

**Financial Solvency Standards Board Meeting
July 19, 2017
Meeting Minutes**

Financial Solvency Standards Board (FSSB) Members in Attendance:

Dr. Larry de Ghetaldi, The Palo Alto Medical Foundation
Paul Durr, Sharp Community Medical Group
John Grgurina, Jr., San Francisco Health Plan
Shelley Rouillard, Department of Managed Health Care
Amy Yao, Blue Shield of California (via telephone)

Department of Managed Health Care (DMHC) Staff Present:

Steven Babich, Supervising Examiner, Office of Financial Review
Wayne Thomas, Chief Actuary, Office of Financial Review
Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations
Michelle Yamanaka, Supervising Examiner, Office of Financial Review

1) Welcome & Introductions – [Agenda](#)

Due to the absence of the Chair, DMHC Director Shelley Rouillard called the meeting to order and introduced the Board members.

2) [Minutes from April 19, 2017 FSSB Meeting](#)

Ms. Rouillard asked if there were any changes to the April 19, 2017 FSSB meeting minutes. Meeting minutes were approved without objection.

3) [Director's Remarks](#)

Ms. Rouillard provided an update on the settlement agreement with Kaiser regarding access to behavioral health services. The three-year agreement is essentially a corrective action plan that includes multiple benchmarks and deliverables that Kaiser must meet or they will be subject to fines of up to \$1 million. It is the result of a two-year investigation into the deficiencies identified in surveys conducted in 2015 and 2017. Kaiser has contracted with a behavioral health consultant to advise the plan on how to improve its behavioral health quality assurance program to ensure swift and effective action is taken to address access, availability and continuity of care issues. Ms. Rouillard said she is very proud of the Department and the work done to reach the agreement. The DMHC's goal was to get Kaiser to commit to improvements, and she is optimistic they will meet those commitments. There will be a follow up survey in 18 months and financial penalties may be imposed if benchmarks are not met.

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Ms. Rouillard commented on federal activity related to the Better Care Reconciliation Act (BCRA), stating the Senate is unlikely to take any action before they go on recess.

Ms. Rouillard stated the future of funding for the Affordable Care Act (ACA) cost-sharing reduction subsidies is uncertain. The plans participating in Covered California have submitted two rates to the Department. The rates will be published for public comment on August 1. Ms. Rouillard added it will be up to Covered California to decide which of the rates it will implement.

Ms. Rouillard provided an update on the development of the Provider Directory Utility. Potential host organizations have been interviewed and a recommendation will be presented to the Advisory Committee on August 9. Blue Shield and the DMHC will ultimately decide who the host will be. Representatives from a broad spectrum of the industry are participating in a business and technical requirements workgroup to develop the specific functions of the utility. Ms. Rouillard acknowledged the broad participation from the industry, both on the plan and provider side, as well as from consumer advocates, hospitals and clinics.

Ms. Rouillard also provided an update on the undertakings related to Centene's acquisition of Health Net. Health Net recently awarded grants totaling \$1.5 million to increase health coverage enrollment, retention and outreach, and to develop a quality improvement technical assistance project to help low performing providers serving Medi-Cal beneficiaries in managed care plans improve certain Healthcare Effectiveness Data and Information Set (HEDIS) scores. Health Net will announce the grantees shortly.

In addition, Health Net released a Health Workforce Development Request for Proposal (RFP) to 50 organizations on July 14 and will hold a bidders conference call on July 21. Health Net anticipates awarding grants totaling \$1.5 million in three categories: retention, training and recruitment. Proposals are due August 4, 2017.

Ms. Rouillard stated Health Net has also established its Infrastructure Investment Committee to provide \$75 million in capital to entities that provide health services to underserved communities. The Committee will be chaired by Sandra Shewry from the California Health Care Foundation (CHCF) and the first meeting is scheduled for October 2, 2017.

Ms. Rouillard explained the DMHC continues to oversee undertakings related to the United/PacifiCare and Anthem/WellPoint mergers that were approved in 2004 and 2005. Both United and Anthem have investment funds available to provide capital for hospitals and clinics in underserved and rural communities. Ms. Rouillard said the Department is working with all three of the plans to publicize the funding opportunities. There are a lot of activities that require technology and system changes, such as provider directories and encounter data, and these investments provide an opportunity for organizations to be able to update their systems. She encouraged anyone who would like more information to contact Mary Watanabe.

Ms. Rouillard outlined the DMHC's budget for the 2017-18 Fiscal Year. The budget for 2017-18 is \$77.2 million and 451 authorized positions, a 28 percent increase in staffing and a 37 percent growth in funding over the last five years. The budget includes four Budget Change Proposals (BCPs), totaling \$6.2 million in additional funding and a net increase of 10 authorized positions. The proposals include:

- Sixteen positions to address increased work load and volume at the Help Center.
- Three positions in the Information Technology (IT) Department to improve IT applications and security.
- Expenditure authority of \$3,588,000 in Fiscal Year 2017-18 and 19.75 positions for the implementation of Assembly Bill (AB) 72.
- Reduction of 18.5 positions related to the end of the interagency agreements with the Department of Health Care Services (DHCS). The DMHC will absorb these reductions so there will not be any lay-offs.

Ms. Rouillard stated the DMHC recently released its 2016 Annual Report. The report contains data on health plan enrollment, consumer complaints and Independent Medical Reviews (IMRs) and highlights the Department's accomplishments.

4) AB 72 Implementation Update

Mary Watanabe, Deputy Director of Health Policy and Stakeholder Relations, presented an update on the implementation of AB 72, including an overview of the key provisions of the law and their effective dates.

Ms. Watanabe provided an update on the filings submitted by plans and delegated entities to the DMHC on July 1, 2017. Plans, and any entity to which they delegate the payment of claims, were required to file information that included data listing their average contracted rate by region and Current Procedural Terminology (CPT) code for the services most frequently subject to Section 1371.9. They were also required to provide their methodology and policies and procedures.

Ms. Watanabe stated she is pleased to report the majority of the entities required to file have submitted something. The DMHC is now working very closely with its vendor, Maximus, to review the filings and follow up with those that have not filed or where there are questions. The group that is struggling to still submit information is capitated providers. These are entities that are neither a health plan, nor a risk-bearing organization, and typically don't work with the DMHC.

Ms. Watanabe stated the focus for the presentation is to get the Board's input on the standardized methodology for calculating the average contracted rate (ACR) that must be developed through the regulatory process by January 1, 2019. Ms. Watanabe outlined the considerations that may need to be taken into account when developing the standard methodology. Additionally, the methodology must take into account information from the independent dispute resolution process, the specialty of the individual health professional,

the geographic region in which services were rendered, and both the highest and lowest contracted rate.

Ms. Watanabe concluded by reviewing the implementation timeline.

Discussion

Dr. Larry de Ghetaldi recommended using the 2017 Medicare regions, which have increased from nine physician payment locations to 30 locations in 2017. He also recommended using the 2017 Medicare fee schedule and noted the difference in fee schedule for different types of providers such as nurse anesthetists and some of the non-physician providers. He expressed concern about rates for anesthesia services because the Medicare rate for anesthesia is ridiculously low and they will likely be paid the average contracted rate.

Dr. de Ghetaldi asked for clarification regarding which Medicare fee schedule the plans are to use in 2017. Ms. Watanabe responded the bill did not specify which year to use. Plans were instructed to make a decision and include this information in the methodology they provided to the DMHC.

Dr. de Ghetaldi suggested using the raw Medicare fee schedule, which should be issued at the beginning of the year, and ignoring the adjustments that are made to the fee schedule. Mr. Durr confirmed the fee schedule is finalized by the end of the first quarter each year.

Mr. Durr recommended keeping the methodology simple and to tie the Medicare fee schedule to the date of service. He agreed with weighting by volume of services because it is an indicator of utilization.

Mr. Grgurina stated another option for the regions would be to use Covered California's regions for the individual and small group markets. He also suggested running the numbers for the various approaches to see what the different options look like. He further explained a formula that appears to make sense may look different when you run the numbers and you may realize there are pieces missing that do not allow the formula to be used.

Dr. de Ghetaldi asked how consumers can be protected in the rare circumstance where when they end up at a non-contracted facility. Ms. Rouillard answered if it is a service that is not available within the plan network and it is medically necessary, the plan needs to cover it at the in-network cost sharing rate.

Ms. Watanabe asked the Board if they had any recommendations for which claims to include in the calculation and the length of time for claims run out. Mr. Durr suggested using only approved claims and to exclude denied claims, case rates and sub-capitation arrangements.

5) Risk Adjustment Transfers

Wayne Thomas, Chief Actuary, Office of Financial Review, provided a summary of the reinsurance payments and permanent risk adjustment transfers for 2016, for those plans regulated by the DMHC and the California Department of Insurance (CDI). Mr. Thomas stated the information was released by the Centers for Medicare and Medicaid Services (CMS) on June 30 and there were 15 health plans in California that participated in the programs.

Mr. Thomas said the reinsurance program has helped reduce the uncertainty of risk in the individual market by partially offsetting insurers' claims associated with high cost enrollees. Health Plans regulated by the DMHC received \$552 million in reinsurance payments. Insurers regulated by CDI received \$145 million in reinsurance payments with Health Net Life Insurance receiving the majority.

Risk adjustment is intended to transfer funds from insurers with low actuary risk to those with high risk. In 2016, a total of \$767 million was transferred between California insurers. Blue Shield and Anthem Blue Cross received the majority of payments compared to Kaiser, Molina and Health Net who had to pay into the risk adjustment pool.

Mr. Thomas noted the risk adjustment transfers represent an average of 8 percent of premium while reinsurance payments represent about 6 percent of premium. He reminded the Board that the reinsurance program was only for three years so 2016 was the last year of the reinsurance program. Additionally, the reinsurance attachment points increased from \$45,000 in 2014 to \$70,000 in 2015 and \$90,000 in 2016. As a result, the health plans were responsible for more of the claims in 2016 and the reinsurance payments decreased.

Mr. Thomas concluded by saying going forward the risk adjustment results by issuer and market may help the DMHC determine the reasonableness of the 2018 risk adjustment that is built into rates.

Discussion

Mr. Grgurina asked if the risk adjustment information included Covered California. Mr. Thomas answered Covered California is included as part of the total market.

Dr. de Ghetaldi noted the negative amount for the DMHC plans is offset by the positive amount for the CDI insurers so across the two books of business it is budget neutral.

Dr. de Ghetaldi asked if the information was at a statewide level or based on the Covered California regions. Mr. Thomas replied it was statewide. Dr. de Ghetaldi added it would be interesting to see the information presented on a per-member-per-month (PMPM) basis.

Dr. de Ghetaldi asked if risk adjustment is doing what it is intended to do, which was to balance risk across different populations. He wonders if it is adequately accounting for the

variation in population risk or if there are other ways to measure risk. Mr. Thomas said it is probably more accurate for the larger plans but there is more fluctuation in the risk adjustment amounts for the smaller plans.

Ms. Yao stated there is not a perfect risk adjustment model in the industry, but she believes it has been working very well. Ms. Yao also pointed out that the risk adjustment transfers seem to be from the HMO products to the PPO products. That makes sense because the PPO products tend to attract the sicker patients, where the HMOs seem to have the healthier populations. She added if it weren't for the risk adjustment program, the plans attracting the sicker patients would likely not have been able to continue so it has been critical to stabilize the market and maintain choice in the marketplace.

Mr. Grgurina agreed with Ms. Yao. Historically, PPOs were risk adverse and would leave the market if they picked up bad risk. Risk adjustment has kept these products in the market. It is not perfect, but it certainly helps quite a bit. Mr. Grgurina added that as an employer who provides both a HMO and a PPO, it is difficult to keep a PPO available. Risk adjustment is one way to keep that option available for those who want it.

Dr. de Ghetaldi said risk adjustment doesn't recognize the higher risk associated with poverty and other social determinants of health. In an ideal world, we would recognize those plans that care for higher risk populations with some other social determinant risk factor.

Bill Barcellona, Senior Vice President for Government Affairs, CAPG, shared his observation about the risk adjustment transfer methodology and the impacts on the delegated model over the long term. When California adopted the federal standard for risk adjustment transfer, everybody agreed it was the wisest choice because of uncertainties. However, over the long term the Federal rule is predicated on a PPO claims-based market and it is eating away at California's delegated HMO model because it is forcing the transfer of wealth away from HMO plans. He noted the HMO plans are on a prepaid basis and use capitated providers who report under encounter data, compared to PPO plans with fragmented networks and that are reporting claims data.

Mr. Barcellona added this underscores CAPG's original letter to the Department in 2015 related to the Health Net/Centene merger undertakings and their request for funding for the standardization of the business practices, reporting, and timeliness of encounter data. He thanked the Department for including funding in the Health Net/Centene undertakings to build the right kind of infrastructure in California, an electronic information exchange system that processes encounter data in a more standardized, accurate format.

6) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, provided an update on the financial solvency of Risk-Bearing Organizations (RBOs) for the quarter ending March 31, 2017:

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- 184 RBOs were required to file annual reports. Two RBO's failed to file and the DMHC is working with them to obtain their filings.
- 132 of the 184 RBOs filed quarterly financial survey reports and 52 RBOs filed compliance statements attesting to meeting or not meeting the solvency criteria.
- 5 RBOs filed monthly financial reports as required by their corrective action plan (CAP).
- 175 RBOs reported compliance with the solvency criteria.
 - 26 RBOs were in the Superior category.
 - 97 RBOs were in the Compliant category, including 4 RBOs on CAP that are meeting the solvency criteria.
 - 52 RBOs filed compliance statements and are meeting solvency criteria.
- 9 RBOs were on the monitor closely list and reported non-compliance.
- 13 RBOs are on a CAP, including 9 from the previous quarter and 4 are new. Of the RBOs that filed new corrective action plans, one RBO, Physicians Medical Group of San Jose, has been approved.
- 3 RBOs completed their CAPs – College Health IPA, Horizon Valley Medical Group, and Northern California Physicians Care Network.
- There are 88 RBOs that have Medi-Cal enrollment, covering approximately 4.4 million lives.
- The top 20 RBOs serve approximately 3.3 million Medi-Cal lives. Seventeen of these RBOs have no financial concerns, 2 RBOs are on CAPs, and 1 is on the monitor closely list.
- The remaining 68 RBOs service approximately 1 million Medi-Cal lives. Of these, 54 have no financial concerns, 8 are on the closely monitored list and 6 are on CAPs.

Ms. Yamanaka stated 24 audits are scheduled for 2017. Sixteen have either been completed or are currently in process and eight audits have not yet begun for 2017.

Discussion

Mr. Durr asked if RBOs that are not meeting standards are prioritized when scheduling audits. Ms. Yamanaka explained staff resources are limited. However, the audit schedule can be adjusted to prioritize RBOs that are not meeting standards.

Mr. Grgurina asked what it means to be on the monitor closely list. Ms. Yamanaka said if examiners see concerns such as net losses, continued net losses or low or declining solvency criteria, RBOs are placed on the monitor closely list. The Department will ask additional questions and place a higher priority on reviewing their filings.

Ms. Rouillard asked if being monitored closely requires RBOs to file monthly. Ms. Yamanaka stated examiners will ask for monthly financial reports, if necessary.

Dr. de Ghetaldi noted the State of California spends a lot of money managing a small number of problem RBOs. He asked what is done when an RBO has repeated issues quarter after quarter. Ms. Yamanaka stated health plans audit their RBOs on an annual basis and that the DMHC monitors health plan CAPs as well as their oversight of the RBOs.

Mr. Durr noted one RBO, Accountable Health Care IPA, has a history of being in and out of compliance and failed three different metrics including tangible net equity (TNE), claims timeliness and working capital. The RBO has significant enrollment of 150,000 to 200,000. Mr. Durr asked what the process is for analyzing swings in compliance. Ms. Yamanaka stated the Department rejected the first CAP and is reviewing the new CAP for this RBO. The DMHC is asking additional detailed questions and reviewing monthly financials.

Mr. Durr asked if there was anything else the Department can do when there are repeat challenges with an organization. Ms. Rouillard stated the DMHC's authority is oversight of health plans. The health plans are responsible for monitoring the RBOs, and the DMHC can have the plans take action against the RBO, such as by freezing enrollment. In the case of Accountable, the DMHC had a monitor go in to make sure the RBO was functioning properly. Ms. Yamanaka added a final option is to de-delegate.

Mr. Barcellona asked that a chart showing enrollment by product line for the RBOs be included in future presentations. Mr. Barcellona asked Ms. Yamanaka what the current non-Kaiser commercial enrollment is in the RBOs. Ms. Yamanaka answered she did not have that information but could get it for him.

7) Health Plan Quarterly Update

Steven Babich, Supervising Examiner, Office of Financial Review, presented the highlights of the health plan quarterly update for the first quarter of 2017:

- There were 74 full-service health plans and a total of 123 Knox-Keene licensed plans.
- Two new full-service health plans were licensed in May, both Medicare Advantage (MA) restricted licensees.
- Enrollment in full service plans exceeded 26 million lives, almost equally divided between commercial and government enrollment.
- There were 16 plans on the closely-monitored list, which is a slight decrease from the 20 plans that were on the list last year.
- There were no TNE deficient plans for the first quarter of 2017.
- There were 24 plans on CAPs, including 8 pending approval and 16 in progress.

Mr. Babich concluded by providing an update on the TNE disbursement of all plans and the closely monitored plans by enrollment and by line of business.

Discussion

Dr. de Ghetaldi stated that in the run up to the implementation of the Affordable Care Act, there was anticipation that there would be a lot of churning between Medi-Cal and Covered California. He asked whether plans, groups and patients were impacted with any disruptions of care or other issues. Mr. Grgurina responded it is happening but not to the extent anticipated. One reason is because California took the option of doing 12 months of continuous eligibility in Medi-Cal, instead of every six months, which helped to stabilize things.

Mr. Grgurina also pointed out that people who are on Covered California are enrolled for a year unless their income really drops and they move to Medi-Cal. Those two pieces helped to avoid a tremendous amount of churn. It is not that there is not churn, but it is not the huge problem expected prior to 2014.

8) Proposed Meeting Schedule

Ms. Rouillard reviewed the proposed 2018 meeting schedule:

- Wednesday, January 24, 2018
- Wednesday, April 18, 2018
- Wednesday, July 18, 2018
- Wednesday, October 17, 2018

Ms. Rouillard stated the April 18 meeting may be rescheduled due to a potential conflict with the CAPG conference.

9) Public Comment on Matters not on the Agenda

Ms. Rouillard asked for public comment on items not on the agenda. There were none.

10) Agenda Items for Future Meetings

Ms. Rouillard stated the next meeting, scheduled for October 18, would likely go much longer as she expects at least one, if not several, regulation package to be discussed. She asked if there were any agenda items for future meetings.

Ms. Yao requested an update on dental Medical Loss Ratio (MLR).

Mr. Grgurina asked for an update on the federal activity to repeal the ACA and an update from DHCS on the implementation of the Medicaid Managed Care Final Rule. Ms.

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Rouillard stated DHCS was not able to attend this meeting due to a stakeholder conference but would be invited to future meetings.

Dr. de Ghetaldi expressed interest in the County Organized Health System (COHS) and Local Initiative (LI) report. Ms. Watanabe stated the report is presented every six months so it should be ready for the next meeting.

Dr. de Ghetaldi also suggested a discussion regarding Medicare Accountable Care Organization (ACO) arrangements, what is happening in California and whether the Board has a role in reviewing these arrangements.

11) Closing Remarks/Next Steps

The meeting was adjourned at 11:17 a.m.