STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

DEPARTMENT OF MANAGED HEALTH CARE

980 9th STREET, 5th FLOOR

SACRAMENTO, CALIFORNIA, 95814

WEDNESDAY, OCTOBER 16, 2024

10:00 A.M.

Reported by: John Cota

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APPEARANCES

BOARD MEMBERS

Jeff Rideout, MD, Chair

Abbi Coursolle (participated virtually)

Paul Durr (participated virtually)

Mark Kogan, MD (participated virtually)

Mary Watanabe

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations

Sarah Ream, General Counsel

Shaini Rodrigo, Staff Services Analyst

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

William "Bill" Barcellona
America's Physician Groups

Beth Capell
Health Access California

Speaker

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PROCEEDINGS

10:01 a.m.

CHAIR RIDEOUT: Good morning, everybody. This is Jeff Rideout, I am Chair of the Financial Solvency Standards Board for the Department of Managed Health Care, and this is our Quarter 3 meeting of the FSSB, as it is known. We have a number of items to cover. The first item actually requires a quorum and we haven't quite got there yet so when other people join we will come back to Item 2 on the agenda.

So, I think with that I will make sure people are aware of the rules of the road, which are the important part of this. They go on a little bit long, but I want to make sure people have this in mind.

The meeting is being conducted in a hybrid format, as you can see with the opportunity for public participation in person or virtually through video conference or teleconference.

Please note the following for those joining us in person today: The restrooms on the floor are locked. The bathroom badges are on the table near the entrance to the room. Please make sure to return them to the table. Please silence your cell phones.

For our Board Members here in person, please do not join the Zoom meeting with your computer audio.

Questions and comments will be taken after each agenda item, first from the Board Members and then from the public. For those who wish to make a comment, please remember to state your name and the organization you are representing. If any Board Member has a question, please use the Raise Hand feature. All questions and comments from Board Members will be taken in the

order in which the raised hands appear. Public comments will be taken from individuals attending in person first. For those making public comments at the podium here in the front of the room, please be sure to leave your business card or write down your name and title and leave it on the podium so that our transcriber can accurately capture your information.

For those making public comments virtually, please use the Raise Hand feature.

For those joining online or via telephone please note the following: For members of the public attending online, as a reminder, you can use the Zoom meeting on your phone should you experience a connection issue. For attendees on the phone, if you want to ask a question or make a comment please dial *9 and state your name and the organization you are representing for the record. For attendees participating online with microphone capabilities, you may use the Raise Hand feature, and you will be unmuted to ask your question or leave a comment. To raise your hand, click on the icon labeled Participants on the bottom of your screen, then click the button labeled Raise Hand. Once you have asked your question or provided a comment, please click Lower Hand.

As a reminder, the FSSB is subject to the Bagley-Keene Open Meeting Act. The Bagley-Keene Act requires the Board meetings to be open to the public. As such it is important that Board Members refrain from emailing, texting or otherwise communicating with each other off the record during the Board meetings because such communications would not be open to the public and would violate the Act. We also ask that you do not use the Zoom Chat feature as these comments or questions may not be viewable by the public.

Likewise, the Bagley-Keene Act prohibits what are sometimes

referred to as serial meetings. A serial meeting occurs if a majority of the Board Members email, text or spoke with each other outside of a public FSSB meeting about matters within the Board's purview. Such communications would be impermissible, even if done asynchronously. For example, member one emails member two, who then emails member three. Accordingly, we ask that all members refrain from emailing or communicating with each other about Board matters outside the confines of the public Board meeting.

So, those are the rules of the road. Any comments or questions before we move on?

Okay. I will check attendees, but let's go to, Mary, your Director remarks.

MEMBER WATANABE: Thank you, Jeff. I will just start by saying thank you for the Board's flexibility in moving our meeting date up a little bit so we are not meeting right after the election. It does mean that this is our last meeting of the year.

I do want to take just a moment to thank Shaini Rodrigo who has provided administrative support for these meetings for a number of years, who this is her last meeting, but appreciate her support and wish her well in her next adventure. So, thank you, Shaini. Yes, thank you. I do want to -- go ahead. All that work that goes on behind the scenes to make sure the logistics are smooth for us means a lot.

I will just share another exit. I think many of you are aware of this, but Secretary Mark Ghaly left our Health and Human Services Agency at the end of September, and Secretary Kim Johnson, who was previously the Director of the Department of Social Services, is officially our new Secretary. So, I look

forward to working with Secretary Johnson. I just wanted to make sure you all are tracking that news.

I also have a couple of enforcement actions that we have announced since our last meeting that I wanted to go over quickly with you. The first is last week we announced a $35 million settlement agreement with L.A. Care. You may remember, in early 2022 we announced a historic enforcement action against the largest Medi-Cal plan for violations including handling of enrollment grievances, processing requests for authorization, inadequate oversight, and supervision of its contracted entities regarding timely accessing claims payment issues. L.A. Care has agreed to pay $13.5 million in a financial penalty and contribute $21.5 million to initiatives focused on health equity, Cal-AIM and behavioral health. They also have a similar settlement agreement with the Department of Health Care Services and will pay, be paying a $13.5 million financial penalty and investing $6.5 million in their community in L.A. County. So, a total of $27 million in financial penalties and $28 million in community contributions.

I just want to take a moment to acknowledge our Office of Enforcement, our Office of Plan Monitoring and Pritika's team in the Office of Financial Review for the work that they have done on this. Some of this work actually dates back to 2017, so this has been in the works for quite some time. So, appreciate the hard work on my team to get us to a settlement agreement and to L.A. Care for their cooperation so we could finally put this one to bed and get to work fixing these issues and making the community investments.

At the end of September, we also announced that Anthem Blue Cross has agreed to pay $8.5 million for failing to address claims payment

disputes in a timely manner. These were disputes from doctors, hospitals or other health care providers. This enforcement action was in response to referrals from our provider complaint section out at our Help Center. I know we don't often talk about the work we do at our provider complaint section, but I think this is really significant for providers who have payment dispute issues, and really for ensuring stability of our health care system.

And then finally I wanted to share one other enforcement action which was in August. We announced an $850,000 fine against Anthem Blue Cross for wrongfully denying requests for gender affirming services. The plans have agreed to change their policies to comply with the law and ensure members receive medically necessary care. The plan has also agreed to retrain clinical review staff and dedicate a full time case manager to address the needs of the health plan members diagnosed with gender dysphoria.

As you may recall, we had our transgender, gender diverse or intersex working group meeting over the last couple of years, and I think it really just highlighted the challenges this community faces both in discrimination but just in accessing gender affirming services. So, I really just want to acknowledge the great work that my team has done to reach this enforcement action and the settlement agreement here with Anthem Blue Cross.

On a related note, I want to share that in September we launched our TGI web page on our website. This includes resources for TGI individuals such as what gender affirming care should be covered by plans, how to contact the Help Center, and a wide range of both state and federal resources and protections on that website as well. So, I want to acknowledge Amanda Levy who did a fantastic job under some pretty short time frames to get that web page

up and launched. Thank you, Abbi, acknowledging that great work. It is a really great resource. It will be a living, breathing web page. I am sure we will make changes and updates and add new information. So, I would encourage you to take a look. If there's anything missing or any changes please reach out to Amanda and we will do that.

And I will just share maybe, I think at our last meeting I provided an update on the work we are doing to set new Essential Benefits and a new Benchmark Plan in California. Just wanted to share that that work is ongoing. We are likely going to have a public meeting before the end of the year to share some of the analysis that has been done and give an update. So, I will have an update for the Board, likely at our next Board meeting as well.

And with that, I would be happy to take any questions from the Board or the public. Go ahead, Paul.

MEMBER DURR: Yes, Mary, so just a question. So, it is great the enforcement actions. Do you routinely have a number of those in progress, and do you have the appropriate staffing necessary to manage through that? So, these are the ones that obviously you can make public because it is settled, but obviously there's more that you and the team are working on that cannot be made there. Just want to make sure that you have the appropriate staffing to do that. I mean, going back to 2017, that's a labor of love, as I was mentioning earlier, and we appreciate that from certainly the provider side. But just wanting to make sure that you have the support that you need.

MEMBER WATANABE: Yes, no, I appreciate that. I think I will say yes. I think right now we do have the resources that we need. I think we always have some challenges, particularly filling some of our attorney classifications just

because of our wages. But I am actually really excited. Our Office of Enforcement, I want to say, has at least tripled in size in the last few years as we have had new legislation that has actually strengthened our authority. I will say we have had a number of very large, significant enforcement actions with historic penalties. I think L.A. Care is an example as well as Kaiser. The size of these cases and the number of issues. It is truly a team effort. With L.A. Care it was a team effort, not just with our Office of Enforcement, but also with our Office of Plan Monitoring and Pritika's team in Financial Review.

So, you know, at any given time we have a lot on our plate in our Office of Enforcement, so they are always busy. But I think, you know, the good news is we are getting some of these bigger, significant matters wrapped up. There will be ongoing, obviously, oversight and monitoring. But I think as long as we can fill the positions we have got we are in a good position.

CHAIR RIDEOUT: I notice that Mark and members of the Board have joined. Do either of you have questions? And we will cycle back to a proper introduction after we are done with this section.

Hearing none we will take questions from the public in the room.

Hearing and seeing none, any questions on the phone?

No. Okay. So, that concludes the Director's Remarks unless you wish to say anything else, Mary.

MEMBER WATANABE: I don't. I think we have an agenda item on Board Member Solicitation, but I can do that after we do the introductions and the minutes.

CHAIR RIDEOUT: Okay. So, we will go back to the top. I want to have the members of the Board introduce themselves formally. So, Paul, if you

want to give just your background and your title.

MEMBER DURR: Sure. Paul Durr, glad to be here. I am CEO of Sharp Community Medical Group. We are an Independent Physician Association in San Diego. Thank you.

CHAIR RIDEOUT: Abbi.

MEMBER COURSOLLE: Hi, thanks. Abbi Coursolle, she/her pronouns. I am a Senior Attorney with the National Health Law Program and also with the Health Consumer Alliance. We do consumer health care advocacy around the state, and I am based in Los Angeles.

CHAIR RIDEOUT: And Mark. And I think, Mark, you are on call today, if I remember.

MEMBER KOGAN: Yes, I am. Mark Kogan, I am a private practice gastroenterologist in Berkeley, on call at Alta Bates. And I will apologize ahead of time, I know for sure I am going to have to leave in about 15 to 30 minutes but hope to be back on at some point as well.

CHAIR RIDEOUT: Okay. That gives me motivation to get the minutes and the transcript approved. So, let's take the transcript first. Were there any corrections on the transcript from Board Members? I had none.

Okay, hearing none could I get a motion to approve the transcript?

MEMBER DURR: Motion to approve.

MEMBER KOGAN: Second.

CHAIR RIDEOUT: Any opposition to that?

Okay, hearing none the transcript is approved.

And then also there was the meeting minutes. They actually go by meeting summary. But any corrections to that?

Hearing none could I get a motion to approve the meeting summary.

MEMBER DURR: Motion to approve.

MEMBER KOGAN: So moved.

MEMBER COURSOLLE: So moved.

CHAIR RIDEOUT: Second? Okay, second from Abbi.

All right, any opposition?

Okay, those are approved.

So, we are now on to Board solicitation. Mary.

MEMBER WATANABE: Yes. So, I think I alluded to this a little bit at our last meeting. Let's see. Make sure I get the bill number right. AB 2767 expanded our Board membership from 7 to 11 members and added two new categories, which include consumer advocates and individuals with training and experience in large health insurance purchasing. So, before the end of the year, probably within the next couple of weeks, we will be issuing a solicitation for Board Members, including anybody that meets these new categories.

And then we also have a number of Board Members whose terms are expiring, or their extension that I asked them to stay on is also expiring. So, Jeff and Paul, I think I asked you to stay an extra year, which would be through the end of this year, Abbi's term expires in January, so we are going to be looking for seven new members total. But I will just note that I have let Jeff, Abbi and Paul know that they are welcome to reapply if their interested in continuing on the Board. So, just wanted to make sure everybody is aware we will be looking for some new members in the new year. We don't necessarily need to fill all four of those new positions, but we certainly can if we have a good response. So, we

will make sure that gets out to our Listserv, to the Board Members and the various associations, but please reach out and let us know if you have any questions.

CHAIR RIDEOUT: Thanks, Mary. Any questions from Board Members on the solicitation? Paul, Abbi and I seem to have not stepped in it over the last year or so, so that's good.

Any questions from people in the room?

And any questions on the phone about the solicitation? Okay, none there. All right. We have covered that item.

We will now go to our main event. We will have Vishaal Pegany give us an update on the work that the Office of Health Care Affordability is performing. So, Vishaal, thank you for coming in person.

MR. PEGANY: Good morning, everyone. Vishaal Pegany, Deputy Director for OHCA, Office of Health Care Affordability. Glad to be here again before the FSSB. Before we, before I provide an update on OHCA implementation I just want to give you a brief agenda on the next slide.

You know, I'll provide an overview; ways to collaborate and engage with OHCA; and then also provide an overview of the Office; major accomplishments and milestones that we have achieved to date; and then what we have for upcoming goals and objectives.

And then on the next slide, we put this in almost every kind of overview deck that we have about HCAI's mission. It was updated in light of transitioning from OSHPD, the Office of Statewide Health Planning and Development, to a new department of Health Care Access and Information that better reflects the portfolio the responsibilities of HCAI. So, HCAI's mission is to

expand equitable access to quality, affordable health care for all Californians through resilient facilities, actional information, and the health workforce each community needs.

And then on the next slide you will see that we have several program areas, including a historic responsibility for ensuring compliance with seismic safety requirements of health facilities. We also manage several data assets, particularly the newly established health care payments data program. It is one that I want to highlight, which is California's All Payer Claims Database. Affordability is a new program area with the addition of OHCA to HCAI's portfolio. Later in the presentation I will cover progress to date on key milestones we have achieved.

And then on the next slide I just want to emphasize to both the FSSB and stakeholders that are listening in that OHCA has many forums to receive input from stakeholders. These include our public meetings of our Health Care Affordability Board-one more slide-and our Advisory Committee. OHCA has also convened an Investment and Payment Workgroup which provides input to OHCA on the delivery -- on the development, excuse me of primary care, alternative payment, model and behavioral health definitions, data collection processes and benchmarks.

Internally, we are also coordinating very closely with our sibling state departments to align on efforts for primary care, behavioral health, quality and equity, performance measurement and alternative payment model adoption goals. We do get a lot of questions from our stakeholders in terms of how are the departments aligning on efforts, so we do have a bimonthly forum where all the sibling departments get together to discuss common issues.

We also have the Total Health Care Expenditure Data Submitter Workgroup, which is a forum for data submitters to receive up to date information on submission requirements, troubleshoot data submissions and address any technical issues related to the data that we are collecting on total health care spending.

And then lastly, as needs for stakeholder industry input arise will convene additional technical work groups as needed.

And then these are just some of the cross-department work group members that we work with very closely.

Then on the next slide. And then one more.

You know, as many of you know, the office was established in July of 2022. We have three key responsibilities. One is to slow spending growth, two is to promote high value care, third is to assess marketing consolidation.

And with regard to our first key responsibility, we did accomplish a major milestone as shown on the next slide. So, in April 2024 the Health Care Affordability Board approved a statewide health care spending target for California. It is a 3% spending target for performance year 2029 and it is gradually phased in. The basis for the 3% target value is based on the average annual rate of change in historical median household income growth over a 20 year period from 2002 to 2022, which signals that health care spending should not grow faster than the income of California families.

So, you know, within the context of the spending target, the enabling legislation does require some coordination between OHCA and the state regulators for insurance with regard to consideration of the spending target during premium rate review. So, I have included the statutory text here. The

purpose of this language was to convey that those with health coverage should benefit from the intended impact of a spending target to slow the growth in health care costs. We are still in the early stages of implementation. We are working with DMHC on how we could implement the intent of this legislative tax so that we have a good feedback loop so that the spending target is considered during DMHC's work on premium rate review.

And then on the next slide there is parallel language shown for the Insurance Code.

And then moving on to the next slide, I wanted to just briefly mention that we also do have a program that looks at assessing market consolidation. So, we review proposed mergers and acquisitions within the health care delivery system. We monitor the impact of market consolidation and evaluate transactions that could hurt competition, access and affordability. And then depending on the nature of the transaction, we could refer it to appropriate regulators such as the attorney general for further action.

We have revised our regulations to strengthen our oversight of proposed transactions to ensure that entities do not evade the legislative intent to provide notice to the Office of a pending transaction.

We maintain a public list of notices we have received. We provide the status update on whether they are subject to a cost and market impact review.

And then on the next slide I included a few highlights on our work on APMs and workforce stability standards. This past June, our Board approved our APM standards and adoption goals. The standards and adoption goals are intended to move the health care system away from traditional fee-for-service

payments and towards value-based payments that incent equitable, high-quality and cost-efficient care. In the appendix to these slides there's more details on the APM standards and the different adoption goals we have for each market.

And then just touching on workforce stability. We are also charged with monitoring the effects of spending targets on the stability of the health care workforce. You know, with the goal that workforce shortages do not undermine health care affordability, access, quality and equity. So, to achieve workforce stability in the context of spending targets we have adopted workforce stability standards, which are also included in the appendix.

And then going on to upcoming goals. So, at the time that I sent these slides over to you, primary care benchmark was an upcoming goal. But hot off the press, the Board took action this past Monday to approve OHCA's primary care investment benchmark. The benchmark considers current and historic underfunding of primary care services and is intended to promote improved outcomes for primary care and sustained systemwide investment in primary care. More details about the benchmark are also in the appendix.

So, moving on to equity, quality and equity performance measurement. This fall we will be proposing a set of standard quality and equity measures for assessing health care quality and equity across health care entities. So, the purpose of this is that as OHCA is reporting on spending growth we are also reporting on quality and equity at the same time.

And then lastly, OHCA will define, measure and report on behavioral health care spending compared to primary care spending. This is an area that is less well developed, there is less foundational work done on definitions and data collection, so we will be breaking some new ground with

respect to measuring behavioral health care spending. We expect the Board to consider and vote on a benchmark for investment in behavioral health care sometime in late spring.

And then on the next slide just have a brief mention of our cost reducing strategies workstream. So, we have had health care entities come in and speak about the work they are doing to reduce costs while maintaining quality of care and improving equity. So, we have had health plans, hospital systems and physician organizations come and speak to the Board. So, we are actively always soliciting from organizations if they have any data or any findings about the impact of the work they are doing on cost.

And then on the next slide, just wanted to briefly mention our work on gathering data on total health care expenditures. So, we do have active regulations in place to collect data from payers. This fall, the first set of data was due September 1st. It was looking back at calendar years 2022 and 2023. And the purpose is to collect some initial data before the spending targets take effect. So, that we put out a report on essentially kind of a snapshot of what spending looked like before the targets take effect.

So, the data collection that we have done so far has primarily focused on payers. We do instruct the payers to do some provider level reporting by attributing spending to physician organizations with attributed lives. We outline a few attribution approaches in our data submission guide. And then we do also want to measure hospitals and measure how they are performing relative to the target. So, we have convened a hospital spending and measurement work group to provide input to OHCA on measurement and reporting for hospital spending.

And then on the next slide, this is just a brief recap of what we mean by Total Health Care Expenditures. So, it is essentially three buckets that we are calling Total Medical Expense. So, it is claims payments, non-claims-based payments such as capitation, and then cost-sharing obligations for members. And then we add those three up and get TME. And then the fourth one is Health Plan Administrative Costs and Profits. And then when we add TME and the fourth bucket together we get our Total Health Care Expenditures, which is the measure used to assess performance relative to the statewide spending target.

And then as I mentioned earlier, the TME approach to measure spending works pretty well for payers and physician organizations with attributed lives. So, OHCA will need additional strategies to better understand hospital spending across all patients. So, we are able to capture some hospitals that have a physician organization attached. We are able to know what their spending is for the attributed lives that are part of the health system. But we want to have an ability to measure spending for standalone hospitals that may not have a physician organization that is affiliated or owned or under corporate ownership.

So, the next slide visually conveys this point. So, at the highest level, OHCA will measure total medical expenses for all services and insured patients. So, payer level reporting on Total Medical Expenditures is relatively more straightforward. And then as part of our data collection process we have provided specifications to payers on how to attribute spending to physician organizations, including those affiliated or under common ownership with hospitals. So, the measurement of spending by physician organizations will

include all spending that is part of covered benefits, including hospital spending. But we know that 40% of health care spending in California occurs in hospitals, so we need additional strategies to measure spending across all patients, not just hospital spending and physician organizations with attributed lives. So, we have convened a -- we are working on a provisional approach for measurement that is informed by our hospital spending and measurement work.

And then that wraps up kind of the key updates that I wanted to share today. And, you know, the next slide just included some resources; and I am happy to turn it over to the Chair to facilitate any discussion.

CHAIR RIDEOUT: Thank you, Vishaal. Before we turn to committee members for questions, Mary, do you have any comments you want to make, especially the connection to rate reviews?

MEMBER WATANABE: Yes, no, sure. And Vishaal, I appreciate you coming today, I think this is really helpful. We have done our rate review this year for 2025. We have gotten a lot of questions just about what is DMHC considering. So, I think for the purposes of our discussion with the Board today, some of the things that I am hoping you all will help us think about is, you know, California has made it very clear that we have set a spending target. We want to see the entire health care system working to meet that spending target. I think one of the challenges we have had is we are getting questions from consumers about, well, why did my premiums go up more than three and a half percent in 2025. And so I think it has really highlighted the complexity of what OHCA is doing with the spending target. It is not quite an apples-to-apples comparison of the three and a half percent, that it is based in the spending target versus our rate review.

So, I think just for the Board and for the public too, what we are thinking about is just what should we be considering in our rate review? You know, we are looking at 2025 rates now, next year we will be looking at 2026 rates. And then, you know, OHCA's review and kind of things respectively. But I want to be careful that at least in our Board meetings we are not having conversations -- there's a lot of forums to talk about OHCA and the work that OHCA is doing. But I really, I think, wanted to focus our conversation today on just kind of what should the DMHC be thinking about? What are you as our Board Members thinking out in the spending target? I know there's a lot of questions, a lot of probably additional guidance that will be issued. So, Vishaal, maybe my question for you too is, do you have any sense of timing on when additional guidance will be coming out? I know there's a lot of questions still about the spending target, many things that will be considered. But I mostly wanted to frame this for the Board as we are really kind of focusing on input on what the DMHC should be doing.

CHAIR RIDEOUT: Vishaal, any comments you want to make?

MR. PEGANY: Sure. So, as far as the spending target, you know we have emphasized our other work streams in terms of primary care investment moving towards those APM adoption goals. So, those are kind of some markers we put out there that we hope health care entities, that, you know, payers specifically support.

And we do get a lot of questions on kind of measurement and enforcement of the target, so that's kind of a to be -- that's kind of a TBD in terms of it is actively being worked on. We will have a public process put to the Board. There has been a lot of robust stakeholder input on OHCA having reasonable

factors for exceeding the target. Oregon has similar factors, such as if there's high-cost specialty drugs that have entered the market that may not be within the control of a provider organization. And there's other things that we may want to see in the health care system, such as more investment in primary care. So, we are working on those, and we will have a public process with our Board to consider what could we put in context to describe spending, and then what could be reasonable factors for exceeding the target.

CHAIR RIDEOUT: Vishaal, just as a follow-up to that; this came up at the meeting on Monday. Clearly there's a disconnect in some states between the affordability target and actual rate approvals. So, like, Massachusetts is still clipping at I think 6% analyzed. Is there anything we can learn from those states that are -- you mentioned Oregon, you know, having some exclusion categories. But is there anything else that we should be thinking about to include in the rate reviews for DMHC?

MR. PEGANY: Yes, that's -- we have had meetings with DMHC, with Pritika and her staff and her team. And, yes, we have explained kind of the intent of what we are doing. We are fully aware kind of the, you know, DMHC is kind of looking forward and what plans are projecting, what spending will be. So, yes, don't have anything concrete or specific, but, but yes, it is something we are actively going to continue to work together as two sibling state departments.

MEMBER WATANABE: Maybe I will just add. I mean, I think our intent is really to ask the plans questions about what are they doing to take steps to meet the spending target. But I think I welcome the Board's opinion too on are there other things we should be considering or looking at. Pritika always reminds me that rates have to be actuarially sound. And if they are, they are actuarially

sound, you know, that's kind of our basis for determining if something is unreasonable or not justified. But I think we would welcome input on what other information we should be looking at as the plans, you know, are taking steps to meet the spending targets.

I will just tell you; I am pleased to hear more plans are telling you that these are coming up quite frequently in their contract negotiations. I think there are some challenges there, just with the cost of care workforce, and still seeing some significant requests for rate increases. So, I think we are all kind of navigating that together. But just, you know, would welcome the conversation in these meetings, particularly on what the DMHC should be looking at or questions we should be asking as we go forward.

CHAIR RIDEOUT: One thing that again came up on Monday was sort of sector analysis and getting more precise about what's driving the costs and whether those are justified or not, so that would be one comment. And you know, sector can be defined in a lot of ways, geographic, line of business, integrated, degree of integrated care or not, so where the money is being spent. So, all those things did come up and I think that's probably where most of us would like to see some of this go.

Let me turn it over to other committee members for questions. Paul or Abbi or Mark if you have questions. Paul.

MEMBER DURR: Yes, I will start. So, Vishaal, thank you very much. I always enjoy hearing your presentation, it is very informative. I think to where Mary's question is, it leads me to think of the ability for OHCA to adjust those targets based on legislative actions that are taken to enhance benefit. And that, I think, Mary, is one thing we have talked about before as well is that there's

so much which is being added on to the health care community for different types of benefit enhancements, and that is a cost that really previously wasn't accounted for in the provider space. And so when those get added to health plans, then that's an additional cost burden. And I wonder how you envision any of that impacting, you know, a target that we are setting many years down the road from now. I think it is aspirational, which we all would agree with. But it has got to be balanced with some of these things are now health care costs as we define those; whereas today or yesterday, they were consumer cost or this was out-of-pocket cost. So, you kind of get to the same point. But I am wondering, do you have any thoughts as to how the targets might change year to year with new advances, new mandates that we direct and ask the plans and then ultimately providers to cover?

MR. PEGANY: Yes. So, the target itself, we know there's going to be, you know, it is going to be a dynamic context in which we are in, you know, things happening in the market, new benefit mandates and so on. So, we can't predict all of that up front. Just kind of put in a lot of inputs to kind of get this target that's going to match kind of what's going on in the environment. So, what we are doing is contextualizing spending so that, you know, if a health care entity does exceed the target and it is a market-wide event such as like -- the example we often give is the introduction of new drugs like Sovaldi. In Massachusetts, you know, everyone flipped past the target, and that's a warranted factor for exceeding the target. So, if there's something like new mandated benefits, that's something that OHCA would consider the context; it would likely be a reasonable factor for exceeding the target. So, we are really focused on kind of variation and outliers in terms of, you know, potentially taking action on those during their

(indiscernible). But I do want to just point those kind of, those more market-wide events that impact everyone.

MEMBER DURR: And I appreciate that. Thank you, Vishaal. Because what you remind me then is what Mary's question was, which is the disconnection that consumers will have when they get a 5% increase in their premium and yet it is because of some of those things. So, how do we bridge that information sharing across the continuum of departments, let alone to the consumer to say, this, you know, this target is 3.5%, but with this, there is an expectation that it will be a little bit more. Because wanting to help the department recognize their fiduciary duty back and they will get the complaints from the consumers that are saying, I am not living underneath that, and yet, there's other components of it that are driving that. Cost of living as you said, a minimum wage increase and all of those types of things. Somehow, a coordinated message from the state that was recognizing that aspect would be helpful as well.

The other comment that I would make is, I know you are building the quality targets and metrics. I would strongly encourage you to listen to Jeff and what IHA has because providers only have limited capacity on the metrics that they can manage. And the more that they are aligned with existing, vetted quality metrics, that would be very helpful to us on the provider side and I appreciate that.

CHAIR RIDEOUT: Thank you, Paul, for that mention. I am sure Vishaal understands this, but we did change all of our metric approaches to align with what DMHC, DHCS, CalPERS and Covered California already did the heavy lifting on aligning both the metrics, how they are stratified for race and ethnicity,

and what the benchmarks are. So, in your comments, you mentioned health care entities, including hospitals. We don't have a say in the hospital metrics, but would you see plans and provider organizations needing to align with new metrics? Because you say it is coming out in the fall.

MR. PEGANY: We have looked at existing measures and we intend to align with those.

CHAIR RIDEOUT: Great. Okay, any other questions from committee members?

If not, I will turn to questions from or comments from people in the room, from the public. It looks like we've got Bill coming up.

MR. BARCELLONA: I guess I am first in line today. Bill Barcellona, America's Physician Groups. Vishaal, thank you for the report, and again, thank you for all the hard work that OHCA has done to get up to speed, to implement this program, adopt the targets and start to provide a strategic oversight of the California health care system. And yes, at APG we certainly encourage the collaboration between DMHC and OHCA in this area. It has a lot of direct impact on our membership at APG since both departments have some direct oversight about our members' operations.

One of the things that I want to continue to stress is that provider behavior is driven by benefit design. And certainly the data we have seen from IHA over the past year indicates that we have a huge difference between the PPO market and the fully insured HMO market with delegated model delivery systems. And that continues to inform us at a very strategic level about what works and what doesn't in terms of cost control in the state. So, with that in mind, I wanted to ask the Director today about a recent comment on the change

in benefit design that the Department of Managed Health care is seeing. Wanted to just confirm what you told us last week about, did you -- did you say that 80% of the benefit designs now have high deductible?

MEMBER WATANABE: Yes, no, thank you, Bill. And actually I think, Vishaal, you can correct me if I am wrong, but I think the UC Berkeley Labor Center also presented at the OHCA Board meeting on the trends they are seeing in deductibles. So that just over 20 years the number, and I think these are public plans, but it is in their documents. It was shared also at our meeting on our rate review trends. But I think what we are seeing is the number of plans or the individuals who have a deductible has increased significantly, and then the amount of those deductibles are increasing. And I think just in the context of affordability this is becoming my number one priority and focus. It is just, you know it, what is the value of your health care coverage if you have, let's just say, a 3,500 or 4,000 deductible in the context of behavioral health especially. It is concerning to me that someone has to pay that amount out-of-pocket before the health plan's coverage really kicks in. And so is that -- are we really providing useful coverage and is that a barrier to care? So, I think Pritika and her folks, we get some data on deductibles, that is something we are going to be looking at. But the data, I think -- Vishaal, am I saying that right? That that presentation was also made to OHCA from the UC Berkeley Labor Center? I believe so.

MR. BARCELLONA: It was.

MEMBER WATANABE: Yes. Their report is public. And again, I think it is -- I believe it is on public sector. But again, I think that is something that we are starting to hear more about and I think it is just something for us all to be watching and mindful of as we try to control costs. Do we see those deductibles

continue to go up? That just, I think, really makes coverage unaffordable or inaccessible.

MR. BARCELLONA: I know that the licensing division used to track deductibles in plan filings here at DMHC, and I know that the Knox-Keene Act had caps on deductible limits for plans. That's still the case, isn't it?

MS. REAM: I don't know that the Office of Plan Licensing currently tracks which products have deductibles and which don't. I mean, they are not doing an aggregation of that data. But there are limits on the amount of deductible they can propose.

MR. BARCELLONA: Yes. I know we used to review the filings and impose caps on deductibles so I'm just wondering, I've forgotten what those caps are, it's been so long.

MEMBER WATANABE: We do, I think in OFR. Pritika's team also gets some data. So, I mean, it is something that I think we will continue to look at. I think it is an important metric. I think just as OHCA is considering too what changes we start to see as the plans and the health care system in general starts to work to meet these targets. So, want to make sure the coverage is still accessible.

CHAIR RIDEOUT: IHA actually tracks out-of-pocket costs, which is highly related to deductibles. And we do that by line of business; we do it at a detailed level. And we are seeing that trend that you described, but it is mitigated in the HMO product models quite a bit, so the rise is not going up anywhere near as fast in that product line.

MR. BARCELLONA: Okay. So, you are still seeing first dollar coverage predominant in the HMO?

CHAIR RIDEOUT: Yes.

MR. BARCELLONA: Okay.

CHAIR RIDEOUT: I mean, relative to --

MR. BARCELLONA: Yes.

CHAIR RIDEOUT: That comes from plan submissions to us where they calculate the out-of-pocket costs on a per-member basis.

MR. BARCELLONA: Right.

CHAIR RIDEOUT: Which is highly related. And that goes into our total cost of care measure, which is highly related to the total health care expenditure metric that Vishaal had there.

MR. BARCELLONA: I know it has always been hard over the past 20 years for delegated model groups to track the impact of high deductibles within the HMO plans, on the IPA side. On the multi-specialty medical group side they also function in PPO markets and I know that there's some data emerging now that says, that shows that some of our larger groups are carrying significant unpaid amounts for patients based on deductibles, so it is starting to hit the groups as well as the hospitals. All right, thank you.

CHAIR RIDEOUT: Other questions for the public in the room?

We will move to questions for from the public on Zoom.

MR. STOUT: There’s none at this time.

CHAIR RIDEOUT: And questions from the public not on Zoom but on a phone?

MR. STOUT: None at this time. Oh, one question. When prompted please state your name and organization.

MEMBER WATANABE: Go ahead, Beth.

MS. CAPELL: Beth Capell, Health Access. Thank you for this discussion. The UC Berkeley Labor Center report found that 80% of Californians with employer-based coverage now have a deductible, and that's true regardless of whether it is an HMO or a PPO, so both. That is up from 20 years ago when it was about 30%, so deductibles are not only much larger but much more prevalent. And it seems to be -- and that's true across both the public sector and the private sector, and that's based on census data, the map survey. So, it is a big number, it is a big problem. It is part of why we are glad this discussion about OHCA, and rate review is going on because lack of affordability for consumers is what has driven the discussion around OHCA. Thank you.

CHAIR RIDEOUT: Thank you, Beth.

Any other questions from the public?

All right. Hearing none, I think we will move on to the federal update from Sarah.

Vishaal, thank you for participating today.

MS. REAM: Do you have a preference as to whether I sit here or go to the podium?

MEMBER WATANABE: Can you hear her okay? Yes, you can sit.

MS. REAM: Okay, great, thank you. I am Sarah Ream. I am the Chief Counsel for the Department of Managed Health Care. And I am going to be talking about two federal updates today. The first is what is known as the end -- well, is the end of what's known as Chevron deference. And the second is an update on the HHS, the federal HHS rules regarding the permissibility of copayment accumulator programs. I will trip over my tongue on that one a bit.

So, let me start off by talking about Chevron deference. So, earlier

this year at the beginning of the summer there was a lot of talk in the media and pundits were talking about the end of this concept of Chevron deference. This sprang from the Supreme Court issued a ruling in June that overturned 40 years of precedential decisions regarding how much deference a court needs to give to a federal agency's interpretation of statutes. It stands to be seen yet how much impact this is going to have on federal regulations. I am happy to say, though, that with respect to state regulations the impact will likely be minimal.

So, let me get into it. What was Chevron deference and where did it come from?

So, like I said, 40 years ago in 1984 the Supreme Court issued a case called *Chevron USA v. Natural Resources Defense Council*. And the federal government in that instance -- the Supreme Court said in that instance that if a federal agency adopts a regulation that is interpreting an ambiguous statute or a statute that could be interpreted in multiple ways, the courts, if there's a challenge to that regulation, have to defer to the agency's position, the agency's interpretation, unless that interpretation is just not permissible, it is not reasonable, nobody could come to that conclusion. In essence, what the court did was said, the scales tip in favor of the federal agency and the federal agency's interpretation.

The Supreme Court now, the current Supreme Court though, revisited this issue of deference and flipped it around and said, ultimately it is for the courts to say what the proper interpretation is of a statute. The courts can give due deference to the agency's interpretation, particularly if the agency's interpretation is contemporaneous or within a short period of time of the statute being enacted. If the agency has given a lot of thought to its regulation, then that

should be given, you know, consideration. But the courts do not have to just accept what the federal agency's interpretation is of a statute. It lies, it is the constitutional authority of the courts to interpret statutes, and they can override the regulations.

So, the good news for DMHC and state regulators is one, the ruling doesn't impact any current federal regulations. It does not over, you know, they are not overturned. It will make it easier for litigants at the federal level to challenge regulations, to successfully challenge federal regulations. And how you feel about a federal regulation you may think that's a good thing or you may think that's a terrible thing, it just depends on your point of view. However, as I mentioned, with respect to California there really should be no impact on our regulations, what we do. First of all, at the basic level, the Supreme Court's decision only impacts federal regulations. It doesn't -- it has no bearing on state regulations.

Secondly, and maybe more importantly, California has never adopted Chevron-style deference. So, our courts have always had the ability to have the final say on how a statute should be interpreted. The court can use its independent judgment in determining whether or not a state regulatory agency's interpretation of a statute is appropriate. This is actually most states in the nation have followed the California approach. They do not, you know, they have not adopted Chevron deference. So, I know some, some experts, some pundits are saying, well, it may not actually be as much of a sky is falling situation at the federal level because the sky hasn't fallen in these states where they have, they give the courts more deference. So, we will wait to see what happens on that.

If you are interested in it, it is an interesting case. It is *Loper Bright*

Enterprises v. Raimondo, Secretary of Commerce. It goes into a lot of history. It is just sort of an interesting reading on the balance between state -- federal regulatory and the court jurisdiction. I will warn you though, it is 114 pages long, and very much of that has to do with regulation of ocean fisheries, so I learned a lot more. When you read the case you learn a lot about herring fishing, so just be forewarned. But it is, it is an interesting case. It is just interesting to see the change in how the court is approaching that.

Next I am going to be talking -- next slide, please.

I am going to be talking about copayment accumulators and the federal Health and Human Services agency's action or inaction with respect to copayment accumulators. So, just, I don't think -- I think it goes without saying that we all know that pharmaceutical drugs, prescription drugs, are a big driver in the cost of health care. Some manufacturers of brand name drugs offer programs where they will assist consumers with the consumers' out-of-pocket cost to obtain that drug. So, the manufacturer will give a coupon or a rebate to the enrollee, which reduces down the enrollee's amount the enrollee has to pay for their copayment or to reach their deductible. You know, if the enrollee has a deductible, they don't have any coverage yet, the copayment assistance can really draw down that price.

But some people believe that there may be an issue, that there's a problem with this, because the assistance could actually hurt consumers in the long run because it may incentivize the use of brand name drugs over less expensive generic drugs. They also argue that copayment assistance from the manufacturers simply shifts the cost of more expensive drugs to the health plans, which then ultimately pass it on to the consumer. Likewise, copayment

assistance may hide from the enrollee the actual cost of the drug, and then when the copayment assistance or the coupon runs out, if it runs out midyear, then the enrollee may suddenly be hit with a much higher copayment when they go to get their drug at the pharmacy.

So, to address copayment accumulators, whether you like them or you don't like them, or copayment assistance, some health plans have implemented, and this is not just in California, it is statewide, have implemented what is called copayment accumulator programs. Under these programs, the health plan or health insurer essentially excludes the amount of the manufacturer's copayment assistance when they are calculating how far along the enrollee is in meeting their out-of-pocket max.

So, by way of example, consider an enrollee who has a $200 copayment for pharmaceuticals. But the manufacturer gives that enrollee a coupon that covers $190 of the prescription drug cost. So, when the enrollee goes to the pharmacy they pay $10. If the plan has a copayment accumulator program, only $10 is being accumulated toward the enrollee's out-of-pocket maximum, not the full $200. So, the enrollee thinks it is $10, that's the cost, they go, they get their drug. Let's say in June the pharmacy assistance ceases or the manufacturer's assistant ceases. Now when the enrollee goes to get that drug they are hit with a $200 copayment, and they discover that they are nowhere near meeting their out-of-pocket max like they may have thought they would. They thought they were going to get that out-of-pocket max closer, they might exhaust it during the year. They may not now. And as you can imagine, advocates for enrollees, particularly enrollees with high-cost medical conditions, tend to like the accumulator programs. They said this helps enrollees. The plans

don't necessarily like it. There's a lot of different, different thoughts about this.

In the 2020 Notice of Benefit and Payment Parameters, the big regulation put out by the Federal Health and Human Services Agency, HHS tried to put some guardrails around when a plan or insurer can use a copayment accumulator. HHS said that a plan can impose a copayment accumulator only if there is a generic drug equivalent available to the enrollee. So, if the enrollee could get the brand name drug -- excuse me, could get the generic drug, but the enrollee or their provider chose to go with a brand name drug, the health plan could essentially say, fine, but any assistance you get from the manufacturer will not accumulate towards your copayment. You know, it could serve -- these programs arguably could serve as an incentive for enrollees to choose less costly generics.

But then in 2021 HHS through their Notice of Benefit and Payment Parameters regulation removed the guardrails. So, they said, actually a health plan or insurer can have a copayment accumulator no matter what, even if a generic isn't available, even if the only drug that is available to the enrollee is a brand name drug. The health plan may still exclude any assistance that the manufacturer gives the enrollee from accumulating towards that out-of-pocket max. So, again, so in that instance the enrollee who was getting the $190 assistance from the manufacturer, they are only getting $10 of credit towards their deductible or towards their out-of-pocket max.

After that, a group of advocates for HIV-positive and Hepatitis-positive patients sued the federal government for the 2021 rule that removed the guardrails and they won. They won in court in 2023. A federal court invalidated or vacated the 2021 rule and rolled the clock back to 2020. So currently -- and

the court did that because they said that HHS' interpretation was in conflict with the underlying statutes. So, currently on the books right now is a rule that says health plans can use an accumulator program, but only when there is a generic available. So, that's on the books.

But HHS has said they are not going to -- they are not going to enforce the rule. So, it is kind of the Wild West back in the East Coast where HHS is. It is -- so, we are stuck in a position where we don't know. What happens if a health plan or insurer has an accumulator but there is no generic in place? The feds have said they are not going to enforce the rule. The feds have said that they are going to come out with a new rule. I think everybody was expecting that the new rule would be in the 2025 Notice of Benefit Parameters, it wasn't there. So, we are just waiting to see. Or the 2026, I'm sorry, the next one out. We thought it would be in there. It wasn't in there. HHS has said they are going to come out with one. They haven't yet. So, in the meantime we don't have a federal -- we have a federal rule that is not being enforced by the federal regulator.

California, we do not have laws on this. Some states do. About 19 states in the nation have laws on this, California is not one of those. So, that is, that is where we are with the copayment accumulator. Depending on the next administration, at the federal level we may see a lot of action, we may not see a lot of action on this, but it is just, it has been an interesting journey on that one.

That is all I have here. I am happy to take questions.

CHAIR RIDEOUT: Okay, any questions from members of the Board?

Not seeing any.

Any questions or comments from the public in the room?

Okay, questions or comments from those on Zoom?

And any questions from those on the phone from the public?

CHAIR RIDEOUT: Thank you, Sarah.

MS. REAM: Thank you.

CHAIR RIDEOUT: All right, we will move on to the Legislative Update from Amanda. Flanked by the attorneys here so I feel safe.

MS. LEVY: Well, thank you all, thank you for having me. I look forward to giving this Legislative Update yearly. Suffice to say, it has been another busy year. So, we can go to the next slide.

Well again, it wouldn't be a legislative update without noting there is another record number of bills that the Department of Managed Health Care will be implementing. We have 23 bills that were signed into law and DMHC will be working with stakeholders over the coming months regarding the implementation of these bills. This will all lead up to a end of the year legislative implementation All-Plan Letter, which will cover many of these bills, and then we additionally -- we sometimes issue separate guidance on certain pieces of legislation.

We wanted to include on the screen and in our packets the list of all the bills that the Department will be implementing, but I will not be reviewing these individually. Next slide please.

So, as you can see, the topics vary. They cover areas of mandated benefits, removal of cost-sharing for certain services, and there are several behavioral health bills to implement. We also have included AB 2767 here, which adds members to this Board, as Mary mentioned earlier. Next slide please.

I will be speaking about three bills that have received a fair amount of attention in more details on the next set of slides. Next.

I am going to begin with AB 3275. This changes the timeframes for reimbursing, contesting, and denying claims for health care services from respectively 30 and 45 working days currently to 30 calendar days for all complete claims.

The bill further increases the penalty on health plans and insurers for not automatically paying interest owed on a claim from $10 to $15 or 10% of the accrued interest on the claim, whichever is greater.

Further, the bill notes that enrollee complaints about a delay or denial of payment of a claim are to be treated as a grievance.

This bill applies to DMHC/CDI-regulated plan, and it also applies to Medi-Cal managed care plans per statute. The effective date of this bill will be January 1, 2026, so we have a little bit of time to work on it, and I know that we are already contemplating changes in how to get that to work. Next slide.

Senate Bill 729 requires a large group health plan contract to provide coverage for the diagnosis and treatment of infertility and fertility services.

The bill requires a small group health plan contract to offer such coverage.

Large group health plans are required to cover three completed oocyte retrievals, and unlimited egg transfers. And these are in accordance with guidelines established by the American Society for Reproductive Medicine. Next slide.

The bill further revises the definition of infertility to be broader, to

cover same sex couples.

And the bill prohibits placing different conditions for coverage limitations on fertility medications or services, or on the diagnosis and treatment of infertility and fertility services as compared to other conditions.

The effective date in the statute is July 1, 2025; and the bill will apply to CalPERS plans on July 1, 2027.

Just a note here though, the governor's signing message did request the legislature to push its initial implementation of the bill from July 1, 2025, to January 1, 2026.

And in terms of its applicability, SB 729 applies to DMHC, CDI, does not apply to Medi-Cal managed care plans or contract plans with a (inaudible). Next slide.

We wanted to include just a couple slides about Senate Bill 1120, as there has been so much conversation in the last several years about artificial intelligence. This bill assigned us to deal with AI related to -- as it relates to prior authorization utilization management. So, the bill requires a health plan that uses AI, an algorithm, or other software tools for UM functions based in whole or part on medical necessity, to ensure that these tools base its determination on specified information and that they be fairly and equitably applied.

It prohibits these AI tools from denying, delaying or modifying health care services that are based on medical necessity. Trying to put some guardrails into the system as we continue to explore AI use in our health care system. Next slide.

The bill requires adverse medical necessity decisions to be made only by a licensed physician or licensed health professionals. The bill applies to

DMHC, CDI and Medi-Cal managed care to the extent that DHCS maintains any necessary approvals. This will be an effective date of January 1, 2025.

So that concludes just a brief presentation. As you can see from the list, we will be working diligently throughout the fall and into next year on implementation. We look forward to doing so with our stakeholders. So, with that, I will turn it back over and ask for questions, turn it over to the Chair and ask for questions.

CHAIR RIDEOUT: Thank you, Amanda.

Any questions from committee members? Paul, it looks like you have your hand up.

MEMBER DURR: I do, Jeff, thank you. So just, Amanda, thank you for the discussion. Just to comment on, because I do want it to be noted on AB 3275 on the 30 day limitation, because that will impact provider groups, as you know. And I think what we tried to make the legislature know is that, you know, we get paid once a month from health plans, so, you know, that doesn't always align with the timing of when we are going to have to be paying this. So, you know, within 30 days it seems to make sense, but just to keep that in mind. And I know we talked about it last week to some degree, but I just wanted to make a note of that. That it will create some more challenges, probably for meeting the claim timeliness turnaround times, which I know we are going to have to update as well as part of our financial solvency regs. But just wanted to note that for comment here at the FSSB. And appreciate your thoughtfulness and engagement with the provider community as you build out those regs.

CHAIR RIDEOUT: I am not seeing other comments from committee members so I will turn to the public in the room.

MR. BARCELLONA: Bill Barcellona APG. With respect to the implementation of AB 3275. Just to remind the Department, we surveyed our membership last week about the changeover in programming for all adjudication systems within California. There's only a handful of vendors. I think it is three main vendors at this point who run the claim systems for plans and for payer groups like our members. So, the timing of the reprogramming for the claim systems is going to be crucial because it will depend on the finalization of the regulation probably before we can actually undertake the reprogramming effort. So, timing is everything. The shorter the time frame, the greater the cost, because of the concentration of vendor staffing across the state. So, we know we want to be mindful of cost control. Vishaal's not here any longer, but I hope he hears my comment. So, let's keep in touch as we develop the regulation and keep that in mind. We will try to get some cost estimates out on the reprogramming effort. Thank you.

CHAIR RIDEOUT: Bill, can you share the name of the vendors that you are focused on?

MR. BARCELLONA: It used -- well, I mean, the main vendor was, is still referred to as EZ-Cap in the industry, but I think they have a new name. So, I can get that information.

CHAIR RIDEOUT: It would be helpful, thank you.

Other questions from public in the room?

Okay, we will go to questions from the public on the Zoom.

None. Questions from the public on the phone?

Okay, that will conclude that section.

So, we now turn to Pritika for the Federal Medical Loss Ratio

Summary.

MS. DUTT: Good morning. I am Pritika Dutt, Deputy Director of the Office of Financial Review at the DMHC. I will provide you a quick update on the 2023 annual Federal Medical Loss Ratio or MLR reports that were filed by health plans subject to the MLR reporting requirement. These reports are due for the previous year to the DMHC and to CMS on July 31 of every year. However, due to the changed health care, the changed health care issue, CMS provided health plans and insurers additional time, so they had until August 15 to submit information to the DMHC and CMS. For details related to this presentation, please refer to the Federal Medical Loss Ratio Summary for Reporting Year 2023 and that was provided as part of the meeting. We also have the MLR reports that are submitted by health plans publicly available on our website.

Federal laws require health plans that sell health care products directly to enrollees and employer groups to spend a certain percentage of their premium dollars on providing health care services. The MLR requirement went into effect for reporting year 2021, so the health plans in the Small Group Market and the Individual Market have to spend 80% of their premiums on the provision of health care; and in the Large Group Market the plans are required to spend 85 cents of every dollar on the provision of health care. And that includes quality-related expenses as well. If the plans fail to meet this requirement, they have to pay a rebate to the enrollees or the employer groups. For rebate purposes and for MLR calculation purposes, the MLR is based on a three year average. And for example, for reporting year 2023 the MLR and rebate calculation is based on a three year average of a health plan’s premium and medical expenses so it includes the 2021, 2022 and 2023 data.

So, page 2 of the handout shows an MLR for the plans in the Individual Market. And as I mentioned earlier, the Federal MLR reporting requirement for the Individual Market is 80%. The MLR for the 13 plans in the Individual Market ranged from 85.5% to 124.6% and there were no rebates issued in the Individual Market. So, as you can see, all the plans surpassed the 80% and some were over 100%, so these plans were spending more than they were bringing into premiums.

For the 2022 federal MLR reporting year we had 12 plans in the Individual Market, and the MLR range from 84.2% to 101.3% and there were no rebates issued in 2022 in the Individual Market.

Page 3 of the handout shows the MLR for the health plans in the Small Group Market. For the Small Group Market, the MLR is 80%. For the 12 plans in the Small Group Market, MLR ranged from 77.1% to 98.4%. One plan, which is United Healthcare Benefits Plan, reported MLR below 80% and were required to pay rebates to the enrollee totaling $24 million. It's millions, not $24.

And then in the previous you probably noticed that Blue Cross was coming up in the Small Group Market, reporting below the 80% threshold and paying rebates year after year. We have been working with Blue Cross as part of our rate review process and then pushing their plan back on their rates and making sure that they are on their rate projections. When they are submitting their rate documents to us, they are projecting to meet that 80% requirement.

For reporting year 2022 there are 14 plans in the Small Group Market and MLR ranged from 78% to 99.2%. Two plans, which was Anthem and United Healthcare Benefits, reported MLR below 80% and required to pay rebates to the enrollees totaling $77.9 million. So, the rebate amount has

dropped when compared to 2022.

So, for the Large Group Market, as I previously mentioned, the MLR requirement is 85%. We had 22 health plans in the Large Group Market, and MLR there ranged from 86.8% to 116.1%. All plans met the MLR requirement, and no rebate was required to be paid.

In 2022 the MLR in the Large Group Market for Full Service Plans ranged from 84.7% to 113.8%. One plan reported MLR below 85% and paid rebates totaling $243,000.

There's a few health specialized plans that are subject to the MLR reporting requirement. So, we had one specialized health plan that had to submit the MLR report, and it was OptumHealth Physical plan. They reported MLR of 72.7% which was below the 80% required, and the plan ended up paying rebates totaling $1,130. So, it was a low amount because, again, the premium in the specialized market is generally low. Okay.

And then we had three specialized plans that were subject to the large group reporting requirement. So, again, like for these plans, the requirement was 85% and there was rebates paid totaling $2.3 million in the Large Group Market. OptumHealth Behavioral Solutions of California reported an MLR of 73.7% and paid rebates of $1.8 million. And OptumHealth Physical Health of California reported an MLR of 67.1% and paid rebates of $507,000. Managed Health Network surrendered its license on November 17, 2024 and will be no longer subject to the federal MLR reporting retirement.

Okay. We have been collecting this data for a long time. So, this chart here shows the total rebates paid by health plans since 2011. So, the plans have to issue rebate checks by September 30, 2024. And as part of our

MLR examinations, our team verifies whether the plans are complying with the requirement and paying the required rebates. So, rebates may be issued in a number of ways. Enrollees might receive a rebate check in the mail, a deposit paid into the account used to pay a premium, or direct reduction in the future premium. And as you can see, compared to -- if you just look at the right-hand side, you can see the rebates have significantly dropped in 2023.

That brings me to the end of my presentation. I will take any questions. Back to you, Jeff.

CHAIR RIDEOUT: Sure. Questions from the committee members? Pritika, I had one observation. So, a number of the plans that are above the MLR, and well above 100%.

MS. DUTT: Right.

CHAIR RIDEOUT: They look like local initiative plans or local plans.

MS. DUTT: Yes.

CHAIR RIDEOUT: Are you monitoring those for solvency in any way?

MS. DUTT: Yes. So, one of the things we look at when we get these reports, also the rate filings when we see high MLRs, we also look at the plan's financial statements, because we do get them quarterly and annually. So, we make sure that the plans have adequate reserves. So they have, like, you know, excess TNE to observe these losses. So, we do have the conversations with these plans through our rate review. Again, also we monitor them based on their financial reporting quarterly and annually.

CHAIR RIDEOUT: Paul, I see you have your hand up.

MEMBER DURR: Yes, thanks, Jeff. I was kind of going down the same road, Jeff, that you were with Pritika. The Individual Market seems very interesting with how many people have very high MLRs in 2023 and the consistency to the prior year. In particular noted like with Kaiser and Blue Shield of California, which have a significant amount of members. And I was wondering if there's any insight into that, especially like with Kaiser being over 100% that means they are not covering any administrative costs. So, is that because they are very competitive in the market, and is that what we want? Obviously, there is that piece of it. But it just speaks to the strategy that those plans are going through to be in that position, and especially Kaiser doing it year over year. Any insight that you have?

MS. DUTT: So, again, like speak to Kaiser. So, as you know, Kaiser has the medical, the Permanente Group, and then the hospitals. For the medical groups, Kaiser pays capitation and 100% of the capitation counts as medical expenses. So, part of the capitation amount does include administrative costs. Like I said previously, we also look at the reserves for Kaiser as a whole, right? We look at their TNE, how much excess TNE they have, cash. Just looking at different financial ratios to make sure they are meeting their financial solvency requirements. So, Paul, I think the main thing is they are, they are highly capitated. So, like I said, 100% of those capitations count towards the MLR.

MEMBER DURR: Yes. And it gets to, then, how do they account for it versus other plans. So, I am thinking like a Kaiser, because the Individual Market is very different than the other pieces of it. So, it is really about how a plan that is as big as Kaiser, not to just signal them out, we could talk about Blue

Shield too, but how they are able to cross-subsidize that and how do they do the accounting to say that 100% of the cap is counted here when it does include some administrative services. I don't know that fine detail within that. But just more of an observation that I was kind of highlighting because it just --

MS. DUTT: We also look at their performance in the other markets like the Small Group, Large Group. They have other products. They have, they have Medicare, Medi-Cal, so we look at the overall performance too as we are evaluating their financial solvency. So, this is something that our rate review team, the actuaries do deep dive into when they look at the rate filings every quarter, annually, to make sure that the plans are projecting to meet the MLR requirement. So, about 80%, 85%. But that's something that we do look at, like they do look at the TNE. Okay. They can't take this loss if comes down to it.

CHAIR RIDEOUT: Good questions. Pritika, just one other observation. There seems to be a bit of a trend with United as parent organization in some of these. Is that something the Department monitors differently, or? It is not consistent, but it is not just the big penalty, it is also the specialty care and things like that.

MS. DUTT: Right. So, we have been working with these plans. Again, the rebates are small. I think the main thing is, in these markets -- the specialized plans, the premium is so small so, I think -- like I said, one of the things is we keep working with them and we keep asking them the different things they are doing to meet the MLR requirement. But it gets challenging a little bit, because that's something we see in the dental when we get the dental MLR reports. Because, again, it is -- the premiums are low.

MEMBER WATANABE: And some of the same administrative

requirements as the health plans on small premiums.

CHAIR RIDEOUT: Okay. All right, taking questions from the public in the room if there are any.

I am not seeing anybody. Questions from the public on Zoom?

MR. STOUT: None at this time.

CHAIR RIDEOUT: And any questions from the public on the phone?

MR. STOUT: None at this time.

CHAIR RIDEOUT: Okay, that will conclude this section.

We now stay with Pritika on the 2023 Risk Adjustment Transfers.

MS. DUTT: Thank you, Jeff. I will provide you an update of the 2023 risk adjustment transfers. Typically, CMS releases the Risk Adjustment Transfer Summary, of course, at the end of June. This year it was delayed since CMS gave extensions to health insurers due to the changed health care issue.

The ACA included three premium stabilization programs, which was risk corridors, reinsurance and risk adjustment. The risk corridors and reinsurance programs lasted from 2014 to 2016, and the risk adjustment program still continues today. The risk adjustment program transfers funds from lower risk, non-grandfathered plans in the Individual and Small Group Markets to higher risk, non-grandfathered plans, both in and out of the Exchange. The purpose of the program is to discourage cherry picking. The plans that end up with a healthier population must compensate plans that have more costly enrollees.

For benefit year 2023, $1.32 billion was transferred between the California health plans and the insurers. Three DMHC plans were on the

receiving hand. Blue Shield received $1.26 billion in risk adjustment transfers and Health Net received $8.7 million; United Healthcare Benefits Plan received $17.7 million. Thirteen DMHC plans, Aetna, Anthem Blue Cross, Chinese Community and so on, you can see it in the handout that was provided, had to pay into the risk adjustment pool, with Kaiser paying $730 million. Overall, the PPO plans ended up on the receiving end, while HMO plans ended up paying. This year Anthem ended up paying $73 million into the risk adjustment pool, when netted with the amount of plan paid in the Individual Market, with the risk pool they received in the Small Group Market. Additionally, Health Net ended up on the receiving end in 2023 since the plan's PPO business moved to the DMHC licenses plan from a CDI-regulated insurer. One thing I want to point out here is the $730 million that Kaiser paid ends up in their MLR calculation, so it increases the MLR because they paid that $733 million. And that $730 million is an aggregate between the Individual and the Small Market payout.

And then in 2018 CMS added a High-Cost Risk Pool program to the risk adjustment transfer methodology. The High-Cost Risk Pool helps ensure that risk adjustment transfers better reflect the average actuarial risk, while also providing protection to issuers with exceptionally high-cost enrollees. The High-Cost Risk Pool reimburse plans for 60% of the enrollees aggregated costs that exceed $1 million. So, it is supposed to help the plans with those expensive enrollees where the cost is over $1 million.

For benefit year 2023, the DMHC-regulated plans received $235 million, with Blue Shield receiving $84 million, Kaiser received $72 million, and Anthem received $51 million.

Okay. So, how does risk adjustment impact premium rates and

MLR? So, if the plan received risk adjustment payment from CMS, the plan would reduce the same amount of -- the same amount of its current year's incurred claims. And in saying incurred claims, that's the medical costs. And then if the plan paid into risk adjustment, like Kaiser did, the plan would -- the plan would increase their medical expenses for that year.

The risk adjustment transfers represent an average of 10.2% of premium, or about $54 per member per month, assuming the statewide average premium of $509 per year PM. The amount of risk adjustment consumed in setting rates varies by plan, depending partly on the relative risk score to the statewide average risk score.

And the 2023 risk adjustment transfers from CMS was used by health plans to estimate their 2025 risk adjustment amount when they were developing the 2025 rate setting. So similar to other assumptions used in rate setting, over or underestimating risk adjustment may impact the rate profit as well as the plan's medical loss ratio.

So, that ends my update on risk adjustment transfers. Back to you, Jeff, for questions.

CHAIR RIDEOUT: Thank you. Questions from the committee? Paul, go ahead, please.

MEMBER DURR: Yes, Jeff, sorry. Pritika, I always like this but remind me. I think there is consistency year over a year that PPO plans are always the beneficiary and HMO plans are always the payer, if I remember right.

MS. DUTT: Yes. Correct.

MEMBER DURR: And I just wonder what that correlation is. And where I think about it is the data IHA presents, which is HMO is lower cost, better

quality and all that. Is there some relationship between that? It is just odd that it seems like it is like that every year, other than -- it is more of an observation, no need for comment, just an observation.

MS. DUTT: People probably picking PPO products. And I am making a general statement, Mary can jump in too. Are the people picking PPO products wanting the flexibility to be able to go out-of-network, right, like to different providers. Where, like, they may be using more of the health care too, so a more sicker population. But being that, again, the risk adjustment program is supposed to help the plans which have the more costly enrollees. That's why the PPO ends up being on the higher receiving end.

CHAIR RIDEOUT: I think it also comes back to how it is measured; you know.

MS. DUTT: Data.

CHAIR RIDEOUT: You know, Paul mentioned IHA. We actually have a clinical risk adjustment as well as age and sex, and then we wage adjust the results. So, you may not catch everything doing it that way, but I am not familiar anymore with how this risk adjustment is done. So that might be a question. And then I think the second thought would be, you know, OHCA is going to be risk adjusting the affordability expense, and hence the target, but they are not using clinical risk adjustment, which I think is a big miss. So, the debate we often get into is how much of this clinical risk adjustment versus anything else that's under the control of the plan of the provider? So, I don't know if you know that or not but it might be interesting to see. Is there some, do these line up or not? That's another thing to align, I guess.

MR. BARCELLONA (OFF-MIC): (Inaudible) contribute to this

conversation.

CHAIR RIDEOUT: You will get your turn, Bill.

Other questions from committee members?

Hearing none, we will turn to members of the public in the room.

MR. BARCELLONA: All right. Bill Barcellona, APG.

Just a reminder, when this all came down with the creation of federal exchanges and state-based exchanges, the risk adjustment methodology that the federal government chose for the exchanges is the opposite of the Medicare Advantage risk adjustment methodology. The exchanges use a risk adjustment modifier that favors the accuracy of claims data over encounter data. Encounter data is less accurate. It is more timely but it is less accurate and so this is how you end up with a model that favors PPO, which is based on fee-for-service claims payment data over HMO that's capitated. And so you see it back and forth. And yes, it is a problem, but it is a problem because we have not successfully improved the accuracy of encounter data submission over the past decade. So, who's at fault for that?

MEMBER WATANABE: Despite a tremendous amount of work that is going into it.

MR. BARCELLONA: Right. Thank you.

CHAIR RIDEOUT: Other comments from the public in the room?

Okay, we will go to comments from the public on Zoom?

MR. STOUT: None at this time.

CHAIR RIDEOUT: Comments from the public on the phone?

MR. STOUT: None at this time.

CHAIR RIDEOUT: Okay, that concludes that section.

We will move on to 2025 Premium Rates. Pritika, you are up again.

MS. DUTT: The purpose of this presentation is to provide you an update of the 2025 Premium Rates in the Individual and Small Group Market. For this presentation, you can refer to the 2025 Premium Rate Report that was included in the meeting handouts.

On September 30, 2024, the DMHC finalized its review of the 13 individual rate filings with rate increases/rate changes effective January 1, 2025. This included 12 plans that offered on-exchange benefits, and they also negotiated rates with Covered California prior to coming to the DMHC for a rate review.

The DMHC actuaries reviewed 2025 Individual rate filings and supporting documentation from health plans and determined the rate increases were not unreasonable. So, everything appeared fine. For the 13 individual rate filings, the final rate increases ranged from 1.8% to 15.4%, with an average increase of 7.8% across all plans. If you are following the chain -- the press release from Covered California, they reported an average of 7.9%. And that is because the DMHC filings also included off-exchange products. And we have -- we have 13 plans instead of 12, because in Covered California -- because we have Sutter that only offers off-exchange products. So, Sutter, like I said, offers non-exchange individual products and has projected enrollment of 3,049 and reported an average annual increase of 10.8%. The average premium ranged from $502 to $908 per member per month. Kaiser has the most projected lives in the Individual Market, and the rate change for Kaiser was 6.4%. Blue Shield is the largest plan in the Individual Market, the second-largest plan in the Individual Market, and the average rate increase is 8% for 2025.

As I previously mentioned, if you try to compare the data to Covered California you may see a slight differences there. The primary drivers for increase in premium rates in the Individual Market was due to the rise in health care utilization after the pandemic, increases in pharmacy cost, inflationary pressures in the health care industry such as rising cost of care, labor shortages and salary and wage increases.

On October 3, 2024, the DMHC completed its review of the 12 Small Group rate filings with an effective date of January 1, 2025. For the 12 Small Group rate filings, the final rate increases ranged from 0%, so no change, to 16.8%, with an average increase of 7.2% across all Small Group plans. 1.9 million enrollees received coverage in the Small Group Market.

We are currently reviewing the 2025 large group rate methodology filings. We received those filings on September 2 and so the work is still in progress with respect to review there. The preliminary analysis shows for the 22 health plans the proposed rate change is 7.7% in the Large Group Market. We expect to finalize our review during the first week of November. So, compared to 2024 where we saw double digit rate increases for the Individual, Small Group, Large Group Markets, the 2025 average rate increase across all plans is less than 8% for 2025. And then for future rate filings we will be coordinating with OHCA and asking plans questions related to the spending target as far as our rate review. I can take any questions that you have.

CHAIR RIDEOUT: Paul.

MEMBER DURR: Yes, Pritika, I just can't help but comment. Your explanation for the increases, your brief summary, which was done in a sentence, was fascinating and amazing. I wish Vishaal was in the room to hear

that because that gets into the disparity, Mary, that we were talking about earlier. Is that this is why. All of the things Pritika put in that one sentence about going up because of increased utilization, labor challenges. You named them out, five of them or so. Fabulous job. That's the message we need to get out to Vishaal. That's the message that the consumers need to hear, that this is what's going on, this is what's driving that. It is a beautiful bridge to what you started with, Mary. Thank you, Pritika.

CHAIR RIDEOUT: Other questions from the committee?

Hearing none, I will move to questions or comments from the public in the room.

SPEAKER (OFF MIC): (Inaudible).

CHAIR RIDEOUT: Please. Would you like to use the podium?

SPEAKER: No, that’s okay.

CHAIR RIDEOUT: Okay.

SPEAKER: So, you mentioned that Blue Shield will be increasing their rates, correct, in 2025?

MS. DUTT: Yes.

SPEAKER: What will be the percentage that they are increasing?

MS. DUTT: For Individual or Small Group Market? Which market?

SPEAKER: Individual.

MS. DUTT: Sure. Blue Shield is at 8%.

SPEAKER: Eight percent.

MS. DUTT: Yes.

SPEAKER: This increase, will it also include them rendering better services as a part of their grievance process, when it becomes, when it pertains

to the substandard grievance processes that they have had in the past? Because, I mean, if they are increasing their rates, right, one would think that they are also increasing their productivity and how they treat grievances, correct? Because if members are paying for services, one would expect those services to be a part of their care plan, correct, unless they are paying for services that are not being rendered. So, that question is something that I would like to address.

MS. DUTT: Mary, do I take that or?

MEMBER WATANABE: Yes, I mean, I will just, I will just comment. So, I think we look at their justification for their rate increases and those are separate from the requirements in the law that they have to meet, whether it is timely access, grievance processing. There's a lot of other things that they have to comply with in the law that are separate from their justification for their rate increases, and we review that.

SPEAKER: Okay. But that kind of skirts over my question because I asked specifically about that. I understand that there are other factors pertaining to that, come into that. But I would think that focusing and honing in on the specific question that I asked is important, and important to consider. Because again, members are paying for services that are not being rendered, especially if the grievance process is a part of what they are paying for and it is not done accurately. But I will save my further statements for public comment.

MS. DUTT: So, we look at, when we do a rate review we look at like their claims data; we look at a lot of backup data to ensure that their, in this case 8%, is justified. Like Mary said, our other offices look at a plan's compliance with the other requirements of the law. So, it is like -- so in here we are focusing on your 8%, is it justified? Do you have backup data to support

that? So, that's what the actuaries are looking at; our other offices are looking at other compliance with other requirements.

SPEAKER: Are we able to get public records to see what, exactly what the requirements are in order for how they justify the percentage?

MS. DUTT: So, the rate filings are publicly available on the DMHC's website. So, if you go on our website, all the premium rate filings are public documents.

SPEAKER: To not add an undue burden or delay, I think it will be best for me to just request those public records in, like, written form. You know, just getting right straight to the point. So, I don't have to have, like, a go on your website response because it is kind of hard for me to navigate your website a little bit to find the information that I need to find. So, I guess if I do want the answers I will ask you in writing just straight across for that information.

MEMBER WATANABE: That's fine. That's fine.

MS. DUTT: There's a lot of documents so we can provide you a link.

MEMBER WATANABE: That's fine.

CHAIR RIDEOUT: Any other questions? And this is the public comment period as well so is there anything else that you wanted to say?

SPEAKER: I just want to make sure that I am able to actually have my speech at the end of the meeting. I don't want to disrupt the meeting.

CHAIR RIDEOUT: Okay, all right. Any questions or comments from the public on Zoom?

MR. STOUT: Yes, we have one. When prompted, please state your name and organization.

CHAIR RIDEOUT: You are on.

MS. CAPELL: Hi, Beth Capell, Health Access California.

With respect to the rate increases, I can assure you that in the public discussion at the Office of Health Care Affordability, all of the points that Dr. Durr raised were raised in the context of that discussion. The Board based the increase in the cost target on the ability of consumers to afford care and tied it to the growth in median family income over the last 20 years. And the approach of the Office of Health Care Affordability is rather than regulating the component rates, like how much individual doctors are paid or how much hospitals are paid, was that health care entities could actually meet the triple aim of lower costs, better outcomes and improved equity. And so that's the mission of the Office of Health Care Affordability, but where it pays off is in the discussion on rate review and the discussion you have had today. So, thank you, and we will look forward to more of this.

CHAIR RIDEOUT: Thank you, Beth.

Any other questions or comments on Zoom from the public?

MR. STOUT: None at this time.

CHAIR RIDEOUT: And any questions or comments on the phone?

MR. STOUT: None at this time.

CHAIR RIDEOUT: Thank you. All right, we will move on to the provider solvency updates with Michelle.

MS. YAMANAKA: Thanks, Jeff. Good morning, Michelle Yamanaka, Supervising Examiner in the Office of Financial Review. Today I am going to give you an update on RBO -- a risk bearing organization report, RBO financial reporting for the quarter ended 6/30/2024.

We have 210 RBOs that are required to file financial survey reports. There are two non-filers that were not/are not represented within this presentation. Both of those RBOs have less than 10,000 lives and were not on a CAP this quarter. There is one new RBO that began reporting in Quarter 2, and three RBO accounts that were deactivated. Of those deactivated accounts, one RBO was noncompliant with the grading criteria and had less than 10,000 lives, and two RBOs had between 10,000 and 30,000 lives and were compliant with all grading criteria.

There are 189 RBOs, or 91% of the RBOs that are compliant and are meeting all grading criteria. This includes 10 RBOs on our monitor closely list. And there are 19 RBOs, or 9% of the RBOs, that reported noncompliance and are on a corrective action plan or a CAP.

For our annual reporting for the fiscal year in 2024 we received one Annual Survey Report. A Majority of the RBOs have their fiscal year end December 31, the year isn't over yet. Those reports are due in 2025.

And for the fiscal year in 2023 there are 6 RBOs that have not filed their annual survey reports, which include certain independent auditors' reports. We sent a referral over to our Enforcement Division for administrative action; and of those, 5 of those RBOs have less than 10,000 lives, and one RBO has between 20 and 50,000 lives.

We also receive monthly financial statements; and 14 of those RBOs are required to file financial statements on a monthly basis. To provide some additional information on the rating criteria. There's a handout titled RBO Enrollment and Grading Criteria. It is the grading criteria for the past five quarters per RBO and it includes information, the enrollment information ranges,

relative TNE, relative working capital calculations, as well as the cash-to-claims ratio and the claims timeliness percentage.

Moving on to corrective action plans. We have 19 again. We have 19 RBOs or 9% of the RBOs. Fifteen of those RBOs are continuing from the previous quarter and we have 4 new CAPs as of quarter ended June 30. Of the 15 continuing, 13 are meeting their projections, 2 are not and we continue to work with those 2 RBOs to obtain a viable path and to make sure they are on their way to meeting the grading criteria. Of the 4 new CAPs, 2 were noncompliant with the claims timeliness efficiency and 2 RBOs were noncompliant with the financial metrics, TNE, for working capital and for cash-to-claims. Of the 19 CAPs, 14 are approved by our review as of June 30.

We also have a CAP summary report which lists each RBO. The report is sorted by MSO and it provides information regarding the RBO and their noncompliance, health plan information, enrollment information, grading criteria, and the derivation of their corrective action plan.

After our June 30 review of the RBOs, 7 of the CAPs were completed, leaving two CAPs in progress.

Moving on to the grading criteria. The first is tangible net equity or TNE. For this calculation, we use the TNE and the required TNE to calculate this ratio. The required TNE is the greater of 1% of annualized revenues or 4% of non-capitated medical expenses at. At quarter ended June 30, 153 RBOs or 73% of the RBOs had more than 500% of required TNE. One RBO reported noncompliance, which is represented in the less than 100% column.

Moving on to working capital. The calculated working capital, also known as the current ratio, by taking the comparison of current assets to current

liabilities. This measures if the RBO can meet its short-term obligations that are due within a year. At quarter ending June 30 over 90% of the RBOs reported, were able to cover their current liabilities; and there were 3 RBOs that were not meeting this working capital requirement.

Moving on to cash-to-claims ratio. The calculation for this ratio is an RBO's cash, health plan capitation receivables collectible within 30 days, divided by the total claims liability. The minimum requirement is .75, and this slide represents the 208 RBOs. At June 30, there were two RBOs that did not meet the cash-to-claims requirement; and a majority of the RBOs have sufficient cash to cover their claims liabilities.

And last is claims timeliness. There is a correction to the slide, the handouts to the Board. For the zero to 10,000 lives you had 3, 3 RBOs for this category. After additional information received, we changed it to 1. There should be 1 RBO represented in this category. So, we have a total of 4 RBOs not meeting the claims timeliness reporting, not meeting the claims timeliness requirement. One RBO in our zero to 10,000 lives, 1 RBO in our 10 to 25,000 lives, and 2 RBOs in our 25,000 lives.

Moving on to enrollment. This slide represents enrollment information reported by RBOs as of quarter end June 30, 2024. There were approximately 10.2 million enrollees assigned to the RBOs. This is a decrease of approximately 87,000 enrollees from the previous reporting period of March 31, 2024. And, the decrease was in Commercial and Medi-Cal enrollment, with an increase in Medicare enrollment. Next slide please.

Looking at the RBOs that have Medi-Cal lives assigned to them. As of June 30, there are approximately 6 million lives assigned to 79 RBOs. This

represents 59% of the total lives assigned to the 208 RBOs. Of those 79 RBOs, 68 RBOs had no financial concerns, 4 RBOs were on our monitor closely list, and 7 RBOs were on corrective action plans.

And looking at the top 20 RBOs that have more than 50% Medi-Cal lives assigned to them, at least 20, there's approximately 4.8 million lives assigned to the 20 RBOs. Eighteen of those 20 had no financial concerns, and 2 of those RBOs were on corrective action plans.

And that concludes my presentation. Happy to take any questions.

CHAIR RIDEOUT: First, I will start with questions or comments from committee members.

Michelle, I have one on the claims timeliness of RBOs.

MS. YAMANAKA: Sure.

CHAIR RIDEOUT: I realize 4 under 95% is small, but is that measured on a 30 day turnaround, a 45 day turnaround?

MS. YAMANAKA: It is a 45 day turnaround.

CHAIR RIDEOUT: So, would this change significantly with the new legislation?

MS. YAMANAKA: Yes, very possible.

CHAIR RIDEOUT: Okay. All right, any other questions from committee members? That was for you, Paul. (Laughter.)

All right, any questions or comments from members of the public in the room?

Hearing none I will move to questions or comments from the public on Zoom.

MR. STOUT: None at this time.

CHAIR RIDEOUT: Any questions or comments from the public on the phone?

MR. STOUT: None at this time.

CHAIR RIDEOUT: All right, thank you, Michelle.

We will move on now to the Health Plan Quarterly Update; back to Pritika.

MS. DUTT: Okay. I will provide you an update on the financial status of health plans at quarter ended June 30, 2024. All licensed health plans are required to submit quarterly and annual financial statements to the DMHC. Additionally, we get monthly financial statements from health plans for either newly licensed or if we have financial concerns with the plans or if the TNE falls, the tangible net equity falls to 150% of required TNE. We also included a handout that shows the enrollment at June 30, 2024 by line of business and the tangible net equity for five consecutive quarters, so it goes from June 30, 2023, to June 30, 2024, for all licensed health plans. So, we provided the handout that shows enrollment, TNE. We have also added working capital and cash-to-claims to that handout so you have more data in there and it is not just limited to enrollment and TNE. The information in the handout is broken into three categories of Full Service, Restricted Full Service and Specialized Health Plans.

As of October 1, 2024, we had 140 licensed health plans. We are currently reviewing 11 applications for licensure, 6 full service and 5 specialized. Of the 6 full service, 4 are looking at getting licensed for restricted Medicare Advantage, 1 for Medicare Advantage so they can contract directly with CMS, and then 1 for Medi-Cal. For the 5 specialized plans, 3 are looking to get licensed for EAP, 2 for dental. Additionally, we have been meeting with several

entities that are interested in obtaining a Knox-Keene license.

As of June 2024, there were 30.15 million enrollees in full service plans licensed with the DMHC. Total Commercial enrollment includes HMO, PPO, EPO and Medicare Supplement. And as you can see on the table, compared to the previous quarter, total full service enrollment had a slight decreases. It is not much but it still decreased. And the decrease was driven in the Government enrollment, as you can see in the future slides.

This slide shows the makeup of HMO enrollment by market type. HMO enrollment in all markets remained relatively stable compared to previous quarters.

And this slide shows the makeup of the PPO/EPO enrollment, again by market type. Which as you can see, the enrollment in the PPO/EPO market remained relatively stable compared to previous quarters.

This table shows the government enrollment, which is Medi-Cal and Medicare. Enrollment for both Medi-Cal and MA experienced significant growth until June 30, 2023. At June 30, Medi-Cal enrollment decreased by about 121,000 lives and Medicare Advantage enrollment increased by 25,000 lives compared to March 31, 2024. The slight drop in Medi-Cal enrollment due to redeterminations as part of public health emergency unwinding. Redeterminations started last summer and continued for the year. And DHCS has a neat dashboard on their website that shows all the enrollment changes in Medi-Cal managed care and Medi-Cal fee-for-service.

We have 27 health plans that we are monitoring closely, which includes 22 full service plans and 5 specialized plans. There are various reasons why we monitor health plans closely, which may include but is not limited to plans

newly licensed, new enrollment, financial solvency concerns, concerns with parent entity, claims processing issues identified during our exams, enforcement actions, staff turnover, to name a few, based for many more reasons. And the majority of the plans monitored closely are not very large in terms of enrollment.

One health plan did not meet the Department's minimum financial reserve or tangible net equity requirement. Meritage Health Plan reported TNE deficiency for month ending August 31, 2024. We continue to work, we continue to work with Meritage on a regular basis. We are having frequent meetings with the plan and the plan is on monthly reporting. So, the plan's parent Babylon filed bankruptcy last year so, like I said, we have been working with the plan since the bankruptcy, and the plan is in the process of changing -- right now the Department is reviewing a change in control filing.

This chart shows the TNE of health plans by line of business. 74 health plans reported TNE over 500% of required TNE, and 8 plans reported TNE below 150% and are required to submit monthly financial statements to the DMHC.

And this chart shows the TNE of full service plans by enrollment category. 65 health plans or over half of the total licensed full service plans reported TNE of over 200% of required TNE.

This chart shows the breakdown of the 24 full service plans in the 150% to 250% range. If a health plan's TNE falls below 150% the plan is placed on monthly reporting. We also monitor the health plans closely if we observe a declining trend in their financial performance, which includes their TNE dropping, their net income is dropping, they are reporting losses, decline in enrollment and so forth.

This chart shows the TNE of full service plans by quarter and summarizes the information in the handout. For detailed information on plan TNE levels and enrollment please refer to the handout that was provided with the meeting materials. Over 50% of the health plans reported over 250% of required TNE. Because TNE also includes plans' fixed assets, receivables and assets that may not be easily converted to cash, we also analyze other financial criteria to ensure financial viability of health plans. High TNE may not always equate to a high cash position or indicate a financially solvent plan.

This slide shows working capital for full service plans by enrollment as of June 30, 2024. Working capital measures the health plan's ability to pay its bills that are due within the year. We want the ratio to be over one, which indicates the plan has enough short-term assets to cover short-term liabilities that will be due within the year. And as you can see here in this table, 16 health plans reported working capital of less than one, where one equates to 100% when you look at percentages.

And this slide shows the cash-to-claims ratio for full service health plans by enrollment. So, cash-to-claims ratio mentions a health plan's ability to pay its unpaid claims using its cash, marketable securities and receivables. It is calculated by dividing cash, marketable securities and receivables by claims payable incurred but not reported claims. Similar to working capital, we want the health plans to maintain a cash-to-claims ratio of over one, or 100%, because it shows they have enough cash to pay their claims to providers.

And that brings me to the end of the presentation. Back to you, Jeff, for questions.

CHAIR RIDEOUT: Paul, committee member.

MEMBER DURR: Thank you. Yes. First question, Pritika. I love your summary so thank you. Meritage, interesting because that name is unique so I went back and it is also what Michelle was talking about. I assume it is the same organization, Meritage Health Plan --

MS. DUTT: Yes.

MEMBER DURR: -- Meritage Health Network. Is there a bigger concern with Meritage? Obviously, you guys are talking because you are right next to each other, but I would presume that there is a bigger thing going on with Meritage there.

MS. DUTT: So, the plan that works on the health plan monitoring and the RBOs. They coordinate on the oversight activities around RBOs and health plans. They are affiliates. So, for Meritage Medical Network, it is the parent entity for Meritage Health Plan. Their parent entity Babylon filed bankruptcy last year and so Meritage has been in the process of identifying buyer, a buyer. We are currently reviewing a change in control filing from the plan, which is in the DMHC review. So, we are making sure that the change in control filing meets the DMHC's requirement, it checks all the boxes, the plan is clearly outlined. So, in the meantime we are working on corrective action plans for both the RBO and the health plan. So, like I said, all the, the full teams are coordinating on the analysis and the review.

MEMBER DURR: Okay, perfect. My only other comment was the notice on the cash-to-claims ratio and the working capital. You have got 16 plans, you have got 30 plans that are less than one. Obviously indicating that -- because when you look at tangible net equity, they all have pretty good tangible net equity, so it is still the fact that they are doing investments and other things.

So, obviously you are aware of that, and no concern, but only concern about liquidation of some of that stuff to get cash to be able to pay the providers appropriately and do all of that. I just found that an interesting observation that, you know, they must be doing something else with their cash.

MS. DUTT: Some of the TNE could be made up of buildings, right, they own.

MEMBER DURR: Right, exactly.

MS. DUTT: You cannot sell that to pay bills.

MEMBER DURR: Right. You can borrow against it, but you can't --

MS. DUTT: You can borrow against it, yes.

MEMBER DURR: Yes, exactly. That was my connection because they have to be putting that cash into other purposes. What I want to make sure is that they are not disadvantaging the providers and not having the cash to pay them appropriately. So, thank you.

CHAIR RIDEOUT: Paul, to follow up on that. Noticing the same thing. You have got 30 plans out of 97 that have a cash-to-claim ratio of less than one. And I think one of the reasons we have been asking for these kinds of metrics is because they are more revealing to a certain extent.

Pritika, is there a way you could trend cash-to-claim and working capital by quarter like you do for TNE? It should be pretty simple I would think.

MS. DUTT: We can, yes.

CHAIR RIDEOUT: That's moving --

MS. DUTT: You will just get a longer table. But we can add that, definitely. We have all the data.

CHAIR RIDEOUT: All right. Other questions or comments from committee members?

Seeing none and hearing none we will move to questions or comments from the public in the room.

Seeing none we will move to questions or comments from the public on Zoom? There are none.

CHAIR RIDEOUT: And finally, questions or comments from the public on the phone?

MR. STOUT: None at this time.

CHAIR RIDEOUT: Okay, we will move on to an administrative matter for meeting dates for 2025.

MEMBER WATANABE: So, we shared the meeting dates at the last meeting, and our goal is to finalize these. We didn't hear any feedback on these dates, so hopefully they work for everybody. So, we will plan on our next meeting being in February unless anybody says there's a conflict. But we didn't hear anything, so we will go forward with these.

CHAIR RIDEOUT: Okay, the next item is Agenda Items for Future Meetings. And, Mary, maybe you can start with what we will look at at the next meeting in February.

MEMBER WATANABE: Yes. So, I think at our next meeting we will plan on having a Covered California presentation on just kind of all the things that happened during open enrollment. So, that's the plan for February. And then we will be back on a cadence to have DHCS probably join us every other meeting and fill in with an update on OHCA and all things from HCAI too. So, that's -- I think, we typically present or at least share the dental MLR report in

February too, and then happy to answer questions. But I think that's what we have scheduled for February unless you all have other items.

CHAIR RIDEOUT: Any other items? Public thoughts?

All right, our last is just Closing Remarks and we will have one more public comment, I think. We are heading into the end of the year, so I want to wish everybody Happy Holidays, whatever you celebrate or don't celebrate. It has been, I think, a good year, a very busy year for sure. I personally found the level of engagement, especially on the OHCA report today, very helpful because it helps us see that alignment and where it is going, so thank you for teeing that up. All right.

So, did you have a final public comment you'd like to make?

SPEAKER: Yes, and I will actually come up to the podium.

CHAIR RIDEOUT: Okay, thank you.

SPEAKER: Jeff, first I would like to thank you for always being respectful. I felt like you were respectful the last time that I actually appeared virtually. And I just want to let you know personally that my disdain has nothing to do with you. I actually have a disdain toward Sarah Ream and Mary Watanabe for their actions, or I should say dis-actions, for the things that I went through when I had my complaint against my insurance companies that they actually did not pay attention to.

I actually wrote a public comment that I would like to be a part of your minutes. You can attach it as an attachment. I don't have my name on here or any private information, but I wanted to just summarize it. I had intentions on coming up here, talking about how last time I was asked to provide my name and stuff like that, but I feel like it is not imperative for me to discuss that now,

considering the fact that you respected my wishes to speak earlier, sitting down, and I really appreciate that, and I mean that from the bottom of my heart, okay. So, although I have disdain, I am still a respectful individual that can understand when I am respected as well.

Now, I don't speak about just myself. I speak for the -- I am advocating for the rights of other people as well, and that's why I am here. I am here to discuss about the disparities within the health plans. I actually have 100% proof.

Last time when I was meeting with you, virtually, it was said to me that you guys don't enforce, you only assess. Well, I've seen that that's not true because I have your press release right here. And although it is dated in 2017, it is a press release where the Department of Managed Health Care actually fined and enforced grievances or issues within Anthem Blue Cross for $5 million for systemic grievances within their plan, with their grievance system, the same issues that I have had with their grievance system and other health plan grievance systems as well.

It is imperative that when members call in for verbalizing their grievances, that the grievances are taken into consideration. They are not, in turn, manipulated, lied, which in turn becomes fraudulent statements. Because when they respond to your grievances, those grievances are actually provided to you, to the -- to the insurance plan, and eventually to the Department of Managed Health Care later on if the member does not like the response. And, I mean, I have recorded all the conversations between myself and the health plans, to where I have substantial proof that those lies were done, and I did not appreciate that.

One example in which -- recently I asked for my designated record set from Anthem Blue -- Anthem Blue Cross. I asked for my designated record set on multiple occasions. I called Anthem Blue Cross, and I was actually laughed at on the phone. All those calls are recorded. I was told that they do not have designated records set. I was told to call my -- my doctor's office. And they told me they were not going to look up what the term designated record set meant. It is a term solely for insurance companies. Not for doctor's offices, for insurance companies alone. And I was laughed at.

So, I filed a complaint with the Department of Managed Health Care prematurely. I already knew I had to wait 30 days. I did it prematurely to put some fire underneath the insurance company. I already knew what the rules were. But low in turn, my prematurely complaint was taken by the Department of Managed Health Care, and it was provided to Anthem. Anthem finally sent my records. But guess what they did? They sent it to the wrong address. They sent my PHI to an address where I lived over 8 to 10 years ago. No one ever confirmed what my current address was. No one ever cared to confirm it. No one ever had the decency to call me to confirm it. That was a hot mess. And then when I found out it was sent over there, I asked for the tracking number. I did not receive the tracking number so I can actually file charges against the person that had my PHI or to even file a report with the United States Post Office until one to two months later. And the Department of Managed Health Care were very well aware that I needed that tracking number in order to do that.

Then this is the response I got from the Department of Managed Health Care, saying that Anthem complied with the law.

First of all, they were late giving me my records, that's number one.

Number two, they sent it to the wrong address. And number three, I was laughed at when I continued to ask them where to send my request to. Because per law I am supposed to provide that request in writing. I never even submitted the request in writing. For if I had been able to, just like I did with Health Net and Molina, I would have provided them my old address versus my current address. I did it exactly with Molina and Health Net just like that, and I would have been able to do that with Anthem, but they prohibited me from doing that.

CHAIR RIDEOUT: Just, respectfully.

SPEAKER: That's fine. I have a statement, so that's fine.

CHAIR RIDEOUT: Can you include all of this detail in the written statement that you will provide.

SPEAKER: Oh yeah, yeah, yeah. Most of it is in my written statement. And again, all I want to do is have this attached to your minutes when you create your minutes. And again, this right here alone, this press release about how Mary Watanabe said that all you guys do is assess, when you -- when you do more than assessing, you enforce, which was a blanket lie. I --

CHAIR RIDEOUT: Maybe one correction. I believe her comment that was from the last meeting --

SPEAKER: I --

CHAIR RIDEOUT: Was about this advisory committee. We are advisory.

SPEAKER: Mm-hmm.

CHAIR RIDEOUT: The Department is not advisory, obviously. So, I just want to make sure that that's clear.

SPEAKER: And I also want to make sure that I address the fact

that I would love to attend your health equity and quality committee meetings. Unfortunately, there has been absolutely no updates to this committee as to when future meetings will be held after their last meeting, which was held on October 16, 2023, an entire year ago. I have looked for future meetings. I could not find this. Because my situation is more catered to the quality and equity, not financial solvency.

However, the things that I addressed earlier are catered to financial solvency. Because here's the thing, if I am paying for those services, which are a part of being able to pay for them to learn how to adequately take my grievances on the phone and not change it and alter it into something that was never said, into something that they want to manipulate it to, I am paying for services that are not being rendered, and I have a problem with that. Because they are collecting government -- it is a misappropriation of government funds, because that's how they receive their funds. Because if you are getting Medi-Cal they are getting the money from the government. If I am paying directly, I say for instance because I am a state employee now, they are getting my money out of my paycheck every single month, and I am paying for services that are not being rendered, and that is a problem for me.

So, again, I know that I was prepared to read this, but, you know, sometimes emotions get away. And I appreciate you, I really appreciate you for taking the time to listen to me. Now I have the proof that you wanted last time.

CHAIR RIDEOUT: Thank you.

All right, I think we will consider the meeting adjourned at this point unless there are any other comments. All right, thank you very much.

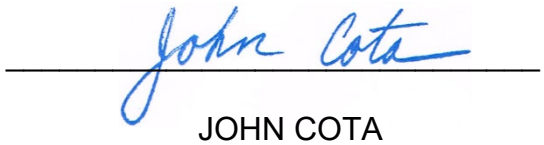
(The meeting was adjourned at 12:28 p.m.)

CERTIFICATE OF REPORTER

I, JOHN COTA, an Electronic Reporter, do hereby certify that I am a disinterested person herein; that I recorded the foregoing California Department of Managed Health Care Health Financial Solvency Standards Board meeting and that it was thereafter transcribed.

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

IN WITNESS WHEREOF, I have hereunto set my hand this 5th day of November, 2024.



JOHN COTA

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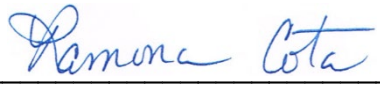
I, RAMONA COTA, a Certified Electronic Reporter and Transcriber, certify that the foregoing is a correct transcript, to the best of my ability, from the electronic recording of the proceedings in the above-entitled matter.



November 5, 2024

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