STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, FEBRUARY 22, 2023

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Larry deGhetaldi, MD, Chair

Scott Coffin

Abbi Coursolle

Paul Durr

Jeff Rideout, MD

Mary Watanabe

Amy Yao

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Sarah Ream, Chief Counsel

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Jessica Altman, Executive Director
Covered California

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PROCEEDINGS

CHAIR DEGHETALDI: Hello, everybody. Welcome to the FSSB Board meeting for February 2023. This is Larry DeGhetaldi, our Chair this year. I would like to welcome everybody from our DMHC staff to Board Members and the public.

I think, Mary, the agenda shows introduction of new members but maybe you will mention that in your comments after I go through the usual housekeeping notes. Does that sound okay?

MEMBER WATANABE: (Nodded.) I am nodding my head yes, go ahead.

CHAIR DEGHETALDI: I saw the nod. Okay. Let me just review. Go with me, I will go through this fairly quickly. Sort of the ground rules, what we call the housekeeping notes for the Board Members and the public.

And so for our Board Members, please remember to unmute yourselves when making a comment and then mute yourselves when not speaking. For our Board Members and the public, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue.

Questions and comments will be taken after each agenda item. For the attendees on the phone, if you would like to ask a question or make a comment please dial *9 and state your name and the organization you are representing for the record. Typically, if you come on for a later comment you don't have to restate your organization.

For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or 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 remember to click Lower Hand because we won't know whether you have raised your hand again. All questions and comments will be taken in order of the raised hands.

As a reminder, FSSB is subject to the Bagley-Keene Open Meeting Act. Operating in compliance with the act can sometimes feel inefficient and frustrating but it is essential to preserving the public's right to governmental transparency and accountability.

Among other things, the Bagley-Keene Act requires the FSSB meetings to be open to the public. As such, it is important that members of the Board 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.

Likewise, the Bagley-Keene Act prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if a majority of the Board Members emailed, texted or spoke with each other about matters within the FSSB's purview. Such communications would be impermissible, even if done asynchronously. That is, member one emails member two, who emails member three. Accordingly, we ask that all Members refrain from emailing or communicating with each other about FSSB matters outside the confines of a public FSSB meeting.

Are there any questions from Board Members about that? I think you have heard it multiple times before.

Okay then, we get to jump right in. I think my agenda is not up, Mary, but I think your comments --

Oh, I'm sorry, the transcript from November 16. Are there any corrections or additions? And if none, I would like a motion to accept the meeting summary.

MEMBER DURR: I will make a motion to accept.

CHAIR DEGHETALDI: Okay, Paul, thanks.

MEMBER YAO: Second.

CHAIR DEGHETALDI: Second? Was that Amy? I couldn't hear.

MEMBER YAO: Yes, I just said yes, accept, second.

CHAIR DEGHETALDI: Hi. Hi, Amy, hi.

Okay, all those in favor raise your hand or say aye.

(Ayes and raised hands.)

CHAIR DEGHETALDI: Okay, now it is Mary's turn.

MEMBER WATANABE: Did you want to do introductions really quickly of the Board just for anybody that may be joining us that is new?

CHAIR DEGHETALDI: Oh, goodness, oh, goodness, absolutely. Let's start again south to north, putting Paul on the spot, I think.

MEMBER DURR: Paul Durr, CEO for Sharp Community Medical Group, an IPA in San Diego.

CHAIR DEGHETALDI: And who is next coming north?

MEMBER RIDEOUT: I don't know north/south but this is Jeff Rideout; I am the CEO of the Integrated Health Care Association. Thank you, Larry.

MEMBER YAO: Amy Yao, Chief Actuary of Blue Shield of California.

MEMBER COURSOLLE: Abbi Coursolle, Senior Attorney with the

National Health Law Program.

CHAIR DEGHETALDI: Scott.

MEMBER COFFIN: Scott Coffin, CEO, Alameda Alliance for Health.

CHAIR DEGHETALDI: And Larry DeGhetaldi, a family practice physician in Santa Cruz, part of Palo Alto Medical Foundation. Great. And I don't think we missed anyone so let's move forward.

MEMBER WATANABE: Yes, you ready?

CHAIR DEGHETALDI: Excellent. Let's hear about -- Well, let me just say, again thank Ted Mazer for his service. He is on the Gulf Coast side of Florida dodging hurricanes and I think he would like to be back in California joining us today, but alas. Maybe, Mary, you can talk about Ted's replacement.

MEMBER WATANABE: I would be happy to start with that. We do have a new Board Member. We had thought maybe he would be joining us today but he had a previous commitment that he had, plans he had made in advance of accepting the position on the Board. So we will be welcoming Dr. Mark Kogan at our next board meeting. He is a practicing gastroenterologist who is in the San Pablo area. He still sees patients one day a week at the Contra Costa Regional Medical Center as well. He is very familiar with a lot of the groups that we work with including the Medi-Cal managed care plans. He has been on the Finance Committee for an IPA. He currently serves on the board and executive committee of the Alameda Contra Costa Medical Association and has served on the CMA board for nine years as well. So looking forward to welcoming Dr. Kogan. Ted did warn him and gave him lots of background about the Board but he is very excited to learn and get to know all of

us at the next meeting so we look forward to having him join us in May.

So I will just continue on with a couple of updates. I will just note, Jessica Altman, the Executive Director of Covered California is here with us and I am going to move quickly because I can't wait to hear her updates. I don't believe, at least in my time at the Department, we have had Covered California present at our FSSB meeting so looking forward to hearing from Jessica.

I will just start quickly with the governor's budget. So Governor Newsom released his proposed ‘23-24 state budget on January 10. Due to continued high inflation, multiple Federal Reserve Bank interest rate increases and further stock market declines the governor's budget forecast general fund revenues will be about $29.5 billion dollars lower than were projected at the adoption of the 2022 Budget Act. This will result in a projected budget gap of about 22.5 billion in the upcoming fiscal year.

So to address the projected budget gap the governor's budget reflects a balanced plan of funding delays, reduction, fund shifts, trigger reductions and limited borrowing.

I am pleased to see that the governor's budget includes about 230.5 billion for all of our health and human service programs. So within our California Health and Human Services Department budgets the administration really focused budget solutions on delaying new or one time spending. It does propose the renewal of the Managed Care Organization or MCO tax to support the Medi-Cal program, offsetting an estimated 6.5 billion in general fund spending over three years. So the MCO tax is something I think many of us are familiar with.

It also maintains continued funding to expand full scope Medi-Cal

eligibility to all income-eligible Californians regardless of immigration status. It sustains approximately 10 billion in total funds committed to continuing the transformation through CalAIM and about 8 billion in total funds across various departments to expand the continuum of behavioral health treatment and infrastructure capacity.

The DMHC's budget, we have nine budget change proposals primarily related to new legislation implementation and increased workload as we have continued to grow. So we will have more to come on kind of the state's budget and the DMHC's budget after we have the May revision and we have a better sense of actual state revenue, so more to come on that.

I did want to mention one budget item that we will be working on that I will continue to provide updates on, which is that we will be convening a Transgender, Gender Diverse and Intersex or TGI Working Group. This was a requirement of SB 923 which was authored by Senator Wiener and signed by the governor last year. The California Health and Human Services Agency has delegated the function of convening this working group to the DMHC. This working group, their recommendations will really align really well with some of the health equity and quality work we did last year. The purpose is really for them to make a recommendation on a quality standard to assess patient experience and to measure cultural competency related to the TGI community. They will also make recommendations for a trans-inclusive training curriculum that will be used by health plan staff who are in direct contact with enrollees in the delivery of health care services. We have issued a solicitation for participation on the working group. We got a very good response and we will be announcing and selecting those members shortly. We expect the first working group meeting to

convene here in probably the next month or so and these meetings will be open to the public. So excited to be working on that this year.

A quick update on our Health Equity and Quality Committee. I know we have talked quite a bit about this. But at the end of last year we issued guidance to the plans on the measures to be collected and reported for measurement year 2023. We made the decision to adopt all 13 measures that were recommended by the committee and will require those measures to be stratified by race and ethnicity.

We have not made a decision yet about the Benchmark Committee. If you know this is what keeps me up at night. We are taking a little more time to engage with stakeholders and continue the discussion about some different approaches. But anticipate we will make a decision probably sometime this summer so we can we can begin the process of codifying those measures in the benchmarking regulation.

I wanted to just highlight two reports that we have released since the last meeting. Our first is our prescription drug cost transparency report that was required by SB 17. We released this towards the end of last year. This report looks at the cost of prescription drugs on health plan premiums and includes a comparison of prescription drug costs over the last five years. The report revealed that health plan spending on prescription drugs increased by 2.1 billion since 2017 and it increased by 700 million in 2021. The report also includes some really good information on the total volume of prescription drugs covered by plans and the total costs paid by plans. And this is the report where we also look at the 25 most frequently prescribed drugs, the 25 most costly drugs and the 25 drugs with the highest year-over-year increase in total annual

spending. At the next board meeting Pritika will be telling, sharing more information with us on the average rate increases in both the individual, small and large group market and we will have more information about kind of overall what we are seeing in prescription drug cost trends as well. You can find that report on our website under our Report webpage.

At the end of January we released our timely access report for measurement year 2021. This report includes the results of the provider appointment availability surveys submitted by health plans, including the percentage of providers who had an appointment available within the timely access standards. Overall in measurement year 2021 we saw a decline compared to the prior year. Commercial plans reported the smallest decline across all categories. And we saw Medi-Cal plans report a larger decline, primarily for non-urgent appointments. Again, that report is on our website so you can check that out.

And then finally, just a COVID update. I know everybody is tracking and thinking about the end of the state public health emergency here this month and the end of the federal public health emergency in May. Sarah Ream is going to talk a little bit more about the impact of that and the legislation we have had a little bit later here in our agenda.

But that is my update. I would be happy to take any questions.

CHAIR DEGHETALDI: Sure. Any questions from Board Members or comments or concerns? Paul.

MEMBER DURR: Yes, Mary, great overview, thank you. My question centers around the budget and the staffing, as you mentioned, to increase that. Are you able to find the staff, one, having the budget, but are you

able to find staff? Because the work that you are doing is very important and I know that there is a lot there. But just if you could comment on staffing?

MEMBER WATANABE: Yes, no. I will say that I think like everybody else we are also having some challenges just with the number of applicants. In my twenty-plus years in state service we have never had an issue with getting an overwhelming response to most of our applications and we just are not getting that like we used to. We are primarily telework and so we are hoping our telework environment helps to encourage that. We certainly would not have the space to house the number of employees we have now. We are also getting creative just in how we promote and try to recruit. So, you know, we are seeing a little bit of an improvement in the last few months, I don't know if others are, but that continues to be a challenge. Particularly in our -- we are looking for lots of attorneys, our IT classifications and some of the more technical classifications as well.

CHAIR DEGHETALDI: Other Board Members? Mary, I did want to comment. I think that the pivot to health equity in the post-COVID era is, you know, everyone is focused on that. And I have been promoting DMHC's work on the 13 core measures as sort of, at least California leading. And because, you know, so many different agencies focus on different clinical quality measures, to have sort of a core set of 13 is really important. And I just want to thank you and DMHC for working, you know, making these 13 visible, 12 quality, one patient experience. CMS just published a paper in *New England Journal* identifying core measures that need to be studied around the country for quality and their health equity focused on social determinant data capture, which we are all doing, certainly on the acute side.

I just wanted to reflect on my 25 years on clinical quality. Medical groups have better information on California's patient's story than health plans. Ideally, you combine them both. And I think IHA's work on clinical quality CMQCC's work on maternal safety and maternal mortality, you know, combined the health plan data and medical group data. I am a little bit worried that the health plans don't have the health equity data in and of themselves and that we need a convener or a way to capture what the provider organizations have and the health plans have so that we have a full picture of health equity. You know, the race/ethnicity data. And you mentioned SOGI data, sexual orientation. We need that data. We need disability status. We need the, you know, poverty lens as well.

So just going forward I am worried that we may not get there if we don't get both, you know, health plan data on health equity and provider. Do you understand what I am saying?

MEMBER WATANABE: I do.

CHAIR DEGHETALDI: Is how do we get the whole --

MEMBER WATANABE: Yes, no, I do.

CHAIR DEGHETALDI: Yes, I am just worried about that. I don't know if others are. Anyway, yes.

MEMBER WATANABE: I know Jeff has something to add here, I am sure. But I will just say this came up in the committee discussion. One of the recommendations was for us to have a process measure which we are still planning to do, which would really ask the plans to report on the completeness of their demographic data beyond just race and ethnicity. SOGI data is obviously at the top of that list along with disability status and others. So we plan to start to

look at that. There is also a lot of work with the Data Exchange Framework and other federal activities that I think are looking to improve the collection. But agree that that's not just at the health plan level but will require the medical group data as well because a lot of that data is really collected at either the physician level or at the provider group level. But appreciate your comment. Jeff, you want to add?

MEMBER RIDEOUT: Yes. We have shared this information both in this forum and other forums, but a couple of things. Our data set, which is 20 million member level records from all the major health plans, what we found is that on average the race/ethnicity field is filled out less than 10% of the time, and that will be higher or lower depending on the plan. But there is no reason to believe that that number is going to be any better if the plans themselves are asked to report on the measures directly. And I personally just will say, I think it is creating more issues in terms of reliability if the plans are reporting directly versus using a common data source, whether it is ours or the HPD's or anybody else's.

The second thing I would say, and this goes to another project that we are working on, is encounter data. If you look at the four core measures that Covered California, CalPERS, DHCS and DMHC are aligned around, which are a subset of the 13. Each one of those has some very, very challenging issues related to provider versus plan data. So immunizations, colorectal cancer screening, hemoglobin A1c level requires a lab result. You know, you just go down the list and these are sort of the ghosts of the past. But these are the ones that go missing because people are capitated for those services oftentimes and so those are the ones that go with an encounter data program.

So I would stress, and Mary you have heard me say this in other forums, encounter data equals better quality data; and demographic data needs to be either collected directly or we need to impute it up to the point where we understand better that the data coming in is reliable enough to report on. So maybe a plug for us, maybe not.

I am just saying that these things are all really converging very rapidly now and solving for the quality of the data coming in, as well as sort of the various performance levels that seem to be coming out of different plans or providers, if that is the accountable entity, you know, we are going to be chasing a lot of, you know, is this a data problem or is this a real performance issue? And I know a lot of people don't want to believe that those two things should be separated, they are one and the same, but I think the challenges of solving those things are really upon us more than ever before. So that's my soapbox.

CHAIR DEGHETALDI: And Scott.

MEMBER COFFIN: Yes, a comment just to add on, you know, around the importance of data and gathering all this data because many of the system leaders are looking at ways to combine this data and also share the appropriate data for purposes of coordinated care. The standard enrollment file that comes from the Department of Health Care Services into the managed care system does not contain a lot of that social determinants information that we need. And so like in Alameda County we have, over the years, invested in a local health information exchange which we are building upon, and we are still learning, you know, which data elements need to be navigated through the system and then, you know, shared externally for purposes of care coordination. But I would just highlight that the standard data that is coming, you know, through

the enrollment process is limited and you have to build upon that.

The second is, there is a significant amount of contact information that is incorrect and so recently the Department Health Care Services issued some statements around the bad addresses. And so it is just something for everyone to call out, I think, and realize that we need to think about ways to locally be able to help update those records. As they are, you know, visiting for their primary care or specialty appointment, that we are able to take that information and provide it back to the state for purposes of updating. Because it is significant; 20 to 30 percent is what we are seeing here in Alameda County.

CHAIR DEGHETALDI: Thanks, Scott. Any other comments?

I would just say, Mary, in an ideal world, and let's just talk about a Medi-Cal patient colorectal cancer screening. The patient-reported data on race/ethnicity is the gold standard. We have that data, most providers are capturing that. We probably have a better understanding of the patient's clinical history on the cancer screening metrics. The health plans could help augment that data. As what Scott said, a Health Information Exchange could augment that data to have the most accurate, complete SDOH-laden race, real data, disability status. And that, I would hope that we could get there.

Scott, is your hand still up or you just don't know how to lower it?

MEMBER COFFIN: I am just figuring now what Lower Hand means so I will go ahead and do that, thanks.

CHAIR DEGHETALDI: Good, yes. Hey, okay, well done. If we can then, Mary, thank you for that.

This is really exciting. We are going to have a presentation, I think this is the first time in my 10 years on the Board, from Covered California, and to

learn about all the exciting stuff that our Exchange partner. And I think Covered California after the ACA was passed was the very first data exchange, correct me if I am wrong, that was approved in the nation? So let's hear. And I think, is it Jessica, are you going to run with this? Oh, you are on mute.

MS. ALTMAN: How about now?

CHAIR DEGHETALDI: Perfect, thanks.

MS. ALTMAN: It was a device setting issue, but that happen. As long as you can hear me I think we are good. I think the DMHC team is going to be kind enough to help me control my slides. Perfect.

So first of all, it is wonderful to be here. Wonderful to get to speak with all of you and great to hear, I think, some of the conversation. I think as you will see, there are a lot of through lines to many of the things that you are talking about here, many of the questions that you asked, and some of the work that we are doing at Covered California. And really the work that we are doing at Covered California in close partnership and alignment with other entities across the state including DMHC, including CalPERS, including DHCS, but also, you know, partners like IHA, like PBGH. So it is a really exciting time to be in California.

By way of a first update, I am the new Executive Director. Many of you have probably been very familiar with Peter Lee and his incredible leadership. As Larry mentioned, the first state to pass legislation to create a health insurance exchange in California, the largest state-based marketplace in the country, and just an incredible force for the Affordable Care Act.

I have been here, somehow my one year mark is coming next month so it has flown, flown by. But by way of introduction, I come with a deep

background in the Affordable Care Act having served in the Federal Department of Health and Human Services just after the passage of the Affordable Care Act, working to implement all of the new provisions.

And then most recently, before California, serving as insurance commissioner of Pennsylvania, where I had the opportunity to lead the effort to transition Pennsylvania off of the federal exchange to their own state exchange, which they did just three years ago, so much later than California. But in that role, among many other things, Pennsylvania is a bit different from California so the insurance commissioner there is a cabinet appointed, not elected position, and there isn't a separate health care related regulatory agency. So among many other things, overseeing solvency was within my purview so this is certainly what you all are working on is something that is deep in my history.

But with that, wonderful to meet all of you. I should add, I grew up in California. I grew up in the Bay Area so for me this is an incredible opportunity to come home to do the work that I love to do. I could not say better things about the fantastic team at Covered California and across state government, coming quickly on my year.

So on the next slide, just to -- I thought it was important to start with kind of where we are. Covered California, somehow we just celebrated our 10th anniversary and just completed our 10th open enrollment period. So hitting that decade, hitting that turn is a natural time to both reflect on where we have come and what we have accomplished and also look forward to where we go from here and what we do in the next 10 years.

And it was really exciting to be able to enter this 10th open enrollment period with really, really at a high point in Covered California's history

in California's efforts to increase access to health care. We had the highest enrollment ever last year. As we headed into open enrollment over 1.7 million Californians enrolled. We continue to have over 1.7 million Californians enrolled following this open enrollment period.

We saw also the lowest uninsured rate in the state during the pandemic, so an incredible outcome in light of so many challenges in health care. And I will talk more about this later, but we also are offering the highest level of affordability that we have had on Covered California empowered by first the American Rescue Plan and then the Inflation Reduction Act, which has extended our enhanced and expanded subsidy structure that we now have, through 2025.

Just to comment on what we saw from a rate perspective this year. After the very late passage of the Inflation Reduction Act, which secured those extended subsidies, we locked in a final rate change of 5.6%, which is higher than we have had in recent years. Much lower than what was seen around the country and really just a general return to normalcy after some very unique and low years during the pandemic. And just for -- many of you may know this but Covered California negotiates rates with our plans and then DMHC reviews them as the regulator. So that is a very close working partnership and way that we kind of work together from our different vantage points, perspectives and leverage points as well through that process.

And I will just note the last bullet here. I think Covered California in many ways is a tale of resiliency and stability through the Affordable Care Act. This is one of many measures that just shows how we have delivered on that and frankly outperformed the rest of the country in navigating through these years for a lot of very good and very important reasons and one of them is that our

average rate change in recent years is just 2.3%.

So on the next slide, and I did mention this, this just shows, again, the incredible progress that California has made since the passage of the Affordable Care Act. Driving our uninsured rate down from 17% to somewhere around 7% depending on which data source you are looking at. And I will just note that this is the largest decrease of any state in the nation since the passage of the Affordable Care Act and really indicative of how we have leaned in both through Covered California and our efforts to reach Californians but also, of course, through the Medicaid expansion and the incredible work of DHCS and our partners in Medi-Cal.

I also want to note on the next slide that as -- so we reached record enrollment, and I mentioned this, during the pandemic. One of the things we were incredibly excited to see at a time when we were laying bare so much of the disparities and inequities in our healthcare system is that we saw disproportionate gains in coverage for our communities of color. So a 14% increase for White and Asian American enrollees, but 18% for Latinos and a 33% enrollment increase for African Americans. I am happy to talk about this later since there was discussion. We actually have real data on over 80% of those that we cover and so a real opportunity for us to have access to that robust data and have such an in depth understanding of the demographic makeup of those that we cover and what that means for their access to care.

On the next slide I think one more here just showing our current demographics. I will skip over quickly.

And then on the next slide, one more, please, thank you.

So this is, again, just another reflection, kind of a different way of

cutting the data on that line graph that we saw. The reason, if you look here, anything that is in color is because of the Affordable Care Act. And I think that shows how our coverage pie, as we see in this pie graph, has grown and has really been built into the fabric of how we provide care. And I cannot say enough about how much this meant during the pandemic and how much it meant that when people if they lost a job, if they lost coverage related to their job, even if they lost their job just for a temporary period of time, that they didn't have to lose access to health care at the same time. That it didn't matter that they had a preexisting condition, any of those things. This has really been such a core of what we went through in the past recent years.

On the next slide. So I did want to just highlight this because in our world it is everything but I think others in healthcare haven't always, always paid as much attention to it. But this is really looking at what the enhanced subsidy structure has meant for those that are covered through Covered California. And I would note, the impact has been incredible in many ways. California also led the way in this conversation with the state subsidy that Governor Newsom and the legislature put forward and Covered California implemented before the pandemic. And really the federal subsidy structure is an expanded version of what California moved first to do and really showed that there were areas where the ACA original subsidy structure wasn't doing what we wanted it to do. But I think also I am already starting to just remind folks that as excited as we are to see the extension through 2025, 2025 is going to be here faster than we know and so it is important to think about both what we have now and what we are able to offer and what that means to Californians. But also just to think about what might happen here. And I would note that this is one thing that President

Biden called for in the State of the Union to make permanent, so there is a conversation going on about that.

So on the next slide you can see one of the first of three graphs. This really focuses overall what does the enhanced equity structure mean for what our enrollees are paying? So we have nearly a quarter of subsidized enrollees who have a $0 monthly net premium, and this is from 2022. And nearly half of enrollees are paying $50 or less per month for their coverage.

The next two slides really break this down into two groups, which I think is important. The enhanced subsidies both increased the subsidies available to those already having them, which is what you can see on this slide are the lowest income populations that we cover, are seeing their premiums drop from an average of 131 to an average of 75. Those less than 150, $30 less per month, which is a huge savings when you are talking about individuals and families at this income level.

But then the other thing on the next slide that this enhanced subsidy structure did was make subsidies available to those that didn't have access to them before. So the original ACA structure provided subsidies up to 400% of the federal poverty level, but not above it, so there was what many people refer to as a subsidy cliff. These new laws came in and said, We are not going to have a cliff anymore, we are instead going to have a rule that no one should have to pay more than eight and a half percent of their income for a benchmark plan. And that opened up subsidies for middle income families who were really seeing unaffordable levels before. And here you can see that that is resulting in an average of over $300 in savings per month for those in these middle income brackets that are -- many of whom are covered through Covered

California.

On the next slide again, and I think in particular since we haven't presented to you all before, I wanted to just talk about -- oh, sorry, I forgot I had one more slide here. So just summarizing:

Nearly a quarter of subsidized enrollees have a $0 monthly premium.

Nearly half of enrollees are paying $50 or less per month.

Nearly half of those with incomes under 400% can find a Silver plan for less than $10 a month.

And we also estimate that about over a quarter million uninsured Californians could get a Covered California plan for under $10 a month.

And so we really view the first three bullets as incredible progress and the fourth bullet as an opportunity and a responsibility for us to continue to work to reach those that could be covered.

I will just throw out one more statistic for you, which is that when you bring Medi-Cal into this picture we estimate that there are over 1 million Californians who are eligible for low or no-cost coverage, either through Medi-Cal or Covered California, but who are going uninsured today. And so again, I think the incredible progress we have made but also the work that we have left. Sorry about that.

So moving on to the next slide, I just wanted to talk about some of the things that are unique to Covered California that have really, in particular, facilitated our commitment to move beyond coverage. To focus on quality and value and to be a catalyst for change in those areas but then also some other things about what that has meant for competitiveness in the market.

So the first is, on the next slide, a real commitment to standard benefit plan design. So all the plans in Covered California fall into a metal level. You can see here those metal levels are delineated by actuarial values of 60, 70, 80, 90%. And we actually go through a process each and every year where we design the cost-sharing structure that really allows these plans to be at those actuarial values.

And when you standardize those factors, first of all, you can prioritize how you want consumers to see costs, you can prioritize helping consumers to avoid gotcha costs that they don't expect and don't understand. But it also changes the competitive playing field where in other states you have these benefit designs, how you do the deductible, how you do the cost-sharing. It becomes one of if not the primary competitive factor. Where in California, because this is standardized, our plans are competing on network, they are competing on quality, they are competing on customer service; and so a really important underpinning that has been with Covered California since the beginning.

On the next slide, I do want to just talk a little bit about choice here. You can see across the map that the vast majority -- so all Californians have access to at least two plans. The vast majority of Californians have access to three or more. And in fact, the majority have four or more issuers looking at this map. I think we also do look at this and say, we really would like to have -- not to have regions that have just two, right? How do we bring choice and competition to these regions? But also many of you are familiar, and there is another slide later that speaks to this, with the nuances of healthcare markets across the different regions of the state. The rural areas, right, have challenges with

bringing in a diversity of providers that allow for a differentiation of networks and many of those different factors. So we have been increasing -- we welcomed a new entrant into the market last year and we have had other new entrants in recent years and are expecting new entrants to apply for this coming year, so a lot of really positive trends from a choice and competition perspective in Covered California. I think, frankly, as much as we have the conversation about areas where we would like to be more competitive, we also have conversations about places where we may have too many choices and choice overload and an overwhelming abundance of choice in some of our competitive regions. So this is definitely something that we think about quite a lot.

The next slide shows our standard plan designs. I will not go through this in detail, I promise. Given, this slide always, I think, makes people dizzy. But what I would really highlight for you is the color blue. And the color blue that you can see across all of our different plan designs delineates which benefits are provided outside of the deductible. So the deductible does not apply to the services that are in blue. As we have gone through this process, which is a really collaborative process, with our plans, with our advocates, with our other partners, this has been the number one priority in many ways of our standard plan designs is how can we make sure that outpatient services, primary care, you know, all these types of things are outside of the deductible to the extent that they can be. Also just note, this is a big challenge and everyone cringes at this every year because you look at this and you see something that is too high. But everything you try to lower you have to raise something else in order to stay at the actuarial value. So this is always a really important conversation for us but one that we see brings so much value to our consumers by trying to get this as

right as we, as we possibly can.

On the next slide I just wanted to comment briefly on risk adjustment because I think someone had requested that I touch on this and it is a core part of how the ACA marketplace works. It has been a hot button issue in the ACA more broadly. I will say, in California we are very committed to understanding this impact and to working collaboratively with the plans, with DMHC, to understand what is happening. But really, we also have at our disposal such robust sources of data that help us give a lot of information upfront to better estimate what is going to be coming and be as accurate as possible. I think we have really seen improvement in this space and, again, a lot of stability in at least understanding what to expect when it comes to risk adjustment. And ultimately, in the world of trying to predict risk, understanding what is coming is the most important thing. And, you know, coming from other states and the national perspective I can just reiterate the incredible value that going those extra steps in this process gives.

The next slide actually speaks a little bit to those data sources so I won't cover it in detail.

But I do want to get to the next slide, which I think speaks both to all of the collective efforts across Covered California, across DMHC, to hold our health plans accountable but also to the stability that we have seen. So this is looking at the medical loss ratio and the profit. Our plans are generally well above the minimum medical loss ratio in this market and we have seen an average of 2.4% profit in this market. Which, again, when you look across the bullets on the right, are the national story. So first of all, in general, that is comparable to the large group market, which is a very good thing. It is also not

comparable to the individual market across the country in 2019. What many states saw nationally was in the early years there was a lot of losses, a lot of very high medical loss ratios, over 100% across the country. And then that kind of really shifted the other way as market dynamics changed, as premiums were lifted to address that. And that there was an overcorrection, to be frank, and we did not see that here in California. Again, that speaks to all of, all of those efforts. Next slides. Slide, only one.

Again a reiteration here on MLR. This is the entirety of the history of MLR rebates payed in our market, which is far fewer than you see in many other states across the country. And again, when you look at 2020 and you are in the pandemic years there were certainly, and I think you all know this, very unique patterns in terms of utilization and cost that resulted in some unexpected results here. So not unexpected to see some things happening in the 2020 timeline that wouldn't be happening in three years. Next slide.

This is just showing the regional premium variation. And again, as I mentioned when we looked at the other slide around choice earlier, I think gets to a lot of the same nuances, unique factors, geographic factors. I do -- it is always important when you are talking about Covered California to stress that over 90% of the people that we cover are receiving financial assistance and that our premium subsidy structure is based on your income and what you can really afford to pay rather than the underlying premium. So this is an important factor to look at. Health care costs more broadly and trends and regional differentiations, it does not necessarily equate to what the majority of Covered California’s enrollees are paying for coverage because of the subsidy structure.

So this is a little -- that is sort of the next section and I will try to go

quickly because I know we are pretty into time here and I want to leave time for questions. But that is kind of where we have come from. And as we turn this corner, right, as we head into this next 10 years, I do want to talk about a couple of the areas that we are really leaning into. I am not going to talk a lot about how we are leaning into reaching the uninsured and continuing to bolster those efforts. Please do not take that as that we are not doing that, just rather that I think for this group there were some other areas that I thought best to focus on.

A couple, the first of which is how can we maintain the high levels of coverage that we have and how can we make transitions across coverage as seamless and simple for consumers as possible? How can we do more to do the work for consumers that are moving across forms of coverage rather than making them do the work and potentially fall through the cracks in the meantime? And the second of which is really, we have always, as I mentioned before, had improving quality and improving equity as a part of the core mission and vision of Covered California. But we are really doubling down on that commitment. I think the progress that we have made on coverage has really allowed us to continue to build that out and really to lead in that space alongside so many California partners. So we will kind of touch on both.

So the first in this already mentioned at the top of the call, and you can go to the next slide, which is we are heavily anticipating the -- one more slide. Sorry. Actually two more slides. There we go.

The end of the public health emergency and the unwind. And this is a big deal sort of at the macro level for Covered California at the end of the day. DHCS is estimating that between 2 and 3 million Californians will ultimately be redetermined no longer eligible for Medi-Cal as we go through the 14 month

process, and counties and DHCS go through the process of performing those redeterminations. Many of those people we expect, and we have seen this even in a data and survey research that we have done before the pandemic, on where Californians go when they transition off of Medi-Cal. Many are going to go to employer coverage. Many are going to have access to coverage because of their own employment, because of their spouse's employment, because of a parent's employment, whatever that may be. But many also will be looking to Covered California for coverage. And California, as usual, was really thinking ahead and passed legislation actually prior to the pandemic. Senate Bill 260 that allows Covered California to as automatically as we possibly can connect those consumers who are transitioning off of Medi-Cal onto Covered California.

So on the next slide, we have been doing this now in preparation for the Unwind because as you can imagine, and I think people know this but just to reiterate, that during the pandemic people were gaining access to Medi-Cal but Medi-Cal was not going through their usual process of checking eligibility over time. Seeing if people's income were to go up or down and therefore no longer be eligible, so we are about to kind of start that. But because of that, the normal inflow of folks from Medi-Cal to Covered California has not been happening. So this is going to be, we are going to turn that on and we are going to go through that process.

So what we are going to do is take all of the information that Medi-Cal has collected, new income information on the household, basically, all of the things that we need to understand what someone is eligible for. And we are going to take them through a tailored pathway that says, here is the lowest cost Silver plan where you live, do you want it? Yes or no. So it is an easy button,

make one click. Many of those people will have no premium and they just have to say yes. But you are accepting a tax liability when you accept our premiums subsidy so it is important that they take that proactive step. And then if you have a monthly premium you pay that first month's premium and you are done.

You can of course say, maybe I don't want the lowest cost Silver, maybe that's not the plan that I have now, can I look at other options? You can, of course, say, I really want someone to talk to, can I get some help and be connected either to our service center or to one of our over 11,000 enrollment partners. So this is really a tailored, supported pathway for consumers that are transitioning off of Medi-Cal.

I just would also say in the background and you all should know, incredible coordination and collaboration that is happening between Covered California, between DHCS, between the counties and all of our partners to both prepare for this, collectively understand what we expect. But then also to recognize that once this starts we are going to have to be in close touch about what we are seeing and where we may need to adjust and we are all understanding and deeply committed to that.

The next slide, which I won't spend a lot of time on given where we are, is kind of a calendar. So if you are really interested in when this is going to be happening you can take a look at this later. It kind of walks through the timeline for when the first redeterminations are going to be starting and when the first transitions may be happening. Which summary is over the summer in the June, July, August timeframe.

The other area I wanted to make sure that we focus on today, and again this was also touched on at the beginning of the of the call, is our efforts to

improve quality and improve equity and really thinking about how can we use our levers as a purchaser. The contracts that we have with the qualified health plans that offer through Covered California to move the needle on quality and ultimately to move the needle on health outcomes that we know matter. That matter to the health of our population, that matter to reducing disparities and improving equity. And so we have in our contracts really starting this year that we just entered, so plan year 2023, really robust new standards around quality, both establishing a baseline level of quality and then establishing an aspirational, quality level that we want to see our plans attaining as well.

And just as a foundation here, want to reiterate those measures, and I think Jeff mentioned this at the beginning, are the same measures that CalPERS is using, they are built off of measures that are priority measures for DHCS through the Medi-Cal program. They are coordinated with the work that Mary and her team are doing on measures. And so there is a real commitment to saying, as we are all moving towards improving quality and deciding what measures matter and what measures are going to really move health care, that we are doing that together. I will just note the work already being done by Covered California and CalPERS and DHCS as we are all working to put steps along these lines in our contract. The three of us cover over 40% of California and so this is a huge opportunity to see where alignment can drive change. Let's go two more slides. Next one.

So this is our overarching framework, our goals that really capture what guides, where we prioritize our work with our plans to improve quality. I won't spend a lot of time here.

But on the next slide you will see what we have really prioritized in

the alignment work that I was just speaking to. So reducing disparities, improving behavioral health, primary and value-based care which we will talk more about. Affordability and costs really important as we see the Office of Health Care Affordability coming forward and Data Exchange.

The next slides really walk through the new initiatives that I was just talking about. So this is our quality Transformation Initiative where we are having financial incentives for our health plans to reach an aspirational level of quality on four core measures. We want them all to meet or exceed the 66th percentile of the national benchmark for each of these measures. Starting for plan year 2023 we have .8% of premium at risk. But that will move up to 3% and then ultimately to 4%, 1% per measure, effectively, in plan year 2026. And so this really is a significant incentive base to really move forward and make improvements on these core measures.

On the next slide you can see what those measures are. So controlling high blood pressure, hemoglobin A1c control, colorectal cancer screening, childhood immunizations.

I do want to note that I think we all recognize the importance of doing more on behavioral health, that we want to also move in that direction. But the measures are just not as developed and mutually agreed upon in that space as they are in those matters so we are having reporting on depression screening and follow-up for both adolescents and adults, and pharmacotherapy for opioid use disorder. But we are not -- we have not yet tied financial incentives to those, those two measures, they are reporting only.

And then as mentioned also that all of these measures will be stratified by race and ethnicity for reporting only in the initial year, but we are

looking at methodologies where we can actually tie outcomes and accountability to improvement by demographic group. And again, for us, this is really empowered by the fact that we do have such a robust data set on race and ethnicity for Covered California.

On the next slide, this is the other half of our quality initiatives. So the first was the aspirational piece, this is more of the foundational piece. So we want all of our plans to be beating, at minimum, the 25th percentile composite benchmark for the QRS Clinical Quality Management Summary Indicator, that is a core measure set used in the ACA marketplaces. We will give plans time to address this if they are not meeting this benchmark. But if they are not able to improve and not able to meet this over the monitoring period they will be asked to leave Covered California until such time that they can improve their quality.

I just want to say here, you know, our message on both of these initiatives, and it is not just our message, it is really how we feel is, we don't want our health plans to have to -- we certainly don't want them to have to leave, we certainly don't want them to have to pay the financial accountability measures that are attached with QTI. We want to see the measures improve, we want to see care delivered better, and we are here to help and partner with the plans in any way that we can to make that happen.

On the next slide I will skip through this for time and then I am going to skip through actually the last few areas pretty quickly. So let's go, keep going to the first substantive -- so the next slide. Yes, perfect.

So just also want to add that as I talked about how equity is inherent in the QTI initiative and the 25-2-2 initiative, but that is really layered on a whole lot of other ways that Covered California is working on equity and

improving equity and reducing disparities through enrollment and outreach, through the benefit designs and the ways that we can improve access and health literacy.

But you can also see on the next slide, we generally have these progressive plans to address issues that are important to us. We have somewhere we can start, somewhere where we can bite off and chew, but then we also build over time. So you can see back in 2017 we were looking at demographic data collection and disparities measurement. We were looking at having our plans -- sorry, not looking at it, we have done this. Have disparities reduction interventions that they report to us on and about focus on improving certain outcomes for certain populations. We are requiring our plans to meet the NCQA health equity accreditation by this year. And then we are looking forward to incorporating equity in QTI. So really keeping equity at the center of so much of this.

And I do you want to just highlight on the next slide that not only are we committed to really working on this disparities reduction methodology using the data tools that we have, but we are doing that in partnership with DHS and CalPERS, so all of this is happening in alignment and coordination. Next slide.

I am going to, I think I am over time so I am going to say we are also doing really great things in primary care. I want to give a shout out to Jeff and his team at IHA who is our partner in one element of this. That we have a whole set of things focused on matching and making sure that all of those that are enrolled through Covered California are matched with a primary care physician and ideas about how we can continue to build on that and making sure that's not just a name on a piece of paper but actually resulting in connection to

primary care.

We are working on measures so we are working with the California Quality Collaborative as a part of the PBGH program that includes looking at measures for advanced primary care. We are following the money and really having reporting on the adoption of primary care clinicians that are paid through the HCP-LAN categories 3 and 4.

And then continuing research really looking at primary care spend using the IHA definition of primary care spend, the percent of spend within each of those categories, and how we can continue to look at are we spending the right amount on primary care and do we need to be looking at that or even setting a target?

So a lot of great work going on in the primary care space but given time I just skipped through about five slides.

So with that I think that is a great overview of where we are in some of the hot topics for Covered California. Given that this is our first time and certainly my first time in front of this Board, happy to answer current questions, but also bigger questions about our role in what we do for health care in California. Thank you so much.

CHAIR DEGHETALDI: That that was amazing. And yes, this is not Pennsylvania, this is California, and we have got, I am sure we will have some great questions and then we will open it to the public. We have about 22 more minutes that we set aside for this great journey here. But I loved that. I am going to look for our hands from our Board Members. Alameda County, always there, and then and then Jeff. So Scott.

MEMBER COFFIN: Jessica, thank you. That was just an excellent

presentation. Really reinforces the direction that we have been heading, you know, as a Medi-Cal public health plan in Alameda County. I am most interested right now in partnering up on the continuous coverage initiative. Last week we had the benefit of having the Department of Health Care Services senior leadership team director Michelle Baass and her team here for a listening tour and we talked about continuous coverage as a core topic in addition to health equity, and again, many of these other topics you already covered.

But I would like to invite a conversation about an outreach campaign in terms of partnering up between Alameda County, Alameda Alliance and Covered California. One of the concerns that that I have over this 14 month period that is coming up very soon is just what is the beneficiary going to be hearing and receiving? And we want to coordinate that that message. And so we are going to be partnering with Department of Health Care Services and Department of Managed Health Care on this but I would also invite a discussion with you at some point soon to talk about how we can link in with Covered California.

MS. ALTMAN: Yes, I'd welcome that, Scott, and thank you for bringing that up. I think, first of all, you all should know that I talked about the coordination and collaboration with Covered California, with DHCS with others. But that is really at a macro level. But also things like the notices that consumers are going to receive are going to be cobranded. We are talking about the outreach and even the marketing because DHCS does have funding, core marketing that they are doing and how we can do something that is complementary and building off of that. And I think, obviously coming from the place of -- the first and foremost goal is that anybody who is still eligible for Medi-

Cal, we want them to stay there. But that anybody who is actually no longer eligible, how can we support them as much as possible? So I think the more that we can all be connected, I know DHCS has their Ambassadors Program and is really working on doing that. We are doing cross-training and having Covered California train those groups and vice versa, so a lot of really great foundation there, and would love to dig in at a local level with anyone who is interested and how we could even build on that even further.

MEMBER COFFIN: That's great. Thank you, I will be in contact.

CHAIR DEGHETALDI: I think Jeff is next.

MEMBER RIDEOUT: Jessica, thank you so much for both the presentation and your support of IHA and the work that we do on your behalf. I just wanted to highlight a few things that I know kind of factor into how you are thinking about contracting with plans and the quality. The primary care spend study is an interesting one, where what we found through the program and the analysis is for a 1% increase in primary care spend the system saves almost a billion dollars. And there is a huge range of spend on primary care. Again, using a standard definition, which we did with Millbank and with Covered California and RAND, and using a single analysis so that we get the noise out of the analysis and actually can look at the results and say, that's big. You know, there is a huge range and it doesn't take a lot to move things in a good direction. And we have seen that with integrated versus non-integrated care as well. So great to feel that we can help move this and transform the industry in that direction. So thank you for all the work, Jessica, and your support.

MS. ALTMAN: Thanks, Jeff.

CHAIR DEGHETALDI: Thank you. I think it’s Amy.

MEMBER YAO: Yes. Hi, Jessica, very nice meeting you. A really great presentation and a great summary of the past 10 years accomplishments and a clear vision for the next 10 years, the quality and equity.

So my question is also related to the primary care initiative. We are a big believer that, you know, primary care has to be really helped to make the coverage affordable. So we internally did a study. This is a struggle for us so I would probably like to hear Jeff's and everybody's idea, how can we get more engagement from the members to truly work with primary care physicians. You know, on our HMO plans we have seen for certain providers, 50% of the members have never seen their assigned PCPs. And even if their own, even the people's own PCP, still a big percentage of members never engage. So we have tried many different methods and encouraged the provider or the member to get them together, but it is very difficult as a health plan to really make that connection. So in this whole initiative if there could be certain reporting or requirement for the providers to make that connection, I think you will be going a long way to help affordability.

MS. ALTMAN: Yes, that's great. One of the slides that I skimmed over at the end, and actually I think is one slide before this so maybe we can even pull it up. Yes. So the first bullet here, I think very aligned with what you said, is, we have really focused on PCP matching. How can we build on that to make sure and have reporting on are they actually having a visit, right? So creating that connectivity through, again, not just having the name on the piece of paper but does that actually equate to the consumer receiving primary care? And frankly, just being connected into the healthcare system because of the value that Jeff so rightly called out that we know comes from primary care. So I

think we are really excited to continue to build on this really great foundation that we have collectively set on primary care and think about some of those ways that we can all work together to do that. Because I think that is an outcome that government plans, providers, patients, advocates, everyone agrees we need to be moving in that direction. I think that is part of what makes this piece of the work so exciting.

CHAIR DEGHETALDI: Paul.

MEMBER DURR: Jessica, a fabulous presentation and thanks for your leadership and vision. My question has to do more with looking at the future and the subsidy and the advocacy work that is being done across the country to look more specifically of maintaining that. I wanted your thoughts about is there bipartisan support to really enable and then continue those subsidies because of the impact? That when you think of what happens in California, we are using the health plans to drive lower cost and more coverage. So it is not government funded, it is government managed. But what is your take on that?

MS. ALTMAN: I mean, the technical answer is there is not, there has not been bipartisan support for this, there was not bipartisan support. And I mean, to be fair, both times that we saw the original passage of the American Rescue Plan and then the extension, the Inflation Reduction Act, it was a big package of things so there were not Republican votes for either of those packages. But nor has there really been a lot of Republican sentiment in support of the ACA.

You know, in particular, I think there has been a lot of finger pointing at that second piece of the subsidies that I talked about, which is removing the cliff and instead having the rule that no one should pay more than

eight and a half percent of their income. It is where, you know, several poverty levels get thrown around, like, oh, we are subsidizing someone at four times the federal poverty level, how can we be doing that? Well, those were families that were paying upwards of 20%, even 30% for older individuals, of their income for the premium, right. Those are not acceptable levels that we should expect of anybody to be paying in our healthcare system for coverage and a lot of people were having to choose to forego coverage because they couldn't afford it. And so, you know, from our perspective, and some of the work that we do, yes, we want to put the charts and the data and the big picture, but we also want to put a human face to those families, to those stories, to really try and move that narrative. But, you know, I think we do have some work to do as well as we don't know what will happen. There will be another election cycle before we are in this place so there is a lot to be found.

I do think it is also, it is always hard to give something and take it away, politically, so I think that is in our favor and there will be a lot of conversation about the meaning and the impact that this has had. And frankly, I think the unwind is one opportunity for us to show how this is going to empower us to keep people covered and not to increase the ranks of the uninsured, which could be, would be the alternative.

CHAIR DEGHETALDI: Okay, so I -- Jessica, again, let me just second all the positive. I have some comments. The first on federal poverty limit. It is the same in Biloxi, Mississippi as in San Francisco.

MS. ALTMAN: Oh, I know. Someone wrote it on the back of a napkin. Made it up.

CHAIR DEGHETALDI: It is insulting for California, particularly as

our cost of living, our hospital wage index continues to rise faster than the rest of the nation. One thing that I will just speak a little bit provincially. The cost, the geographic variation in cost within California is astounding and looked almost twofold. I know that the same Silver plan for Kaiser in San Francisco is 50% more than Los Angeles; and so there are geographic stressors that we need to be mindful of within California, variations on our consumers, and just keep that in mind.

The risk adjustment transfer world is being -- the risk adjustment, the HCC world is being blown up with the current Medicare Advantage stuff that is going on in DC. I just worry whether or not work -- and I love the risk adjustment transfers. As Amy knows, as soon as it comes out on June 30th I jump on it. It is a beautiful public policy to reward a Blue Shield. And I would say that even if Amy wasn't on the Board, to reward a Blue Shield for caring for sicker Californians more. But I don't think we capture SDOH inputs. I don't think we capture the stuff that drives health care expenditures for some underserved populations. I don't think we -- I think we need to pay more for the very people who have been deprived health care for whatever reason, right?

The auto enrollment for the redetermination. This is speaking to the value of primary care. If somebody loses because of redetermination their Medi-Cal provider, we should do everything we can to reenroll them in a plan where they can have their same provider, right? So just keep that in mind if we do this automatically. Because the value that Jeff describes for primary care, you'll lose it when you are forced to move from one primary care physician to another, I think.

And one last thing, just humor me, I was going to be an invasive

cardiologist in 1980, third year medical school. I ran into a professor of medicine that convinced me that the only ethical place to go in medicine was primary care. At USC. The guy's name was Peter Lee. The father of Peter Lee ruined my life, probably in a good way. So those were my thoughts, anyway.

MS. ALTMAN: Thank you. I come from a family of family docs and OB/GYNs so I am a part of that. I am not an MD myself but I come from that.

CHAIR DEGHETALDI: Yes.

MS. ALTMAN: I do want to just note on the auto enrollment that we are having a conversation about how we could potentially use that process to support continuity of care. And it is complicated. I mean, first of all, we have many of the same plans that offer through Medi-Cal but not all of them. But again, the plan, it is not really about the plan, it is about the provider, so there is that other layer of understanding the networks. And even if you have the same plan, they may not have the same network so you may not have the same provider, so there is sort of that layer of --

CHAIR DEGHETALDI: Yes, I know.

MS. ALTMAN: And then the other for us is just, it is about cost. And there can be, you know, price relativity, the way our subsidy structure works can be significant. And so, you know, at what point, you know, at what expense are we willing to prioritize continuity of care and make that choice for the consumer? And so I think we are going to have that conversation but we are going to have it in a really thoughtful way of looking at what are the -- first of all, what do we have from a data perspective? What can we have to support this process? But also what actually is going to best serve the consumer through that process?

CHAIR DEGHETALDI: Jeff.

MEMBER RIDEOUT: Just one comment. I think the emphasis on primary care is hugely important. I think it is also related to the emphasis on integrated care and it is also related to capitation and it is also related to continuity of providers of all types for patients. And, you know, we have been tracking this forever at IHA. But I always looked at the rate submissions to Covered California and tried to understand the reason why some were double digit and some were single digit. And the one thing you could see was the single digit submissions tended to be with those networks that were more integrated and therefore more focused on primary care. So I think, I think the signals are telling us all we need to know. We do have to adjust for wage, we do have to adjust for market differences as much as possible. But I think it is pretty clear what will drive better valued care and it has been clear for a long time.

CHAIR DEGHETALDI: Okay, then we could -- if no other Board Members have questions, this was, Jordan, if we have any questions from -- and I am sorry, I didn't do this after Mary's report. But if a member of the public has a question or a comment, Jordan, what have we got?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: Well, that doesn't mean it wasn't a great presentation. Jessica, thank you. This is super important. And, you know, particularly as we go through redetermination and undocumented Californians will gain access to Medi-Cal in the next 10 months and some will lose access through redetermination. In any case, lots of lives moving back and forth. You know, thank God we have covered California and the Lee family and all the trouble, good trouble they produced in California. Okay. Then we are going to

move on to Sarah, if that's okay. Bye. Thank you. Sarah.

MS. REAM: Yes, good morning. And I'm sorry that I am the sad soul who has to go after Jessica's really interesting presentation. But I will try to keep my regulations and federal update as lively as one can keep such updates. So next slide, please.

So as I talk about all the time, DMHC has a lot of regulations in the hopper in various stages of development. Currently in formal rulemaking, which means we have filed the rulemaking package with the Office of Administrative Law, we have had a comment period and we are going through that formal process. So we have one regulation in that process right now and that is to effectuate SB 855 regarding mental health and substance use disorder coverage requirements. We began formal rulemaking in December. The first comment period closed last month, the end of January. We are now analyzing those comments. We are required to prepare a sort of a response document which will be public at the end of the whole process here. And we are making some changes to the reg based on the comments we received. So we are finalizing those changes now and we expect to share or go out for a second comment period in the next several weeks, maybe a month. So we are well down the path on this regulation I am happy to report. Next slide, please.

So we have -- I feel like a stuck record. I am always saying we have a lot of regulations in process and we do, we have a tremendous number of regulations in process. I am going to talk about just five of the ones that are pretty far along at this point.

So the first that we are working on is a regulation regarding the Assembly Bill 72 ACR inflator. So if you will recall, AB 72 requires plans to

reimburse certain non-contracted providers at the higher of either 125% of Medicare for the service, or at the plans' average contracted rate. This regulation will add an inflator to that average contracted rate, to the plans' average contracted rates for purposes of AB 72 so that those rates will keep up with inflation. This reg in large part will mirror, the tweak it will make will mirror what CDI already has in its regulations. So it is not a, it is not a huge change but we think it is an appropriate change. We are very close to starting the formal rulemaking process on this one so keep your eye out for this in the next several weeks. That is going to be starting. And then we will have a comment period. We will take comments and move on from there.

The next regulation I want to talk about is iatrogenic fertility preservation. This regulation will interpret and make specific Senate Bill 600 from back in 2019 and it requires health plans to cover fertility preservation services when an enrollee is receiving a health care service or health care treatment that may directly or indirectly cause that person to be infertile. We have worked very closely with stakeholders, with plans, with providers, with experts in this area, to draft this regulation and we have shared drafts along the way as we have been working on it. We are also close to this one pulling the plug and getting it going for formal rulemaking and we anticipate starting that in in the spring, so in the next month or so.

Next is a reg that we have been working on for quite a while. The current -- so this is the general licensure. We also call this the risk regulation. The current version of this regulation requires an entity that accepts any amount of global risk to either obtain a health plan license or an exemption from licensure under the Knox-Keene Act. And just as a reminder, global risk is the combination

of professional risk and hospital risk, institutional risk. So if an entity is accepting both of those in any amount, they right now either need a license or they have to come to us for an exemption.

We initially developed a phase-in period just because we knew this was somewhat of a departure from what the industry had been accustomed to and during that phase-in period, we implemented an expedited exemption application process. We then decided to make some tweaks to the regulation based on what we have learned during that, that phase-in period so we have extended the expedited application process until we promulgate the updated reg. Like I said we are taking what we have learned, we are refining the requirements. And hopefully we will make the expedited, the exemption process clearer, more understandable from the outset so entities will know whether yes, I am certain to get an exemption or maybe, maybe it is a wobbler, or, you know, I really actually need to come to the Department to get a license. And we are targeting the start of formal rulemaking on this one for this summertime.

And then finally we have the rate reviews. We have large group, small group and individual rate review reg, I feel like we have been talking about the large group rate review reg for a long time. The regulation will implement AB 731 from 2019 and SB 546 from way back in 2015. For this regulation we shared a draft with stakeholders quite a while ago received, helpful feedback. So we are hoping to start the formal rulemaking process on this reg this year. I know I feel like I have been saying that for two years now. But on this one, you know, we are looking to move it this year.

And then with respect to the individual and small group rate reporting, just as a background. AB 2118, which was enacted in 2020, requires

full service plans to report annually information about their premiums, cost sharing benefits, enrollment and trend factors for their various products in the individual market in markets and in the small group markets. The bill included a waiver that allows the DMHC to issue guidance through 2023. So based on that waiver last summer we issued an All Plan Letter that outlines the information plans have to -- it may have in the summer before that actually, pardon me. We issued an APL that tells plans what they have to file with their annual aggregate rate filings for the small and individual markets. The waiver allows us to tweak our guidance so we get information. It allows us to do the best reg possible. And we plan to start formal rulemaking on this one also later this year.

So that is the end of my regulation update. Before I move into the federal update let me take any questions.

CHAIR DEGHETALDI: Yes, Amy.

MEMBER YAO: Yes, so I do have a question on the AB 72, on the inflator. So you mentioned the rate is the greater of the 125% of Medicare or the average in-network payment rates. So the Medicare rate itself and the average in-network rate itself actually has an embedded inflator already. So why do we need another inflator on top of that?

MS. REAM: So it gets -- Thank you for that question. And we had actually had the similar question and talked to CDI and various industry advocates and consumer advocates about that. The AB 72 inflator we are contemplating will get us there just a little faster than we would if we didn't have it. So overall we do see the same increase. We never see a decrease, really, do we? But increase in rates based on inflation. But it just, it advances that, the implementation essentially of that increase by just a bit to give the providers that

increase a little more quickly than they otherwise would.

MEMBER YAO: Okay. Okay, I (indiscernible). Okay, thank you.

CHAIR DEGHETALDI: I do need to point out that Medicare rates for physicians have been flat or dropping so there is no inflator for Part B payments to California's physicians. So I would think that in Medicare's -- we are starting to see, Amy, significant access problems for Medicare beneficiaries in the state because the Medicare payments for at least on the Part B side have lagged inflation for so long. It is a looming catastrophe. I don't quite know how the inflators would work on the average contract rate, because maybe to Amy's point, there probably should be some inflation built in to average contract rates. Anyway. Other questions?

Then we jump to federal, I guess, right?

MS. REAM: Should we do -- I think --

CHAIR DEGHETALDI: Do you want to open for -- sure. Let's open for public questions, Jordan, on this half of Sara's report.

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: Okay, great. Let's go to federal.

MS. REAM: Great. All right, next slide, please.

So I am going to be talking about the end of the federal public health emergency and the impact that it will have on California enrollees and our health plans.

So just to orient ourselves here, probably everybody knows these dates already but just in case it is not the top of your mind. So May 11, 2023 is when the federal PHE ends. What this means is that the CARES Act and the Families First Corona Virus Response Act will terminate with respect to many of

the provisions that are in there.

The next key date is November 11, 2023 and that is a key date for California; and what that is, is six months after the end of the PHE. So California, we have built in a sort of a phase-out of the -- so it is not an abrupt end to a lot of our protections when the federal PHE ends, there is going to be a bit of a run out. And what this will impact is the reimbursement for out of network providers who provide COVID services, and then the impact, it will impact enrollee cost-sharing if the enrollee goes out of network for certain COVID services. Let's go to the next slide please.

So I am going to break this down by impacts to enrollees and impacts to providers.

So until -- so in California, until November 11, even though the public health emergency ends earlier, until November 11 all COVID testing, vaccines and therapeutics from a licensed provider are still at no cost-share to the enrollee, the enrollee doesn't have to have prior authorization, and they can go in or out of network. So it is really business as usual in California up until November 11.

After November 11 it is still mostly business as usual for the enrollees. Still no prior authorization for COVID tests, vaccines or therapeutics, no cost-sharing if the enrollee goes in-network. An enrollee can go out of network, but if they do they may be subject to cost-sharing. So that is really the only difference there once November 11 rolls around is that if an enrollee goes out of network they may be subject to cost-sharing.

And then finally, we have had a fair number of questions about what happens when the federal PHE ends with respect to over-the-counter tests.

Because you will recall, the federal government is telling, you know, requires that plans and insurers cover at least eight tests per month per enrollee. We have interpreted SB 510 to include or require that the plans continue to cover at least eight over-the-counter OTC tests per month, indefinitely. Again though, if an enrollee goes out of network after November 11 they may be charged a cost-sharing.

I know it gets a little -- with all these different timeframes it can get a little, make your head spin. But essentially, enrollees can still get the services forever. The differences is starting in November if they go out of network they may be subject to cost sharing. Let's go to the next slide, please.

So then the provider impacts, which are a little different; so the impact on providers is a little different than what is going on in the world for enrollees.

So until May 11 the CARES Act and the FFCRA are still in effect. So between now and May 11 if an enrollee goes to a provider to get a COVID test and the COVID test is diagnostic, as defined under federal law, the provider can get its cash price, as posted on its public website.

If it is not a diagnostic test, if it is a screening test, so let's say it is a test to just -- you don't have -- the person doesn't have symptoms, they don't have exposure or known exposure or a suspected exposure, they just need a test to go back to work or they want to make sure -- they are going to go visit their grandparents, they want to make sure that they are not positive, they are going to travel. That would be considered a screening test. For a screening test California law applies and then it is not the cash price that the plan has to reimburse. The plan has to reimburse at the at least 125% of Medicare. So this

is the for out of network. If it is in-network it is whatever the contracted rate is. This is gets very, very complex and different, there's different iterations. So I definitely recommend that if you have questions about what's happening currently, what the current state of the law is, that you reference to our APL 22-014. That gives a nice breakdown of what happens when the federal law applies and what happens when California law applies. But this is the state. Things are -- there's a lot of moving parts here until May 11. Next, next slide, please.

Between May 11 and November 11, so between when the federal public health emergency ends and six months after the federal public health emergency ends, all COVID testing, immunizations and therapeutics will be governed by California law. So that reimbursement is based on California law. There is no more of the cash price reimbursement under the CARES Act. So under California law, out of network providers have to be reimbursed at at least 125% of Medicare.

Then beginning November 12 reimbursement for those services drops down to 100% of Medicare. So there is sort of a bit of a step down there. So that's really, once the PHE ends it is California law governs the reimbursement and we are having 125% of Medicare then down to 100% of Medicare. Next slide, please.

And we will be issuing another All Plan Letter just to reiterate how these different dates play in, what they mean in California for providers and for plans. So be looking for that to come in the next couple of weeks. We are hoping to get that out because we have been getting a fair number of questions from all stakeholders about what happens when the federal public health emergency ends. So happy to take questions on this.

CHAIR DEGHETALDI: Abbi.

MEMBER COURSOLLE: Thanks, Larry. And thank you, Sarah, for that presentation. This is sort of a narrow question and maybe a little bit of a suggestion. I think in our experience, people aren't really differentiating between in-network and out of network when they are accessing COVID testing because it hasn't mattered up until now. But given that that distinction will start becoming pretty germane to people I'm wondering if you all are in communication with the plans about communicating with their enrollees about which, which options are in-network for them and what is out of network; and if that is not something that you are already contemplating, my recommendation that you do, so.

MS. REAM: Thank you for that. Let me take, we will take that back. I know it has been, you know, I think you are right, enrollees have been, grown accustomed to be able to go to any provider that is available. So we will take that back. Appreciate that comment.

MEMBER WATANABE: And Abbi, I will just jump in here and let everybody know, we have recently updated our consumer fact sheet. So we have a COVID fact sheet related to testing and vaccines, it is on our website. We recently updated it to reflect the end of the federal public health emergency as well. So for those of you that are engaging with consumers, that is a good resource to point people to, but we can certainly take back the messaging to the plans.

CHAIR DEGHETALDI: Other board questions?

Sarah, PAXLOVID is really catching on. Do we know how long the feds are going to cover? It is over $500, you know, to purchase. Do we know how long the feds will cover PAXLOVID for patients?

MS. REAM: I don't know. You know, I know that's a big question for everybody.

CHAIR DEGHETALDI: Yes.

MS. REAM: I am not -- how long they are going to continue that coverage.

CHAIR DEGHETALDI: It has been wonderful to have.

Any other board questions?

And now from the public?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: Then it is I think Pritika. I think it is dental loss ratio. Oh yes, here we go.

MS. DUTT: Thank you, Larry. Good morning, I am Pritika Dutt, Deputy Director of the Office of Financial Review. I will provide you an overview of the 2021 Dental Medical Loss Ratio Reports. We received the filings from health plans on July 31st of 2022 for reporting year 2021. In addition to the PowerPoint presentation we have also included the *2021 Dental Medical Loss Ratio Summary* report, which provides the enrollment and dental MLR information for 2020 and 2021 for all dental plans that were subject to the reporting requirement. Next slide.

So health plans offering commercial dental plans are required to file the annual MLR reporting form.

There is no minimum Dental MLR Requirement.

Annual Dental MLR Report is organized by product type, which is Dental HMO and Dental PPO, and by market type, Individual, Small Group, and Large Group.

The plans first reported data in 2015 for calendar year 2014. Current data is for calendar year 2021. We received Dental MLR reports from 18 plans. Next slide.

We will go over the results of the Dental HMO plans first and then the Dental PPO products. Next slide.

For reporting year 2021 we had 18 plans that offered dental HMO products.

The Dental HMO Individual Market MLR ranged from 5% to 81%. And the weighted average MLR -- the average MLR was weighted by enrollment across all the individual dental plans. And the weighted average MLR was 61%. So for the 14 Individual plans that offer DHMO products, their average weighted MLR was 61%.

For the Small Group Market the MLR ranged from 37% to 88%, and the weighted average MLR by enrollment was 50%. So there are 18 plans that offered Small Group DHMO products.

And the Large Group Market MLR ranged from 38% to 75% and the weighted average MLR was 63%. And there were 15 dental plans that offered Large Group DHMO products.

For 2021 the weighted average MLR by enrollment remained slightly stable with a +/-2% change from 2020 for individual market, small group and large group markets.

In reporting year 2020 the Individual market weighted average MLR by enrollment was 59%.

For the Small Group Market the weighted average MLR was 51%.

And for the Large Group Market the weighted MLR was 62%.

And the number of plans remained unchanged from 2020 to 2021. Next slide.

This is a new slide that we added; it wasn't there when we presented this information last year. So this chart shows the Dental HMO MLR weighted by enrollment from 2014 to 2021. For the most part the trend has remained consistent from 2014 through 2021 with some variations. We noticed in the earlier reporting years, you know, from the earlier reporting years, the data quality has improved significantly. Next slide.

This chart shows the average premium for dental HMO plans. For 2021 the average premium for DHMO plans in the Individual market was $11, for the Small Group market it was $14, and the Large Group market was around $14.50. As you can see, the premiums for DHMO products were pretty low. Next slide.

Now I will go over the results of the Dental PPO products.

There are three DMHC plans that offer Dental PPO products.

There are two plans in the Individual Market and had MLR of 62% and 69%, and the weighted average MLR for the two plans by enrollment is 64%.

For the three plans in the Small Group Market, the MLR ranged from 55% to 65% with a weighted average MLR of 57%.

And for the three plans in the Large Group Market, the MLR ranged from 57% to 88% and the weighted average MLR by enrollment was 88%.

For reporting year 2020 the weighted average MLR for the Individual PPO Market was 64%.

The Small Group Market MLR was 58%.

For the Large Group Market the weighted average MLR was 87%.

So it is almost consistent from year over year. Next slide.

This chart shows the Dental PPO MLR weighted by enrollment for 2014 through 2021. Similar to DHMO products, for the most part the trend remained consistent from 2014 through 2021 with some variations. Again, like I said, you will see some fluxes from 2014 to 2015. So 2014 was a first year that we received data from health plans and then we noticed over the years, like I said, data quality has improved significantly. Although compared to DHMO products, the dental loss ratios for PPO products were much higher. Next slide.

This chart shows the average premium for dental PPO plans from 2014 through 2021. For 2021 the average premium for DPPO plans in the Individual market was $48, for Small Group it was $50, and for Large Group it was around $42. As you can see, the premiums for DPPO products were almost three times higher than DHMO products. The dental PPO products provide enrollees with greater flexibility in terms of provider choice. Next slide.

I wanted to point out that the reported MLR varies widely among product and market types due to differences in benefit plans, premium structure and the provider payment arrangements such as capitation, fee-for-service, staff model operations. Again, there is no standard benefit design requirement for dental plans and there is no MLR requirement. There are a variety of plans offered with premiums, you know, as you seen in the previous slides, the premiums are very low for some of the products.

So, with that I will take any questions.

CHAIR DEGHETALDI: Any questions? It is really for information. We have been studying this for a long time and observed that the DLR is significantly lower than the MLR. The more comprehensive the benefit structure,

the closer it gets to sort of what we would call an 85%. I think 88% is what you showed for the Large Group.

MS. DUTT: Correct.

CHAIR DEGHETALDI: Yes. So, Amy.

MEMBER YAO: Yes. Pritika, thanks for the information. I think it looks like the premium and the loss ratio has been (indiscernible) for the past year, many years. So don't take my question the wrong way. I am not, you know, looking for anybody to answer. I am just trying to, back in my mind, I am trying to understand, you know, we are doing this reporting. What is the ultimate goal we are trying to achieve from this reporting? It will be just always informational or there are going to be some next steps around this? So anyway, I am not expecting any answer. I know that kind of --

MEMBER WATANABE: Amy, maybe I will I will jump in here. I will say this is a report that I think we revisited with the Board last year just to say, is there still value in presenting it. I think when the legislation was initially passed to collect and report this information there was an intent maybe for the legislature to take some action to set a dental MLR. That has not happened to date. I know there is a state where that has happened recently. So, you know, our intent really is to bring transparency to some of the data that we collect, we have a requirement to continue to collect the data. This is, this is our forum where we can publicly present the data. I know it has been a little bit awkward because we continue to present it without an ask, necessarily, from the Board, but appreciate you bearing with us as we at least present some information. And we do monitor the trends to see. I think in the early years we saw some outliers that were really, really low and we have seen some smoothing of that. So again, it is really,

really about transparency. Hope that helps a little.

CHAIR DEGHETALDI: And Jeff.

MEMBER RIDEOUT: Yes, just one --

CHAIR DEGHETALDI: Amy, if you had a follow up question? I don't know.

MEMBER YAO: Oh, no, I don't. Yes, thanks. Thank you, Larry.

CHAIR DEGHETALDI: Okay. Sorry, Jeff.

MEMBER RIDEOUT: Yes. I think just in other experience with other boards I have both for profit and not for profit. One technique could be produce the reports, highlight anything that we should be made aware of, maybe even talk about the things that we should be made aware of, but don't make it a standing item. Now, that would assume that we have other things that we could talk about that were more important, but I think we do. I mean, if you look at the, you know, your report, Mary, today, we could spend more time with that. I think certainly Jessica's report would be great. I think we all acknowledge that there is not much in this for us other than we are doing it. So maybe it is a way of acknowledging, yes, we are collecting the data; and we will rely on, in this case, DMHC management to tell us what we should be looking out for, if anything, rather than, you know, putting it up every time. You know, that's another way to do it.

MEMBER WATANABE: Yes, no, I mean, we would be happy to take that back. I think we have tried to be responsive to the Board's request to continue to share it. I would welcome input from others too. I mean, I think one option is I could include just a quick summary of anything that you should note in my director’s remarks and we can send the report out and share it as more an

informational-only document. I am seeing lots of nodding heads. So we will take that back and consider that for next year.

CHAIR DEGHETALDI: Sure.

MEMBER WATANABE: You know, obviously, if the legislature takes some action and this gets more attention and there is something more to it we can revisit that. But I think, Pritika, for next year we will consider just having me highlight anything noteworthy or newsworthy in my remarks and then we will just share the report with you. I appreciate your feedback on that.

CHAIR DEGHETALDI: Mary, what state is doing the dental loss ratio?

MEMBER WATANABE: I believe it is Massachusetts.

CHAIR DEGHETALDI: Yes, they are always out first with stuff.

MEMBER WATANABE: Yes.

CHAIR DEGHETALDI: I would be curious to watch that. If you do go with written reports maybe comment on what the -- Do you know what their minimum MLR is there?

MEMBER WATANABE: Pritika, you can correct me, but I think it was 83%. And it was, I believe, done through a ballot initiative and it was kind of in between 80 and 85. You know, we have had a lot of discussions here about concerns with setting an MLR absent a standard benefit design. So, you know, we will be watching that closely. It is the first time we have seen something like that. Pritika, I don't know if you would add anything?

MS. DUTT: Mary, it is 83% and it goes into effect 1/1/2024.

MEMBER WATANABE: Okay.

MS. DUTT: We are watching that closely.

CHAIR DEGHETALDI: Jeff.

MEMBER RIDEOUT: I am all for being first and the quality of work that Massachusetts does in general. But I would say, you know, it is not going to make any difference if we don't have a standard benefit design or if we don't subset the information into those that do have a similar benefit design versus those that don't. I mean, I am not trying to defend the industry here at all, but we have heard over and over again, it is apples and pineapples and, you know.

MEMBER WATANABE: Right.

MEMBER RIDEOUT: And I think we just have to decide if we want to get better at this then we need to look at how we are analyzing the data differently than what we are doing now. And we have to kind of take that initiative as opposed to assume that we are looking at anything that makes sense. Because we are not, really, I mean, they are all very different.

CHAIR DEGHETALDI: Great. Jordan, any questions from the public?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: Okay then, we will see you in another topic soon, Pritika. I think Michelle is up, right?

MS. YAMANAKA: Hi, thank you, Larry. Michelle Yamanaka, Supervising Examiner. I am going to give you an update on risk bearing organization or RBO reporting for the quarter ended September 30, 2022.

We have 208 RBOs that are required to file financial information with the Department. There was one new RBO that began reporting this quarter. The RBOs are required to file annual reports as well. We have received 14 annual surveys for the RBOs fiscal year ends March 31 and June 30. A majority

of the RBOs have a fiscal year end of December 31 and the reports are due 150 days after their fiscal year end. So these, a majority of the reports we will receive at the end of May. We also have 11 RBOs that are filing monthly financial statements to the Department as a requirement of their corrective action plan or CAP. Next slide, please.

Again, we have 208 RBOs that are required to report. We had one non-filer that just recently submitted their September 30 filing and that that report is under review. For the remaining 207 filings, 180 RBOs or 87% of the RBOs reported compliance with all solvency criteria; and 27 RBOs were non-compliant with one or more of the grading criteria, which represents 13% of the RBOs. It should be noted that 5 of these RBOs, 5 of the 27 RBOs have more than one CAP, which brings our total CAP count to 32 RBOs that we were monitoring as of quarter ended September 30.

Moving on to the next slide regarding the corrective action plans. For those 32 corrective action plans, 28 are continuing from the previous quarter and we received 4 new CAPs for the quarter ended September 30. Of those 4 CAPs, 2 were due to non-compliance with claims timeliness, 2 of the CAPs were due to non-compliance with TNE, working capital and/or cash-to-claims. Of the 28 continuing CAPs, 22 of those CAPs were improving and are on the way to meeting their approved projections and 6 CAPs were not improving. For these 6 CAPs, 3 of the CAPs we extended the time period to obtain compliance by one additional quarter; and the 3 other CAPs we are working with those RBOs. The 32 CAPs, 28 are approved and are in review. And for additional information on the corrective action plans there is an attachment which includes additional information such as the MSO and it is also sorted by MSO. But it includes the

MSO if they have one, or contracted one, the contracted health plan's enrollment information, the quarter the CAP was initiated, the grading criteria deficient and the grading criteria deficiency. After our September 30 review, 11 of the 32 CAPs were completed, those RBOs met their approved CAP projections; and 3 of the CAPs, 3 of the 4 CAPs were approved. Moving on to the next slide.

These next four slides are new from the previous, our previous presentation, and they have to do with the grading criteria from the September 30 filings.

The first is tangible net equity. We compiled the data, the TNE data from the quarterly survey reports and we use the TNE and required TNE to determine the ratio. Less than 100% percent -- less than 100% represents non-compliant with the TNE requirement. This slide shows that there are 152 or 72% of the RBOs reported TNE in excess of 500% and 5 RBOs reported non-compliance with the TNE grading criteria. Next slide please.

Regarding the working capital, we calculated the relative working capital, which we took the current assets and excluded the unsecured affiliate receivables and divided that by the current liabilities. The results show the number of times the RBO, the current asset -- this slide shows the number of times the current assets cover the current liabilities. Over 97% of the RBOs were able, had sufficient current assets to cover their current liabilities; and 5 RBOs that had less than 1.0 were on a corrective action plan for non-compliance with the working capital requirements.

Moving on to cash-to-claims. The calculation for the ratio is the cash, short-term investments and health plan capitation receivables collectable within 30 days, and divided that by the total claims liability. And this is the

calculation for the cash-to-claims ratio.

This slide shows that a majority of the RBOs have sufficient cash reserves to cover their total claims liability. And 4 RBOs did not meet the cash-to-claims ratio, which was .75, and are on a corrective action plan.

And the last to present is the claims timeliness requirement. Claims timeliness is 95% in order to report compliance. Next slide please.

In general, cash-to-claims is caused by various reasons such as claim system conversions, changes in MSOs, transitioning to work from home and staffing issues. There were 10 RBOs that reported non-compliance with the claims timeliness criteria at quarter ended September 30, 2022.

Moving on to enrollment. Next slide please. The RBOs report enrollment with their quarterly survey reports. This slide represents that the RBOs reported approximately 9.2 million enrollees that were assigned to them. This is an increase of approximately 166,000 enrollees, about a 2% increase from the previous reporting period. And we continue to see the increase in the Medi-Cal enrollment range.

Moving on to RBOs that have Medi-Cal lives assigned to them. At September 30 there were approximately 5.4 million lives assigned to 88 RBOs. This represents approximately 59% of the total lives assigned to the RBOs. Of those 88 RBOs, 69 RBOs had no financial concerns, 2 were on our monitor closely list, and 17 were on corrective action plans.

Looking at the top 20 RBOs that have Mei-Cal lives assigned to them, these top 20 RBOs, next slide, please, approximately 4.1 million enrollees, approximately 45% of the total enrollment were assigned to these top 20 RBOs. 15 of these RBOs had no financial concerns, 1 was on our monitor closely list

and 4 of these RBOs were on corrective action plans. For the RBOs, for these 4 RBOs, they were all on corrective action plans for claims timeliness, non-compliance with the claims timeliness criteria, and reported compliance with all the solvency metrics. And the remaining 68 RBOs, 58 had no financial concerns, 1 was on our monitor closely list, and 13 were on corrective action plans.

And that does it for my presentation regarding the RBOs at September 30. I am open to questions. Thank you.

CHAIR DEGHETALDI: Looking for Board questions. Jeff, good.

MEMBER RIDEOUT: So Michelle and Mary, I kind of ask a variation of this question every time. But how much can the registry of RBOs be used to align with other efforts to track provider performance or provider existence? And I know that we are measuring the financial metrics that the enabling legislation way back when requires us to do, but it seems like that RBO list is going to become more important or could become more important for OHCA, it could become more important for any number of, who are the providers and how do we define them and what are the subgroups of providers? As you know, we work in this world a lot and the RBOs level is too general to really make too much sense because a lot of RBOs have multiple regional operations and stuff. But I am just trying to, we are trying to create a hierarchy in Symphony now that starts with RBO and then goes down to the individual physician or practitioner level. So I just want to know whether we are chasing something that doesn't have that kind of specificity or whether you are seeing some alignment within different government agencies even to use the RBO registry, as I would call it?

MEMBER WATANABE: Yes, and Pritika could probably jump in

here too. I don't know that I have the answer yet. I will say that we are obviously having a lot of conversations with HCAI and the new Office of healthcare affordability just to see how our data can be used. But, Pritika, anything else you want to add?

MS. DUTT: No, Mary, you are on point. We are working with HCAI and the Office of Health Care Affordability and we will have further conversations to share our data and, you know, use that effectively.

CHAIR DEGHETALDI: Jeff, you have a follow-up question?

MEMBER RIDEOUT: Just because it is publicly available, we have inputted that into the Symphony environment already. So, you know, we are trying to get at all different levels and all the relationships which change constantly. But it is doable in kind of a production environment and we hope that we can contribute that. And HCAI is coming back to us now and saying, is that something that could be available to them directly.

MEMBER WATANABE: Okay.

MEMBER RIDEOUT: So FYI.

CHAIR DEGHETALDI: Other Board Members?

Michelle, I want to compliment you on slides 30, 31 and 32, which is, as I think of them as, total TNE or total assets versus liquid assets versus cash-to-claims. Because, you know, if your assets are not liquid it is probably not a good indicator of your TNE status.

Following up on Jeff's question, there is about a million Medi-Cal lives that are in RBOs that are challenged. I wonder what their quality scores, their health equity scores, I wonder access scores. I wonder if -- I am concerned that when RBOs are under financial pressure, Jeff, that they will, that the

benefit -- that patients will suffer. Or we will have less access or lower health equity kinds of metrics. And so I guess having a full understanding of what happens to patients when organizations are under financial strain. I don't know if, Jeff, you were referencing that, but that has been a concern I have had for a long time.

MEMBER RIDEOUT: I wasn't specifically but it is one thing you could do with that level of detail, certainly.

CHAIR DEGHETALDI: Other Board Members?

Michelle, we love this.

And, Jordan, from the public?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: Then we go, I think go back to Pritika, I think.

MS. DUTT: The purpose of this presentation is to provide you an update on the financial status of health plans at quarter ended September 30, 2022. All licensed health plans are required to submit quarterly and annual financial statements with the DMHC. Additionally, we get monthly financial statements from plans who are newly licensed and also from plans whose TNE falls below 150% of required TNE or if we have concerns with a plan’s financial solvency. We also included a handout that shows the enrollment at September 30 and TNE for five consecutive quarters for all licensed plans. That information is broken into three categories: full service, restricted full service and specialized. Next slide.

As of February 15, 2023 we had 143 licensed health plans. We are currently reviewing 12 applications for licensure, 7 full service and 5 specialized.

Of the 7 full service, 3 are seeking license for Medicare Advantage, 3 for restricted Medicare Advantage and 1 is looking to get a license for Medi-Cal. For the 5 specialized plans, 3 are looking to get licensed for EAP, for Employee Assistance Programs, and 2 for dental.

And then we licensed one health plan since the last FSSB meeting. Community Family Care Health Plan, Inc. was licensed on February 14 as a restricted Medi-Cal plan.

And we have two plans that surrendered their licenses. One was Humana EAP and Work-Life Services of California, Inc.; the other one was Inter Valley Health Plan, Inc., which was a Medicare Advantage plan. Next slide.

At September 30, 2022 there were 29.55 million enrollees in full service plans licensed with the DMHC. Total commercial enrollment includes HMO or PPO/EPO and Medicare supplement. As you can see on the table, compared to the previous quarter total full service enrollment increased by approximately 356,000 lives. Medi-Cal enrollment increased by 380,000 lives while commercial enrollment dropped by 51,000 lives. Next slide.

This slide shows the makeup of HMO enrollment by market type. HMO enrollment in all market types remained relatively stable compared to previous quarters. Large group HMO enrollment decreased by 31,000 and Individual enrollment decreased by 36,000 lives. Next slide.

This slide shows the makeup of PPO/EPO enrollment. As you can see on the table, PPO/EPO enrollment remained relatively stable. We are working on making changes to our health plan financial statement reporting templates, which will provide a breakdown of PPO/EPO and other lines of --

MEMBER WATANABE: You muted yourself.

MS. DUTT: I noticed that. I will start again there. So we are working on making changes to our health plan financial statement reporting template, which includes the enrollment template as well, so we are going to further break down by enrollment type. So in the future, sometime next year we will be able to provide further breakdown of enrollment in future meetings. Next slide.

This table shows government enrollment, which is Medi-Cal and Medicare Advantage. Overall government enrollment increased. The majority is due to Medi-Cal enrollment, which increased by 380,000 lives. And then Medicare Advantage also experienced a slight increase, they added like 30,000 lives. So next slide.

There are about 4 million enrollees in the closely monitored full service plans. Of the 28 closely monitored full service plans, 14 are restricted licensees and had 419,000 enrollees. The total enrollment for the 3 specialized plans that were closely monitored was 64,000 lives. And 1 plan was a vision plan and 2 were dental plans of the specialized plans. Next slide.

So this slide here shows the two plans that were TNE deficient. Brandman, as you may recall, was also here last quarter. So Brandman reported TNE deficiency for month ended April 30, 2022. The plan is still TNE deficient as of now. It has zero enrollment and it is currently looking for a buyer. For Medcore Health Plan, the plan filed its annual audited financial statements for 2021 late. So we received it on December 5 of 2022 but they were due April 30 of 2022. So we received the financials late. As a result of audited financial statements the CPAs made adjustments, they made some reporting adjustments which caused Medcore Health Plan to be TNE deficient at December 31, 2021

and all quarters of 2022. So we are currently working with Medcore HP on their TNE deficiency and are getting financial projections and on a plan to get them cured. So we will continue to provide updates to you at the next quarterly meeting. Next slide.

This chart shows the TNE of health plans by line of business. A majority of the health plans with 500% of TNE are specialized health plans. This is because the required TNE is higher for full service plans because the medical risks -- the medical expenses are higher for full service plans. So next slide.

This chart shows TNE or tangible net equity of full service plans by enrollment category. 68 health plans or over half of the total licensed full service health plans reported TNE of over 250% of required TNE. If the plan's TNE falls below 150% of TNE, of required TNE, they are placed on monthly financial reporting. Next slide.

And this chart shows the breakdown of the 22 full service plans in the 150% to 250% range. As I mentioned earlier, if a plan's TNE falls below 150% they are placed on monthly. We might also place plans on monthly reporting if we have financial concerns with them, if we see a declining trend in the plan's TNE or financial performance if there's continuous net losses reported by the plan. And again, if a plan is newly licensed we have them on monthly reporting the first 12 months so we can monitor their progress. Next slide.

This chart shows the TNE of full service plans by quarter. For detailed information on health plan TNE levels and enrollment please refer to the handout that was provided with meeting materials. Also this chart pretty much summarizes the handout, the information that is included in the handout.

So with that I will take any questions.

CHAIR DEGHETALDI: Any board questions? I am surprised.

I had just one thought, Pritika. There's 6.5 million Californians on Medicare, 14.5 million perhaps on Medi-Cal. The subset that are duals pose particular challenges, particularly as we move into CalAIM. And I wonder if at some point we either by inviting the office of Medicare Innovation and Integration, DHCS's department, to get a better understanding of the duals and the end sort of the challenges that they produce on both plans and providers who care for them. Particularly current state. You know, San Mateo, some of our counties are already in the DSNP world. Maybe Scott could comment. But I do think that that population deserves particular focus. Scott, I don't know if you are still with us, but anyway, just a thought.

MEMBER COFFIN: No, I am here. I concur. I concur with your, with your point.

CHAIR DEGHETALDI: Okay, if no Board Members, members of the public, Jordan, have a question?

MR. STOUT: There are none at this time.

CHAIR DEGHETALDI: Okay. Then I think the next topic is we ask for comments from the public for matters not on our agenda. Is there? Yes.

MR. STOUT: Seeing no hands.

CHAIR DEGHETALDI: Okay. And then I think we go to the Board and ask for folks to discuss any interested future agenda items.

MEMBER COFFIN: I have one. I really think it was valuable to have the presentation from Covered California and I would encourage that, you know, that invitation be extended, especially as we get closer to this period of time when the redeterminations start back up, and then maybe periodically.

Because as I raised, you know, the issue there and I am really glad there is an openness to partner with Covered California. You know, I foresee that Medi-Cal beneficiaries are going to experience a series of communications and part of our job, I think, is to help sort that out and minimize and really coordinate that message. So I think it would be really good to have Covered California come back, you know, at the quarterlies just to update on how that's going.

MEMBER WATANABE: I will just note that we are making a little bit of shift from what we have done in the past. Those of you that have been on the Board for a while know that we have historically had DHCS attend most if not every one of our meetings, and we are mixing it up a little bit. So we will have -- we will try to get Covered California to come back. We are hoping to have HCAI and the Office of Health Care Affordability come periodically. And so we are trying to align the DHCS attendance at the meetings when we present the financial report. Just I welcome all your feedback and I want it to make sense and the right cadence to have both Covered California and HCAI.

And Larry, hear you on the duals and potentially either CMS or someone from DHCS to come and talk about that. I think that has been raised before, we will take that back as well.

CHAIR DEGHETALDI: There was a tie Jeff and Amy. So, Amy, why don't you go?

MEMBER YAO: Thank you. Thanks, Jeff. Yes. So I think I would like to hear some maybe at the right time the updates on some of the California key initiatives. For example, on the affordability and the data exchanges. And we talked about here, data is going to be the foundation for quality, for health equity. So would just like to hear the progress on those. Thank you.

CHAIR DEGHETALDI: And Jeff.

MEMBER RIDEOUT: So I will call it the Mary Special and see if she wants to react to it. I think in a future meeting, and I can't promise by the next one, we could put together a blinded report, blinded to plan and provider, that would have the four core measures across the four government entities, adjusted for imputed race and ethnicity and also correlated to encounter data volume for the key providers providing that. So it is kind of putting all of this into one picture. And it is an early snapshot. And I am sure my staff is going to kill me when I tell them that that's what I said we could do. But sometimes having a deadline is a good thing. If people want to see that kind of report we could try to get that together. And then I can say you all made me do it.

CHAIR DEGHETALDI: We will make you do it, Jeff, yes.

MEMBER WATANABE: Larry is making you do it. Tell your staff --

CHAIR DEGHETALDI: I like to make Jeff do things that he wants to do anyway so to offer somebody else to blame.

Any other Board Members? I do --

MEMBER RIDEOUT: I also get to see whether anybody actually watches these from IHA or not, you know.

CHAIR DEGHETALDI: There you go. There you go.

I mentioned, I have been speaking to the Madera Community Hospital closure as a horrible crisis in that community. There are other hospitals that are either in bankruptcy or others that have, you know, sort of had a temporary saving effort. I wonder if we could hear from CHA at some point. Because if, you know, if sole community providers on the hospital side are failing, what is the story there? What is the impact? What is the root cause? Because it

is one thing to see access decline, it is another to see it evaporate, you know. So that is concerning.

At some point I know that the CMA is working on an expansion of the MCO tax to augment payments to providers in the Medi-Cal fee schedule. When that gets fleshed out I would love to hear about it because I think it could help improve the perennial struggles of some of our high Medi-Cal RBOs, you know. Hopefully, anyway. Those are a couple thoughts. Any others?

Okay. Closing remarks from Members of the Board. Pritika said we would be done by 12:30 and we are making her, you know, again honest.

MEMBER WATANABE: Larry, I will just add. I think our next meeting is scheduled for May 17. It will be a busy one as we will have the Medi-Cal financial report along with the reports on the individual, small and large group rates and impact of pharmacy costs too.

CHAIR DEGHETALDI: Uh-huh.

MEMBER WATANABE: We will kind of take your list here and see what we can sprinkle in with DHCS and data as well.

CHAIR DEGHETALDI: Sure.

MEMBER WATANABE: Just be prepared, we will probably go the full three hours.

CHAIR DEGHETALDI: Right.

MEMBER WATANABE: And this will be likely our last virtual meeting and then we will move to in-person meetings in August.

CHAIR DEGHETALDI: Right. I do like your idea of the cadence of DHCS there at each meeting where the full finance, you know, I think that's great. And then maybe we could have our visitors, you know, so-called visitors, at the

other, you know, fill in. Like at this meeting Covered California came and that's a great flow, I think. Anyway.

MEMBER WATANABE: I think so. We will try it and see how it goes. It will give DHCS a little bit of a break too because they have got a lot on their plate. So definitely let us know if you have other feedback.

CHAIR DEGHETALDI: Anything else from members of the Board or staff? I just want to thank everybody, it was great. The Covered California thing will stay with me for a while. So thanks. Thank you, everybody.

(The meeting was adjourned at 12:22 p.m.)

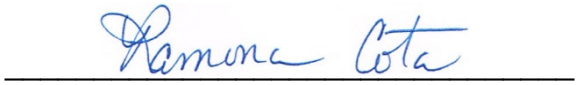
CERTIFICATE OF REPORTER

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 12th day of March, 2023.



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