Financial Solvency Standards Board Meeting
September 14, 2016
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Edward Cymerys, Collective Health
Larry de Ghetaldi, Sutter Health
Jacob Furgatch, Coast Healthcare Management
Betsy Imholz, Consumers Union
Dave Meadows, Liberty Dental Plan
Ann Pumpian, Chairperson, Sharp HealthCare
Dr. Jeff Rideout, Alternate, Integrated Healthcare Association
Shelley Rouillard, Department of Managed Health Care
Dr. Rick Shinto, Alternate, InnovaCare Health, Inc.
Dr. Keith Wilson, Molina Healthcare

Department of Managed Health Care (DMHC) Staff Present:
Steven Babich, Supervising Examiner, Division of Financial Oversight
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

1) Welcome & Introductions- Agenda

Chairperson Ann Pumpian called the meeting to order and welcomed attendees. The board members introduced themselves to the audience.

2) Minutes from June 15, 2016 FSSB Meeting

Edward Cymerys requested one correction to the minutes, to clarify his request that the Board discuss the impact of startup companies focused on particular populations, not that there is a lack of such organizations. Dr. Rick Shinto made a motion to approve the June 15, 2016 minutes with the proposed change. Mr. Cymerys seconded the motion. The meeting minutes were approved with the change noted by Mr. Cymerys.

3) Director's Remarks

Director Shelley Rouillard announced several appointments to the DMHC executive team and provided an update on other recruitments. Naresh Baliga is the new Deputy Director for the Office of Technology and Innovation. Elizabeth Landsberg is the Deputy Director for the DMHC Help Center and will be starting on October 24. The Department is advertising for the Deputy Director, Office of Plan Monitoring, which combines the

Division of Plan Surveys and the Division of Provider Networks. Lastly, the first round of interviews for the new Chief Medical Officer (CMO) position are complete and the second round will begin soon. Ms. Rouillard expects to select a candidate by the end of September 2016.

Ms. Rouillard provided an update on health plan mergers. The acquisition of Cigna by Anthem Blue Cross is still under review. Aetna's acquisition of Humana was approved by the Department. However, the merger will not be finalized until the Federal government approves it. The Department of Justice (DOJ) has sued to block both mergers. Ms. Rouillard reminded the Board that the Department does not review mergers for anti-trust or anti-competition issues. That is left to California's Attorney General and the U.S. Department of Justice.

Some of the unique undertakings related to Aetna's acquisition of Humana include:

- Increased scrutiny over Aetna's rate increases.
- Undertakings around plan performance, improving quality, and maintaining provider directories.
- $49.5 million in community investments, including:
    - $6 million over three years to support consumer assistance programs that serve seniors and people with disabilities.
    - $3 million over three years to the California Dental Association Foundation to support their Community Dental Programs and scholarships for dentists to learn how to treat young children.
    - $1 million for telehealth services.
    - $23 million to expand the service center in Fresno.
    - $16.5 million for infrastructure investments to support accountable care organizations, or integrated delivery systems, and participation in the Integrated Healthcare Association (IHA) Pay-for-Performance Program.

Ms. Rouillard noted the undertakings won't take effect until after the Federal government approves the merger.

Ms. Rouillard provided an update on the follow-up survey of Anthem Blue Cross and Blue Shield related to provider directories for the individual market. In 2014 after the launch of Covered California, there were a lot of complaints from consumers about the inaccuracy of the provider directories. After a year of investigation and surveying of the provider directories, the DMHC reached a settlement agreement with both plans that included corrective action plans (CAPs) and a combined fine of $600,000. While the follow-up survey results were not very encouraging, Senate Bill (SB) 137 was signed by the Governor and sets up strict standards and procedures for plans to follow to improve the accuracy of provider directories.

Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations, and Mahavir Jogani, Attorney, Office of Plan Licensing, have been leading a series of workshops with the California Department of Insurance and stakeholders related to the development of Uniform Provider Directory Standards. The standards will be released by the end of the year and the plans have a year to implement them.

Discussion

Ms. Pumpian asked if there would be continued fines for Anthem and Blue Shield since the results of the follow-up survey were not promising. Ms. Rouillard responded that despite a lot of work to improve the directories, the survey results were comparable or a little worse than before. The DMHC decided not to fine the plans at this point because the fines won't fix the problem, but hopefully, the full implementation of SB 137 will help.

Betsy Imholz stated her organization, Consumers Union, co-sponsored SB 137 and is optimistic it will make improvements, but the bill is not a cure-all. These two particular health plans have a history of problems and have requested the highest rate increases in the individual market for the coming year. She would like to see special scrutiny of both health plans.

Larry de Ghetaldi inquired whether DMHC asks health plans during a merger to remain in their respective counties. He expressed concern that, perhaps after a merger, plans might exit certain counties and enrollees, such as seniors, will have fewer choices. Ms. Rouillard stated the DMHC has undertakings that would require health plans to make their best effort to maintain and grow their market in California.

4) Board Member Recruitments

Ms. Rouillard announced that, with the exception of Ms. Imholz and Dr. Jeff Rideout, the current Board members will have reached the end of their three-year terms at the end of 2016. DMHC released a solicitation for FSSB Member applications inviting qualified individuals to apply. Board members with expiring terms are also welcome to reapply.

Ms. Rouillard stated that due to the recruitment efforts, the FSSB meeting scheduled for December 14, 2016, is cancelled and the next meeting will be at the beginning of the year with the new Board members in place. Ms. Rouillard also discussed the proposal to adjust the FSSB meeting schedule for 2017 in order to allow the Office of Financial Review more time to analyze financial statements and present their analysis to the Board.

Ms. Rouillard thanked the departing Board members for their long-standing dedication and service to the State of California and presented them with certificates.

Discussion

Ms. Pumpian asked Ms. Rouillard to explain the desired qualifications and experience that an applicant for the Board should have. Ms. Rouillard explained that, by statute, the FSSB will be looking for applicants who have expertise in medical and healthcare economics, accountancy, actuary experience, underwriting in the health world, actuarial studies, management and administration of medical groups or integrated healthcare systems, investment banking, information technology, or other related fields in integrated or affiliated healthcare delivery systems.

5) Department of Health Care Services (DHCS) Update

Sarah Brooks, Deputy Director, Healthcare Delivery Systems, provided updates on the Managed Care Final Rule, the Medi-Cal 2020 waiver, and the quality and performance ratings for the Medi-Cal plans.

The Managed Care Final Rule implements new rules for Medicaid managed care and is the first overhaul of the Medicaid regulations since 2002. While California is ahead of other states in the requirements, there is still much work to be done as some of the provisions take effect immediately or over the coming years. Ms. Brooks highlighted some of the key provisions, including:

- Changes to grievances and appeals, cultural competence, care coordination, quality improvement, program integrity, and annual managed care reports.
- Development of a standard template for Evidence of Coverage (EOC) handbooks.
- Network adequacy requirements, including new time and distance requirements for primary pediatric care, specialists for both pediatric and adult care, hospital, pharmacy, and Long-Term Services and Supports (LTSS).
- Annual network certification to the Centers for Medicare and Medicaid Services (CMS).
- New requirements for beneficiary support systems for LTSS.
- Quality rating system, which is expected to be similar to the Medicare star rating system.
- Minimum Loss Ratio (MLR) requirements.

Ms. Brooks stated DHCS has been analyzing its compliance with the more than one hundred provisions of the Final Rule and determined it is in compliance with approximately half of the provisions so far. DHCS will hold workgroups with the health plans and external stakeholders to solicit input on the implementation of the Final Rule. In addition, DHCS is anticipating processing about 50 contract amendments in 2017 and 2018 and issuing further guidance on the requirements to the plans through about 15 different all plan letters.

Ms. Brooks also provided an update on the 1115 waiver. CMS required DHCS to perform a one-time access assessment to examine whether the Medi-Cal Managed Care Plans are in compliance with current requirements for network adequacy, as defined by either the Knox-Keene Act or the Medi-Cal Managed Care contract for non-Knox-Keene licensed plans. DHCS is amending the contract with the external quality review organization (EQRO) who will conduct this assessment. DHCS is also required to establish an advisory committee to advise them on the assessment. The first meeting will take place in late November and the assessment will likely start sometime in 2017.

DHCS will receive $1.5 billion over the next five years in Federal Financial Participation (FFP) to fund a Whole Person Care pilot program. The purpose of this program is to test the coordination of physical health, behavioral health and social services for high utilizers of multiple health care systems who continue to have poor outcomes. DHCS received 18 applications, 16 of which included some sort of housing proposal. DHCS expects to submit its recommendations to CMS by October 7, 2016.

In response to questions from the Board at previous meetings, Ms. Brooks provided an overview of DHCS's quality efforts. DHCS currently has an External Accountability Set (EAS), which consists of 30 different indicators used to calculate an Aggregated Quality Factor Score (AQFS). The AQFS is an overall performance score for each of the health plans in the counties they operate in. DHCS is currently working on a Plan Rating System, which will use data from 50 different data sources to create a score and real time reports by plan or specific area. DHCS will begin testing the Plan Rating System in 2017 and issue a report publicly in 2018.

Discussion

Dr. Keith Wilson asked whether the new requirements of the Final Rule address timely access to appointments. Ms. Brooks said that there are many standards already in place for timely access and DHCS will start to look at timey access during annual audits and during member and provider surveys.

Dr. Shinto commented that DHCS' implementation of the Final Rule will be similar to what happened in Medicare Advantage (MA). He explained that DHCS should look at MA in order to avoid falling into the same pitfalls that the MA program has.

Mr. de Ghetaldi suggested that for providers, it would be helpful if DHCS aligned its clinical quality measures with what is done for commercial HMO and PPO, Medicare Advantage, and Medicare fee-for-service. Ms. Brooks responded they are talking to other entities who are looking at quality, such as Covered California.

Ms. Imholz asked whether DHCS is working with DMHC on the new requirements related to provider directories. Ms. Brooks replied DHCS is working with DMHC on SB 137. The Final Rule includes additional requirements for the frequency of updating provider directories.

Jacob Furgatch asked what is covered under housing assistance for the pilot program. Ms. Brooks answered housing assistance can range from providing recuperative care, helping an applicant secure housing, teaching a landlord how to work with different individuals, and granting interim housing to applicants. Mr. Furgatch asked whether rent was included. Ms. Brooks answered assistance with rent can be paid through a Flexible Housing Pool, which she defined as funding set aside by the pilot, but can't be paid with the money they are getting from the Federal government.

Ms. Pumpian asked how many pilots DHCS expects to fund. Ms. Brooks answered she is unsure whether DHCS will go forward with all 18 pilots. However, she does expect 20 different pilots to be operating within the State by the second round.

Ms. Rouillard asked whether the financial status of the plans will be part of the Plan Rating System. Ms. Brooks answered DHCS is still working on how to integrate financial status into the rating system.

Ms. Imholz expressed her support for releasing this type of quality data to the public.

Mr. Cymerys commented financial solvency is an important item to address in the Plan Rating System, and that it would be great to try to incorporate a metric or information on the financial status of provider groups.

Dr. Rideout stated IHA released an atlas that looks at commercial PPO and HMO, but they are also trying to coordinate with what DHCS is putting out. He commented on the importance of understanding the categories that impact other categories. For example, chronic care performance is one of the most important measures because it drives utilization and total cost of care, among others.

6) 2017 Rates in the Individual Market

Gil Riojas, Deputy Director, Office of Financial Review, provided an overview of the rate review process and timeline for 2017. Mr. Riojas provided the following summary of 2017 rates in the Covered California individual market:

- The statewide average rate increase is 13.2 percent, with a range of 0.8 percent to 19.2 percent. In comparison, other states experienced increases ranging from 20 to 50 percent.
- Rate changes varied by region, with an increase as high as 28.6 percent in the Central Coast Region (Region 9) to an increase of just 8.4 percent in the Central Valley (Region 10).
- The major factors that impacted rate changes were:
    - A projected increase in medical services and prescription drugs costs of approximately six percent.

- The end of some of the risk adjustment programs put into place for the first three years of the Affordable Care Act (ACA). The American Academy of Actuaries estimates that this will add four to seven percent to premiums for 2017.
- The increased cost of consumers who enroll during special enrollment only after they become sick or need care, as mentioned by several plans.
- Changes in the risk profile of the enrolled population to date.
- Administrative costs.
- Profit margins that ranged from 0.5 percent to 3 percent, with an average of 2 percent.

Discussion

Mr. Furgatch asked whether the weighted average increase of 13.2 percent is weighted by enrollment. Mr. Riojas confirmed it is weighted by enrollment.

Ms. Imholz stated Consumers Union has a contract with DMHC to review rate filings and to submit comments. Overall, she believes California looks good compared to other states. However, she believes the two plans with the highest increases, Anthem Blue Cross and Blue Shield, had a lot of inconsistencies, errors or omissions in their filings. She urged the Department to get more details and evidence to prove the rate increases are justified.

Ms. Imholz added there is an undertaking the DMHC negotiated with Blue Shield of California that the plan will make every effort to keep their rates as low as possible.

Dr. Rideout stated, in his work at IHA, they see clear advantages of integrated care. He noted the plans with primarily integrated networks had single digit rate increases, so there appears to be a correlation between integrated care and lower total cost of care.

Mr. Cymerys noted Covered California has 11 participating health plans, compared to other states where there are only one or two. He added that some states were aggressive in trying to limit rate increases and plans left those markets. It is important to find a balance between restrictive rate increase limitations and enticing plans to engage in the marketplace.

Dr. Shinto asked whether DMHC has a way of holding plans accountable for their premium increase justifications. Ms. Imholz responded Consumers Union has found inaccuracies, conflicts in data, and missing data throughout the rate review fillings. She also said the DMHC is identifying ways to ensure that health plans not only verify, but justify their increases.

Mr. Furgatch clarified most Covered California enrollees do not receive their care through an integrated model but instead through individual direct arrangements with the

plan. In addition to rising premium costs, many of these enrollees are in high deductible bronze or silver plans, so the premium increases are significant for these enrollees.

Mr. de Ghetaldi asked why the highest rate increases are in the area from northern Los Angeles up to Santa Cruz and whether there was something unique about this geography that is leading to the increase, such as an inadequate network or risk factors. Mr. Riojas stated the response from the plans has been it costs more to contract with providers in those areas.

Tam Ma, Health Access California, expressed her concern about the lack of justification for the rate increases, and that as sponsors and supporters of the rate review law in California, Health Access California is concerned about the potential lack of compliance of health plans. Furthermore, Ms. Ma explained that her organization is willing to re-open discussion regarding legislation that would give regulators authority to approve rate increases prior to the rates taking effect.

7) Risk Bearing Organization Sub-Delegation

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, reviewed the definition and criteria of a Risk Bearing Organization (RBO) and defined sub-delegation as an RBO delegating all or part of its risk to another RBO.

Ms. Yamanaka detailed the potential compliance issues associated with RBOs and sub-delegation. Since sub-delegated RBOs do not have a direct contract with healthcare service plans, plans are not required to maintain the same level of oversight to ensure compliance that they have with the RBOs they contract directly with.

Ms. Yamanaka cited an example of a RBO with a direct contract with four health plans and sub-delegated contract with another RBO. Approximately 9% of the reporting RBO's enrollment was from the four health plans. However, the remaining 91% fell under a sub-delegated model with another RBO. In this example, the four health plans would not have oversight for 91% of their enrollment. Additionally, the sub-delegated RBO does not provide financial reports to the plan and the plan does not participate in the CAP process.

Ms. Yamanaka highlighted several options available to the DMHC to address the lack of oversight for sub-delegated arrangements, including:

1. Require health plans to oversee the sub-delegated RBOs in the same way they oversee directly-contracted RBOs.
2. Require health plans to include provisions in their contracts with RBOs that stipulate that sub-delegated RBOs will be held to the same requirements that regular RBOs are subject to.
3. Prohibit sub-delegation altogether.

Discussion

Mr. Furgatch said one of the fundamental challenges is the definition of an RBO because as the regulations are written, any primary care physician receiving monthly capitation could meet the requirement of an RBO, but that is not the concern that DMHC has for regulating RBOs.

Dr. Shinto stated the integrated delivery systems works and any move away from integrated care will destroy the health care system. He added not all organizations are sub-delegating as a pass through. Some, like Sharp and other large groups, might pass delegation, but they have the same level of oversight as the health plans.

Dr. Wilson asked how many lives are affected by sub-delegated RBOs where there is no oversight. Ms. Yamanaka replied there are 10 to 12 RBOs that she knows are sub-delegating, but the degree of sub-delegation and the amount of enrollment passed down varies. She estimated the amount of enrollment impacted is in the hundreds of thousands.

Dr. Wilson stated the cure should not be worse than the disease and it would be a dangerous, disruptive pathway to assign a higher level of regulation without understanding the impact and magnitude of the problem.

Dr. Rideout said of the three options, the first option was the most logical because it is an extension of the oversight that already exists. However, it presumes the health plans are effective in monitoring the RBOs they have now. Ms. Yamanaka said her team has been looking at the health plan procedures for monitoring RBOs and of the plans she has visited thus far, those plans are engaged with the RBOs during the CAP process and have systems in place to monitor the RBO's financials.

Ms. Pumpian asked whether DMHC is receiving more complaints from enrollees using these sub-delegated RBOs. Ms. Yamanaka replied she has not seen a noticeable difference. However, DMHC does not have visibility into the enrollment that is sub-delegated.

Dr. Wilson suggested that rather than prohibiting sub-delegated arrangements, DMHC should suspend an RBO's ability to sub-delegate when they are on a CAP until the appropriate measures are in place to ensure the proper oversight.

Ms. Imholz commented the number of consumer complaints doesn't prove much because consumers are reluctant to complain and they don't know who to complain to.

Bill Barcellona, with CAPG, expressed his belief that CAPG can help the DMHC understand the sub-delegated arrangements and where to go next. Mr. Barcellona added these sub-delegated entities are most common under the Medi-Cal line of business, since most groups that are on CAPs are Medi-Cal groups.

Mr. Barcellona said the law is old and has been implemented well by the Department with very few failures, but the market is changing. There are exotic new business models that include clinics and hospitals who are active in risk-based payment models. The law doesn't capture all of the entities that are now working collaboratively in risk arrangements.

Mr. Riojas stated the purpose of the presentation was to facilitate a discussion with the Board about issues they are seeing and the Department is not necessarily planning to implement one of the options yet.

Mr. Cymerys added the Board should keep in mind that these sub-delegated RBOs are not necessarily nefarious and are not necessarily an attempt to bypass the law. Rather, many of them use these models to achieve better outcomes for patients, especially patients who are the most sick and costly.

8) Provider Solvency Quarterly Update

Ms. Yamanaka provided an update on the financial solvency of RBOs for the quarter ending June 30, 2016:

- 177 RBOs were required to file annual survey reports. Of these, 175 have filed, one RBO is a non-filer, and one RBO's fiscal year ends in April, so their financials are due at the end of September.
- 127 of the 177 RBOs filed quarterly survey reports, 49 RBOs submitted compliance statements and there was one non-filer.
- 4 RBOs filed monthly financial statements as required in their CAP.
- 33 RBOs are in the superior category.
- 88 RBOs are in the compliant category, of which six are on CAPs, but they are reporting that they meet the solvency criteria, and seven are on the closely monitored list.
- 7 RBOs are reporting non-compliance with the solvency criteria.
- The number of RBOs on a CAP has decreased from the previous quarter, with 13 total RBOS on a CAP. Six of the thirteen RBOs are meeting their CAP and five are new or in process. The remaining two include one that had an enforcement action to freeze enrollment and one that has a compliance date of September 30.
- There are 85 RBOs that have Medi-Cal enrollment, covering approximately 4.1 million lives.
- The top 20 RBOs serve approximately 3 million Medi-Cal lives. Sixteen of these RBOs have no financial concerns and four are on CAPs.

- The remaining 65 RBOs service approximately 1 million Medi-Cal lives. Of these, 54 have no financial concerns, seven are on the closely monitored list and four are on CAPs.

Ms. Yamanaka stated of the 24 audits the Provider Solvency Unit scheduled for 2016, seven have been completed and the remaining 17 are still in progress.

Discussion

Mr. Furgatch said that it looks like they are able to do approximately 25 audits per year so there is a seven year cycle for audits. For his organization, they have an extensive audit every year, but not every RBO is doing that. Mr. Furgatch reiterated his point that the health plan is ultimately accountable for the appropriate oversight of the RBOs.

9) Health Plan Quarterly Update

Stephen Babich, Supervising Examiner, Division of Financial Oversight, presented the highlights of the health plan quarterly update for the quarter ending June 30, 2016:

- There are 74 full-service health plans, which is an all-time high.
- Enrollment in full-service plans is 25.79 million, with commercial enrollment slightly higher than government enrollment.
- Growth in the commercial market has largely been a result of growth in Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs).
- The number of specialized plans has increased from 20 last year to 28.
- There are now 22 full service plans on the closely monitored list, compared to 16 in the prior year.
- There was one tangible net equity (TNE) deficient plan. However, that plan is no longer TNE deficient.

Mr. Babich provided an update on the TNE of all plans, including the 28 closely monitored plans. He noted the report had been changed to reflect TNE by market segment rather than by enrollment. He explained that while several plans are well above 500% TNE, they can still be on the closely monitored list for various other reasons.

Discussion

Ms. Imholz asked about the specific reasons for placing a plan on the closely monitored list irrespective of a high TNE percentage. Mr. Babich replied that plans can be placed on the closely monitored list for a variety of reasons such as a plan having issues with their claims shop or a new implementation not going well.

Dr. Rideout said it would be great for the Board to know the names of the organizations that remain on the closely monitored list and which organizations are moving on or off other lists.

Mr. Babich expressed concern about disclosing the names on the closely monitored list because there may be reasons they are being monitored that we do not want to disclose or we need to verify that the information we received is valid.

Dr. Rideout said it would be good to see the TNE for liquid versus non-liquid assets, especially for the plans on the closely monitored list. In response to the new format of the report, Dr. Rideout and Ms. Imholz stated they would like to see the TNE charts by market segment and enrollment.

10) 2017 Proposed Meeting Schedule

The proposed meeting dates for 2017 are:

- Wednesday, January 18, 2017
- Wednesday, April 19, 2017
- Wednesday, July 19, 2017
- Wednesday, October 18, 2017

11) Public Comment on Matters not on the Agenda

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

12) Agenda Items for Future Meetings

Ms. Pumpian asked if there were any agenda items for future meetings. There were none.

13) Closing Remarks/Next Steps

Ms. Pumpian said it has been a pleasure to be a part of the group and she has enjoyed hearing the varying perspectives and opinions within the group.

The meeting was adjourned at 12:14 p.m.