DEPARTMENT OF
Managed
Health Care

Financial Solvency Standards Board Meeting
March 18, 2015
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Edward Cymerys, Healthcare Consultant
Dr. Larry de Ghetaldi, The Palo Alto Medical Foundation
Jacob Furgatch, Premier Health Plan and Coast Healthcare Management
Deborah Kelch, Alternate, Independent Consultant
Dave Meadows, Liberty Dental Plan
Ann Pumpian, Chairperson, Sharp HealthCare
Shelley Rouillard, Department of Managed Health Care
Dr. Rick Shinto, Alternate, InnovaCare Health, Inc.
Tom Williams, Alternate, Stanford Health Care Alliance
Dr. Keith Wilson, Molina Healthcare

Department of Managed Health Care (DMHC) Staff Present:
Stephen Babich, Supervising Examiner, Division of Financial Oversight
Pritika Dutt, Supervisor, Division of Financial Oversight
Sandra Gallardo, Attorney, Office of Legal Services
Jenny Phillips, Senior Attorney, Office of Plan Licensing
Gil Riojas, Deputy Director, Office of Financial Review
Michelle Yamanaka, Supervising Examiner, Provider Solvency Unit

1) Welcome & Introductions- Agenda

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

2) Minutes from November 13, 2014 FSSB Meeting

Edward Cymerys made a motion to approve the November 13th FSSB meeting minutes. Jacob Furgatch seconded the motion. Meeting minutes were approved with no opposition.

3) Director's Remarks

Shelley Rouillard introduced Mari Cantwell, Chief Deputy Director, Health Care Program, from the Department of Health Care Services (DHCS).

Ms. Rouillard announced the DMHC released its report on Kaiser's Behavioral Health Services follow-up survey on February 24. Following the initial survey, done in 2012

and released in 2013, the Department fined Kaiser $4 million for failing to provide timely access to mental health services. The initial survey identified four deficiencies. Kaiser has corrected two of them. The Department found that Kaiser has not been able to provide services on a consistent basis within the timely access standards nor to provide enrollees with health education information. The next routine survey of Kaiser is scheduled for the fall of 2015.

Ms. Rouillard stated the non-routine survey reports for Anthem Blue Cross' and Blue Shield's individual provider networks were released in November. The reports indicate about 25 percent of the providers listed as participating in the individual market for both plans were not available to members. The Division of Plan Surveys is preparing to do a follow-up survey in May to see if the plans have fixed the problems as required in their corrective action plans (CAPs).

Ms. Rouillard mentioned other significant areas of work for the DMHC, including implementing federal mental health parity compliance, conducting surveys of all full service and mental health plans specific to their compliance with mental health parity, and implementation of AB 1962 (medical loss ratio for dental plans).

4) Alameda Alliance for Health Update

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

- Financial Summary
    - Number of enrollees increased by 47 percent (77,000 new enrollees) from November 2013 (163,000 enrollees) to January 2015 (240,000 enrollees).
    - The Plan has had five consecutive months of net income, has a cumulative net income of $12.2 million since July 2014, and is compliant with their Tangible Net Equity (TNE) requirement.
    - Turnaround can, in part, be attributed to efficiencies in controlling their administrative costs and favorable Medicaid expansion rates.

Ms. Rouillard added the plan ended its relationship with a Medicare Dual Eligible Special Needs Plan (D-SNP) that is no longer operating. The plan had been losing approximately $7 million annually on this line of business.

- Denials
    - Approximately 60 percent of denials are duplicate claims that should be paid by the delegated provider and not the plan. The Plan hired additional staff to help educate providers about where to send their claims.

- Member Services
    - In November 2014, the average wait time to speak with member services was 14 minutes, but it has since decreased to approximately 58 seconds on average.
- Information Technology (IT)
    - Testing of the HEALTHsuite system continues. Plan representatives are working directly with the software vendor to correct any issues identified during testing. The conservator estimates transition to the new IT system in early July.

Mr. Riojas stated the DMHC continues to have weekly calls with the conservator as well as monthly Board of Governors' meetings. A new CEO may be in place by mid-June.

Discussion:

Larry de Ghetaldi asked how much of their improvement is due to the natural impact of 2014 versus interventions.

Mr. Riojas responded he does not have that information now, but can get it. He added it is definitely a combination of both.

Rick Shinto inquired about the claims denial categories and whether there is any kind of trend. He voiced his concern about the big jump in enrollment and not having a good sense of what is going on internally.

Mr. Riojas responded the DMHC tracks the volume of denials but it was not included in this report.

Mr. Cymerys stated at the last meeting the overall level of denials was 5.5 percent. He asked if claims initially denied are being overturned.

Mr. Riojas stated he will check with the conservator.

Jacob Furgatch asked about the high number of delegated payer responsibility claims. It was high before, but it is higher now. He asked if the DMHC is also looking at the downstream Risk Bearing Organizations (RBOs) affiliated with the organization.

Mr. Riojas replied the RBOs are monitored through DMHC's Provider Solvency Unit and exams are conducted.

Ms. Rouillard added that part of the reason why duplicate claims are so high may be due to the advance payments to providers made by the plan when the claims system failed. When providers could not match the advance payments with claims, they kept

resubmitting the claim. The plan has now matched approximately 95 percent of the advance payments with claims.

Ms. Pumpian asked if there has been a growth in the delegated providers associated with the plan. She stated the plan's improvement in TNE could be because they delegated more. If the providers are not getting paid, there could still be a major problem.

Mr. Riojas replied the delegated providers have been the same since the monitor and conservatorship have been in place. Lack of payment to providers is monitored through the DMHC's Provider Complaint Unit (PCU), who has not seen any significant complaint issues.

Dave Meadows asked why there is so much confusion as to who is responsible for paying claims.

Mr. Riojas replied he does not know why there is so much confusion but the plan recognizes it is an issue and has hired staff to help educate the providers.

Mr. de Ghetaldi asked what kind of financial position or TNE would be expected of a plan to go back into duals.

Mr. Riojas replied it would need to be at a significantly higher level than it is now for them to properly manage it.

Ms. Rouillard added there is not going to be any expansion of the duals for several years and hopefully, the plan will be in a better position to consider it at that time.

5) Medi-Cal Managed Care Plans Financial Status Report

Mr. Riojas presented a financial summary report looking at the enrollment and financial information reported by the Local Initiative (LI) health plans and the County Organized Health Systems (COHS) for the quarter ending December 31, 2014. The report includes self-reported data on medical expenses, per member per month (PMPM) medical expenses compared to revenue, net income, total net equity, cost of operations, and any plan deficiencies.

- LI Health Plans
    - There are nine LIs serving 13 counties.
    - Enrollment
        - Enrollment increased at an even higher rate than expected. All LIs experienced significant increases from December 2013 to December 2014, with individual plan increases ranging from 37 percent to 63 percent.

        - Higher than expected enrollment has led to questions about how the plans are handling the increased number of enrollees and claims. The Department is monitoring the plans through complaints and other reports submitted by the plans.
    - PMPM Medical Expenses
        - A review of PMPM medical expenses from 2011 to 2014 does not reveal any consistent trends or patterns.
        - Plans are including pass-through expenses and revenue in the medical expenses and premium revenue, which may be the reason there were large increases from 2013 to 2014. A line is being added to the financial statement to separate those pass-through expenses and revenue to get a clearer picture of the true impact to the bottom line.
    - Tangible Net Equity
        - For the time period of December 2013 to December 2014, the TNE remained stable for all LIs, with Alameda as the only plan that continues to report under 100 percent.
- COHS
    - There are six COHS plans serving 22 counties.
    - The COHS are exempt from Knox-Keene licensure for Medi-Cal business, but they must have a license for other types of business. Four of the six COHS have other lines of business that require them to file enrollment and financial information with the DMHC. San Mateo County voluntarily included their Medi-Cal enrollment under their Knox- Keene license. Gold Coast Health Plan is the only COHS that does not have a Knox-Keene license and so it is not included in the report.
    - Enrollment
        - Similar to the LIs, COHS enrollment increased significantly from December 2013 to December 2014, with individual plan increases ranging from 37 percent to 46 percent.
    - PMPM Medical Expenses
        - A review of PMPM medical expenses from 2011 to 2014 does not reveal any consistent trends or patterns. Similar to the LIs, PMPM revenue outpaces PMPM expenses.
    - Tangible Net Equity
        - For the time period of December 2013 to December 2014, the reserves are higher in the COHS compared to the LIs with all plans over 200 percent of TNE.
        - Financially, COHS look healthier with more reserves compared to the LIs.

Discussion – LI Health Plans

Mr. Shinto asked if the DMHC was anticipating the level of increased enrollment.

Mr. Riojas replied the DMHC expected a jump, especially with the transition of the Low Income Health Program (LIHP), but did not expect the level of increase that was seen in the LI Health Plans, COHS and other Medi-Cal plans.

Ms. Pumpian stated it takes time for individuals with new coverage to figure out how to access care. She asked if the plans really do have adequate funding for this new enrollment and whether members are accessing care.

Keith Wilson asked what kind of incurred but not reported (IBNR) calculation is applied and if the PMPM expenses are truly reflective of the year.

Mr. Riojas replied the IBNR calculation should be incorporated to reflect the increases. It was not captured in this report, but can be captured going forward to see where the IBNR calculation is and if it is increasing appropriately.

Mr. Meadows stated that Medicaid costs are much higher in the initial six to 12 months, but after they have been continuously enrolled for one to two years, the per member cost drops.

Mr. Wilson stated that has not been their experience with the Medicaid expansion population in California and other states. They have not seen the pent-up demand but instead have experienced a slow uptake.

Mr. Furgatch added he has seen the same thing. The expectation was that there was a huge pent-up demand for some of the expansion patients but that has not materialized.

Mr. Shinto asked about Contra Costa and their PMPM numbers going from $106 to $302. Something changed in the calculation, the population or both.

Ms. Rouillard stated a lot has to do with the Seniors and Persons with Disabilities (SPDs) and Contra Costa is a really small plan. The population of SPDs, in proportion to the rest of the population, is going to have a big impact.

Pritika Dutt, Supervisor in Division of Financial Oversight, added it also includes the pass-through expenses for that period.

Mr. Riojas stated if there were no pass-through expenses in December 2013, there would not be the same increase. That may be the reason for such a large increase in 2014.

Mr. de Ghetaldi stated a population risk adjuster is needed like what Medicare has imposed in Medicare Advantage (MA) and fee-for-service.

Ms. Pumpian asked if Medi-Cal is planning to have a risk adjustment factor put in place for the entire Medi-Cal population.

Ms. Cantwell responded Medi-Cal has different rate cells depending on which aid category someone is in, such as child, non-disabled adults, disabled adults, new adults, duals, and other specific categories. The rate cells represent different levels of acuity. In a two-plan county, risk adjustment is done between the plans, using county average rate setting with risk adjustment, for plan specific rate setting. At this time, there are no plans to change this approach, but over the next several years it may be something they look at as a way to improve rate setting with the health plans.

Ms. Cantwell added that DHCS recently released the Medicaid waiver renewal proposal, which includes a proposal to pay the plans differently over the next five years to allow more flexibility in how the plans spend their money.

Mr. de Ghetaldi commented that his organization added 40 percent Medi-Cal lives, but they don't know much about who they are. They need a way to understand the disease burden of the population like Medicare does on the fee-for-service side.

Ms. Cantwell stated the difference is Medicare does rate setting off a standardized base, whereas Medi-Cal uses plan-specific data to inform rate setting. This allows for plans with fundamental differences to have different rates.

Tom Williams asked why Kern Health Systems was the only plan that did not show a jump in PMPM medical expenses and if this was because they did not include pass-through expenses like the other plans.

Ms. Pumpian added Kern Health Systems had five quarters of negative net income until this December and questioned whether they adequately identified their expenses in December because a $10 million shift is significant.

Mr. Riojas responded there should be a better indication once the pass-throughs are separated.

Mr. Furgatch added the net PMPMs for the LIs range from $1.17 to $8.33 and are significantly higher for the COHS.

Mr. Shinto voiced his concern about whether the plans have the administrative capacity and infrastructure to handle big jumps and movement in their enrollment.

Mr. Furgatch added an opposing concern that the plans may believe it is a trend that will continue and it is only a sudden windfall.

Discussion - COHS

Ms. Pumpian asked why the Health Plan of San Mateo had such a high PMPM premium revenue compared to the other plans.

Ms. Cantwell explained it is plan specific and they provide services that the other plans do not. In addition, they serve populations the other COHS don't. They are the only COHS that currently has coordinated care, In Home Supportive Services (IHSS), long-term care, Multipurpose Senior Services Program (MSSP) and California Children's Services (CCS) kids. Ms. Cantwell added this also explains why there are differences between the LIs and the COHS since they serve different populations and provide different services.

Mr. de Ghetaldi stated the COHS are doing well, but it will be a challenge for the leadership and governance of these organizations not to spend the windfall because 2014 may not be a predictor of the future.

Mr. Riojas responded that it will be incumbent upon the plans to make sure they have adequate reserves in case enrollment and revenues do not continue at this level.

Mr. Furgatch added the net PMPMs for the COHS range from $6.12 to $16.89, which is significantly higher than the LIs.

6) Timely Access Methodology

Jenny Phillips, Senior Attorney in the Office of Plan Licensing (OPL), presented information on the timely access regulation and standardized methodology for determining a rate of compliance.

- History of the timely access statute and regulation
    - The statute (Health & Safety Code Section 1367.03) was enacted in 2002, but the regulation was not adopted until 2010.
    - Directed DMHC to ensure timely access to healthcare services, including:
        - Wait times for appointments with physicians
        - Timeliness of care and episodes of illness
        - Timeliness of referrals and obtaining services
        - Wait times to speak to a physician or nurse for triage services
        - Access to interpreter services
        - Clinically appropriate standards and access to urgent care

- Plans are required to monitor network compliance to ensure a sufficient number of providers and to correct deficiencies when they have been identified.
- Requires full service and mental health plans to submit an annual report demonstrating their rate of compliance with the timely access standards in the previous calendar year.

- 2014 annual report
  - The 2014 report is due on March 31, 2015for the 2014 measurement year.
  - Thirty-four full service plans and seven mental health plans are required to submit.
  - Reports are reviewed by OPL and DMHC's contractor, Managed Healthcare Unlimited (MHU).
  - Components of the annual report:
    - Policies and procedures related to monitoring timely access
    - Rate of compliance with the time-elapsed standards
    - Incidents of noncompliance that resulted in substantial harm or patterns of noncompliance
    - Information regarding advanced access – providers that can guarantee an appointment within the current or next day
    - Description of triage, telemedicine, and health information technology as they pertain to ensuring timely access to appointments
    - Enrollee and provider satisfaction surveys
    - Provider network snapshot, as of December 31
- Improvements to compliant reporting
  - Compliance has historically been monitored using methods that varied by plan including appointment availability surveys, enrollee or provider feedback, or in some cases, using a secret shopper.
  - In 2013, the DMHC collaborated with the Industry Collaborative Effort (ICE) and the plans to develop a standardized survey methodology.
  - For the 2014 report, the DMHC implemented a model provider appointment availability survey and compliance rate methodology.
    - Approximately 75 percent of plans adopted the model for the 2014 measurement year.
    - Many mental health plans are using online surveys for the 2014 measurement year.

- DMHC's implementation of SB 964
    - Amends portions of Section 1367.03 and adds 1367.035 to give the DMHC authority to develop a standardized methodology for reporting timely access compliance.
    - A standardized methodology would allow for comparison across plans and separate rates of compliance for separate networks (Medi-Cal, Individual, Commercial, etc.).
    - An audit option would allow a retrospective look back on all appointments, or a sample of appointments.
    - Plans would report data by different categories which could make the data more meaningful.
    - Looking to assess different appointment types separately (telemedicine, traditional in-clinic, etc.).
    - Requires the DMHC to do annual reviews of compliance and post findings on the website.

Discussion

Mr. Shinto asked if the situation with Kaiser was because they have a system that allows them to include all data.

Ms. Phillips replied it was not that they used actual appointment wait time data, but what they did with the data once they extracted it.

Ms. Rouillard added it was how they were using the information to show they were complying. Kaiser has stepped up in terms of their ability to identify where there are problems and they are monitoring more closely.

Mr. Williams asked if the Kaiser mental health access issue came out of this survey or if it is separate. He also asked what percentage of visits is telemedicine.

Ms. Rouillard replied the Kaiser mental health survey was part of the DMHC's routine three-year survey done in 2013. That survey was not part of this timely access survey.

Ms. Phillips added the percentage of visits that are telemedicine do not show up in the report.

Mr. de Ghetaldi asked about the impact of distance on primary and specialty care since access is not just time, it's also space. He added the new world is not just telemedicine, its e-encounters. A primary care doctor spends one-fourth of their time dealing with patient issues online.

Ms. Phillips responded that OPL assesses whether or not a network is adequate. That is a separate review process, not necessarily through the timely access reporting. She added that there is a desire to understand how the plans are using telemedicine and e-encounters, but it is difficult to collect through surveys and audits.

Ms. Pumpian recommended looking at a different snapshot period of December 31, rather than the end of March since most plans change their contracts at that time. She also recommended asking the plans to include in their report what changes will occur on January 1.

Ms. Phillips responded that this has typically been a look back report and the information reported on March 31, 2015 was for calendar year 2014.

Beth Abbott, Director of the Office of the Patient Advocate (OPA), added that OPA was consulted early and often regarding the timely access methodology. OPA brings expertise and they are an end-user and public reporting partner.

7) Reasonable and Customary Project

Sandra Gallardo, Attorney for the Office of Legal Services, discussed the reasonable and customary survey sent to licensed health plans and capitated providers in February. The survey asked them to share their methodologies for payment of non-contracted emergency services, physician services, and facility and institutional services.

The Knox-Keene regulation states health plans are required to reimburse providers the "reasonable and customary amount for non-contracted services". Plans must use statistically credible information that is updated annually and takes into consideration the six Gould criteria, which include criteria ranging from the provider's training, qualifications and time in practice to fees charged and prevailing provider rates.

The Gould criteria have always favored the fees charged by providers, as opposed to the fees received. Last year, the Court of Appeals ruled in the Children's Hospital decision that the range of payments paid to and accepted by the provider, such as Medi-Cal rates and commercial contract rates, are also relevant.

In the DMHC survey, plans were asked to describe how the Gould criteria are considered, any anticipated changes due to the Children's Hospital decision, and a health plan's percentage of enrollment by county. The DMHC will evaluate the payment methodology trends and produce an aggregate-level report.

Discussion

Mr. Williams asked if this is to make sure that providers get paid enough, or that they are not over-charging, or both.

Ms. Gallardo replied it is to see if the plans are meeting the requirements of the reasonable and customary regulation. There have been provider complaints that they are not being paid enough.

Mr. Cymerys asked if the DMHC anticipates any input at either the state or federal level regarding implementation of the ACA requirements related to reasonable or customary charges.

Ms. Gallardo responded the survey will give an indication if there are any problems that the Department needs to address or if the regulation needs to be revised.

Mr. Furgatch mentioned challenges with the Gould criteria and determining the training qualifications and length of time of practice for a non-contracted provider.

Ms. Gallardo stated the Gould criteria have typically been used when a provider challenged a fee amount through an Independent Dispute Resolution Process (IDRP).

Ms. Pumpian asked when the report is expected to be released and if the report would be made public.

Ms. Gallardo stated complete data should be received by the end of the month. The Department will first do an initial review to determine if it is feasible to do the report internally or contract with an outside vendor.

Ms. Rouillard added the purpose is to understand how groups and plans are calculating what is reasonable and customary to see if there are any patterns. This will inform the Department's decision whether to open up the regulation to provide clarification.

Don Comstock, Comstock and Associates, asked if the medical groups and Independent Practice Associations (IPAs) were asked to provide contracted rates with emergency group physicians by line of business. It will be important to understand what these groups are paying their contracted providers in the same geographic area.

Ms. Gallardo responded this survey is strictly looking at the methodologies of what plans are paying providers, not their contracted rates. However, the Children's Hospital decision stated the contracted rate should be considered in the methodology.

Dietmar Grellman, Senior Vice President at the California Hospital Association (CHA) stated CHA filed litigation on the Gould criteria when the regulations were adopted. The basis of the lawsuit was a concern that it was setting rates. The court ruled that the Gould factors are not rate setting. They are a tool for the Department to use in determining if an enforcement action is warranted. The DMHC issued a bulletin stating the Department would not conduct an enforcement action if certain elements were met, including average contract rates with a delta, and Medicare rates. The Children's Hospital case did not set rates. The court acknowledged there is a delta between what

is negotiated in the contract versus when a health plan chooses not to put a provider in their network.

The ACA is making things change. Hospitals are working towards a system where the charges are more in line with what the expected reimbursement would be. The nickname for the project is "Modern Pricing". It is going to take a lot of time because it requires the hospitals to negotiate and renegotiate contracts with health plans. It also means changes with federal law and federal requirements.

Mr. de Ghetaldi asked if there is a target for the cost-of-charge ratio in five years for California's hospitals.

Mr. Grellman replied there is not a specific target because it is so individual by hospital. Reasonable and customary is fact-specific to a specific institution.

Tim Madden, California Chapter of the American College of Emergency Physicians, thanked the Director for pursuing this methodology. He stated one of the differences between physicians and hospitals is emergency physicians retain the right to go to court to fight if there is a dispute. Typically the dispute is between $100 to $200. They have to aggregate hundreds or thousands of underpayments to make going to court make sense.

8) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Corporation Examiner in the Provider Solvency Unit (PSU), gave an update on financial reporting for Risk Bearing Organizations (RBOs) for the quarter ending December 31, 2014.

- 23 of the 182 RBOs filed their Annual Survey Report.
- 139 filed Quarterly Survey Reports, which includes balance sheets, income statements, statement of cash flow and the grading criteria calculation.
- 43 filed Compliance Statements, which is an attestation of compliance with the solvency criteria.
- Three RBOs file monthly financial statements as required in their CAP.
- The Department has a color-coded system applied to each filing received. Red represents non-compliance, yellow represents compliance, and green are superior RBOs.
    - 27 RBOs are in the green category.
    - 109 RBOs are in the yellow category, including 5 RBOs with CAPs and 12 RBOs on the monitor closely list.
    - 3 RBOs are in the red category.
- A total of nine plans have CAPs

    - One RBO in the green category has an active CAP.
    - Five RBOs are meeting the requirements of their CAP.
    - Two RBOs became noncompliant, including one that has been in the news, The Daughters of Charity Health Systems Medical Foundation. The Department is concerned as their parent no longer has a purchaser.
    - One RBO for which we are unable to obtain an approvable CAP.
- 82 RBOs with Medi-Cal Enrollment
    - Top 20 had approximately 2.6 million Medi-Cal lives assigned to them
        - One has a CAP
        - Two were on the monitor-closely list
        - 17 had no financial concerns
    - Remaining 62 had approximately 620,000 lives assigned to them
        - Six have a CAP
        - Nine were on the monitor-closely list
        - 47 had no financial concerns
- 24 audits are planned for 2015:
    - One has been completed
    - Four are in process
    - Remaining will be conducted throughout 2015

Discussion

Ms. Pumpian asked how many enrollees the Daughters of Charity Health Systems Medical Foundation is responsible for. She also asked if the plans that are contracting with the Daughters of Charity Foundation have any plans to address the enrollment currently assigned to them.

Ms. Yamanaka replied they have less than 50,000 enrollees. The DMHC reached out to all contracting health plans and they all have a plan in place.

9) Health Plan Quarterly Update

Stephen Babich, Supervising Corporation Examiner in the Division of Financial Oversight (DFO), gave an update on the financial state of health plans.

- Licensees
    - Over the last year there has been a net increase of two full-service plans. Changes include:

        - One Medicare Advantage plan surrendered their license, but three new licensees were added.
        - One new vision plan and one dental plan surrendered their licenses.
- Enrollment
    - Over 27 million full-service lives.
    - Over the past year, there has been an expansion in the number of enrollees in governmental sponsored programs, but there has also been a significant increase in enrollment in the commercial market, both in individual and the small and large group markets.
    - Enrollment in the commercial market is now almost the same as government programs, with both at approximately 12 million enrollees.
- Closely Monitored Plans
    - 18 full service plans are being closely monitored.
    - There has been a decrease in the number of Medi-Cal plans being monitored closely compared to last year.
- TNE Deficient Plans
    - One plan is TNE deficient, compared to two plans that were TNE deficient last year.

Discussion

Mr. Meadows asked now much of the enrollment is in Covered California.

Mr. Babich replied approximately one million.

Ms. Rouillard added the changes in individual and small group are not just Covered California. It is a cumulative total of all the changes in the individual and small group markets, both on and off the Exchange.

Mr. Furgatch stated the number of full-service plans that are on the monitored-closely list seems high.

Mr. Comstock asked how many of the closely-monitored plans are new plans.

Mr. Babich replied there are four new plans that are being monitored closely.

Mr. Madden asked why there was a big jump in PPO/EPO enrollment from 2013 to 2014.

Mr. Babich responded the increase in PPO/EPO enrollment could be attributed to California's rebounding economy. Commercial products tend to perform better when the economy is healthy.

Ms. Rouillard added a lot of the PPO/EPO enrollment increase is due to the new Exchange market. Many of those products are the PPO/EPO format, as opposed to the HMO.

10) Public Comment on Matters not on the Agenda

Ms. Pumpian asked for public comment on items not on the agenda. There was none.

9) Agenda Items for Future Meetings

- Update on the Reasonable and Customary Survey.
- Risk-adjusters and quality metrics in Medicare.
- Percentage of Medi-Cal Managed Care dollars spent on value-based incentives and how the COHS are using value-based incentives.
- Medi-Cal waiver proposal.
- DMHC's role in overseeing new payment arrangements, the solvency associated with them, and any new metrics that would be required.

10) Closing Remarks/Next Steps

The next meeting is scheduled for June 17, 2015, followed by September 9, 2015 and December 9, 2015.

The Meeting was adjourned at 12:25 p.m.