DEPARTMENT OF Managed HealthCare

Financial Solvency Standards Board Meeting
August 20, 2014
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Ann Pumpian, Chairperson, Sharp HealthCare
Elizabeth Abbott, Health Access California
Edward Cymerys, Healthcare Consultant
Dr. Larry de Ghetaldi, The Palo Alto Medical Foundation
Jacob Furgatch, AltaMed Health Services
Dave Meadows, LIBERTY Dental Plan
Shelley Rouillard, Department of Managed Health Care
Dr. Keith Wilson, Molina, Inc.
Deborah Kelch, Alternate, Kelch Policy Group
Dr. Rick Shinto, Alternate, InnovaCare Health, Inc.
Tom Williams, Alternate, Integrated Healthcare Association

Department of Managed Health Care (DMHC) Staff Present:
Stephen Babich, Supervising Examiner, Division of Financial Oversight
Gil Riojas, Deputy Director, Office of Financial Review
Tom Tengan, Attorney, Office of Legal Services
Nancy Wong, Deputy Director, Office Plan Licensing
Pritika Dutt, Examiner, Provider Solvency Unit
Jeff Roskelley, Senior Examiner, Provider Solvency Unit

1) Welcome - Agenda

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

2) Minutes from June 20, 2014 FSSB Meeting

Rick Shinto made a motion to approve the June 18th FSSB meeting minutes. Dave Meadows seconded the motion. Meeting minutes were approved with no opposition.

3) Director's Remarks and Introductions

Shelly Rouillard announced Elizabeth Abbott has been appointed by the Governor to be the Director of the Office of the Patient Advocate effective in September. This is her last Board meeting as a consumer representative. Rouillard congratulated and thanked Abbott for her service.

Ms. Rouillard announced the new Chief Deputy Director is Marta Green who was formerly the Deputy Director for Communications and Planning. Gil Riojas is the new Deputy Director for the Office of Financial Review. Also, Nancy Wong, Deputy Director of the Office of Legal Services, is temporarily filling in as the Deputy for the Office of Plan Licensing (OPL). The DMHC is currently looking for a permanent OPL Deputy Director.

Ms. Rouillard commented the Department hopes to provide additional detail regarding the following issues at the next meeting: the impact to consumers if the county-organized health systems (COHS) were to be licensed by the Department, and California Association of Physician Group's (CAPG) proposal regarding a regulation for restricted licensees.

4.) Alameda Alliance for Health Update - Presentation

Gil Riojas, Deputy Director of Office of Financial Review (OFR), provided an update on Alameda Alliance for Heath (Alameda Alliance).

- Alameda Alliance remains approximately $6.5 million tangible net equity (TNE) deficient. The plan is deficient in working capital as well.
- Per the conservator, Alameda Alliance is expected to be financially stable by the end of June. Depending on the plan incurred but not reported (IBNR) calculation there could be a small net profit or loss.
- The claims processing time frame has decreased from 100 to 50 calendar days.
- The claims inventory has decreased from approximately 300,000 in May 2014 to approximately 175,000 claims.
- The improvement in claims processing came at the right time because the Medi-Cal Expansion (MCE) has increased the number of claims submitted. Previously, Alameda Alliance received 60,000 to 70,000 claims per month, after the MCE claims increased to about 125,000 per month.
- At the end of June 2014, OFR received the Alameda Alliance's 90-day financial statement report and is creating a report regarding all of the local initiatives and their financial status.

Discussion:

Larry de Ghetaldi asked what was learned from Alameda Alliance findings to prevent this from recurring in other parts of the State.

Ms. Rouillard replied when DMHC notices a decline in a plan's TNE then DMHC will take action before a plan becomes TNE deficient.

Dave Meadows asked where Alameda Alliance is obtaining their funding.

Gil Riojas replied Alameda Alliance received a $5 million loan from Alameda County.

Mr. de Ghetaldi asked about the lessons learned from Alameda Alliance and how we can prevent this from happening to other plans.

Ms. Rouillard replied there are a number of indicators DMHC will be looking for in the future. Are TNE or other financial indicators in decline? If financial problems are identified then the Department would look at the entire operations. Are there any other potential violations of the KKA, or potential problems with areas such as utilization management? The DMHC would also want to be more engaged with the health plans Board of Directors to ensure they are fully informed of any warning signs and that they understand their fiduciary duties.

Ms. Rouillard also mentioned that OFR is taking a look at the financial status of all the local initiatives and will provide a report on their findings.

Mr. Shinto asked if the conservator is looking at all aspects of how the plan is managed, not just focused on their financial status.

Ms. Rouillard responded that the conservator is looking at all aspects of the plan, including utilization management, provider contracts and member services as well as the financial status.

Ms. Pumpian and Mr. Shinto expressed concern over the new faster rate of claim payment and asked if this was leading to a higher rate of denial of claims.

Mr. Riojas responded that he could look at those numbers to ensure that wasn't the case.

Mr. de Ghetaldi asked will there be an assessment of the governance structure.

Ms. Rouillard replied that the DMHC is looking into an assessment of the governance structure. If there is to be a change, it would need to be a statutory change.

5) Risk Bearing Organizations (RBO) and Affiliate Financial Statements

Tom Tengan, representing the Office of Legal Services (OLS), provided an update on RBOs and affiliate financial statements. He noted that at the last meeting this was a discussion about the requirements for RBOs and their affiliates to provide combined financial statements.

- OLS is working with OFR to look at the specifics of those requirements and the best way to implement them.
- They hope to share the specifics with the Board on or before the next meeting.

Discussion

Mr. Shinto mentioned that at the last meeting there was a question around the definition of “affiliate.” He asked if that had been resolved.

Mr. Tengan responded that is part of the deeper review of the requirements.

6) Impact of Various Tangible Net Equity (TNE) Requirements on RBOs

Gil Riojas, Deputy Director of OFR, and Pritika Dutt, Examiner in the Provider Solvency unit (PSU), provided an update on the impact of various TNE requirements on RBOs. OFR did an analysis regarding the TNE standards for RBOs if they were to become a Knox Keene restricted license plan. They took the minimum TNE standard for a full service health plan and compared that to what RBOs currently report. OFR then stratified it to $1 million, $500,000 and $250,000 and what is currently required ($1.00).

PSU reviewed the March 31st, 2014 numbers and for those RBOs that have less than 10,000 lives, and report compliance statements on the quarterly basis, PSU reviewed the most recent annual financial statement. For most RBOs that was December 31st, 2013.

- As of March 31st, there were 171 RBOs that met the current minimum TNE requirement of $1. OFR received 176 reports with five reporting TNE of less than $1.
- When OFR increased the TNE requirement to $250,000, there were 138 RBOs that met the $250,000 requirement. The numbers declined when the TNE requirement increased to $500,000 and $1 million.
- At $500,000 there were 115 RBOs that would be compliant and at $1 million there would be only 89 RBOs that would meet the TNE requirement.
- The minimum TNE requirement of a full service health plan is $1 million.
- If OFR applied the TNE requirement of a full service health plan to an RBO, approximately 50 percent of the RBOs will be out of compliance and would have to submit a Corrective Action Plan (CAP)

Discussion

Mr. Riojas asked the Board how OFR can best provide them clarity on what a TNE standard should be for RBOs.

Edward Cymerys asked if, when evaluating how much capital an RBO should have, does the Department look at what the Risk Based Capital (RBC) calculation would be for that organization.

Mr. Riojas responded OFR will do an analysis regarding how much capital an RBO should have based on the risk-based capital.

Mr. Cymerys commented that if DMHC is going to set sensible capital requirements for entities taking significant risk, the DMHC should look at what has been done in the industry and evolved over time, and what rating agencies are using.

Mr. Shinto responded DMHC should be basing the metrics based upon the capacity of the company to demonstrate financial solvency.

Deborah Kelch commented the TNE is set in statute for health plans and medical groups although health plans do not meet RBC under the DMHC.

Ms. Pumpian commented the Board needs an analysis on how many and what type of enrollees are taking risk because they will have an impact on how much capital is necessary to create a safe RBO environment.

Mr. Shinto commented there should be standardization for when a plan provides an RBO funds. When something goes wrong then the DMHC goes to the RBO when it is the plan that has the responsibility at the top.

Ms. Rouillard commented the DMHC does involve the plan and holds them accountable when there's a problem with the RBOs.

Ms. Pumpian raised the concern that one plan may be aware of an issue with an RBO, but not necessarily that the same RBO has the same issue through three other health plans. How are those other health plans made aware of the issue with the one?

Ms. Dutt responded that an RBO must submit a CAP for failing to meet the grading criteria. The CAP is sent to the health plans from the DMHC web portal. OFR reviews the CAP with the health plans.

Tom Williams asked what the TNE requirements were for RBOs and are they the same for provider groups and health plans.

Mr. Riojas replied a provider group and a health plan have the same TNE requirements for a restricted license, they just have to be positive.

Mr. Williams commented that if the Board is considering making a recommendation to increase the TNE, then the Board should review the RBC to the Knox Keene TNE analysis.

7) Medi-Cal Managed Care Lives in RBOs - Presentation

Mr. Riojas noted that at the last meeting it was suggested that DMHC should take a closer look at the number of RBOs that report over 50 percent of their total enrollment as Medi-Cal enrollment. Ms. Dutt discussed the Medi-Cal Managed Care lives and RBOs which do not include the managed care enrollment that's assigned to community clinics and the RBOs that report combined financials with health plans.

Ms. Dutt stated the following:

- On March 31, 2014 there were approximately 2.9 million managed care lives that were assigned to the RBOs. Of the 2.9 million, there were 2.2 million assigned to 20 RBOs that were over 50 percent Medi-Cal enrollment.

- The formula for the estimation is by multiplying the statement of organization information reported by RBOs by the enrollment information the health plans report on a quarterly basis.
- There were 93 RBOs that had Medi-Cal Managed Care lives and out of the 93, 73 RBOs had 700,000 lives.
- OFR did an analysis of 73 RBOs with estimated 700,000 Medi-Cal Managed Care lives.
    - Seven were on CAPs. RBOs are placed on a CAP if they meet one or more of five criteria: less than $1 dollar TNE, current assets minus current liabilities is negative, cash-to-claims ratio is less than 75 percent, IBNR methodology, and if they process less than 95 percent of claims within a three month period.
    - 13 were on OFR's monitor closely list.
    - PSU had no concerns with 53 RBOs which made up for 505,000 of the 700,000 lives.
- OFR did an analysis of the 73 RBOs with estimated Medi-Cal. These 73 make up 505,000 of the 700,000 lives.
    - Seven were on CAPs.
    - 13 were on OFR's monitor closely list. RBOs are placed on the monitor closely list if they meet one or more of five criteria: less than $1 dollar, TNE, current assets minus current liabilities is negative, cash-to-claims ratio is less than 75 percent, IBNR methodology, and if they process less than 95 percent of claim within a three month period.
    - PSU has no concerns with 53 RBOs.

Discussion

Ms. Pumpian asked if there are 65 percent of RBOs with more than 50 percent Medi-Cal lives causing concern.

Ms. Dutt replied yes, OFR reviews the RBOs with concern first.

Ms. Pumpian asked if the health plans know of these 65 percent.

Ms. Dutt replied that OFR works with the health plans regarding RBOs on CAPs.

Ms. Pumpian asked if the health plans delegating the risk to these RBOs are notified of the RBO's on the monitor closely list.

Ms. Dutt replied the RBOs file financial records with the health plans.

Mr. Wilson asked how is one placed on the monitor closely list.

Ms. Dutt replied RBOs are placed on the closely monitor list when OFR detects a declining trend in the RBOs enrollment, income, it is generating a net loss, or a significant Medi-Cal enrollment change, either positive or negative.

Mr. Williams asked if there has been a decrease of RBOs placed on the monitor closely list or CAPs compared to the past two years.

Ms. Dutt replied there are additional CAPs mainly from Medi-Cal RBOs.

8) Individual Market Enrollment Data: Q1 2014 Changes - Presentation

Nancy Wong, Acting Deputy Director of OPL, discussed the individual market enrollment data regarding the Q1 2014 changes.

- There are approximately 623,000 enrollees with individual coverage which was almost evenly split between grandfathered and non-grandfathered plans.
- As of May 1, 2014 there were 1.8 million enrollees in individual plans regulated by DMHC.
- As of May 1, 2014, enrollees in the DMHC-regulated individual market basically tripled including enrollees both on and off the Exchange.
    - The majority of increase was due to Covered California, although there was also growth in the off-Exchange market.
    - The plans on the Exchange are required to offer newer products that enrollees can chose from.
    - The largest growth was in Preferred Provider Organizations (PPOs).
    - The majority of enrollees are in silver products so they are eligible for federal subsidies.

Discussion

Mr. Cymerys asked if DMHC noticed enrollees switching back and forth from the subsidized silver plans into Medi-Cal plans.

Ms.Wong replied that OPL will retrieve that data from Covered California and Department of Health Care Services (DHCS). The reenrollment is interesting because enrollees have to be eligible for subsidies based on their tax returns.

Mr. de Ghetaldi asked are these enrollees getting caught in a cycle where they are unable to obtain their primary care doctor.

Ms. Wong replied the DMHC has not heard of any specific comments regarding enrollees being unable to obtain their primary care doctor.

Mr. Williams asked are all individuals that are enrolled through the Exchange in DMHC regulated products.

Ms. Wong replied there is only one Health Net Product regulated by California Department of Insurance for 2014.

Ms. Pumpian commented that an analysis of how many enrollees were in the individual market prior to 12/31 that moved into the Medi-Cal Managed Care market would be interesting.

9) Provider Solvency Updates - Presentation

Jeff Roskelley, Senior Examiner in the PSU, gave the following update regarding Provider Solvency.

- PSU reviews financial surveys, audit claims, claims settlement practices, monitor and approve corrective action plans, provider disputes, and financial audits of RBOs.
- As of June 30, 2014:
    - 172 RBOs filed financial reports were received:
        - 130 were the Quarterly Financial Surveys
        - 42 were Compliance Statements for those with less than 10,000 covered lives.
    - 3 submit monthly financial statements and are either on a CAP or on the closely monitored list.
- There was not much change from March 31, 2014 to June 30, 2014:
    - There was a slight increase to 97 complaints with increase of 26 in the superior category.
- The number of CAPs have reduced from 16 to 12.
    - Five of the 12 CAPs are new
    - Seven are improving
- As of June 30, 2014, the enrollment range for RBOs on a CAP are:
    - Six RBOs are under 10,000
    - Two RBOs are between 10,000 and 20,000
    - Two RBOs between 20,000 and 30,000
    - One RBO between 30,000 and 40,000
    - One RBO over 100,000.
- In 2014, PSU has completed nine audits, is in the process of eight audits and is planning on eight additional audits by the end of 2014.

10) Health Plan Solvency Updates - Presentation

Steven Babich, Supervising Examiner, Division of Financial Oversight (DFO) provided an update regarding health plan solvency.

- DFO's responsibilities are to review health plan filings and financial statements and perform financial, claims initiative, and medical loss ratio examinations.
- DFO compared the Knox Keene licensed plans data for one year from August 14, 2013 to August 14, 2014 regarding the number of licensed plans, enrollment, TNE, closely monitored plans, and TNE deficient plans:
    - 120 licensees are full service plans which is a slight increase from 114 in 2013
        - There are 26.1 million enrollees in these plans 12.4 million are in commercial and 10.2 million are in government plans.
        - The 26 million includes plan-to-plan enrollment which is approximately 2.3 to 2.4 million and another one million which is administrative services only (ASO).
- Full Service Plans on the closely monitored list:
    - Medi-Cal – 9

    - Medicare – 7
    - Commercial – 3
- TNE deficient plans (below 100 percent):
    - 1 full service: 209,500 lives
    - 1 vision: 13,520 lives
- DFO is closely monitoring the 29 TNE plans who report TNE from 130 to 249.9 percent to identify those plans before they get down to 130 percent. At that point an entity would have to report monthly.

Discussion

Mr. Wilson commented at the last meeting Bill Barcellona presented a graph on commercial versus Medi-Cal trends in which those lines crossed with Medi-Cal exceeding commercial.

Mr. Babich replied since that time, there was one entity with a lot of enrollment and when they unveiled a new product, they were instructed to report a certain block of commercial lives in a different manner, and so those weren't getting reported.

Ms. Pumpian asked is there double counting of enrollment in the plan-to-plan?

Mr. Babich replied yes, there are approximately three and a half to four million spread to full service. Under Section 1356, the enrollee of one plan who is also part of another plan counts as two. So, an enrollee is being reported at a full service entity and also with the associated specialized plan.

Mr. Kelch asked is the ASO new data.

Mr. Babich replied the $1 million ASO is included within the 26.1 million.

Mr. Furgatch asked how many enrollees are associated with the closely monitored full service plans list.

Mr. Babich replied just a guess but no more than 25 percent and probably well below that.

Mr. Furgatch asked are the plans on the closely monitored list on a CAP.

Mr. Babich replied the plans on OFR's closely monitor list do not need to be on a CAP. If the plan begins to continue to decline then they are put on a CAP.

Ms. Abbott commented that three years seems to be a long time for a plan to improve their performance since consumers are affected by those plans on a CAP.

Mr. Babich replied that three years does seem excessive especially when plans and providers can renegotiate annually.

Ms. Abbott asked if the DMHC is thinking about urging colleagues at DHCS to expedite their review process.

Mr. Babich replied it would be difficult to expedite the process in cases of revenue problems which seems to be the reason as the first sign of failure.

Comments from the Audience

Meredith Wurden, Acting Assistant Deputy Director for Healthcare Financing at DHCS, commented that their department sets Medi-Cal Managed Care rates by actuarially standards. They usually pay on the lower end.

12) Public Comments

Ms. Pumpian asked if there any public comments on items not on the agenda. There were none.

13) Agenda Items for Future Meetings - 2015 Meeting Dates

Ms. Rouillard mentioned the proposed meeting dates for 2015 are shifting back a month because DMHC receives the financial reports from the plans 45 days after the end of the quarter. This will provide staff adequate time to analyze the data before the next meeting.

Ms. Pumpian suggested that at the next meeting, the Board will look at COHS licensure issues, the CAPG proposal regarding restricted licenses, and the RBO and affiliate financial statement questions. First, defining affiliate adequately and then looking at the whole financial statement issues again.

Mr. Wilson suggested Dennis Balmer's risk-based capital presentation.

Ms. Kelch suggested the trended history of RBO failures.

Mr. de Ghetaldi asked if there is any information on Covered California network adequacy.

Ms. Rouillard commented the final reports for the non-routine surveys of provider networks should be published in time for the next FSSB meeting. She stated the goal is to get them finalized before open enrollment.

14) Closing Remarks/Next Steps

The next meeting is scheduled for November 13, 2014.

The Meeting was adjourned at 12:03 p.m.