STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

THE DEPARTMENT OF MANAGED HEALTH CARE

PARK TOWER, 980 9th STREET

CONFERENCE ROOM, 2nd FLOOR

SACRAMENTO, CALIFORNIA

THURSDAY, NOVEMBER 7, 2019

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

John Grgurina, Jr., Chair

Larry deGhetaldi, MD

Paul Durr

Jen Flory

Shelley Rouillard

Amy Yao

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Sara Ortiz, Associate Governmental Program Analyst

Jenny Phillips, Deputy Director of Legislative Affairs

Sarah Ream, Acting General Counsel

Mary Watanabe, Acting Chief Deputy Director

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Jacey Cooper, Senior Advisor, Health Care Programs
Department of Health Care Services

Anthony Wright
Health Access California

Melissa Borelli (via telephone)

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PROCEEDINGS

10:01 a.m.

CHAIR GRGURINA: Let's go ahead and do a couple of introductions and housekeeping notes. A reminder to please silence your cell phones.

For those at the podium, if you could leave your business card or write your name and title down and leave it with our transcriber.

For the Board Members, remember to press your button. Green light means you are on to speak.

Operator, are you ready to start? (Laughter.) Operator, are you there?

THE OPERATOR: Yes, I am.

CHAIR GRGURINA: Are you ready to go?

THE OPERATOR: Yes, I am ready.

CHAIR GRGURINA: All right, thank you. Okay.

Finally, the restrooms are locked. But don't worry, there are keys in the back of the room. They work for both the women and the men's restroom; here are your instructions. For the men turn the key to the left, for the women turn the key to the right.

MEMBER DURR: Have you tried that one (laughter)?

CHAIR GRGURINA: I have not tried it. These are the instructions, I am sure they are correct. The women's restroom is located outside here. The men’s is across the catwalk and I don't know if there is a bridge toll or not, you'll find out when you use it.

And with that let's go ahead and get started. The first item are the

minutes or the transcript -- thank you. This is why Shelley and her team are here to remind me. We will introduce the Board. Let's go around the table, Larry, start with you.

MEMBER DEGHETALDI: Larry deGhetaldi, Palo Alto Medical Foundation.

MEMBER DURR: Paul Durr, Sharp Community Medical Group.

CHAIR GRGURINA: John Grgurina with the San Francisco Health Plan.

MEMBER ROUILLARD: Shelley Rouillard, Department of Managed Health Care.

MEMBER FLORY: Jen Flory, Western Center on Law and Poverty.

MEMBER YAO: Amy Yao, Blue Shield of California.

CHAIR GRGURINA: All right, thank you, and thank you for the reminder, Shelley.

Next up is the minutes, or now as we have changed, they are an actual transcript. I don't know if you had a chance to read the 96 page transcript. Very different from minutes; I have to admit I liked minutes.

You get to the last page on 96 and the final comment from me looks like something that just came out of nowhere (laughter.) Because underneath it it says, several people were speaking at once. What was happening was, Shelley made the comment of, wow, I didn't know that we were going to make it through all the items in time. That wasn't put in the transcript but what was put in was my comment which was, I was doing the mental math in my head thinking, I didn't know how we're going to make it (laughter). So that's the comment; without Shelley's, doesn't look too good. So speak clearly, one

person speaking at a time, and remember that your comments will be there for posterity and your siblings or relatives may find them and repeat them back to you.

So with that do we have any comments, questions on the transcript, edits?

We are all frightfully scared. Do we have a motion to move the transcript forward?

MEMBER DURR: I'll make a motion to approve.

CHAIR GRGURINA: All right. A second?

MEMBER DEGHETALDI: Second.

CHAIR GRGURINA: Okay. All those in favor?

(Ayes.)

CHAIR GRGURINA: Opposed?

(No response.)

CHAIR GRGURINA: All right, the transcript moves forward.

With that we will go ahead and move on to the Director's remarks.

MEMBER ROUILLARD: Okay, great, thank you, John. So my remarks are going to be pretty brief today.

The first thing I wanted to mentioned is that we have identified a new FSSB member. Unfortunately she couldn't be here today, she is still going through like the approval with her organization. I expect she will be here in February so I'm looking forward to that.

The other thing is, the big news is that Marta Green has left the Department, as of today is her last day. She is going to be the Chief of Health Plan Research and Administration at CalPERS and she starts there tomorrow.

We are going to miss Marta, she has been a great partner for the last eight years here in the Department, but we have a whole slew of people in acting deputy positions who have been doing a great job since Marta has been on maternity leave for the last six months and we will keep on keeping on as we have done. So anyway, so that's that.

Briefly, I want to talk, just mention some items about the mergers that we are still reviewing. We did approve Centene's acquisition of WellCare of California and WellCare Prescription Insurance in September. These are both Medicare Advantage; one is a Medicare Advantage plan, the other is a Medicare Part D plan. Both relatively small in California but large nationally so we determined that it was not a major transaction under AB 595. We didn't hold a public meeting, we also did not do any charitable contributions as part of the undertakings, it's just a straight approval.

We are still reviewing Anthem's proposed acquisition of Beacon Health Options. The only licensed plan under Beacon that we regulate is an employee assistance plan. Also a relatively small plan but we have not concluded our evaluation of the transaction with respect to AB 595.

We also have several other smaller mergers happening with dental plans, vision plans and another EAP that is being bought by a behavioral health so those are still in the works as well.

The next thing I wanted to talk about was the encounter data initiative that Health Net is spearheading. As you will recall we had $50 million that Health Net is dedicating to encounter data improvements. I think some of you probably participated in the summit in August.

So now they -- Manatt, who is facilitating the stakeholder process

on behalf of Health Net has been convening three working groups, one on governance, one on data standardization and one on technology and technical assistance. So those work groups have started meeting, they are going to be meeting every month for the next five months. We expect that there will be a final summit in March where the recommendations and ideas and potential solutions will be presented. So I am participating on the governance work group as are a number of other people. So I have been really heartened by the interest and the involvement of a lot of different entities that can touch encounter data in this project so I'm glad to see that moving forward.

The last thing I wanted to mention was about our Pharmacy Benefit Management Task Force. So AB 315 required us to create the task force, which has now met three times. We have been focused in on like what kind of data health plans or their contracted PBM should be reporting to the Department to help increase transparency around pharmacy benefit managers in particular. We have really very engaged task force members, really trying to focus now on what are the specific data elements that we want the plans and the PBMs to report to us. So we have another meeting coming up on December 4th. All of the materials from the PBM Task Force are available on our website. If you go to 'About the DMHC' and then go to the 'Public Meetings' and under 'Other' is where you will find all of those agenda items and materials with presentations.

So that's it for me. I'll just mention one last thing that everybody has probably, in this room may know by now, but it sounds like Mari Cantwell is leaving DHCS at the end of January. I just got a note from the Secretary and I've been getting texts from a lot of other people ever since so I figure it's public, everybody knows about it now so that is big news. She has done a lot to

contribute to the Department of Health Care Services. So lots of changes happening.

CHAIR GRGURINA: Any questions from the Board Members for Shelley?

MEMBER DEGHETALDI: We are really excited about the Health Net encounter work. I know the Blue Shield provider directory has a nice name, Symphony.

MEMBER ROUILLARD: Symphony.

MEMBER DEGHETALDI: Do we have a similar name and a, sort of, elevator story for the importance of the encounter data work?

MEMBER ROUILLARD: Not yet because we don't know what it is going to be or the its, because it's probably not going to be a single solution. I mean, I would imagine just because it is so complicated and there are so many different areas of work that need to happen at the provider level, at the systems level, at the data standardization. I'm sure there will be a spiffy name for it at some point but we don't have it yet. But if you want to talk to me afterwards I can give you the elevator speech.

CHAIR GRGURINA: Shelley, I would ask that you include Larry in the naming of it --

MEMBER ROUILLARD: Yes, okay.

CHAIR GRGURINA: -- because what folks don't know is that Larry over here was the one who created the banana slug name for UC Santa Cruz.

MEMBER DEGHETALDI: Yes, oh yes.

CHAIR GRGURINA: Congratulations.

MEMBER DEGHETALDI: Thank you.

MEMBER ROUILLARD: Is that a true story?

CHAIR GRGURINA: That is a true story.

MEMBER ROUILLARD: Seriously?

CHAIR GRGURINA: You can find it on Wikipedia.

MEMBER ROUILLARD: Wow. I did not know that, Larry, wow.

CHAIR GRGURINA: So when you get a chance and you want to have lunch or a conversation --

MEMBER ROUILLARD: This is going in the transcript, you know.

CHAIR GRGURINA: I know it's going in the transcript, he's famous (laughter). My daughter is at Santa Cruz and I told her I know the individual who came up with the banana slug name.

MEMBER ROUILLARD: That's funny.

CHAIR GRGURINA: Very famous. Nice job, Larry.

MEMBER YAO: Oh, this is recorded, it's going to be transcribed.

CHAIR GRGURINA: This is the fun that you get when I'm the chair. (Laughter.)

MEMBER YAO: Gosh, I must have missed a lot.

CHAIR GRGURINA: Any questions or comments?

MEMBER ROUILLARD: All right.

CHAIR GRGURINA: Okay, all right, thank you, Shelley.

Next on the agenda is the update of the Department of Health Care Services, which we all want to hear for the CalAIM proposal. But I think Jacey is not here yet so let's go ahead and continue on with the agenda and when she arrives we will go ahead and bring her up.

So next up is the legislative update with Mary.

MS. WATANABE: All right, hopefully you can hear me here. Somebody will flag. It's flashing at me.

MS. ORTIZ: Green?

MS. WATANABE: Green and red and yellow (laughter). Okay, wait, we're good, it's all green now, okay. But somebody tell me if you can't hear me. So Mary Watanabe, I am still the Acting Chief Deputy Director. I am going to give you a quick legislative update here.

So we tracked and analyzed over 50 bills, it was a very, very busy legislative session for us. There's about 20 bills that we are tracking for implementation. And given the very long, robust agenda today we decided to kind of focus on just four that are keeping us busy and that we thought would be really of interest to the Board. So I am going to just highlight those four. But as we continue through the year and implementation we will be providing updates to the Board.

So the first one that is keeping us very busy right now is AB 290 and this is really our third-party premium payment bill. It establishes various requirements for third party entities that pay health care coverage premiums on behalf of an enrollee, including entities that have a financial interest at stake.

The bill limits financial reimbursement for these providers to the Medicare rate for services provided to enrollees that receive premium assistance.

There's a number of effective dates and I'll just give you a few of the key ones here. For enrollees that were receiving premium assistance prior to October 1st of 2019 there is a grandfathering provision for them. we will also be establishing an independent dispute resolution process similar to what we had

for AB 72 and the surprise balance billing protections there. That will take effect October 21st of 2021 and is for plans and providers that would like to dispute the Medicare reimbursement rate and they can demonstrate why they think they should get paid more.

There's also the limitations on the reimbursement for financially interested parties. It takes effect on January 1st of 2022 so we've kind of got a phase-in of some of these provisions.

And then beginning January 1st of 2022, the plans have an annual reporting requirement to the Department on the premium assistance that their members are receiving.

You may have seen some media attention around the American Kidney Fund has announced that they will be stopping their financial assistance programs in California. This obviously has a significant impact to a number of enrollees in the state and so we recently posted a fact sheet to our website to provide information on the enrollment options available to these consumers and some of the organizations that are available to assist them. So if this is hitting your world I really encourage you to check our website. On our home page it is under 'What's New' and we will be sharing that information.

The next one is AB 651 which prohibits balance billing by an air ambulance provider. And this really is just an extension of some of the strong consumer protections we already have around balance billing. And so this really protects consumers when they receive an air ambulance ride, essentially from a non-contracted air ambulance provider. And that will take effect January 1st of this coming year.

And the next one we have is AB 731 and this is probably the one

that is going to be of the most interest for this board and this is really a large group rate review process. And so starting July 1st of 2020 the large group plans will be filing essentially their methodology for large group rates, which we will be reviewing. There's also additional requirements on individual and small group to mirror some of the geographic rate information that will be submitted and that also takes effect July 1st of next year.

And then beginning July 1st of 2021 we will have a process for large group contract holders to request an individual review of their rate and so that will be coming as well.

And then the final one here is AB 744 which is payment parity for telehealth services. It essentially has provisions that plans need to reimburse telehealth visits at the same rate as an in-person visit.

So those are the ones that have the most significant workload for us but there's others that we'll be working with the plans and implementation as well.

And with that I will pause and take questions. And I will warn you, I have Jenny Phillips, our Leg Director, here to bail me out in case you have any technical questions.

MEMBER ROUILLARD: Warning.

CHAIR GRGURINA: Any questions from the Board Members?

Actually, Mary, I'll take one. Can you back to AB 731?

MS. WATANABE: Sure.

CHAIR GRGURINA: You were talking about the methodology for filing for the large group begins as of what date?

MS. WATANABE: So the filings will come -- it takes effect July 1st

of 2020 but it is for rates -- they must be filed with the DMHC 120 days prior to their effective date.

MS. PHILLIPS (OFF MIC): Annually or 120 days --

MS. WATANABE: Yes.

MS. PHILLIPS (OFF MIC): -- for the large groups. So it's a --

MS. WATANABE: Come up so we can hear you and you'll be on the transcript.

MS. PHILLIPS: It's annually or 120 days before a rate change and that is really the methodology in the large group. So it's a filing for the community rated products in the large group market or for the experience rated or blended, so it's sort of two buckets. And then the piece having to do with the individual contract holder, a review of their specific rate, that applies only to contract holders with over 2,000 enrollees. And that applies, that begins the following year, so --

MS. WATANABE: 2021, July 1st of 2021.

MS. PHILLIPS: July 2021.

CHAIR GRGURINA: And did I hear you right? You said whether it's annually or 120 days before changing the rates? So even if the rates are changing --

MS. PHILLIPS: It's a change in the methodology, to be more specific.

CHAIR GRGURINA: Change in the methodology, okay, thank you.

Other questions from Board Members?

MEMBER DEGHETALDI: AB 290, just a little more information. When is it implemented and to which plans does it apply?

MS. PHILLIPS: So it has various implementation dates but it applies to any -- it's only going to apply to the commercial market because you're paying a premium, sorry. I was thinking of the carve-out for Medi-Cal, no, because it has to do with payment of premiums so it would only apply in the commercial market.

MEMBER ROUILLARD: As I understand it there are multiple plans that these people are enrolled in so it's not just specific to any one plan or couple of plans.

MS. PHILLIPS: Right.

MEMBER YAO: I have a question related to the AB 731. So you mentioned July '21 for employers with more than 2,000 subscribers. Do we have to file the methodology of how the individual rate is developed or if there is a rate change you have to file something?

MS. PHILLIPS: So, Pritika (laughter). So now you're getting --

MS. WATANABE: We'll be developing --

MS. PHILLIPS: Yes.

MS. WATANABE: We have a little bit of time to develop our process for reviewing that but I think essentially we will be reviewing that particular group's rate and their methodology. And I don't know if you all have any other thoughts? I'm looking at Pritika and Wayne. Because we will be working on our process for this and working with the plans on that but it will be specific to that individual contract holder.

CHAIR GRGURINA: And Mary, that is if the individual contract holder comes to the Department --

MS. WATANABE: Requests.

CHAIR GRGURINA: -- and says, I would like you to take a look at --

MS. WATANABE: Correct.

CHAIR GRGURINA: And asks for it. Okay, thank you.

MS. DUTT: So in that case we will reach out to the plan and get the specifics for that particular contract. So that one does not kick in until July 1st, 2021. So right now we are developing, we working on developing templates for the community rated and experience rate methodology filing templates.

MS. WATANABE: We will likely be back quite a bit to update you on this over the next year and a half.

CHAIR GRGURINA: I would assume so. And then you would also need to be checking to see how much the workload is going to be.

MS. WATANABE: Yes.

CHAIR GRGURINA: Because if every group over 2,000 was asking for a review you have to see how much work it takes you to accomplish that and respond to that.

MS. WATANABE: We are definitely thinking a lot about that right now.

MEMBER ROUILLARD: Yes.

CHAIR GRGURINA: Given the budget change proposal cycle, yes.

MS. WATANABE: Yes. Yes, heavy on our mind right now.

CHAIR GRGURINA: Okay, any other questions from the Board Members?

MEMBER YAO: I just have one more question. Sorry, I am not up to speed right now on the AB 731. Is that only for the fully insured or is that

including flex funded or ESO business?

MS. DUTT (OFF MIC): It is all commercial.

MS. WATANABE: All commercial. Pritika is saying all commercial.

MS. DUTT (OFF MIC): All commercial policies.

MEMBER YAO: All commercial regardless of funding type, okay.

MS. WATANABE: That are regulated by us or the Department, I should add.

MS. PHILLIPS: Right. Right.

MS. WATANABE: Just to be clear. Other questions?

MEMBER DURR: So a question on that is, what was the intent of the ask in AB 731?

MS. PHILLIPS: To review large group -- the methodology that the large groups have. So really to -- I think it was really to look at the factors that are being used to develop the large group rates and have the DMHC be involved and ask questions and be a part of that process. Because we can declare the rate unreasonable or not justified and then the plan would be required to send a notice out. But I think -- in my conversations with the author's office and the sponsors it was having the DMHC be involved because of just seeing the good work that we have done and the results that we have gotten in the individual and small group market, to have part of that in the large group market.

MS. WATANABE: And I'll just add, you probably remember SB 546. We are getting large group rate information, which has historically, I think, been the black box. There is an interest in understanding more about how large group rates are set. That information that we have been getting in SB 546 has been of a lot of interest and so this is really kind of the next step, building on

more transparency in large group rates.

MEMBER ROUILLARD: It looks like we have the sponsor who wants to say something once the Board Members are done.

MEMBER FLORY: I just had one question on AB 290. You had mentioned there is a fact sheet for folks who will be losing their coverage. Are the plans themselves or the third-party payers doing any additional outreach for folks so they know about special enrollments and other opportunities to enroll?

MS. WATANABE: I will say I am not sure about the third-party payers. We have a number of -- Covered California and DHCS are putting information on their website. Part of our resources are the Health Consumer Alliance and HICAP, so we are also providing resources where you can go for assistance. So we do not know who all of these individuals are so we are trying to get information out broadly so that if they do a Google search they are going to hit one of us, so we are trying to do what we can to make sure that information is available.

MEMBER FLORY: Okay.

MS. WATANABE: Should we hear from Anthony?

CHAIR GRGURINA: Yes, let's take comments from the audience. Anthony. Anthony, can you give us the history?

MR. WRIGHT: You don't want the whole history. Anthony Wright, Executive Director of Health Access California; we are the proud co-sponsor of 731.

So I first want to say thank you to the Department for all the work that you are doing to implement it. And it is you are a victim of your own success (laughter). As I think many of you know, we have been pleased by the results of

the rate review in the individual and small group markets and the savings of hundreds of millions of dollars for such consumers. And frankly, those who are in larger groups wanting to have the benefit of having rates reviewed to see if they are justified and reasonable.

Large group, the thinking was, I think previously, that large groups had a bargaining power, that had different bargaining power than individual or small groups. But if you are an employer of 200 or even 2,000 I am not sure they feel like they are in power to really negotiate with Anthem, Blue Cross, Kaiser, et cetera. And there has been a feeling that some of the rates that have come down have been from a black box and that is where 746 and other efforts -- and this is, I think, another step in the process, building on the good work that the Department has done on 546 on individual rate review, et cetera.

So I think it is a -- it is an evolutionary step but we recognize it is more work so we just wanted to say thank you for the work to improve upon it.

I would also just say that we appreciate the proactiveness of getting the fact sheet up on 290; we have been monitoring that. We were supportive of that bill. And we just want to say, and I think that it is good that the Department is saying clearly that there is absolutely no reason for the third-party payer to withdraw from California, not this year, not in future years. And we want to continue to make that point but we also want to make sure that these patients are taken care of, whether it's getting the third party payers to come back to the table or for the insurers or others in the community to stretch and do what's right to make sure that these patients get the care that they need. Thank you.

CHAIR GRGURINA: Anthony, hold on a second.

MR. WRIGHT: Yes.

CHAIR GRGURINA: One question for you. The individual contract where with over 2,000 they could ask the Department for the review. Is that 2,000 employees or 2,000 members covered?

MR. WRIGHT: I believe --

MS. PHILLIPS: Covered lives.

MR. WRIGHT: Covered lives, yes.

CHAIR GRGURINA: Covered lives, okay, thank you.

MR. WRIGHT: All right, thank you.

CHAIR GRGURINA: Any other comments from members of the audience?

If not, to the operator, any comments or questions from folks on the phone?

THE OPERATOR: I am currently showing no questions. As a reminder, if you would like to ask a question please press star-one and record your first and last name clearly and promptly.

CHAIR GRGURINA: Okay. Well thank you very much, Mary and team.

We will move on to Sarah and the regulation update.

MS. REAM: Good morning. I am Sarah Ream, also still the acting -- in an acting capacity, Acting General Counsel for the DMHC. So I will be providing an update regarding a number of regulations that recently went into effect, a number of regulations that we are working on currently. I will also be providing a very brief update on a few federal actions.

So to start I wanted to give an update on the implementation of our general licensure regulation which went into effect July 1st of this year. Just as a

recap, this regulation defines various terms including global risk, codifies the DMHC's practice of licensing restricted Knox-Keene Act plans and requires an entity that accepts global risk to either obtain a license from the Department or obtain an exemption for the contract under which that entity is accepting global risk.

In June we issued guidance to the health plans that provides for a phased-in exemption request process. So between July 1st of this year and June 30th of next year entities that are entering into global risk contracts or amending or renewing those contracts may take advantage of an expedited request process to get their exemptions processed and through the system.

To date we have received 153 exemption requests. We have received a fair number of requests from the public and from provider groups and plans to make that list available to the public. It was available to the public but one would have had to submit a public records act request. In response to those inquiries we have posted to our website a list of all of the exemption requests we have granted, who requested the exemption and when we granted that exemption. That is available on our public website. It will be updated as we move forward and grant more requests. Someone is also, of course, always -- always has the opportunity to submit a PRA request if they simply don't want to go to the website or can't find that, can't find it on our website.

Before I move on are there any questions about the general licensure regulation?

CHAIR GRGURINA: Any questions from the Board Members? Sarah, I have one.

MS. REAM: Yes.

CHAIR GRGURINA: Which is, did the organizations have the potential to ask for a one year exemption or a two year exemption?

MS. REAM: So it was -- the duration of the exemption is it depends on whether a Knox-Keene licensed plan is a party to the contract. So if the DMHC plan is a party to the contract then the duration of the exemption is the life of the contract. If a Knox-Keene Act plan is not a party to the contract then the duration of that exemption is two years from the date the DMHC granted the exemption.

CHAIR GRGURINA: Okay. And if a contract was held between a Knox-Keene plan and a risk-based organization that was an evergreen contract how would you deal with that?

MS. REAM: So we determined that when the evergreen clause was triggered to renew that would be, that would be a renewal of that contract. The guidance does provide for, make an allowance for non-substantive amendments to contracts, for example, a change of an address, a change of a contact person, those would not trigger the need to get a new exemption. But what we were really trying to capture was if the contract has changed substantively with respect to the risk sharing, the parties to the contract, the duration of the contract. And we anticipate releasing further guidance regarding this regulation hopefully by early, first quarter next year.

CHAIR GRGURINA: Okay, thank you.

MS. REAM: We have had a lot of, a lot of interest in this regulation.

MEMBER DEGHETALDI: Sarah, I should know probably the answer to this, but we spent some years ago a lot of time reviewing the Medicare

shared savings programs, what qualifies or would require a medical group who would be involved in CMS downside risk arrangements.

MS. REAM: Yes.

MEMBER DEGHETALDI: Where are we today? Because these have evolved, there are many different APM models in the fee-for-service Medicare space. Where are we today? And many of them have downside risk and downside risk in year four or five of a five year period. Where are we?

MS. REAM: Sure. So with respect to the general licensure regulation, that regulation -- in the guidance we clarify that an entity, a risk bearing organization, a provider group that enters into a CMS-approved ACO arrangement does not need to receive an exemption from the DMHC or does not need a license for that to enter into that arrangement.

A number of reasons for that. One, Medicare acts as sort of a financial backstop to ensure that if things go not as hoped that the members in that arrangement are not, they are not impaired necessarily in their ability to get the medical care they need. Also there is a regulatory framework already imposed on those arrangements, so we really looked at that as not necessarily what this regulation was intending to capture. The same goes for entities with a CDI, entering into relationships with CDI-licensed insurers. So we looked at those as, okay, those don't, it is not necessary to capture those in that regulation. Does that help answer the question?

MEMBER DEGHETALDI: It does.

MEMBER YAO: So can I ask a follow-up question to Larry's question?

MS. REAM: Sure.

MEMBER YAO: So we have many ACO arrangements with a health plan that are not necessarily Medicare type of contracts and it's growing, I mean, so with the downside risk. So those will be part of this?

MS. REAM: Yes.

MEMBER YAO: So we don't get an exemption for it?

MS. REAM: No, no.

MEMBER YAO: Okay.

MS. REAM: Well, you could receive an exemption.

MEMBER ROUILLARD: Blue Shield is a licensed plan.

MS. REAM: Could definitely receive an exemption.

MEMBER YAO: Ah.

MS. REAM: And it would not be the health plan. The health plan doesn't need to file for an exemption, it's the downstream entities with which you are sharing global risk. Those entities need to either obtain a DMHC license or receive an exemption for their contracts.

CHAIR GRGURINA: And Sarah, a backup question --

MS. REAM: Sure.

CHAIR GRGURINA: -- which is, let's assume they get the exemption and they've got a year exemption and they feel they need more time in order to get the license. Can they get an extended on the exemption?

MS. REAM: We anticipate that that will happen so the entity will come back to us. So if -- backing up. If the exemption is granted for the term of the contract -- because this really is, it's a contract by contract analysis that we have to do, not an entity by entity examination. So the entity, once their contract either is terminating, coming up for amendment, renewal, or if in this interim

period if a Knox-Keene plan is not a party and the two years expires, then yes, we would expect that the entity would come back, ask either for a renewal of that exemption or would be applying for a license.

CHAIR GRGURINA: Thank you.

Other questions from Board Members?

Sarah, did you want to continue on with the others and then we'll open it up?

MS. REAM: Yes, certainly. So we have been really busy in the DMHC with respect to regulations. We had three regulations that took effect on October 1st.

The first regards financial filing requirements for RBOs and this amends the existing RBO regulations to really update it and bring it up to where we think it needs to be to ensure the stability of the health care marketplace. It made a number of changes to the requirements for RBOs including increasing the minimum TNE an RBO must maintain. So by October 1st of 2020 RBOs must have -- all RBOs regardless of size, must have TNE equal to the greater of one percent of annualized revenue or four percent of annualized non-capitated medical expenses.

The second reg that took effect on October 1st was the standard prescription drug formulary template regulation. This regulation does a number of things including define various terms like coverage document, dosage form, brand name, generic drug. These definitions are important so that we ensure that all plans are using the terms to mean the same thing and to allow consumers to better understand how to obtain access to formulary and non-formulary drugs and to understand what their formularies cover. Right now we

are working with the plans to update their -- ensure that they are updating their templates and notices as necessary.

The third regulation that took effect on October 1st are regulations regarding cancellations, rescissions and non-renewals for non-payment of premium. We call these the 1365 regulations. They update the names of notices to better reflect the function of each notice and they clarify the timing of the notices. The regulation also clarifies that enrollee complaints regarding cancellations, rescissions and non-renewals are grievances under the Knox-Keene Act. The regulation clarifies that a plan's failure to comply with notice and timing requirements can be a basis for reinstatement of an enrollee and the regulation also better aligns state law with federal law by acknowledging that the suspension period during the three month federal grace period is permissive, not mandatory.

So we have those three regs just took effect, we have a bunch in the pipeline, I am going to talk about four of those today.

So the first are timely access to care regulations. We are in the process of finalizing the language and the text for these regulations that will adopt a standard methodology for health plans to report timely access to care compliance. We plan to submit the regulation package to the Office of Administrative Law to begin the formal rulemaking process early next year and look forward to stakeholder engagement and the stakeholder process on that regulation.

The next regulation we have in process is the out of pocket maximum or what we call OOPM regulation. We have heard from consumer groups and others that enrollees need assistance in determining when they are

approaching or have exceeded their out of pocket maximum. I think we have all heard stories of enrollees with a shoe box of receipts calculating when have they exceeded their out of pocket max.

So this regulation will put in time frames for how quickly a plan must give information to enrollees upon request regarding the enrollees accumulation toward the out of pocket maximums. It will also require, and I think this is a very important point, that enrollee inquiries regarding cost-sharing accumulation be treated as grievances or exempt grievances to ensure that enrollees are receiving information timely from the plans, so the enrollees are not left with a large time delay when they request information from the plan. And we hope to have a draft of this regulation to share with stakeholders on an informal basis in the next several months.

The third regulation we are working on is a dental benefits matrix. This is to implement SB 1008 from last year, which required that DMHC with CDI -- the California Dental Association and the California Association of Dental Plans, to develop a draft -- to develop a standard matrix for dental plans to use to allow enrollees to do sort of a shop and compare across when they're looking at choices across the dental marketplace, and also to have a better understanding generally of what the plan covers and what the enrollee will be expected to share as part of their cost-sharing. We plan to submit this regulation to the Office of Administrative Law early next year as well.

And then finally the fourth regulation is essentially a clean-up of our regulations related to our help center. These regulations will remove some inconsistencies between various regulations that we have regarding our help center now and will better reflect what the help center and the health plans are

actually doing. So it's really -- it's just bringing these up to date.

And with that, that is the end of my regulations update. I am happy to take any questions or I can move straight into the federal, the federal updates.

CHAIR GRGURINA: Why don't we take questions on --

MS. REAM: Okay.

CHAIR GRGURINA: Questions from Board Members?

Any questions from members of the audience for Sarah?

Operator, any -- oh.

MEMBER ROUILLARD: When you get done with this I have a comment on another regulation.

CHAIR GRGURINA: Okay. Operator, any questions or comments from the phone?

THE OPERATOR: I am currently showing no questions on the phone line. As a reminder, if you would like to ask a question please press star-one.

CHAIR GRGURINA: Thank you. Shelley.

MEMBER ROUILLARD: I just wanted to mention, Larry had brought up the issue of provider directories earlier. So beginning next year we are going to be working on regulations with respect to SB 137. We have a set of regulations in place now but this would be the second set. So over the course of 2020 we will be engaged with stakeholders and then submitting another package next year. I just wanted to mention that to you.

CHAIR GRGURINA: Okay. All right, Sarah, federal update.

MS. REAM: Okay, federal update. So there is a lot going on at the federal level. I am only going to speak very briefly about just two items.

One, *Texas v. Azar*, this is the 5th Circuit Court of Appeal has taken up the decision out of a Texas district court that overruled the ACA in its entirety. No decision on that case yet but it could be any moment now, so waiting on that one. Likely at the next FSSB meeting I will have an update regarding that case.

Breaking news on an unrelated matter but a federal case. Yesterday a federal judge out of a New York district court invalidated the recently adopted federal conscience rule as being unconstitutionally coercive. So this rule would have allowed nurses, doctors, other health care professionals to refuse to perform abortions, abortion-related services, other types of health care services such as certain services for transgender individuals, based on the provider's moral or religious convictions. And the coercive aspect comes to play where if the provider's employer, for example a hospital, clinic or university, didn't fully comply with the new rule.

That failure to comply could result in the US Department of Health and Human Services withholding all funding from the employer. And this federal district judge said that steps -- it goes wherever the line is for persuasive withholding or the federal government tried to persuade an entity to do something, it crosses that line and goes into the realm of unconstitutionally coercive. The judge also held that the rule was arbitrary and capricious and conflicts with federal laws regarding the governing -- excuse me, I'm reading, I want to make sure I get it right. Federal laws governing the obligations of employers to accommodate workers' religious views and for hospitals to provide indigent care.

As with all cases like this, this is not -- this is the first word, not the

final word, it will almost certainly be appealed to the court of appeal and likely to the US Supreme Court. But just interesting to see these cases as they move through the system.

CHAIR GRGURINA: Questions? Larry.

MEMBER DEGHETALDI: Two questions on *Texas v. Azar*. If the appellate court sustains the unconstitutional ruling I would assume that it would be stayed, the implementation would be held off until the Supreme Court would review it. Is that likely?

MS. REAM: I would assume that. Even if the Court did not it's -- the parties would certainly go -- the states would go to the Supreme Court and ask for an injunction or a temporary injunction while the case is moving through the Supreme Court.

MEMBER DEGHETALDI: And I'm not a lawyer but I understand the basis for the ruling was the loss of the individual mandate.

MS. REAM: Correct.

MEMBER DEGHETALDI: Okay. And if California will reinstate an individual mandate will that have any bearing on how California would be seen in this?

MS. REAM: I think that's a question that -- that's a great question and it's one that I think lots of attorneys and policy makers are thinking about right now. California's mandate, though, would not impact whether the ACA falls or remains. Just as a background, so the court, the district court had held that Congress had the power to enact the ACA given its taxation authority and they said the mandate was a tax. Well, by stripping out the mandate the court said, well now Congress does not have the authority to do that. So it's a function of

Congress' constitutional authority. So the California mandate will really -- it makes it a much more interesting question for California but it doesn't go to the heart of that, that case itself.

MEMBER DEGHETALDI: Just approximately four million Californians are on Medi-Cal, I think, because of the ACA and maybe another million more on the exchange, or thereabouts. This is, I mean, this is an existential threat.

MS. REAM: Yes, it's a big deal.

CHAIR GRGURINA: Other comments or questions of Sarah from Board Members?

Any comments or questions from members of the audience?

Comments or questions from the phone, operator?

THE OPERATOR: Yes, we had a question from Melissa Borelli (phonetic); your line is open.

MS. BORELLI: Hi, thanks. I'm just wondering regarding the licensure regulation. You mentioned you had the -- the listing of the entities that had been granted exemptions on the website. Can you give a cookie trail to the website or where folks can look. I just ran a search and all I'm finding is a PDF. So I'm wondering how do you get to it without running a search?

MS. REAM: So it is a PDF. So you won't -- it's not a -- it's a static document.

MS. BORELLI: Okay.

MS. REAM: We can -- let me circle back with our tech folks, this is way beyond my knowledge, to see if we could set up a system where the public could do a search for that. I am not sure that we could do that but let me take

that back, it's a good question.

MS. BORELLI: Well it does, it does show up in a search. I'm sorry, I'm ahead of myself. It does show up in the search, I'm just wondering if there is a much faster way to get that. Maybe --

MS. REAM: Oh, I see what you're saying, rather than a searchable document. To get to -- Yes, so I have the -- so it's -- you can access it by going to dmhc.ca.gov is our home page. Then clicking on the Licensing and Reporting tab. Then going to the Health Plan Licensing page. And then scrolling down to the bottom of that page is where you would find -- there is a button for exemptions granted.

MS. BORELLI: Got it. Thank you, appreciate it.

MS. REAM: Okay, you're welcome.

CHAIR GRGURINA: Any other questions from the phone, operator?

THE OPERATOR: I am showing no further questions at this time.

CHAIR GRGURINA: All right, thank you.

Thank you, Sarah.

MS. REAM: Thank you.

CHAIR GRGURINA: Okay. Since Jacey is not here yet, Pritika, you are up with the Financial Summary of Medi-Cal Managed Care Plans.

MS. DUTT: Good morning. I am Pritika Dutt, Deputy Director of the Office of Financial Review, and I am not acting (laughter).

MEMBER ROUILLARD: She is for real (laughter).

MS. DUTT: All right. So I will provide you a quick update on the financial summary of Medi-Cal managed care plans so I'll report for quarter

ended June 30th, 2019. A copy of the report is available on our public website under the Financial Solvency Standards Board section, also it is included as part of the meeting handout. This report is prepared by the DMHC on a quarterly basis and highlights enrollment and financial information for Local Initiatives, County Organized Health Systems and Non-Governmental Medi-Cal plans. Non-Governmental Medi-Cal plans, or as we refer to them as NGM plans, are plans that report greater than 50 percent Medi-Cal enrollment but are neither a Local Initiative or a County Organized Health System. The report is divided into three distinct areas, first focusing on LIs, next we look at the COHS and in the final section we look at the Non-Governmental Medi-Cal plans.

So there are nine Local Initiative plans that serve 5 million Medi-Cal enrollees in 13 counties.

For the second quarter the Local Initiatives reported a total net income of $40 million.

The tangible net equity, or as we say TNE, the required TNE ranged from 517 percent to 859 percent; so all of the Local Initiatives met the TNE requirement at the second quarter of this year.

There are six County Organized Health System plans that serve 22 counties. We received financial reports from five COHS; Gold Coast does not report to the DMHC.

The five COHS that report to the DMHC serve over 1.9 million Medi-Cal beneficiaries so a little under 2 million lives over the COHS plans.

For the second quarter the COHS plans reported total net income of $41 million.

And the TNE, the required TNE ranged from 665 percent to 1,102

percent.

For the Non-Governmental Medi-Cal plans, we have seven of them that serve 31 counties.

They reported over 3.1 million Medi-Cal beneficiaries.

Total net income for these NGM plans was $106 million.

So a total TNE -- the required TNE for the NGMs ranged from 151 percent to 1,108 percent.

So some of the take-aways from the report:

So the rate of increase in enrollment slowed in 2018 and we observed similar trends in the first two quarters of 2019, and we also noticed that some of the governmental plans had declined in enrollment.

Overall premium, revenue and expenses also stabilized.

Some of the Medi-Cal plans are reporting net losses and what we have learned from these plans are that since they have had high reserves they made the strategic decision to invest in the community and to strengthen their safety nets, which includes providing incentives to providers for better quality outcomes, better HEDIS and encounter data projects, as well as making investment in communities to address the social determinants of health care issues.

Even with all these community investments and net losses the Medi-Cal managed care plans continue to meet or significantly exceed the minimum TNE requirement. So that's one of the things we look at as these plans are reporting net losses, we are looking at what is happening with their TNE and other financial ratios. So as we always do we will continue to monitor the enrollment trends and financial solvency of all LIs, COHS, NGM plans and all the

plans that report to the DMHC.

So with that I'll take any questions.

CHAIR GRGURINA: Questions from the Board Members? Jen.

MEMBER FLORY: I just note that some of them do have very high TNE. Is there any upper cap or encouragement to do more community investment when that is occurring?

MS. DUTT: So one of the things about TNE, it does not -- it doesn't mean like high TNE is all cash. It's made up of their buildings, receivables, so it includes all other non-liquid assets as well. So John, do you want to point out what --

CHAIR GRGURINA: Yes, I'll address it. Jen, I speak from our standpoint. What we did at the San Francisco Health Plan is our board created a policy said that what is the upper end where once we go over that we want to bring the dollars back to our providers to improve access, improve quality for our members. For us our policy is two times capitation premium.

MEMBER FLORY: Okay.

CHAIR GRGURINA: And so once we went above that we started bringing the dollars back in to programs for our providers and we have been doing that for the last three or four years. And that's why -- actually in the document that I believe is on the DMHC website you can see quarter by quarter, you see losses in the San Francisco Health Plan. Not that we were running a medical loss ratio that caused losses, but because we were using those reserves they were board-approved for us to be in a loss position.

And I think each plan is a little bit different. And I think also, quite frankly, each board is different based on their past experiences. So there's a

couple of our sister plans who many years ago were very close to closure, so those boards and those finance committees generally tend to have little higher ratios because they remember the scars of what once happened and they don't want to be there again.

The difficulty for the -- if you look in the two plan model, the Local Initiatives, the County Organized Health Systems is, we don't have access to capital.

So for example, Jacey Cooper is going to walk us through some of the expansions that Medi-Cal is looking in managed care; it's a huge expansion for the San Francisco Health Plan. So while we could look and say, well, it looks like we are at eight times TNE, that seems kind of high, the moment the expansion rolls into us our TNE drives up and our multiples of TNE goes down, allowing those funds to have us the ability to increase the services that Medi-Cal wants us to do. And again, there are no actuarial studies to be able to point, what is the appropriate upper end. It is more of a, what do you feel comfortable with based on your board, your finance committee and your history and where you have been.

MEMBER YAO: So John, I have two questions. One is talking about once there is a growth in membership it could potentially require lots of capital so we are doing some financial modeling around the potential of recession coming. So when that comes, yes, we all anticipate -- I don't know whether our assumption is right or wrong, we anticipate the Medi-Cal enrollment is going to increase, so that could put lots of pressure on the Medi-Cal companies, their TNE position.

CHAIR GRGURINA: And adding to Amy's comments, when the

economy turns not only does that mean there is an increase in the number of eligibles coming into Medi-Cal but it also makes it tighter on the state and the funding.

MEMBER YAO: Yes.

CHAIR GRGURINA: So the rates that are paid to the plans get incredibly tight, which in certain circumstances going back to the 2011-12 when the seniors and persons with disability were moved into managed care plans, every managed care plan lost funding for those members in that year. Which to the credit of DHCS, they took a look at all the encounter data, the pharmacy data, and came back and changed rates later because the economy was in a little bit of a better place to do that. So as Amy said, it's also making sure that you are prepared for it when the loss years come and eventually they do come around.

MEMBER YAO: My second one, I just want to comment. You said there is no actuarial study around what is the level of TNE or your capital position. Actually for us we did engage Milliman, did a study a while back, and they recommended to us somewhere between 600 and 900 as the --

CHAIR GRGURINA: Yes.

MEMBER FLORY: Six hundred and 900?

MEMBER YAO: Yes.

MEMBER FLORY: Okay.

CHAIR GRGURINA: Although, Amy, that was what Milliman did for you at Blue Shield.

MEMBER YAO: Yes, right.

CHAIR GRGURINA: What I am referring to is actuaries that were

hired by states who wanted to see where are and where should we draw the line because then we think it's too much. And those actuaries came forward and said, there isn't an actual line to draw. And they did similar to what you said, it depends, is this a public agency, a for-profit entity, a not-for-profit entity, what kind of membership do they have and what their experience is.

But as Amy is saying, having some kind of range is appropriate. And really the question comes down to, each of the boards of these plans as to what they feel is appropriate and when do they feel they've gotten to a point where it is too much and they need to return the funds back to the community to improve services for their members. And I believe that Larry is on a board that has done that.

MEMBER DEGHETALDI: I am nervous. If you look in aggregate at the Local Initiatives and the COHS they look okay. But if you look at individual -- if you look at the LIs it's really -- the solvency is really dependent on LA Care. And you see a number of plans, and really one that was in receivership, in a negative, five of the last six quarters in a negative position.

I serve on a COHS board for a long time. I think most of the boards, John, were reluctant to raise provider rates during times of plenty but there was some rate increase built in. And now we are starting to see many of the plans have to look at rate reductions to providers, that is going to lead to access problems. I am very nervous about that because the variability of the performance within the two different models we are looking at is very significant and a number of the COHS, if you look at, are struggling.

And I agree that 100 percent of TNE that we tracked over time is greatly insufficient and our board looks at about 600 percent of TNE as -- but I

am nervous about what I am seeing here if you unpack and look at different plans. We have to pay attention. And you will see rate reductions and you will see access erode.

CHAIR GRGURINA: So I think adding to Larry's comment is, the question when you're looking and you're seeing some of the plans with losses the questions is, is the loss a direct result of using reserves specifically for that purpose or is it because in that particular fiscal year the plan is actually in a loss position, which is a different place to be. And then the other piece is, how much reserve are they sitting on to withstand losses for a while?

MEMBER DEGHETALDI: What I'm seeing, at least in our plan is, that the average member, the MLR is okay, 90 percent of the members the MLR is fine. It's the 5 percent that I call the endocarditis patient or the catastrophic patient, we are starting to see a small subset of our members consume our reserves at an unsustainable rate. And that is what we are seeing in our area, I don't know if in San Francisco you see it as well, but that, we have to watch that.

CHAIR GRGURINA: And so the final comment I would make is, as you listen to Larry who is a board member on a plan, who has been there for quite a number of years and has been there through both good times and rough times, this is why you see some higher TNEs is because folks realize that when times get rough and you start to lose money, how are you going to be able to ride that wave to turn your ship around and to be able to have a future going forward.

Other comments or questions for Pritika from the Board Members?

MEMBER DURR: The only thing I would comment, I know there are a couple of plans, I think they are NGM plans, that do pay dividends back to

their parent company and I think that is a very different organization than the other plans.

MS. DUTT: Right.

MEMBER DURR: So keep in mind their TNE maybe looks less but if you factor in the dividends that have been paid back to a for-profit company that also mitigates some of that.

MS. DUTT: And they don't need to hold on to excess reserves either because if they do need money they can, their parent would infuse the cash, unlike the government plans.

MEMBER DURR: Right.

CHAIR GRGURINA: In addition to Paul's comment is, they have the ability to get out and access capital that those that are -- the public plans, the 15 plans don't have access to. So it is a different situation. And Paul is correct that when you're looking and thinking, there's a few of these plans that seem to be about 250, 300, should we be worried about them? For a for-profit plan, no.

MEMBER YAO: Okay. Yes, that was my question. Thank you for answering it.

MS. DUTT: So when we look at these plans we are looking at the system as a whole. So when we're looking at California Health and Wellness we're looking at what's happening at Centene level, it's the whole organization.

CHAIR GRGURINA: Other questions?

MEMBER YAO: I have a question that is more for education. You mentioned the COHS. Not all are governed by DMHC so there is -- who would govern the rest of the COHS?

MS. DUTT: So there are six County Organized Health Systems.

MEMBER YAO: Yes.

MS. DUTT: Five of them report to us because at some point -- so with the COHS their Medi-Cal line of business is exempt from Knox-Keene licensure. So at some point the five of them that report to us had some line of business that needed, they needed license for. For San Mateo they voluntarily came and got a license for their Medi-Cal line of business.

MEMBER DEGHETALDI: Isn't it only Ventura County's COHS that does not report?

MS. DUTT: Gold Coast, yes.

CHAIR GRGURINA: And the reason why the others are in is because of many years ago when Healthy Families was started DMHC did a quick turnaround on a Knox-Keene license restricted specifically for that program, which is why those five were in there.

MS. DUTT: And I think one of them has the in-home support service program.

CHAIR GRGURINA: Other questions?

Questions from members of the audience?

Operator, any questions or comments on the phone?

THE OPERATOR: I am currently showing no questions on the phone lines.

CHAIR GRGURINA: All right, thank you very much.

Pritika, if you don't mind we are going to call Jacey up and you can take a rest until you come back for the multiple other items that you will be back for.

MS. DUTT: Thank you.

CHAIR GRGURINA: Jacey, welcome. We are happy to have you here and looking forward to your presentation.

MS. COOPER: So I will apologize because there's a lot of information to give in a very short period of time so I am going to keep it pretty high level for the purposes of the presentation today and then refer people to our very lengthy proposal on the Department's website for additional details.

So I'll quickly go over some of the over-arching goals of CalAIM, the priorities and how they link with the Governor's priorities, a high level overview of the proposals under CalAIM: A Crosswalk, and then some stakeholder engagement so people are informed.

So I think the biggest need to kind of point out here is the Department started this process in the beginning of 2018 where we went across the state of California meeting with health plans, counties, behavioral health directors, providers of QHC, CBOs, to find out and have conversations around where there are opportunities in Medi-Cal and where can we kind of move the needle in regards to making some of what we felt like was some large needed change.

And we came back and we then met again about eight times at the end of 2018 with a large, 50 group, Care Coordination Advisory Committee is what we called it, to inform and have discussion around some key policy areas.

The Department took those policy areas internally. In 2019 ran data and came back with full proposals of what we are now calling CalAIM, which is California Advancing and Innovating Medi-Cal.

You'll see that the initiatives in CalAIM are broad, they are ever-reaching, they go across all delivery systems, so it includes Medi-Cal managed

care, behavioral health, dental and even our county programs and services.

I think one of the things the Department clearly recognized is that there's been significant changes in Medi-Cal in the last ten years. We have had significant populations move from fee-for-service into managed care. In addition to that with the ACA we just had large numbers of populations, new populations come into Medi-Cal.

And making sure that we have the appropriate systems in place to meet the needs of those beneficiaries is important. We know that if someone comes in to Medi-Cal they could be accessing six or more delivery systems. Managed care, if you have some things carved out for fee-for-service, you have mental health, SUD, dental, IHSS, and if you happen to be CCS you're getting services outside of that as well.

So it's a very complicated system to navigate and we wanted to kind of step back. Because especially for those with probably the greatest clinical complexity, they are often the ones having to navigate the system the most. And how can we build in some integration even though we will probably still have some separate delivery systems in our program.

We also wanted to look at the lessons learned from some of the other initiatives the Department has done. Whole Person Care, the CCI program, some of our pilots with our public hospital systems, as well as a number of various pilots and initiatives the Department has undertaken over the last few years to figure out what should we move forward.

As many of you may know, we are in the process of a waiver coming for renewals. We have our 1115 waiver up for renewal at the end of next year as well as our 1915(b) specialty mental health waiver is up for renewal in

2020. So we really wanted to step back and think comprehensively how could we drive some changes. One of the things that we have been talking about for a long time is that we will have a very small 1115 waiver moving forward due to guidance formalized by CMS, which we were aware of the last time we renegotiated our 1115 waiver, that there would be a very small 1115 waiver because of budget neutrality room no longer being available for the state of California based on new methodologies.

So we will be proposing to move all current managed care, mental health and SUD under one large 1915(b) waiver, is our current proposal. We are hoping that allows for better integration across our delivery systems. We will still have, just to be clear, the counties will be responsible for mental health and SUD services but by combining it will allow us to combine and bring parity across our delivery systems, we feel, significantly in regards to infrastructure, quality, reporting metrics, et cetera.

The other thing that we really focused on with CalAIM was the entire continuum of care. So the focus is really about from birth or early childhood all the way to end of life. Do we have the full spectrum of services needed for our beneficiaries, as well as appropriate step-down services for certain populations that we felt needed to be made available to beneficiaries in Medi-Cal.

We also feel like the items and proposals in CalAIM advance key priorities of the Newsom administration. There is a key focus on some of our most vulnerable residents and beneficiaries in Medi-Cal.

The homeless population is significantly targeted with this proposal in regards to some of our housing pieces that I will go over.

We also are doing essentially a huge fundamental shift in our behavioral health access and services for both our mental health and substance use disorder services.

We wanted to make sure we were meeting the needs of complex conditions for children with complex medical conditions, behavioral health conditions. Dominantly focused on foster care but also anyone with complex conditions.

We wanted to focus on the number of justice-involved populations who have significant clinical needs when leaving incarceration and making sure that we are providing the appropriate care coordination for those individuals leaving incarceration, both on the behavioral health side as well as the medical side and ensuring that they have access to health care coverage upon release from jail.

And then lastly but definitely not least is the growing aging population and making sure that we are proactively thinking about options to meet the needs of those individuals in Medi-Cal.

I am not going to go over the guiding principles because we don't have a ton of time, but they are there to reference. I think there's a few driving pieces that I would mention.

We are really working to align the funding, data reporting quality and infrastructure towards common goals, I think I mentioned that just a moment ago. And that is a driving factor with some of these changes is how we can better integrate or have integration even in a silo delivery system by working towards and seeing where we can line those things up.

I think we also want to ensure that we are delivering person-

centered care that meets all of the needs of our beneficiaries, behavioral, developmental, physical and oral health needs across.

And you will see our positioning on this really has the managed care plan mainly as the quarterback, as we call it, through these transitions, leading that across the delivery systems.

You will see it as we go through it but it is also really focused on identifying and mitigating social determinants of health and reducing disparities and inequities in our program as well.

So go to the main goals of CalAIM. So we have three main goals that really were driven out of the work we did in 2018 with the Care Coordination Advisory Committee as well as the large number of people that we talked to regarding this proposal. And it comes into kind of three pieces and this is what will drive the proposals also.

So the first one is identifying and managing member risk through Whole Person Care approaches and addressing social determinants of health. We have a suite of proposals in that kind of sphere of things to really focus on the high utilizers, your top 5 percent, your most vulnerable populations that are driving up significant costs but also have significant needs that are needing to be met, both clinical and non-clinical and how we can do better to provide those needs.

And then the second goal is really about providing a more seamless and consistent system. We have created a very complicated system in Medi-Cal. Anyone knows when you've seen one county in Medi-Cal you've seen one county in Medi-Cal. And we just need to think about stepping back and making things a little bit more standardized across the entire state of California

and doing that incrementally over time.

And then last but not least is really -- you will see this sprinkled throughout all the proposals but focusing on quality outcomes, using value-based payment, looking at payment reforms significantly across the board and modernization of systems to support a very large, very large program.

So I have a few slides on the first four bullets so I am going to just kind of quickly go over the last three and then I'll kind of go through the slides, so it's a little funky order.

These are the seven proposals that we have kind of tagged under the large underlying, identifying member risk and need. The last three we don't have formal proposals in our CalAIM document, but we have that we want to sit and talk to people about how we would do it.

So for the mental health IMD waiver, the federal government released guidance in 2018 that would allow us to explore drawing down federal funds for IMD services. Currently that is not funds allowable to be claimed, by the federal government, but if you put forward a waiver demonstration you can receive such funds if you meet the expectations of CMS' guidance. In our proposal we have all of those details of the CMS guidance and it is available online if people are interested.

We will have a work group that will discuss whether or not the state of California should explore such an IMD waiver. Just to note, this is similar to what we have in our DMC-ODS or Drug Medi-Cal Organized Delivery System waiver on the substance use side of things, this is just the equivalent to that on the mental health side, for people that are --

CHAIR GRGURINA: Jaycee?

MS. COOPER: Yes.

CHAIR GRGURINA: The IMD stands for?

MS. COOPER: Oh. Institutions for Mental Disease.

CHAIR GRGURINA: Thank you.

MS. COOPER: Thank you, sorry. Yes, if I use acronyms that -- in Medi-Cal we live in acronym soup so --

MEMBER ROUILLARD: We all do.

MS. COOPER: -- always feel free to call me out on it.

The next is looking at full integration plans. So as I was mentioning earlier, someone could be accessing multiple delivery systems in Medi-Cal and we would like to explore the concept of having one plan or entity responsible for all of those services, the physical health, the mental health, the SUD and dental services. It is very complex policy to go through and more so financially to go through because of realignment in Prop. 30, as you would imagine, so a county would have to be willing to participate in this with whichever entity came forward.

But we will have a public work group process to explore this option and we put in our proposal that any pilot would not start until 2024 given the complexity of the policy, the contract build, the bidding, and then lastly, the readiness process. We feel like we needed to do due diligence there for such a complicated proposal.

And the last is to form a work group in early 2020 to come up with a long-term plan for foster care. We really feel like some of our most vulnerable beneficiaries, that we need to come up with a long-term plan, not kind of low-hanging fruit, small changes, but step back and look from other states what they have done on foster care. So those three we will still be developing proposals

that will be publicly vetted and come out at a later time.

So for the population health management components of this. You know, we are really going to be looking for managed care plans. We looked at our contract and there's a lot of language in our contract around care coordination, case management, disease management, a lot of those pieces, but we really felt like we needed to have a concrete proposal or plan from our managed care plans annually, having them tell us how they are meeting the needs of their population, the entire population.

A lot of them do this today. Some do it really well and some, you know, probably could see some improvements in this area, but it really gives us some transparency into being able to see the managed care plans' plan of attack, for lack of a better description.

The nice thing about these population health management strategy documents that would be submitted to the Department annually, we would want it to be based on risk stratification, predictive analytics and other data-driven systems to assess their population.

It would be focused on not just the sick but also what is their plan of attack for preventive services within their plan, as well as assessing member risk and need. And of those that are identified as risk and need, what services are being tied or provided to those beneficiaries.

The next two items that we will get into around enhanced care management in lieu of services, we would expect to see those in these population health management plans so that we have an understanding of if one of your target areas is homelessness, how are you providing services and wrapping those services for those individuals based on identifying that need.

We also have put in some additional language for transition of services being discharged from an in-patient setting, skilled nursing facility. Expectations at a deeper level than what we currently have in our contract and current guidance in regards to those handoffs between delivery systems and levels of care.

And then lastly, mitigating social determinants of health.

The other piece here that we are proposing is a statewide new benefit called Enhanced Care Management. This is really built off of the backbone of the Whole Person Care pilots if you are familiar with those pilots, as well as Health Homes. So what we are proposing to do is transition those Whole Person Care pilots and Health Homes into this new statewide Enhanced Care Management benefit. As you know, both Whole Person Care and Health Homes is only in certain counties; and then for Whole Person Care they all approach it differently so it only covers certain target populations and/or provides certain services.

But this proposal would build statewide infrastructure for a higher level of what we call care management versus just case management or complex case management, which is essentially a high-touch, high-need individual. A multi-disciplinary approach that would be community-based, provider-based. We would explore the plan providing it in some circumstances but they would have to demonstrate how it's being done in the community. This is not telephone-based case management where you call someone and think you're going to reach them. These are very vulnerable individuals that usually need the high-touch by either a community-based organization or a provider in the community.

We have some divined target populations that we will have managed care plans focus on and partner with either their existing Health Home providers, Whole Person Care pilots of course, local governmental agencies as well as counties, to provide these services and to be the Enhanced Care Management quarterback.

There is a lot more detail in the proposal that I won't be able to get into today, but essentially we are focusing on your high-utilizers of hospital and emergency room visits. Individuals at risk of institutionalization, both on serious mental illness as well as serious emotional disturbance for the children who have co-occurring chronic health conditions, as well as those at risk for institutionalization of long-term care or who are in long-term care wanting to transition into the community. Children with complex medical conditions, those transitioning from incarceration, and individuals experiencing homelessness, chronic homelessness or being at risk of homelessness.

So the Enhanced Care Management concept would be building kind of very comprehensive models of care around these target populations, hoping to kind of move the needle in what we consider to be very specific populations that need a higher level touch and care coordination for their services.

The Department is also proposing to implement In Lieu of Services. We have gotten some feedback that we need to come up with a better name than that for those. But right now we are sticking to it because it means something in our world and we will figure out what we call it to the rest of the world.

But essentially we are proposing to add 13 different in lieu of

services that managed care plans would be able to provide. Just to be clear, the reason why are using in lieu of services is there is not enough infrastructure statewide to make them a mandated benefit. We are using in lieu of services to build infrastructure statewide over time and then evaluate those services and then potentially move them into benefits.

One thing to just point out is that in lieu of services are services provided that are not available in the state plan, so they are not official benefits, but they are in lieu of something more expensive, in lieu of an in-patient stay, an emergency room visit, a skilled nursing facility stay. So by justifying that by providing these services you would pay less, essentially, it is in lieu of those higher cost services and over time you are reducing the cost curve and bringing down the total cost of care for these very complex individuals, that it's allowable under a contract amendment with our managed care plans. A lot of other states have implemented in lieu of services.

So I'll quickly just kind of go over at a high level the services that we are talking about. So you are going to see a full housing suite, for lack of a better description, when it comes to our in lieu of services. So really looking at housing transition and navigation services, housing deposits, tenancy and sustaining services. So really beginning-to-end services for care coordination that would be necessary for somebody, a homeless individual to be identified and to get them into housing.

It is a lengthy process and it is something that is really meant for experts. We do know that, for example, Minnesota recently got a state plan adding these types of services into their state plan and a lot of people have them in their 1115 waivers, including California, where we clearly cover all of these

things in our 1115 waiver today under Whole Person Care. In fact, almost all if not every single one of our in lieu of services is currently covered. So CMS has already given us the nod that they wanted to test it in our 1115 waiver and feel like they are useful services to pilot and then to explore how we have a sustainable pathway forward at a statewide basis moving forward.

We also have a short-term post-hospitalization housing similar to what North Carolina recently got in regards to having short-term housing paid for. They have about I think a four-month, we have a six-month in our proposal. Essentially it's post-hospitalization short-term housing to transition someone before getting into housing.

Recuperative care.

Respite is actually a nod to caregiver respite services in the in lieu of for our aging population.

So there is a suite of services for homeless and housing and then there is a suite for our aging population as well.

Looking at nursing facility transitions, both to assisted living facilities as well as to their home. Similar to what you see in the state's 1915(c) home and community-based services, but taking it through the responsibility of the managed care plan. As you know, those waivers are not statewide and many of them have enrollment caps and we really feel like we need to build the provider base significantly in the state of California to meet that need. We have gaps in California around this area.

You will also see a number of wraparound services. So once you move someone safely into their home and community that you can provide the additional wraparound services for someone there.

The one thing I would point out here is we also have in our proposal plan incentive payments specifically around enhanced care management and in lieu of services. We know there are gaps in the state and if we want to see those gaps filled and if we want to see infrastructure built and bring more providers to do that we feel like we should have incentive dollars that can go out to plans who move the needle on building those providers and providing these services to beneficiaries.

The other thing I'd mention on the incentive program, it's a combination of delivery system transformation as well as performance measures, just to be clear on that one.

So the next suite of things, and I want to keep track of my time, I will go through at a very high level for this purpose, and just really a nod to it and then forward. The other ones are kind of, that I went through, are the little bit meatier parts of the proposal.

So we are looking to standardize the benefit in managed care. Essentially what that means is by January 1, 2021, all managed care plans will provide the same benefit across the entire state of California. Which essentially means that we are carving managed care -- I'm sorry -- we are carving long-term care into the managed care plans as well as transplants. Everybody knows we are clearly carving pharmacy out of all managed care to fee-for-service.

There's a few other little small nuances in those changes where we had strange, weird, one-off things that had been built into contracts over many, many years, that will be straightened out as well. But essentially the easy way to think about it is all managed care plans will be responsible for the same benefit come January 1, 2021.

The same thing for standardizing managing care enrollment. You will see in our proposal - and there is a large grid in one of the appendix items - a transition in managed care enrollment.

So we have -- you have mandatory managed care in Medi-Cal, you have voluntary and then you have excluded from managed care. We have split it into a two-phase transition, so essentially all individuals will be in mandatory managed care for non-duals in January 2021 and for duals January 1, 2023. There are exceptions to that. Essentially those that will remain in fee-for-service are restricted scope and share-of-cost. The one thing I would point out is even in areas where you have -- our COHS counties that have share-of-cost currently included in their managed care plan, those will also go to fee-for-service in this proposal, so just notating that. You also always have presumptive eligibility that will remain in fee-for-service. And then lastly, you will have the choice time period that people that are in fee-for-service will continue until they move into their managed care plan.

Transitioning to statewide MLTSS. So really building on the backbone of long-term care being carved in, rolling out enhanced care management for our vulnerable aging adults as well as our in lieu of suite in building infrastructure.

The goal of the Department is to upon the renewal of CCI - we will not renew CCI come December 2022 - we will have our mandatory managed care enrollment for duals, long-term care carved in. We will require all Medi-Cal managed care plans to have a DSNP line of business or a Dual Special Needs Plan line of business by 2023; in the hopes of starting to build statewide infrastructure to eventually get to full managed long-term services and supports

by 2026 is the goal that we are working towards.

For annual Medi-Cal health plan open enrollment we are looking to have an open enrollment process for Medi-Cal. The Department has put this proposal forward many times in the past, the details are online.

We are also requiring or proposing to require all of our Medi-Cal managed care plans be NCQA accredited by 2025.

We are working on regional rates for Medi-Cal managed care.

We are doing broad, sweeping changes for our behavioral health area.

Essentially we are recommending a full payment reform for mental health and SUD moving from cost-based reimbursement to an IGT or an inter-governmental transfer process that would allow them to reinvest revenue that they have on top of costs back into mental health and SUD services.

We are making large, broad revisions to medical necessity in mental health and SUD services in Medi-Cal.

We are focusing on administrative integration. So right now we -- our mental health and managed care plans, at least on the DMC-ODS side, are considered under federal law, managed care plans. And after the final rule came out there has been a large number of requirements that they had to meet, some have struggled with meeting that, so we really wanted to step back. Instead of treating them as two separate plans as we do today I think out of the 58 counties, 56 have actually integrated into behavioral health departments locally at the county level, and we want to treat them as that as well. So what we are looking at administrative integration with our behavioral health area. So having one contract for both mental health and SUD services. One audit, one EQRO,

all the things that come with it. Both at the administrative level -- we are also looking for opportunities for clinical integration on that side as well as oversight.

We will also be encouraging regional contracting for mental health and SUD services as well as we will be renewing the DMC-ODS as well.

We have some proposals in there for the Dental Transformation Initiative which is currently in our 1115 waiver and what we propose to move that forward. Essentially it adds two new dental benefits and some pay-for-performance.

We are looking at enhancing county oversight and monitoring.

And we are looking at improving beneficiary contact and demographic information.

I am going to skip through those slides.

(Skipped slides 21-25 and resumed with slide 26.)

So one of the pieces in our proposal has a little bit more information than this one, we had to do a short version which sometimes can be hard for presentation purposes, but essentially this is a crosswalk of everything in the current Medi-Cal 2020 waiver and where it will go under CalAIM, if it has a home, and what that would be. We are also working on -- of our 22 proposals that we have in CalAIM, where the authority lies for that for people, so they have an understanding in regards to how that will be built. And there is a timeline for CalAIM as an appendix item as well, for those that are interested.

Just so people are aware how the Department is engaging in stakeholder engagement. We are very committed to stakeholder engagement on these proposals through 2019 as well as 2020.

We will be hosting five work groups. We solicited for those work

groups a few months ago. All work groups have anywhere from 25 to 31 individuals that will sit on them. All work groups are open to the public to call in to as well as to come in person. We will only be taking public comment at the end of those sessions in person instead of on the phone. We have hundreds of people calling in to them at this time and we just can't open up the lines for those comments. But for those that would like to comment and are not on a work group we will be accepting all comments into the CalAIM inbox which we have online and I have at the end of this presentation. And we will be getting information out to people about how to engage if you are not on a work group, how to participate. We have a schedule going out about every other week of where these meetings and presentations will be so people can stay informed.

You will see here the work groups that we do have focused on. It's really Population Health Management, Enhanced Care Management, In Lieu of, all the Behavioral Health stuff, NCQA and then the Full Integration pilots.

I think I pretty much said all of that. So I will stop there because I wanted to make sure we had time for any questions.

CHAIR GRGURINA: Questions from or comments from the Board Members?

MEMBER ROUILLARD: There is so much. (Laughter.)

MS. COOPER: I know. It's a really hard presentation to give, by the way, because it's a lot in a very short period of time.

MEMBER DEGHETALDI: Just a real fast -- I started medical school when Gerald Ford was president. This is the best presentation of how you take care of the whole person, I've ever seen. So this is ambitious, audacious and laudatory, so let me start there. Just really fast, a patient story.

MS. COOPER: Sure.

MEMBER DEGHETALDI: A 25-year-old graduate of the foster care system, a homeless person, presented to a local emergency room near death from an aortic valve that had been consumed by a bacteria associated with IV drug use. A two-month hospitalization, two months in a post-acute rehab program, homeless again, relapses in July with the same catastrophic, life-threatening heart valve infection. This is a managed Medi-Cal member. We desperately looked for a tertiary medical center in San Francisco, took him. They identified that the bacteria consuming his heart valve was of dental origin and he had seven dental abscesses that required extraction in an acute facility prior to his second valve replacement; he has again been lost to follow-up.

So it's foster care, it's homelessness, not behavioral health diagnosis, but substance abuse and dental disease that cost, you know, cost $1 million to care for. The systems received about $500,000 from Medi-Cal. But if this patient would have -- this patient, you described how we prevent this from happening.

MS. COOPER: Thank you.

CHAIR GRGURINA: Paul.

MEMBER DURR: I was just going to complement you on quite an initiative. I think it is very, as Larry said, very encompassing and I applaud the effort to really look at the whole person. It really is a meaningful effort to change the way we deliver health care to our most needy population. And I think you did a great job summarizing it as quickly as you could and I applaud the effort moving forward, it's fabulous work.

MS. COOPER: Thank you.

CHAIR GRGURINA: Did you want to comment, Amy or Jenny?

MEMBER YAO: No, my comment is, yes, it's a lot into my head. (Laughter.)

I do have a question, maybe for education for me. I know there is a big Medi-Cal procurement that's coming.

MS. COOPER: Sure.

MEMBER YAO: So with that -- you mentioned about regional rates, et cetera.

MS. COOPER: Yes.

MEMBER YAO: So it's not going to be -- this procurement is county-based, is it going to be more of the regional? What is the connection between the CalAIM --

MS. COOPER: Oh, just to be clear, we are not breaking down the COHS and allied model into regions.

MEMBER YAO: Oh.

MS. COOPER: It's just on the back end from a rate development on the regional part. For the mental health and SUD we are hoping to have regional contracting where some of our smaller, rural counties that are having trouble administratively meeting the need, them being able to contract at the county level for those services. So sorry if those terms were so -- at this time we are not proposing to regionalize Medi-Cal because of our distinct models within Medi-Cal. Sorry, good clarification.

MEMBER FLORY: I'll just say we're lucky this is the shorter version of this, some of us have seen this a couple of times. But we are thrilled as well, particularly with the focus on the whole person care. A lot of what is

proposed in here are solving a lot of the problems that we are seeing through our health consumer centers, particularly as folks leave like a hospital or something like that. Because they have so many other additional needs, how do we make sure that we are helping the whole person. So a lot of details going into this. I am happy to be in one of the work groups, but there is a lot of work to be done.

CHAIR GRGURINA: So I'll add, Jaycee, congratulations, an awful lot of great thought and thinking big as to what do we do going forward. So the piece that you can't answer, I am not asking you to answer, but having spent time at the state is, how are you going to get the resources to be able to execute to get all this done? And that is the piece I know you don't control.

MS. COOPER: Right.

CHAIR GRGURINA: It runs through the entire system. But there is a tremendous amount here that needs to be delivered and executed with a tremendous amount of input from folks on the outside to help you to make the best decisions. But congratulations on this going forward. And as you've identified, it isn't just 2021, it isn't just 2023, it isn't just 2025 or 2026, so a lot of work in here.

MS. COOPER: Right.

CHAIR GRGURINA: But something that an awful lot of pride could be put into and now it's time for us to get ready and try and see what we can bring as part of the vision, so thank you.

Any comments or questions from members of the audience?

Any comments or questions, operator, on the phone?

THE OPERATOR: I am currently showing no questions. As a reminder, if you would like to ask a question please press star-one.

CHAIR GRGURINA: Okay. Before you walk away.

MS. COOPER: Yes.

CHAIR GRGURINA: Very good movement with the quickness of each of the slides and the energy in which you did the presentation, it was very nice.

MS. COOPER: Perfect, thank you.

CHAIR GRGURINA: Thank you very much for coming here, Jaycee.

MS. COOPER: Of course.

MEMBER YAO: I had just one question. Can we get -- (laughter) -- no, no, just an electronic copy of this? Can we get it?

MS. COOPER: Of course.

CHAIR GRGURINA: Will it be on the website?

MEMBER ROUILLARD: It will be on our website.

MEMBER YAO: Oh, okay.

MS. COOPER: And there's a long version on DHCS' website too, so yes.

MEMBER ROUILLARD: It's a hundred and something --

MS. COOPER: There's the long proposal and then we have a PowerPoint that's a little longer than this one; this is the short version of the PowerPoint. I recommend the short version, the other one is really long.

MEMBER YAO: Okay, thank you.

CHAIR GRGURINA: All right, thank you, Jaycee.

MEMBER ROUILLARD: You'll need a binder.

MEMBER YAO: Okay. Kill some trees, okay.

CHAIR GRGURINA: Okay. Pritika, you are back up on the Federal Medical Loss Ratio Summary.

MS. DUTT: Thank you. Okay, I will provide you an overview of the 2018 annual Federal Medical Loss Ratio, which is MLR, reports that we received from health plans at the end of July of 2019. For this presentation please refer to the 2018 Federal Medical Loss Ratio Summary document that was included as part of the meeting handout.

So federal laws require health plans that sell health care products directly to enrollees and employer groups to spend a certain percentage of the premium dollars on health care or medical expenses. The MLR requirement went into effect for reporting in 2011.

For health plans in the small group and individual market they are required to spend 80 cents on every dollar of premium revenue on medical expenses, so that is 80 percent of premium revenues that go into medical expenses.

For the large group market the requirement is 85 percent, or 85 cents on every dollar that the large group plans receive in premium has to be spent on medical expenses. If the plans fail to meet this requirement they have to pay a rebate to the enrollees or employer groups.

For rebate purposes MLR is based on a three year average. For example, for reporting in 2018 the MLR and rebate calculation is based on the three year average of health care premiums and medical expenses for 2016, 2017 and 2018.

So page 2 of the report shows the MLR for the plans in the individual market. All plans that offer products in the individual market and are

subject to the federal MLR reporting requirement met the medical loss ratio of 80 percent so there were no rebates paid in the individual market. The MLR for the 12 plans in the individual market ranged from 81.7 percent to 98 percent.

Page 3 of the report shows the MLR for the health plans in the small group market. For the small group market the MLR requirement is 80 percent. For the 11 plans in the small group market MLR ranged from 77.2 percent to 104.4 percent.

Three plans, Aetna, Anthem Blue Cross and Blue Shield reported MLR below 80 percent and were required to pay rebates to enrollees and small group employers. Aetna reported an MLR of 79.3 percent and paid rebates of $911,000, Anthem reported an MLR of 77.2 percent and paid $61 million in rebates, and Blue Shield reported MLR of 79.7 percent and paid rebates of $9.6 million. The three plans had to issue the rebate checks by September 30, 2019. Rebates may be issued in a number of ways. Enrollees might receive a rebate check in the mail, a deposit paid in the account used to pay the premium or a direct reduction in future premium.

So Table 3 on page 4 shows the MLR for full service plans in the large group market. Twenty-one plans offered products in the large group market and the requirement here for MLR was 85 percent.

The MLR for the large group plans ranged from 84.8 percent to 119.4 percent. One plan was required to pay a rebate. Community Care Health Plan reported MLR of 84.8 percent and paid rebates of $94,000. So the plan has less than 10,000 enrollees in the large group market and all their enrollees are employees of the plan or its affiliated hospital.

So the next page, or page 5, shows the MLR of the specialized

health plans that offer products in the large group market. So there are four specialized plans that are subject to the federal MLR reporting requirement in the large group market. OptumHealth Behavioral Solutions of California did not meet the MLR requirement of 85 percent. The plan reported an MLR of 36.3 percent and paid rebate of $50,000. The plan only has 6100 direct lives. The plan has additional 1.5 million enrollees where they act as subcontractors to provide behavioral health services to enrollees of full service plans and there OptumHealth Behavioral Solutions is not subject to the MLR requirement for the subcontracted lives. The plan has been paying rebate since 2014 and we have noticed that their direct contracted lives has continued to decline. Last year they reported around 7,000 lives, this year it is 6,000, so the enrollment for OptumHealth Behavioral has continued to go down.

One of the trends we noticed for the specialized plans: In 2011 there were 7 health plans that were subject to the MLR reporting requirement, now we have 4. So of the 7 we had one plan that went out of business, the other 2 switched their business model to act as subcontractors to full-service plans and they were no longer subject to the MLR requirement, so of the 7 we have 4 left. So for the remaining plans we have noticed a decline in the enrollments since they started, so there is low enrollment in the specialized plans.

Page 6 shows MLR rebate trends for health plans since 2011. The rebates paid by health plans have fluctuated over the years. Health plans --

So one of the things is the health plans set their rates based on historical costs and utilization data, with the goal in mind to meet the MLR requirement. And that's one of the things we look at as we do our rate review process to ensure that the plan's project meeting the MLR requirement.

However, medical expenses are driven by how much enrollees utilize their health care benefits and provide a cost and this may vary year to year. And as such some plans go over the MLR requirement and some are under so they end up paying rebates for certain years.

With that I will take any questions.

CHAIR GRGURINA: Any questions from the Board Members? Larry.

MEMBER DEGHETALDI: Yes. Maybe this is for Amy. How do risk adjustment transfers factor into the MLR calculation? If a plan makes a large payment to another plan what does that do to the MLR calculation?

MEMBER YAO: It is counted in the calculation, it is part of the factor. So even with that I think Blue Shield still has a medical loss ratio above the 80 percent. So really the big risk adjustment payment which you received is actually related to the population we cover, so they are quite sicker.

CHAIR GRGURINA: Other questions?

MEMBER YAO: Just an observation. I think we probably -- I think the intent of this, we wanted people to price responsibly, you don't want to be creating this fluctuation. So I noticed, if we exclude the $61 million from Anthem Small Business, it looks like they overpriced and they had to pay a rebate, then the total rebate actually is pretty small. I don't know what happened in 2017. Do you know why it was so big, which health plan has a huge rebate for that year?

MS. DUTT: For 2016?

MEMBER YAO: For '17, the $72 million.

MS. DUTT: I think it was Anthem and Blue Shield made up the big amounts.

MEMBER YAO: Okay.

MS. DUTT: There were only two plans in 2017 that paid rebates, it was Anthem and Blue Shield.

MEMBER YAO: Okay. Okay.

CHAIR GRGURINA: Pritika, a couple of questions. The small group market, is that now 2 to 100, is that the definition of a small group?

MS. DUTT: Two to 100, yes.

CHAIR GRGURINA: And large group, is there a definition on that? Is that 2,000 and above?

MS. DUTT: No, it's over 100.

CHAIR GRGURINA: Anything over 100, okay. So the mid-sized groups are included with large groups.

MS. DUTT: Correct.

CHAIR GRGURINA: And then the third question is, I assume that this same analysis is happening over at the Department of Insurance on products over there but we just don't have the information of how much is being sent back there. Okay, thank you.

MS. DUTT: Thank you.

CHAIR GRGURINA: Any other questions or comments from Board Members?

Any questions or comments from members of the audience?

Operator, any questions or comments from folks on the phone?

THE OPERATOR: I am showing no questions on the phone line.

CHAIR GRGURINA: All right, thank you very much.

Okay, Pritika, you can remain up here to talk with us about the

2020 rates in the individual market.

MS. DUTT: All right. So the purpose of this presentation is to give you a brief overview of the 2020 rates for health plans in the Covered California individual market. For this presentation please refer to the 2020 Rates in the Individual Market document that was included as part of the meeting handout; there is only one table on here.

So the table on page 1 of the report displays the proposed and final rate increases as well as the estimated enrollment for 12 health plans that offer individual products. Eleven of these plans offer individual products on Covered California's Health Benefit Exchange program.

Sutter Health plan offers all non-exchange individual products. It has projected enrollment of 3,488 enrollees and an average annual increase of 4.9 percent.

As seen on this chart the average rate change ranged from a decrease of 9.9 percent to an increase of 16.5 percent, and I am looking at the final average rate increase. Overall, the average rate increase for 2020 was less than 1 percent so the average was 0.8 percent across all health plans. So this year the rate changes are driven by medical cost trends, changes in risk adjustment, administrative costs, anticipated changes in market rate health status of covered population.

So through the rate review process we were able to negotiate a reduction in rate change proposed by Chinese Community Health Plan from 19.6 percent to 16.5 percent, which equates to savings of $3.14 million. Chinese Community's high increase is mostly driven by change in the risk adjustment, so they had to pay a lot of funds back in risk adjustment transfer so that is one of

the drivers for their rate increase.

While the Department does not have the authority to deny rate increases the DMHC's rate review efforts hold health plans accountable, ensure consumers get value for their premium dollar and saves Californians money. So we are able to negotiate rate decreases with the plan if we see that their justification does not support their rate changes. Since 2011 through the rate review process we have saved consumers $255 million in premium savings.

So thank you, that brings me to the end of the presentation. Any questions?

MEMBER DEGHETALDI: Do we publish population risk scores for each of the health plans here? Because I suspect that some of the plans are caring for sicker populations. Is that, is that publicly available?

MEMBER YAO: I think the risk adjustment transfer report will have the relative risk score published as well.

MEMBER DEGHETALDI: Okay.

MEMBER YAO: So if you are interested we can get that information, I think.

MS. DUTT: So in the next presentation we did share the risk assessment transfer data.

MEMBER YAO: Yes.

MS. DUTT: So that gets published by CMS annually around June 30th of each year.

CHAIR GRGURINA: Pritika, this is -- the membership that you are showing is both Covered California and the individual market under DMHC?

MS. DUTT: Right, so this is on- and off-exchange enrollment.

CHAIR GRGURINA: Yes.

MS. DUTT: It does not carve it out.

CHAIR GRGURINA: Okay, thank you.

Any other comments or questions? Paul.

MEMBER DURR: Do you know, is the projected enrollment higher than where they currently are? So this is projected enrollment, I presume, for 2020?

MS. DUTT: Correct.

MEMBER DURR: And do we know how it compares to what 2019 enrollment is? Just curious.

MS. DUTT: We can pull that information for you.

MEMBER ROUILLARD: Isn't it true that some of the plans are expanding into new areas?

MS. DUTT: Correct.

MEMBER ROUILLARD: And that would impact, obviously, what the projected enrollment is too.

MS. DUTT: Yes. For 2020 Anthem is moving into additional counties so their enrollment, projected enrollment is way higher than what they are currently reporting for the individual market.

MEMBER DURR: I was thinking the individual mandate coming in also would increase that enrollment projection, so we did see -- that's what I was curious about.

MS. DUTT: Okay.

MEMBER YAO: We are going through open enrollment, right?

MEMBER DURR: Right, right now.

MEMBER YAO: So we don't know.

CHAIR GRGURINA: But also adding, Paul, to your comment, it's not just the mandate, it's also the additional subsidies that the administration is putting forward.

MEMBER DURR: Yes.

CHAIR GRGURINA: So the hope is that the individual market will increase as some folks who have remained out with an increased subsidy and the mandate will join, so that should help to stabilize Covered California and hopefully bring more folks into the individual market; but we will find out in a year from now.

MS. DUTT: So in the future we can add the current enrollment information, that way we can see if it is going to increase or decrease.

MEMBER DURR: Right. Thank you.

CHAIR GRGURINA: Okay, comments or questions from members of the audience? Anthony.

MR. WRIGHT: Just a question. I'm looking at the stats from the MLR report because they're really interesting and then this -- and I know that this is covered enrollees and this is projected. But is there a reason why in the -- like for example Kaiser was 698,000 in the MLR report but 566,000 in the rate report?

MS. DUTT: So we will have to go back and delve into it. So this includes the enrollees that are subject to the MLR reporting requirement. So we'll have to --

MR. WRIGHT: It could be --

MS. DUTT: We'll have to go look at that.

MR. WRIGHT: I appreciate it's just different sources, right. But if these are both individual markets or if there is something different. And also between that. So thank you.

MS. DUTT: Thank you.

CHAIR GRGURINA: Good catch, Anthony. The question becomes, what was Kaiser thinking? We will see and we will find out.

Other questions or comments from members of the audience?

Operator, any comments or questions from folks on the phone?

THE OPERATOR: I am showing no questions at this time.

CHAIR GRGURINA: All right, thank you very much.

Okay, Pritika, next. Let's move to the risk adjustment transfers.

MS. DUTT: All right, let's talk risk adjustment transfers. So I will provide you an update on the 2018 risk adjustment transfers. At the last meeting Shelley provided a summary of the risk adjustment transfer data that was just produced by CMS so for this presentation we are sharing the results with you. So please refer to the report titled 2018 Risk Adjustment Transfers and that is in your meeting handout. The risk adjustment transfer program is intended to transfer funds from the health plans with low actuarial risk to those with high actuarial risk.

Page 2 of the report shows the risk adjustment transfers for the 2018 benefit year for the DMHC plans. For benefit year 2018 a total of $101 million was transferred between the California health plans and insurers. Blue Shield and Anthem Blue Cross received the majority of the payments compared to the other 13 DMHC plans, so only two of our health plans received risk adjustment transfers; the other plans had to pay. So the risk adjustment

transfers represent an average of 8 percent of premium.

Page 3 of the report shows the high-cost risk pool payment for the DMHC plans. For 2018 CMS added a high-cost risk pool program to the risk adjustment transfer methodology. The high-cost risk pool helped ensure that the risk adjustment transfers better reflect average actuarial risk while also providing protection to issuers of health plans and insurers with exceptionally high-cost enrollees. The California health plan insurers received additional $115 million via this new program, $103 millon of those went to the DMHC-licensed health plans.

To fund these payments the high-cost risk pool collects a charge from the health plans and insurers that participate in the risk adjustment transfer programs and it is a small percentage of the premium of these plans. The high-cost risk pool charge was 0.2 percent of premium for the individual market and 0.32 percent of premium for the small group market nationally.

The high-cost risk pool reimburses issuers for 60 percent of an enrollee's aggregated paid claims costs exceeding $1 million.

So the next two pages of this report shows the risk adjustment transfer and high-cost risk pool payment for CDI insurers. Overall it appears that the DMHC-licensed plans are transferring funds to CDI plans in the risk adjustment transfer programs, demonstrating that CDI plans have a higher risk than our plans except for Blue Shield and Blue Cross. Both Blue Cross and Blue Shield offer PPO products, which kind of ends up showing that the HMO plans are transferring risk adjustment transfers to the PPO plans.

And that brings me to the end of this presentation, do you have any questions?

MEMBER YAO: So maybe I can answer Larry's question. I didn't see the relative risk score here. I don't know everybody's but at least for Blue Shield our population is 18 percent sicker than the California average.

MEMBER ROUILLARD: Eighteen percent?

MEMBER YAO: Eighteen, yes.

MEMBER DEGHETALDI: You know, my take on this, if it really reflects variation in population risk it's great policy. And so I think going forward showing the population risk -- but getting back to, Shelley, the encounter data work. I think that all of these transfers are based on diagnosis coding and accurate encounter data to capture. So if we don't appropriately code and identify how sick an individual is then this data, this work is incomplete. Is that a correct statement? I think that accuracy and completeness of encounter data, appropriately measuring how sick every individual person in the risk pool is, is essential.

MEMBER YAO: Yes, I'm in agreement.

MEMBER ROUILLARD: You know, that's a good point. To Pritika's point about, you know, observing the HMOs are paying for the PPOs. Of course in the PPO world you get claims and it's really, it's much more robust data than you have on the HMO side. So if we can get that more accurate, more timely, complete, it may not be such a dramatic shift of money from HMO to PPO, but we'll see. It's a few years down the road.

MEMBER DURR: I agree with that because that's where I was going, Shelley. The other thing that makes me think about the HMO plans, there's a lot more coordinated care effort that is going there, so you would think that there is better management of patient care so they are not getting as sick.

That is less for the PPO plan. Also that the sickness is going to be more on those PPO plans as well.

CHAIR GRGURINA: One question. Maybe, Amy, this will be for you. On the high-risk pool payment as Pritika described it. There is a percentage that comes from each of the plans in the individual market and the small group market and they try to do an assessment. At the end of the day they are going to have to pay everything over $1 million dollars up to 60 percent. What happens if what they collected isn't enough to cover all the costs? Do they come back to the plans and ask for more or do they pay those who are getting the payments less because there wasn't enough in the pool, or do you know?

MEMBER YAO: Honestly, I don't know the answer to that question.

MS. DUTT: It's a new program so we can dig deeper to find that information.

CHAIR GRGURINA: Okay.

MEMBER YAO: When I looked at this data I didn't see -- like for Kaiser, they are -- in general they are paying into the pool, that means their population is healthier. But then when you look at the high-cost risk pool they are the second-highest receiver. It's a little bit contradictory to each other so I don't know how they determine that.

CHAIR GRGURINA: Well part of that has to do with, remember, how many members they have compared to the others. And because they have got a very large piece, what percentage of their members are hitting into the high-risk.

MEMBER YAO: That's true, they could have some --

MEMBER ROUILLARD: They're almost 9 million people.

CHAIR GRGURINA: Although I would say, for those of us who have been around a very long time, while risk assessment and adjustment isn't perfect, and as Larry and Paul raised there are some issues, this is far better than the days where there weren't standardized benefits, there wasn't risk adjustment and it was kind of more of a free-for-all. So it was important to be able to have this. It is important to continue to fine tune it and make it a better process, but it does allow those who have the sicker risk to get higher payments, and those who have captured the healthier to spin some of those dollars back to those that have those with the high-risk.

MEMBER YAO: I would just add one more comment. If we don't risk adjustment it's likely Blue Shield is not going to offer PPO benefit, so the risk adjustment actually enhanced the choice for all members.

MEMBER DEGHETALDI: Amy, because you can't say this, I would just like to thank Blue Shield for doing the lion's share of caring for the sickest Californians.

MEMBER YAO: Thank you.

CHAIR GRGURINA: Okay. Any comments or questions from members of the audience on the risk adjustment transfers?

MS. DUTT: Okay. So I would like to circle back on Anthony's question about the variation in enrollment for Kaiser between the MLR report and the Covered California projected lives for the individual market. So one of the reasons is the MLR information includes the grandfathered lives as well and, you know, the rate information, the 2020 rate information does not.

CHAIR GRGURINA: Very nice to see that you were multi-tasking and now you have set up the expectation --

MS. DUTT: I have a very --

CHAIR GRGURINA: -- that when you don't have the answer we'll expect it in about ten minutes (laughter).

MEMBER ROUILLARD: She has a roomful of people there.

MS. DUTT: I have very smart people behind me.

CHAIR GRGURINA: The smartphones working out in the chairs. Thank you very much. (Laughter.)

Do we have any comments or questions from the folks on the phone, operator?

THE OPERATOR: I am showing no questions at this time.

CHAIR GRGURINA: Okay, all right. Well thank you very much, Pritika.

MS. DUTT: Thank you.

CHAIR GRGURINA: All right, Michelle, you are up next on the Provider Solvency Quarterly Update, welcome.

MS. YAMANAKA: Thank you. Michelle Yamanaka, Supervising Examiner within the Office of Financial Review.

Today I am going to give you an update on risk bearing organization or RBO financial reporting for the quarter ended June 30th of 2019.

We have 188 RBOs reporting financial information to the Department.

The annual reports are required to be submitted by all RBOs 150 days after their fiscal year end. To date we have 3 RBOs that have filed. A majority of the RBOs have fiscal year end of December 31st and those financials will come in in 2020.

For our quarterly reporting, two types of reports. The Quarterly Survey Reports, which are the financial statements and calculation of the solvency criteria. Those reports are filed when RBOs have more than 10,000 enrollees assigned to them or they are on a corrective action plan.

And Compliance Statements are filed by RBOs that have under 10,000 lives assigned to them and they are attesting to meeting or not meeting the solvency criteria.

So for the quarter ended June 30th of 2019 we have 129 RBOs filing financial survey reports and 59 RBOs filing compliance statements.

For monthly reporting there are 5 RBOs that are filing monthly with us as a result of -- as a requirement of their corrective action plans.

MEMBER ROUILLARD: Michelle, could I pause you there for a second?

MS. YAMANAKA: Yes.

MEMBER ROUILLARD: Under the new RBO regulations isn't the reporting going to change for the 10,000 and under?

MS. YAMANAKA: Yes, that is correct. So effective October 1st of 2019 all RBOs will be filing quarterly survey reports, there will no longer be the compliance statement option. And those, the first filings will be received in -- hold on, let me think for a second. So it will be for the December 31st, 2019 period, which is due February 15th. So those new financial statements -- the financial survey reports have been enhanced. So we will be having additional financial information provided to the Department so we will probably have additional information for you come the -- when we receive those financial filings.

MEMBER ROUILLARD: Yes. So our next -- our 2020 meeting is

February 5th, you won't have it for that, so it will be for the next one.

MS. YAMANAKA: No, it will be for the May, the May meeting, yes.

MEMBER ROUILLARD: Okay, got it.

MS. YAMANAKA: Okay, moving on to the financial reports that we received. The last column on this table shows the results for the quarter ended June 30th, 2019 and it shows that we have 181 RBOs reporting compliance with the solvency criteria. The Department has three categories that can be assigned to each survey report and those are Superior, Compliant or Non-Compliant.

For the quarter ended June 30th we have 44 RBOs or 23 percent of the RBOs submitting a Superior filing and this includes one RBO on a corrective action plan, 70 RBOs in our Compliant category, and there are 5 RBOs on corrective action plans in this category and 8 RBOs on our monitor closely list. And we have 7 RBOs or 4 percent of the RBOs reporting non-compliance with the solvency criteria.

Moving on to corrective action plans. Again the last column of this table are the results for the quarter ended June 30th, 2019 and it shows that we have 17 corrective action plans.

We have 3 new corrective action plans that were filed for quarter ended June 30th, 2019 and 14 continuing RBOs or corrective action plans from the previous reporting period. And of those 14, 13 are meeting or are improving and there was one RBO that was not meeting their corrective action plan. For that one RBO we received revised projections and it shows that the RBO will meet its compliance date of September 30th of 2019.

There was a handout titled CAP Review Summary. This handout is sorted by MSO and reflects the duration of our CAP monitoring as of the quarter

ended June 30th, 2019. The table shows that there are 14 RBOs that filed 17 CAPs. We have three RBOs on two corrective action plans. And this represents 7 percent of all RBOs.

Of the 17 CAPs, 11 are approved; 6 are in review, and of those 6, 4 are continuing from a previous period and 2 are new as of June 30th, 2019.

The Office of Financial Review conducts an analysis of RBOs that have Medi-Cal lives assigned to them. As of the quarter ended June 30th we have approximately 3.9 million Medi-Cal lives assigned to 92 RBOs. We took the top 20 RBOs and it showed an estimated of almost 2.9 million lives assigned to those 20 and the remaining 1 million lives are assigned to 72 RBOs. So for the top 20, 3 of those RBOs are on a CAP, 3 are on our monitor closely list and 14 had no financial concerns.

Looking at the remaining 72 RBOs that have 1 million lives assigned to them, we have 5 RBOs on a CAP, 4 are on our monitor closely list and 63 have no financial concerns.

The Office of Financial Review also conducts financial and claims and provider dispute audits of RBOs. For the year 2019 we have 24 audits scheduled; 11 of those have been completed and there are 13 in progress. Of those 13, field work has been completed on 5 and we are going to be starting or are currently in process of the 8 that are scheduled.

And with that, are there any questions?

CHAIR GRGURINA: Paul.

MEMBER DURR: I just want to make a comment that looking at the status of risk bearing organizations for the quarter ending June 30th, it's the highest of all the Superior groups. So 23 percent of the groups are in the

Superior, which is the highest it has been; and looking at the Non-Compliant, that's one of the lowest at 4 percent. So I think it tells that the groups are improving on their overall financial.

MS. YAMANAKA: Yes. Right now as of June 30th, just looking at the financial health of the RBOs -- well, the ones that we can see. And I'm talking about financial survey reports.

MEMBER DURR: Right.

MS. YAMANAKA: They look well. And also for our corrective action plans there's the non-financial indicators as well as the financial. So the ones that are for TNE working capital cash to claims, those RBOs are doing -- they are definitely improving. There was just some indicator which could have -- it's showing a financial indicator but there are other reasons for non-compliance and they are, they're addressing those issues. And for the ones that have had concerns, and there has been a little bit of consolidation as well in those areas, yes.

MEMBER DURR: Thank you.

MEMBER FLORY: Just one question on the audits because it's showing like 24 a year. Does that mean that they are like periodic, every 7 or 8 years an RBO gets audited, or is it some -- something triggers that?

MS. YAMANAKA: That would be the -- that would be every 7 to 8 years just because of the staffing that we have.

MEMBER FLORY: Okay.

MS. YAMANAKA: However, the way we conduct our audits we have to -- because there are a set number of examiners and we have other workload, which is the financial review on the CAPs, we kind of prioritize. We do

a priority, for example. If there is a need to go out we will set those at the upper end of the need to go to make those a priority, yes.

MEMBER FLORY: Okay.

CHAIR GRGURINA: Any other questions from the Board Members?

Questions from members of the audience for Michelle?

Operator, any questions or comments on the phone?

THE OPERATOR: I am currently showing no questions. I would like to remind participants, if you would like to ask a question over the phone line to please press star-one.

CHAIR GRGURINA: Thank you. All right, Michelle, thank you very much.

MS. YAMANAKA: Thank you.

CHAIR GRGURINA: Okay, Pritika, you are back up. Apparently your break is over.

MS. DUTT: This is the last one, John, so good afternoon.

The purpose of this presentation is to provide you an update of the financial status of health plans at quarter ended June 30th, 2019.

At September 27, 2019, that's the date of the data pool, we had 127 licensed health plans, which is 2 more compared to the same period last year. We licensed 3 additional full service plans, one Medicare Advantage, one restricted Medi-Cal and one restricted Medicare Advantage. And one vision plan surrendered its license so that brings the total to 127.

We are currently reviewing 14 applications for licensure and I think that's the most it has been for a while. So 9 full service and 5 specialized. A

breakdown on the 9 full service, 5 are seeking licensure for Medicare Advantage plans, to be Medicare Advantage plans, 3 are looking to be restricted Medicare Advantage plans, 1 is looking to be a restricted commercial plan. And for the five specialized applications in review, 2 are looking to get licensed for Dental products and 2 are looking to get licensed for Behavioral Health looking at EAP, which is Employee Assistance Programs, and then 1 restricted Vision. So our licensing review team is a little bit busy.

At June 30th, 2019 there were 26.3 million enrollees in full service plans licensed with the DMHC. As you can see on the table, compared to the same period last year, total full service enrollment decreased by 200,000 enrollees, which was less than 1 percent decrease. And the decline was due to a slight decrease in Medi-Cal enrollment.

This slide shows the makeup of HMO enrollment by market type. The large group HMO enrollment had the largest increase, so there are more enrollees that receive health care benefits through their employers. The small group enrollment also slightly increased. The individual market saw a slight decrease in enrollment, they lost about 10,000 enrollees June 30th, 2019. So overall HMO enrollment increased when compared with the same period last year.

So this slide shows the makeup of PPO/EPO enrollment. So right now we are not getting our PPO enrollment broken out separately. That's something we are looking at getting in the future, but right now we are getting a combined number. And as you can see on the table, the total PPO/EPO enrollment has been on a declining trend. Over the last four years PPO enrollment has declined by 400,000 lives. However, as I mentioned earlier, even

with a decrease in PPO enrollment, commercial enrollment has been on an increasing trend.

So this table here shows the government enrollment, which is Medi-Cal and Medicare Advantage enrollment. Overall government enrollment decreased and that is driven by a Medi-Cal enrollment decrease of 250,000 lives, while plans with Medicare enrollment experienced slight increases, adding about 40,000 lives. We saw similar trends when we presented the March 31st, 2019 information at the last FSSB meeting.

We are currently monitoring 31 health plans closely due to various reasons. So last quarter it was 32 so we have one that fell off.

So the reasons for a plan being on monitor -- that we monitor closely are their declining financial health, issues with claims processing system or if a plan is going through a claims system conversion. And then there's issues that we identify during our financial audits. If a plan is newly-licensed it takes a while for them to break even so we watch them closely. We also, as I had mentioned earlier, we also look at the parent entity financials, and if we have concerns with the parent entity financials we will place these entities, the plans on the watch list. And then also if a plan has low enrollment we tend to watch them closely as well.

Compared to last year we have more plans on the watch list. A majority of the restricted health plans are on the watch list, either they are recently-licensed within the last couple of years or they have low reserves. So 13 restricted licensed health plans are on the watch list, so the breakdown is 5 of them are restricted for commercial enrollment, 5 are restricted Medicare Advantage and 3 are restricted Medi-Cal. So for the restricted licensees, they do

not contract directly with enrollees, employer groups, CMS or DHCS, they get their enrollment through contracts with other full-service plans who directly contract with employer groups, CMS or DHCS. So a majority of the restricted licensees come from the RBO world where the reserve requirement is significantly lower.

So this chart shows the enrollment for the plans on the watch list at June 30, 2019.

The total enrollment for the closely monitored full service plans is 7.5 million. Of the 29 closely monitored full service plans 13 are -- as I mentioned earlier, 13 are restricted licensees.

The total enrollment for the specialized service plans is 120,000 lives. For the two specialized plans one is a behavioral and one is a dental plan.

So this chart here shows the plans that were TNE deficient at quarter ended June 30th, 2019. So we had two health plans that reported deficiency with the Department's minimum TNE requirement. Chinese Community Health Plan cured its TNE deficiency within five days of getting a notification letter from the Department. So when we see a plan that reports a TNE deficiency we send a letter out to the plan and tell the plan to cure the deficiency within five days. So Chinese Community responded and the parent entity put in the money to cure the deficiency right away.

Vitality Health Plan of California, which is a Medicare Advantage plan with around 9,000 lives. So Vitality first reported non-compliance with the TNE requirement at year-end December 31st, 2018. So it's a newly-licensed plan, the plan went operational on January 1st, 2019. The plan is on a corrective action plan with the Department and is currently providing weekly progress

reports to the Department. We are working with the Office of Enforcement and CMS on this issue.

So this chart shows the TNE of all plans by enrollment category. Sixty-seven health plans, or over half of the total licensed health plans reported TNE of over 500 percent of required TNE.

This chart here shows the TNE of health plans by line of business. A majority of the health plans with over 500 percent of required TNE are specialized plans, so 34 of the 67 are specialized plans. This is because the required TNE is higher for full service health plans because they are at risk for higher medical costs or medical expenses. For most plans the TNE is driven by medical expenses. The higher the plan's medical expenses the higher the reserve requirement is.

This chart shows TNE by enrollment for the plans that are being closely monitored. Three plans over 300,000 lives have more than 500 percent of TNE.

This chart shows the TNE by line of business for plans that are being closely monitored. So four of the health plans on the watch list have greater than 500 percent of required TNE. So these plans are on a watch list because we have had claims processing issues that were identified during our last exam or if we receive an uptick of provider complaints at our provider complaint unit, we have whistleblower complaints, so there are various reasons for these plans to be on the watch list.

So currently we have 22 health plans on a corrective action plan as a result of our routine financial exam or any other financial issues that we have with these plans. So most of these CAPs are due to claims processing issues

identified during the exams.

On average we complete 47 exams each year. For fiscal year 2018/19 we have completed 47 routine examinations. For fiscal year 2019/2020 so far we have completed 11 exams, 18 are currently in progress and 19 are scheduled to start sometime this year.

And this brings me to the end of the presentation. Any questions?

CHAIR GRGURINA: Questions from the Board Members? Jen.

MEMBER FLORY: Not a question but just a comment. Thank you for putting both the total commercial and the government enrollment together because we are aware of the decline in Medi-Cal enrollment and it is interesting to see they are not all being picked up in the commercial market. We have had some speculation whether that's the individual mandate and people just not keeping up their Medi-Cal; and then we are also hearing from immigrant communities that people are actively disenrolling because of public charge concerns.

MEMBER DEGHETALDI: I had a question on as we go forward into DSNP mandates for managed Medi-Cal I wonder if we should start to track duals in our managed Medi-Cal plans? Because I am not sure where they fit today. Are they in Medi-Cal or Medicare Risk?

MS. DUTT: They are in Medi-Cal --

MEMBER: They're both.

CHAIR GRGURINA: They're dual. You're going to count the dual as yours as Medi-Cal, but then you're going to have them on the DSNP side as well.

MEMBER DEGHETALDI: Okay.

MS. DUTT: So for our -- for reporting purposes we have instructed the health plans to report it under Medi-Cal.

MEMBER DEGHETALDI: I would like to see them broken out because I think a fifth of Californians on Medicare are Medi-Cal-eligible and it's a huge opportunity and risk.

CHAIR GRGURINA: I think when we eventually get to that day there's going to be several reports we are going to be asking for.

MEMBER DEGHETALDI: Okay.

CHAIR GRGURINA: Not just membership but it's also going to be financially --

MEMBER DEGHETALDI: Yes.

CHAIR GRGURINA: -- how are the plans doing that have been mandated to enter into that marketplace.

MEMBER DEGHETALDI: Right.

MS. DUTT: So, Larry, we are not currently collecting that data.

MEMBER DEGHETALDI: Okay.

MS. DUTT: But as we are enhancing our enrollment reports we can keep that in mind.

MEMBER DEGHETALDI: Sure. It's not important right now but as we do this. And will the COHS be required to be Knox-Keene licensed if they are in a DSNP plan?

MEMBER ROUILLARD: Don't know.

MEMBER DEGHETALDI: Don't know. Okay.

CHAIR GRGURINA: Any other questions from Board Members for Pritika?

Any questions from members of the audience?

Operator, any questions or comments from folks on the phone?

THE OPERATOR: I am currently showing no questions at this time.

CHAIR GRGURINA: All right, thank you.

Thank you, Pritika.

MS. DUTT: Thank you.

CHAIR GRGURINA: Okay. I think next up on the agenda is the 2020 meeting schedule.

MEMBER ROUILLARD: Right.

CHAIR GRGURINA: And we'll have Shelley do that because I believe Mary went off to do other work in her acting role.

MEMBER ROUILLARD: Right, she did. Yes, she did, she did.

So in your packets you've got proposed meeting dates for next year, February 5th, May 13th, August 19th, November 18th. I expect that we will be meeting on the fifth floor of this building because we are having renovations done in one of our large meeting rooms up there that we are hoping will accommodate the FSSB in the future; but we will notify you of that in plenty of time. But it's still going to be in this building one way or another.

CHAIR GRGURINA: Okay, thank you.

Any comments from members of the audience for matters that were not on the agenda?

Any public comments from folks on the phone, operator?

THE OPERATOR: I am showing no questions at this time.

CHAIR GRGURINA: All right, thank you.

All right, the next item is to ask the Board Members, are there any agenda items for future meetings you would like to see?

I think given that none of us are coming forward, Shelley, your team and you have done a nice job of adding many items at these meetings (laughter) that I think you've got it taken care.

MEMBER ROUILLARD: Yes. More to come.

CHAIR GRGURINA: And then I think Larry just highlighted one for the future, which is, as we move down into 2022 and closer to 2023, all of the changes that are coming down the pike for the health plans. There should probably be some more reporting and taking a look at how things are going.

MEMBER ROUILLARD: Okay.

CHAIR GRGURINA: With that we are ready to close. It's hard to believe we are already at November 7th. We won't see each other until February so wish you a Happy Thanksgiving, Happy Holidays and a great New Year and we'll see you in February.

And a special thank you to the staff at DMHC who puts this together for us.

MEMBER ROUILLARD: Thank you.

(The meeting was adjourned at 12:20 p.m.)

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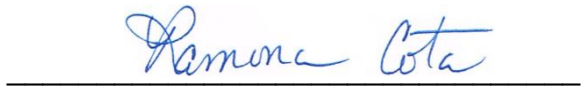
CERTIFICATE OF REPORTER

I, RAMONA COTA, an Electronic Reporter and Transcriber, do hereby certify:

That I am a disinterested person herein; that the foregoing Department of Managed Health Care, Financial Solvency Standards Board meeting was electronically reported by me and I thereafter transcribed it.

I further certify that I am not of counsel or attorney for any of the parties in this matter, or in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 29th day of November, 2019.



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