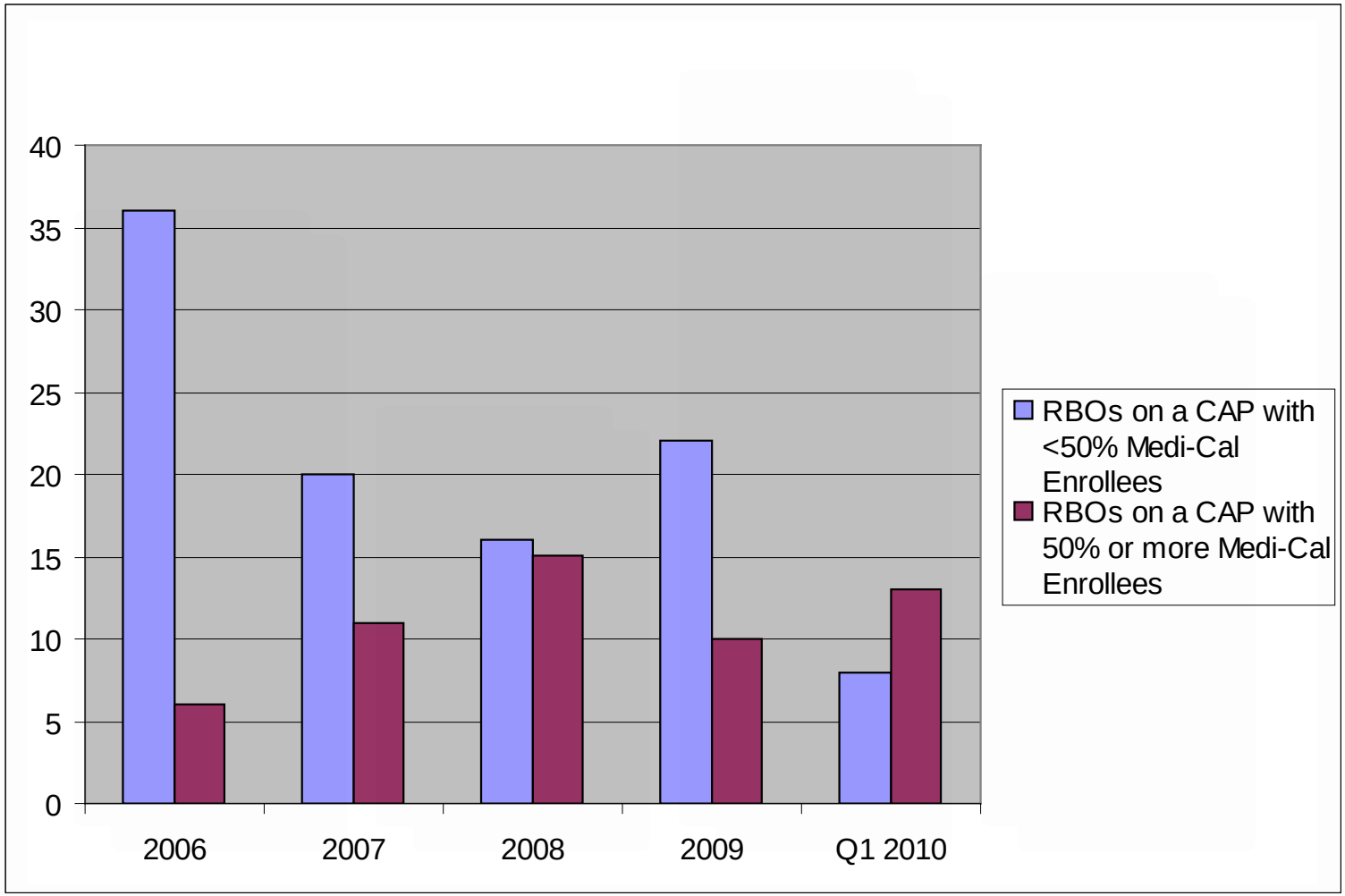
RBO CAPs: >50% Medi-Cal versus <50% Medi-Cal



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SB260 Update

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SB260 Update

- Passed in 1999
- Regulations Promulgated in 2001
  - Court challenges
  - Utilized FSSB to address and revise
- Current regulations became effective in 2005
- Improving metrics
- Areas for improvement

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SB260 Improvement Areas
Reporting

- Not all capitated providers are RBOs
  - "Contracts directly with health care service plan…"
  - FQHC, Ownership…..
- Compliance statement versus quarterly financials
  - Quarterly financials not required if <10,000 enrollees
  - ALL RBOs are required to submit annual audited financials
- County of operation
  - Many operate in multiple counties and locations
  - Report MSO address versus that of RBO

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SB260 Improvement Areas

Economic Issues

- Reporting of Affiliates (consolidated reporting)
  - Only required if legally and financially responsible for claims
  - Plans required to report “combined” if entities are economically dependent
- Sub-delegated enrollment
  - No notification to plan or DMHC
  - Passing on capitation risk
- MSO Oversight
  - Report on behalf of RBOs
  - Transition/change of MSOs
  - Responsibility for preparation of CAP and attestation
- Reserves
  - Regulation requires TNE of $1
  - Plan withholds and contract terminations

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SB260 Improvement Areas
Economic Issues (2)

- Insolvent RBOs
  - Emergency providers cannot deny treatment
  - Commercial plans not required to pay “2X”
  - Providers are left unpaid
- Questions to ponder?
  - How complete/accurate is annual risk disclosures
  - Should downstream risk be limited?
  - Can we incent healthy commercial providers to take state sponsored business given the expansion of health care reform?

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SB260 Improvement Areas
CAP ISSUES

- CAP process too slow, breaks down
- Department cannot share CAP information
- Limited enforcement tools for providers
  - Freeze Enrollment
  - Re-assign enrollees

- Potential Solutions
  - Ask ICE to revisit process and tool
  - Revisit confidentiality restrictions on CAPs
  - Consider monetary penalties for non-response
  - Stronger financial requirements (higher reserves, c-c 1:1, etc.)?
  - Ability to appoint conservator?

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Backup

California Managed Care Market

- 111 Knox-Keene Health Plans (57 Full Service Plans)
- 20 million enrollees in full service plans (12 million enrollees in commercial)
- 1.8 million PPO enrollees (DMHC only)
- 500,000 PDPs
- Kaiser – 6.71 million enrollees, Robust HIT
- 274 provider groups with 7.9 million enrollees
- Approximately 500 hospitals contracting

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DFO Financial Monitoring Tools

Rating System:

- Compares the score of individual plans against other plans in the same category:
  - Score calculated by DFO based upon the plan's filed financial statements
  - Comparison is against a number which is the mean of the scores of the plans in the same type
  - The Plan's score is converted to a letter grade (A thru E) for prioritizing the degree of monitoring

Audit Alerts:

- Triggered by letter grade going down
- Multiple factors then considered before performing an audit

Goal: Prior identification of financial insolvency (4 - 6 months)

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2005-2010 DFO Major Achievements

- Internal Review Committee (IRC) conducted an internal quality assessment that reviewed a sample of examination reports and supporting working papers to ensure that established policies, procedures and applicable auditing standards were being followed by all examination staff.

- Developed and implemented new examination electronic reporting system to ensure continued undisrupted e-filing for the health plans and to allow the public viewing of health plan financial information.

- Use of Audit Command Language (ACL) software in the performance of claim and dispute sampling, financial reporting of total claim liability/IBNR, and other financial areas.

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