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To: ALL INTERESTED PARTIES

From: Department of Managed Health Care

The following is a brief summary of the comments and events that occurred during the financial Solvency Standards Board (FSSB) meeting on November 28, 2000.

I. Introduction: Overview by Scott Syphax, Chair.

The purpose of today's meeting is to receive a summary from the three subcommittees that have studied separate aspects of the draft SB 260 regulations and to hear public comment.

The committee adopted the meeting summaries from the previous FSSB meetings.

II. First Session: Discussion of the October 26th Subcommittee Recommendations on SB 260 Draft Regulations.

- A. Definitions and Organization Criteria. The subcommittee recommended certain language changes to the existing draft regulations. The changes were discussed by the full Board. After determining that a stand-alone external party was not feasible, it was recommended that the Department assume this function. Confidentiality protection for financial disclosures was discussed. A risk-bearing organization should be required to maintain positive TNE and working capital.

Public Comment: Consumer focus: (1) maintaining financially solvent risk-bearing organizations is fundamental to consumer protection; (2) the Department should be designated as the "external party;" (3) medical groups' financial data should be afforded the same confidentiality protection as is currently recognized for health plans; and (4) positive TNE and working capital should be maintained "at all times."

Health plan focus: (1) the regulations need to distinguish between risk-bearing and risk-sharing arrangements; (2) the term "proprietary information" needs further clarification; and (3) TNE requirements should be tied to the number of covered lives assumed by a medical group.

Provider focus: (1) the definition of "lawfully organized physician organization" should be consistent with the prohibition against the corporate practice of medicine; (2) provider groups are willing to demonstrate compliance with SB 260's financial

standards, but do not believe supporting financial documentation should be shared; (3) 95% compliance with claims payment standards should be deemed substantial compliance; (4) TNE and working capital requirements should be positive; and (5) the Department needs to consider whether medical groups who accept block transfers have the financial ability to assume the actuarial risk.

- B. Risk-Sharing and Organization Information. The subcommittee recommended certain language changes to the existing draft regulations. The changes were discussed by the full Board. Staff was requested to review CALINX, consider public comments and prepare a recommended list of plan disclosure elements. The electronic transmission of this data should be encouraged but not mandated. The issue of cost on the part of small medical groups for preparing audited financial statements was discussed. The wording of the reporting requirements for changes in a medical group's financial condition was referred to staff for additional drafting. The Board passed a motion directing the Department's staff to draft language requiring medical groups to prepare audited financial statements. However, a phase-in period was not precluded.

Public Comment. Consumer focus: (1) medical groups who cannot afford to prepare audited financial statements should not accept risk; and (2) the requirement that provider groups maintain positive TNE "at all times" should be maintained.

Health plan focus: (1) a distinction between risk-bearing and risk-sharing should be included; (2) unless medical groups supply audited financial statements, plans cannot rely on the accuracy and veracity of the documentation; and (3) if plans are going to be held responsible to monitor the solvency of medical groups, they need additional financial data not mandated in the proposed regulations.

Provider focus: (1) while CALINX is a good starting point, specific detailed mandatory data disclosures on the part of plans are necessary; (2) the minimum disclosure elements should be the California Information Initiative; (3) requirements for TNE "at all times" present tax and seasonal problems for providers; (4) reporting requirements for provider groups should be phased in to avoid disrupting patient care; and (5) plans should be required to disclose basic rate development information.

- C. Organization Evaluation, Corrective Action and Plan Reporting. The subcommittee recommended certain language changes to the existing draft regulations. The changes were discussed by the full Board. The Department should be designated as the external party. While the trigger factors for a corrective action plan need further consideration, the grading process should authorize the Department to conduct a more detailed financial examination of risk-bearing organizations. Plans should be given the ability to investigate provider solvency issues before they are required to notify the Department of an organization solvency deficiency.

The corrective action should be initially drafted by the risk-bearing organization and then provided to the health plans for comment. If the parties agree, the corrective action plan should be submitted to the Department for approval (with or without amendment). Once approved, affected plans would be prohibited from terminating the provider contract during the remedial period for solvency considerations. The Board approved

the motion that SB 260's financial criteria are minimum standards that do not preclude plans from requiring provider groups to meet more stringent financial requirements. Plans are to be required to submit, on an annual basis with quarterly updates, the profile of their contracts with risk-bearing organizations. The Board requested staff to develop a standard template or statement of organization to facilitate reporting obligations.

Public Comment. Provider focus: (1) federal antitrust prohibitions should not pose an obstacle because the draft regulations contemplate sufficient state action; (2) a risk bearing organization should be able to limit to a single corrective action plan; (3) timelines for reporting are inconsistent. Plan disclosures to risk-bearing organizations should be completed before medical groups are required to prepare audited financial statements.

III. Second Session: Discussion of Next Steps Related to Draft Regulations

Today's commentary will be converted into a workable set of draft language, which the Board will review and finalize at its next scheduled meeting. The Board will further consider the issue of a "phase-in" for the preparation of audited financial statements.

At the conclusion of the next meeting, the Board anticipates recommending draft emergency regulations to the Director for consideration. Pending final action by the Director, the recommended emergency regulations will be noticed and implemented.

IV. Third Session: Discussions of Financial Solvency Standards Board Reporting Requirement.

This discussion was held to the next regular scheduled meeting of the Board.

V. Fourth Session: Discussion of Proposed Schedule for 2001/Closing Remarks

For the first half of calendar year 2001, the FSSB will continue to rotate its meeting locations. The meeting was adjourned.