Financial Solvency Standards Board Meeting
October 18, 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
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
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 Systems
Ryan Witz, Assistant Deputy Director, Health Care Financing

1) Welcome & Introductions - Agenda

Chairperson Betsy Imholz called the meeting to order.

2) Minutes from July 19, 2017 FSSB Meeting

Ms. Imholz asked if there were any changes to the July 19, 2017 FSSB meeting minutes. Meeting minutes were approved without objection.

3) Director's Remarks

Director Shelley Rouillard informed the Board that the Chair's term expires at the end of the year. However, Ms. Imholz has agreed to continue in her role for another year through the end of 2018.

Ms. Rouillard provided an update on recent federal activities impacting health care. On October 12, 2017, the President directed the Departments of Labor, Treasury, and Health and Human Services to "facilitate the purchase of insurance across state lines" and to "prioritize three areas of improvement in the near term":

- Allow small group employers to group together to self-insure or purchase large group insurance, and would categorize these plans as a single employer for the purposes of ERISA, thus exempting those plans from all state regulation and state consumer protections.
- Promote short-term, limited-duration insurance by seeking to extend the allowed coverage period to 185 days and allow one additional 185 day renewal period. These products are regulated by the California Department of Insurance (CDI) not DMHC.
- Promote health savings reimbursement arrangements, which already exist for some people with employment-based insurance.

Ms. Rouillard stated while the Department is analyzing the impact of the Order in California, there are no immediate changes as a result of the Executive Order. The Executive Order only directs federal agencies to make future regulatory changes that are in alignment with the stated goals.

Ms. Rouillard discussed the second major announcement from the Administration regarding the decision to cease funding for the Cost-Sharing Reduction (CSR) subsidies for low-income consumers who purchase individual coverage on the Exchange. The Administration had been funding CSRs on a month-to-month basis, but decided to stop funding them effective November 2017. This means subsidies will not be reimbursed for October, November and December of this year. Additionally, 18 states, including California, have filed suit to stop the Administration from halting CSR payments.

Covered California announced their final rates for the individual and small group market on October 11 and DMHC posted the final rates on its website the same day. The Covered California individual rates include a surcharge, an increase on the Silver tier products to compensate for the loss of CSR subsidies. The DMHC and CDI required Covered California plans to file two sets of rates; one set assumed the continuation of CSR payments and the other set of rates assumed the discontinuation of federal CSR payments. Despite high overall rate increases ranging from a low of approximately 10 percent to a high of 45 percent, Ms. Rouillard acknowledged Covered California's efforts to protect consumers from high rate increases.

In addition, through the Department's rate review process, DMHC was able to reduce the individual market rates for both Anthem Blue Cross and L.A. Care, and reduce Anthem's increase in the small group market to zero. The total savings for consumers is approximately $123 million in 2018, which more than doubled the DMHC's total overall savings since the inception of the rate review program.

Ms. Rouillard acknowledged the efforts of staff who reviewed the rates, including the plan's assumptions and justifications, to achieve the best possible result for consumers in California. Staff acknowledgements included Pritika Dutt, Deputy Director of the Office of Financial Review; Wayne Thomas, Chief Actuary; and the Department's actuarial vendor, NovaRest.

Ms. Rouillard provided an update on the Provider Directory Utility. Blue Shield of California entered into an agreement with the Integrated Healthcare Association (IHA) to host the provider directory utility. IHA has hit the ground running and is expected to have a number of plans and provider groups participating by the end of 2018.

IHA expects to issue the Request for Proposal (RFP) for the database vendor by the end of 2017. They have engaged a Chief Technology Officer and launched a market research effort to understand the needs and expectations for the utility.

Ms. Rouillard also provided an update on Health Net's Community Investment and Infrastructure Investment Advisory Committees, which were created as a result of the undertakings for the Centene/Health Net merger in 2016. A combined $1.5 million has been awarded to 10 health care and community-based organizations across the state to help individuals retain and understand how to use their healthcare coverage, improve the quality and availability of health care, and enhance health outcomes. The list of grantees for the first cycle is available on Health Net's website at www.healthnet.com.

For the fall grant cycle, Health Net will focus on health care workforce development and will target another $1.5 million to help recruit, train, and retain physicians and medical assistants working in areas with provider shortages. Another area of focus is encounter data standardization, specifically working to address the immediate needs of providers to improve the collection and reporting of encounter data. Health Net will be funding an assessment of staff readiness and system capabilities of provider organizations and practice management entities.

Ms. Rouillard stated Health Net's Infrastructure Investment Advisory Committee, chaired by Sandra Shewry of the California Health Care Foundation (CHCF), met for the first time on October 2, 2017. The Committee is charged with advising Health Net on capital investments for healthcare infrastructure and care delivery improvements in the Medi-Cal program. Anyone who would like more information about funding opportunities should contact Mary Watanabe.

Ms. Rouillard provided an update on legislative implementation initiatives at the DMHC. Assembly Bill (AB) 72 prohibits surprise balance billing for non-contracted providers in contracted facilities, establishes an independent dispute resolution process (IDRP), and directs the Department to establish a standardized methodology for determining the average contracted rate (ACR). A public meeting was held on September 12, 2017 to solicit stakeholder input on the standardized methodology for calculating the ACR. Ms. Rouillard thanked those who participated and submitted comments. She stated there will be further opportunity to participate during the formal rulemaking process, which will likely start in the next month or so in order to finalize regulations by January 1, 2019.

The IDRP launched on September 1, 2017 and the Department has not yet received any requests for IDRP. The Department has an Administrative Procedures Act (APA) waiver for the IDRP and will consider doing regulations in the future.

Ms. Rouillard provided an update on the implementation of Senate Bill (SB) 546, the legislation that mandates large group plans file aggregate rate data with the Department. Large Group rates were filed on October 1, 2017 and the Department has begun its analysis of the data. An update will be provided at the January FSSB meeting and the findings will be presented at a public meeting hosted by the Department in January or February 2018.

Ms. Rouillard informed the Board that the Governor signed SB 17 last week, a prescription drug transparency bill sponsored by Senator Hernandez. The bill requires health plans to report certain prescription drug information to the Department beginning in October 2018. It adds additional filing requirements for health plans that file large group aggregate rate information. The information will be incorporated into the annual public meeting on large group rates beginning in 2019 and will be reported to the Legislature.

Lastly, Ms. Rouillard provided an update on a couple of regulation packages. The AB 72 ACR regulations should be filed with the Office of Administrative Law (OAL) in the next few weeks. The other regulation package defines risk and codifies the current practice for issuing restricted licenses. It has been filed with the OAL and will be published in the California Regulatory Notice Register on October 17. The first formal public comment period will end on December 11.

Ms. Rouillard concluded by inviting the Board and participants to sign up to receive notifications of regulation packages or other information of interest to the Department's stakeholders via the "Keep In Touch" box on the Department's website.

Discussion

Ms. Imholz acknowledged the work of Covered California, the Governor, and the Legislature for taking proactive steps to manage the uncertain moment in our history. Ms. Imholz also acknowledged the DMHC for the detailed review of proposed rate increases, and for the savings for consumers.

Ms. Imholz asked if the Department had received any consumer complaints about notices related to AB 72 which possibly do not comply with the law. Mary Watanabe, Deputy Director of Health Policy and Stakeholder Relations, responded she was not aware of any complaints, but anyone with concerns about the notices should contact the DMHC Help Center.

4) 2018 Rates in the Individual Market

Pritika Dutt, Deputy Director, Office of Financial Review, provided an overview of the 2018 rates for the individual market, including a review of the rate-setting timeline. She stated the rates were finalized on October 11, 2017 and will go into effect on January 1, 2018.

Ms. Dutt reiterated that due to the uncertainties in the marketplace, plans were required to file two sets of rate findings. One assumed that CSRs would be funded, while the other included a surcharge which presumed the CSRs would not be funded. CSRs are discounts which lower the amount eligible enrollees have to pay for deductibles, copayments and coinsurance for Silver-Tier plan products.

Ms. Dutt provided an overview of the DMHC rate review process. Department actuaries review the rate filings to determine if the proposed rate increases are justified. The DMHC does not have the authority to approve or deny rate increases. However, if the DMHC determines the rates are unreasonable or not justified, it has the opportunity to negotiate with the plans to lower rates for consumers.

The statewide average increase for all Covered California health plans regulated by the DMHC ranged from 9.8 percent to 44.7 percent. The final rates were those that assumed CSRs would not be funded. Eligible enrollees will continue to receive CSRs and the Advanced Premium Tax Credit (APTC). In addition, Anthem Blue Cross and L.A. Care modified their original proposed rate increase for their individual products for a total savings of $30.75 million.

The key drivers for rising rates in 2018 include:

- Medical and pharmacy cost trends
- Changes in the risk adjustment program
- Uncertainty in the marketplace, including the continuation of the individual mandate
- Administrative costs, including taxes, fees, and some non-medical expenses
- Anticipated changes in the market-wide health status of the covered population, referred to as the risk mix

Ms. Dutt thanked the rate review team for completing the review on time despite the additional work load of reviewing a second set of rates.

Discussion

Amy Yao acknowledged the work of Covered California's to stay ahead of the curve compared to other states. Ms. Yao clarified the net premium for subsidized consumers actually did not go up despite the surcharge due to the increase in the Advanced Premium Tax Credit (APTC). The second thing California did to mitigate the impact to consumers was to create an off-exchange silver plan for unsubsidized consumers so they could change plans and not pay the higher premium.

John Grgurina asked how Covered California will proceed if the CSRs are funded through legislation or through the courts. Ms. Rouillard indicated any action would

depend on timing, but if CSRs were funded prior to January 1, 2018, there would be interest in ensuring consumers receive the lower rates. Covered California, the DMHC, and plans would need to collaborate to figure out how that would work. However, once the plan contract starts on January 1st, no changes would be made.

Dr. Larry de Ghetaldi asked what the projected enrollment is and if there is expected to be a decline in enrollment. Ms. Dutt answered some of the plans will experience a decline such as Anthem Blue Cross, who pulled out of some regions.

Dr. de Ghetaldi expressed concern about access and whether there are a sufficient number of plans in each region. Ms. Rouillard indicated the DMHC has completed its network adequacy reviews and has not found significant problems.

Dr. de Ghetaldi asked if there was a decline in enrollment of the younger population and if this is part of the risk trend over time. Ms. Yao confirmed Blue Shield has seen a slight decline, but there has not been any dramatic shifts in the market. Ms. Rouillard added there are concerns that the implementation of the most recent Executive Order could siphon off the younger and healthier population into other products.

Ms. Imholz stated the public may be confused about the dates for the open enrollment period. While the open enrollment period ends on December 15, 2017 for the Federal Exchange, in California the open enrollment period ends on January 31, 2018.

In addition, the public may hear that the federal government is not making the CSR payments and misinterpret this to mean their co-payments and deductibles will go up, which is not true because consumers will still receive the CSRs. Covered California is educating consumers about this, and she hopes the DMHC will as well. Ms. Rouillard indicated the DMHC will continue to play a role in educating the public about this particular issue.

Mr. Grgurina reminded the Board of the advantage California has with running its own state-based exchange and the ability to continue to market to people, whereas the Federal Government has removed all the dollars for marketing. This may negatively impact the risk pools in the Federal Exchanges.

Ms. Yao asked if the DMHC would work with the CDI to implement any regulations as a result of the Executive Order promoting short-term health plans. Ms. Rouillard confirmed DMHC's ongoing collaboration with the CDI on rates and issues in the individual market.

Dr. de Ghetaldi stated California has been a leader with strong consumer protections around health care financing, which could be eroded as a result of the Executive Order if plans are allowed to sell insurance across state lines.

5) Department of Health Care Services Update

Sarah Brooks, Deputy Director, Health Care Delivery System, DHCS, provided an update on the Managed Care Final Rule, including DHCS's approach to implementation and an update on implementation activities as of July 1, 2017.

Ms. Brooks explained the Final Rule was the first major overhaul of the managed care regulations since 2002. It aligns Medicaid with other health insurance coverage programs and improves state accountability and transparency. The Final Rule became effective on July 5, 2016. However, many of the changes are being implemented on a rolling basis. A DHCS internal evaluation was completed to determine where DHCS was in compliance and where changes needed to be made in regulations, contracts, guidance documents, etc. Stakeholder input was solicited throughout the process then plan guidance was issued via All Plan Letters (APL) and contract amendments.

Ms. Brooks provided an update on the initiatives that have been implemented as of July 1, 2017, including:

- All health plans will be required to use the member handbook template, which was issued in October. DHCS worked closely with DMHC to ensure there were no concerns with the language in the template.
- The Medi-Cal beneficiary support website was reconstructed making it much easier for beneficiaries to get information about their health plan, compare plans based on quality data, and find information about formularies and coverage.
- Beneficiaries are now required to exhaust the plan's internal appeal process prior to requesting a State Fair Hearing. An APL was issued to provide guidance to the plans and the contracts were amended to include this requirement.
- An Initial Health Assessment is now required for all Medi-Cal beneficiaries, not just Seniors and Persons with Disabilities (SPDs), to ensure providers are able to identify high-risk beneficiaries who may need additional care coordination.
- The record retention policies were updated to require records to be kept for 10 years.
- The financial sanction limit was increased.
- The DHCS is working on a new annual managed care report that will combine information that is currently in a number of separate lengthy reports into one report.

Ms. Brooks noted the DHCS issued eight APLs related to the Final Rule in the last year, with more to come in the near future around sanctions. In addition, a contract amendment has been submitted to CMS, and the DHCS is working closely with CMS to address any issues. DHCS has determined that the health plans are in compliance with these new requirements effective July 2017.

Ryan Witz, Assistant Deputy Director, Healthcare Financing, DHCS, provided an update on directed payments. Historically, the plans have been required to provide financing for hospitals through directed, or supplemental payment programs. However, these programs were deemed impermissible in the Final Rule. Examples include the hospital quality assurance fee, several programs for designated public hospitals, and a supplemental payment to Martin Luther King Hospital.

Mr. Witz explained that while the Final Rule deemed pass-through payments impermissible, it did include a 10 year phase-down, which DHCS will take advantage of. In addition, there are other directed payments that will shift from a pass-through payment to a directed payment based on either value or utilization.

DHCS submitted five proposals to CMS on June 30, 2017. The proposals are effective for the 2017-18 fiscal year. However, they are still pending approval by CMS. Mr. Witz stated the goals of the programs are to maintain or improve quality and access to care and to improve encounter data reporting. He noted that they were modeled after other states that are farther along in the approval process.

Mr. Witz reviewed the details of the following five proposals:

1. The Public Hospital Directed Payment Program focuses on the 21 public hospitals in California. The approach allows for a funding pool to be divided amongst the hospitals based on utilization. It includes different class structures to maintain uniformity and treatment within certain subsets of the hospitals.
2. The Public Hospital Quality Improvement Program takes advantage of the value-based program allowed under the Final Rule. Payments will be based on 20 to 25 quality measures funded through the Managed Care rate setting process.
3. The Private Hospital Directed Payment Program impacts the 400 private hospitals in California. This proposal replaces SB 239 and, similar to the public hospital program, payments would be made based on utilization as reported in encounter data. The funding would be a known amount from the hospital quality assurance fee and the annual appropriation amount.
4. The Proposition 56 Physician Directed Payment Program would be a new supplemental payment program focusing specifically on 13 Evaluation and Management (E&M) codes, including the top ten most utilized primary care and specialty care codes and three additional mental health procedure codes.
5. The Proposition 56 Dental Managed Care Directed Payment Proposal would be a uniform increase of 40 percent of the scheduled maximum allowance for certain procedure types. Payment will be risk-based for the dental managed care plans and based on actual utilization.

Discussion

Ms. Yao asked how long the directed payments will last. Mr. Witz answered the Proposition 56 proposals are for one year and would be funded through the annual appropriation. The proposals being reviewed by CMS are viewed as five-year proposals, though they require annual approval through rate certifications.

Ms. Yao asked if these payments will replace existing payments or if they will supplement the existing structures. Mr. Witz stated they will replace the existing programs. The funding levels that existed before need to be redirected to a permissible directed payment program, while also ensuring they meet CMS requirements to tie the payments to actual utilization.

Mr. Grgurina commended DHCS for the work it has done to implement the many changes required by the Final Rule and for working with plans, stakeholders, and with CMS, in particular. Mr. Grgurina stated intergovernmental transfers are critical for public hospitals, including the Universities of California (UCs) and private hospitals. Especially notable was the work DHCS did to research the approaches other states have taken with CMS to determine the best way to continue to deliver funding to the hospitals that really need it.

Dr. de Ghetaldi acknowledged the importance of the directed payments to facilities who serve a disproportionate share of low-income Californians. The payments help to maintain quality access and decrease cost shifting to commercial payers that would otherwise occur.

Ms. Rouillard asked if the plans keep any of the pass-through payments to hospitals. Mr. Grgurina stated plans do not keep any of it despite the administrative complexity. The Final Rule no longer allows a simple pass-through that designates to a plan a certain amount for a public cost. The payments, however, do not currently show up in the plan's financials. This may or may not change in the future given that they are no longer technically pass-through payments.

Ms. Rouillard asked if the plans or DHCS will evaluate whether the hospitals hit their quality targets. Mr. Witz stated DHCS would evaluate hospital performance. Mr. Grgurina indicated plans will integrate the same quality metrics into their performance improvement programs. This is done in part to streamline the number of quality targets hospitals must meet for DHCS requirements, plan requirements, and the Prime Program requirements.

Ms. Rouillard asked if both the dental fee-for-service providers and dental plans would be receiving the directed payments. Mr. Witz stated the directed payments would go to both delivery systems.

Ms. Yao asked how these payments will be handled for medical loss ratio (MLR). Mr. Grgurina stated currently pass-through payments are not counted as revenue or as an

expense. It remains to be determined if the payments will be counted as revenue and if the full expense will be sectored out. Mr. Witz added the MLR calculations within the Final Rule do not take effect until 2020.

Ms. Imholz acknowledged the potential positive impacts of the proposals and the changes required by the Final Rule. She expressed concern that the plans will have the resources to handle the new requirements, especially the requirement related to the administrative grievance process. She asked if this was something DHCS had considered. Ms. Brooks explained in urgent situations, beneficiaries are allowed to go directly to a State Fair Hearing, including when plans are unable to meet certain timelines or requirements. Ms. Rouillard added the DMHC's Independent Medical Review (IMR) process will remain available to Medi-Cal Managed Care beneficiaries who have had denials of care as well.

Don Comstock, Comstock and Associates, commented in regards to the 13 codes in the ACA 1202 and its benefit to providers. Physicians that were a part of medical groups were left out of this compensation, but they are in effect the same as an individual physician. They should be compensated accordingly.

Mr. Bill Barcellona, CAPG, acknowledged the DHCS for their hard work in implementing the Final Rule. Mr. Barcellona commented on the lack of transparency around basic capitation rates for the Managed Care Plans, which has created difficulty for Risk-Bearing Organizations (RBOs) who need to assess the financial exposure that they will assume in capitated contracts with Managed Care Plans. DHCS hosts a web page entitled, "The Medi-Cal Managed Care Monthly Capitation Report" which has not been updated since May 2014. This report is useful for smaller RBOs that need to assess their risk very carefully. Mr. Barcellona urged DHCS to continue to publish this report and update the website.

6) 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 June 30, 2017. 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:

- The LIs serve over 5 million Medi-Cal enrollees in 13 counties. From June 2016 to June 2017, enrollment increased by 205,685 lives, or 4.1 percent. Total Medi-Cal enrollment for LI plans increased by 84% from December 31, 2013 to June 30, 2017.
- Almost all LIs reported positive net income in June 2017 and for the last five quarters. However, there was a decrease in net income for some LI plans, likely due to the decrease in Medicaid coverage expansion rates.

- San Francisco Health Plan (SFHP) reported three consecutive quarterly net losses. However, they are meeting the Department's Tangible Net Equity (TNE) requirement at 899 percent TNE.
- The average TNE overall was stable in 2016 and 2017. For June 2017, the reported TNE ranged from 338 percent to 899 percent of required TNE.
- Liquid TNE, or cash on hand, ranged from negative 2,182 percent to 489 percent.

County Organized Health Systems:

- The five COHS that report information to the Department, serve approximately 2 million Medi-Cal enrollees. From June 2016 to June 2017, enrollment decreased by 19,618 lives, or nearly one percent. Total Medi-Cal enrollment in COHS increased by 64 percent from December 31, 2013 to June 30, 2017.
- Almost all COHS reported positive net income since March 2016.
- Only Partnership Health Plan reported a negative net income, but they are meeting the Department's TNE requirement.
- All COHS reported over 700 percent of required TNE, with reported TNE ranging from 722 percent to 1,393 percent.
- Liquid TNE ranged from negative 70 percent to 826 percent.

Non-Governmental Medi-Cal Plans:

- The 5 NGM plans serve over 3 million enrollees in 31 counties. From June 2016 to June 2017, enrollment increased by 94,000 lives, or 2.7 percent. Total Medi-Cal enrollment for NGMs increased by 69 percent from December 31, 2013 to June 30, 2016.
- All NGM plans reported positive net income for June 2017. Almost all NGM plans reported positive net income since March 2016.
- All NGMs reported over 200 percent of required TNE, with TNE ranging from 229 percent to 1,168 percent.
- Liquid TNE ranged from negative 130 percent to 843 percent.

Ms. Dutt noted the inclusion of dividend information on page 27 of the report.

Discussion

Mr. Grgurina acknowledged the DMHC's prompt response to SFHP's reported losses for three consecutive quarters. In June 2015, the average per member per month (PMPM) premium revenue was $371. A year later, the average PMPM was $340 dollars, and later went down to $316 due to the reduced Medicaid expansion rates. Plans determine the amount of reserves to set aside, then make decisions about

investments to providers or the community, improving access to services and in services for members. The SFHP Board approved the spending, and it is why SFHP is currently in the negative.

Mr. de Ghetaldi stated if a plan's reserves are strong, it can increase PMPM expenses, which is to increase the rates paid to providers or some other way to fund the community's healthcare infrastructure. The COHS he serves on, the Central California Alliance for Health, chose not to raise rates but instead to go with block grants. Based on San Francisco's experience, it could be that a downward slope may be projected if rates are raised compared to a one time grant.

Mr. Grgurina explained the central question for plans and their governing boards is whether to increase provider rates and overpay for services already received, which will result in a loss position for a while. However, at some point, rates must be cut because they cannot be sustained. Plans could alternatively, as Mr. de Ghetaldi mentioned, use the funds for different programs in a one-time fund. SFHP has opted to increase rates as high as they can to reach a break-even position and any dollars over that are used in one-time funds.

Ms. Rouillard noted the significant fluctuation in the net income of the Medi-Cal plans from quarter to quarter and plan to plan. She added this must make it challenging to plan for the future.

Ms. Imholz noted the large range in TNE and the differences in circumstances among each plan. While the Board is concerned with solvency, too much reserves is not useful either.

Mr. Grgurina responded that it is important to understand the unique circumstances of each plan. SFHP, for example, has a tremendous amount of capitation that requires very little to be set aside when using the formula for TNE. Annual premium revenues are in the range of $550 to $600 million a year and SFHP's TNE is around $11 million to $12 million, which is about one week's worth of expenses. The SFHP Board has targeted at least two months' worth of premiums in reserves or about nine to ten times TNE. Larger plans with a lot of fee-for-service business may be okay with a much lower TNE. Other states have hired outside actuaries and other experts who have concluded that there is no exact science to the right level of reserves because it depends on the particular plan.

Mr. Grgurina asked Ms. Dutt to repeat the calculation for liquid TNE. Ms. Dutt stated liquid TNE excludes receivables, fixed assets, and affiliate payout. Mr. Grgurina commented on the perception that a negative 70 percent liquid TNE may seem scary, but plans may be waiting for a huge receivable from DHCS at the end of the month. They will get paid the following week and the numbers will look different. Ms. Dutt confirmed this statement was correct and it is why the Department also reviews working capital and cash on hand.

Ms. Yao asked if Kaiser is included within the report. Ms. Dutt indicated Kaiser's enrollment information was included to demonstrate the large number of Medi-Cal enrollees, but because their Medi-Cal enrollment is less than 50 percent of their total enrollment, the financial information for Kaiser was excluded. Ms. Rouillard noted the same was true for Anthem.

Dr. de Ghetaldi stated, in Monterey County, the actual risk was lower than expected and revenues were greater because healthy 30 year olds are going into Medi-Cal Managed Care instead of Covered California because their incomes are so low. As a result, the Medi-Cal Managed Care Plans in the region are doing well but Covered California is struggling with 10 to 54 percent premium increases.

Mr. Grgurina added, across the United States, there were roughly 18 million people enrolled in the Exchanges and approximately 19 million people qualified for a waiver or paid the penalty. Depending on the risk mix of the unenrolled group, if a good number of them came into the Exchange, it could very likely change the outcome of the Exchanges.

7) Financial Summary of Medicare Plans

Ms. Rouillard introduced the Financial Summary of Medicare Advantage (MA) Plans and Medicare Advantage Restricted License Plans (MA-RL). She stated this was the first time information on the MA plans was presented to the Board and acknowledged Ms. Dutt and her team for composing the report. The DMHC has very limited oversight over MA plans, with the exception of financial solvency.

Ms. Dutt explained the difference between MA and MA-RL plans. MA plans contract directly with the Centers for Medicare & Medicaid Services (CMS) while MA-RL plans provide and administer healthcare services to Medicare enrollees as subcontractors to MA plans.

She shared key trends from the report for both the MA and MA-RL plans for the quarter ending June 30, 2017. The report highlights enrollment, financial metrics, and TNE for plans with Medicare enrollment that is greater than 50 percent of their total enrollment.

Medicare Advantage (MA) Plans:

- There are 12 plans that have a MA licenses with DMHC. However, the report includes only 11 of the plans because Humana Health Plan of California, Inc. did not have any MA enrollment as of June 30, 2017.
- MA Plans provided services to 469,583 enrollees, of which 440,592 are MA enrollees.
- From June 2016 to June 2017, enrollment increased by 35,038 lives, or 8.1 percent.

- PMPM premium revenue outpaced PMPM medical expenses for 9 of the 11 plans.
- Eight of the eleven plans reported positive net income. MA plans reported net income of $13.7 million compared to the maximum of $9.8 million for last year.
- Alignment Health Plan reported five consecutive quarters of net losses, but it is backed by private equity funds and receives cash infusions to stay afloat.
- Aspire Health Plan also reported five consecutive quarters of net losses, but it is backed by two hospital systems in Monterey County.
- The TNE for MA Plans overall was stable in 2016 and 2017. All MA Plans had TNE that exceeded the regulatory requirement, with TNE that ranged from 110 percent to 1,348 percent of required TNE.

Medicare Advantage Restricted License Plans (MA-RL):

- There are 11 MA-RL plans currently serving 18 counties. Two plans, Medcore Health Plan and Sequoia Health Plan, are newly licensed so financial information was not included in the report.
- MA-RL plans provided services to 104,000 enrollees, including 94,000 Medicare enrollees.
- Total enrollment in MA-RL plans increased by 100.5 percent since June 2016.
- All MA-RL plans, except Prospect Health Plan, Inc. and Providence Health Network, had higher PMPM premium revenue than PMPM medical expenses.
- Four MA-RL plans reported positive net income. Providence Health Network reported consecutive net losses for all the quarters shown. Americas Health Plan and Dignity Health Provider Resources, Inc. reported net losses for at least four of the six quarters.
- The TNE for MA-RL plans was stable in 2016 and 2017, except for Providence Health Network, which reported a TNE deficiency. TNE ranged from 113 percent to 533 percent of required TNE.

Ms. Dutt concluded by noting the overall TNE stability of plans and both enrollment and the number of licensed Medicare plans has increased. In 2014, there were three MA-RL plans and now there are eleven licensees. The Department is currently reviewing applications for one MA plan and six MA-RL plans so more may be added in the near future. As the Baby Boomer population becomes Medicare eligible, the number of Medicare beneficiaries will increase and so will the number of MA plans.

Discussion

Ms. Imholz asked if Kaiser was excluded because it is not a licensed MA plan. Ms. Dutt responded their Medicare lives did not exceed 50 percent of their total enrollment. Ms.

Imholz asked how many Medicare enrollees are under Kaiser. Ms. Dutt indicated Kaiser has 1.1 million Medicare lives.

Mr. Grgurina agreed with the 50 percent threshold and suggested including a listing of the other plans with their enrollment numbers in future reports.

Mr. Conklin asked Ms. Dutt to clarify if Humana's enrollment is now under Arcadian. Ms. Dutt explained Humana has two plans in California, Humana Health Plan of California and Arcadian Health Plan. Humana transferred all of its enrollment to Arcadian, even though the plan is still branded as Humana.

Mr. Grgurina appreciated the look back period on PMPM medical expense and premium revenue chart. He said it is important to understand that the PMPM net revenue is not profit, it is what you have to spend on administrative expenses. For example, in June 2017, Prospect Health Plan reported negative $1 million in revenue. This means the plan's medical expenses were $1 million over their revenue and they still had to meet their administrative costs on top of that.

Dr. de Ghetaldi said 40 percent of California's Medicare beneficiaries are in MA. Every time a fee-for-service beneficiary selects an MA plan, the quality of care and access to care improves in California. It has also been shown nationally that the growth of MA plans contributed to the positive health outcomes and longevity of the Medicare population. He noted there are a number of counties where MA is not available and it needs to be fixed. When clinical quality is compared across payers, MA plans perform exceedingly well in many areas including colorectal screening, breast cancer, and diabetes care.

8) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, provided an update on the financial solvency of RBOs for the quarter ending June 30, 2017:

- 184 RBOs filed financial information with the Department, including 179 RBOs that were required to file annual reports. Of those, 178 RBOs have filed and administrative action has been taking against the one non-filer.
- 138 of the 184 RBOs filed quarterly financial survey reports and the remaining 46 RBOs filed compliance statements attesting to meeting or not meeting all of the financial solvency criteria.
- Six RBOs filed monthly financial survey reports as required by their corrective action plan (CAP).
- 176 of the reporting RBOs reported compliance with the solvency criteria, including:
    - 40 RBOs, or 22 percent, were in the Superior category.

  - 90 RBOs, or 49 percent, were in the Compliant category, of which 4 RBOs were on a CAP and reported meeting the solvency criteria and 9 RBOs were on the monitor-closely list.
  - 46 RBOs, or 25 percent, filed compliance statements.
- 8 RBOs reported non-compliance.
- 14 RBOs were on a CAP, of which 4 are new and 7 RBOs are meeting their approved CAPs. 3 RBOs did not meet their CAPs, but are on their way to compliance.
- 3 RBOs completed their CAPS – Facey Medical Foundation, Physicians Medical Group of San Jose and Family Care Specialists Medical Group.
- There were 89 RBOs with Medi-Cal enrollment covering approximately 4.3 million enrollees.
- The top 20 RBOs served approximately 3.3 million Medi-Cal lives. Of these, 17 have no financial concerns, 2 are on the monitor-closely list and 1 was on a CAP.
- The remaining 69 RBOs served approximately 1 million Medi-Cal lives. Of these, 57 have no financial concerns, 7 were on a CAP, and 5 were on the monitor-closely list.
- At the end of 2016, the plans reported nearly 8.5 million lives assigned to RBOs, including approximately 3.1 million in commercial coverage, 4.3 million in Medi-Cal and 900,000 in Medicare.
- From 2011 to 2016, enrollment assigned to RBOs increased from 6.3 million to 8.4 million with the largest increase occurring in 2014 and 2015 as a result of the Medi-Cal expansion.

Ms. Yamanaka stated the Office of Financial Review has 24 audits scheduled for 2017, of which 8 are completed, 13 are in progress, and 3 are planned.

Discussion

Mr. Grgurina asked how long it takes to know how the RBOs on CAPs are doing. Ms. Yamanaka stated filings are submitted 45 days after the end of each quarter, so the filing for the quarter ending in September will come in around November 15. Mr. Grgurina asked if a similar chart was available on the DMHC's website. Ms. Yamanaka said portions of all of the RBO filings are on the website but not the chart presented to the Board.

10) Health Plan Quarterly Update

Stephen Babich, Supervising Examiner, Office of Financial Review, presented the highlights of the health plan quarterly update for the second quarter of 2017:

- There were 74 full-service health plans and a total of 123 Knox-Keene licensed plans.
- Enrollment in full-service plans was 26.18 million lives, an increase of 1.5 percent from 2016.
- There were 24 plans on the closely-monitored list, including 20 full service plans with 2.5 million lives and 4 specialized plans with slightly over 3 million lives.
- There was one TNE-deficient plan, a specialized vision plan.
- There were 25 plans on CAPs, including 18 in progress and 7 pending approval. Most are a result of routine financial examinations, which include a heavy sampling of claims.

Discussion

Mr. Grgurina asked about the increased number of examinations scheduled for the 2017-2018 year. Mr. Babich responded that the chart was fluid and the 26 planned examinations would carry over to the following fiscal year. The total number for the year should be 40.

Deb Espinal, Kaiser Permanente, asked Mr. Babich to explain the full service enrollment numbers and what he meant by no double counting. Mr. Babich explained lives could be counted twice given plan-to-plan relationships as each plan is responsible for reporting each life. However, for the purposes of the report, each life was counted once.

11) Public Comment on Matters not on the Agenda

Ms. Imholz asked for public comments on items not on the agenda.

A representative from the Center for Public Interest and Law in San Diego asked if web casting would be available for future FSSB meetings. Ms. Watanabe stated the DMHC was close to procuring a new webinar system that would allow for more than 50 participants in meetings. DMHC always strives to accommodate as many stakeholders as possible and will consider this request as well.

12) Agenda Items for Future Meetings

Ms. Imholz asked the Board Members to review the proposed meetings dates for 2018 and send their feedback to Ms. Watanabe.

Ms. Imholz asked if there were any agenda items for future meetings. Dr. de Ghetaldi suggested revisiting whether ACOs should be under DMHC's purview. The Medicare Access and CHIP Reauthorization Act (MACRA) is in its first year and the Merit-based Incentive Payment System is mostly next generation ACOs. The Board should consider these from a regulatory perspective because of the challenges if groups under-perform.

Ms. Imholz asked for reactions from the Department. Ms. Rouillard confirmed the suggestion was a good one.

Ms. Yao recalled the comments from CAPG and suggested a review of the Medi-Cal CAP rates, the methodologies and dates. In addition, given the many packages under review by CMS, it would a good to get an update on the proposals.

13) Closing Remarks/Next Steps

The meeting was adjourned at 11:56 a.m.