Financial Solvency Standards Board Meeting
January 23, 2018
Meeting Minutes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Jeffrey Conklin, Adventist Health Plan
Dr. Larry de Ghetaldi, The Palo Alto Medical Foundation
Paul Durr, Sharp HealthCare
Betsy Imholz, Consumers Union
Dr. Jeff Rideout, Integrated Healthcare Association
Shelley Rouillard, Department of Managed Health Care
Amy Yao, Blue Shield of California

Department of Managed Health Care (DMHC) Staff Present:
Steven Babich, Supervising Examiner, Office of Financial Review
Pritika Dutt, Deputy Director, Office of Financial Review
Gabriel Ravel, General Counsel
Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations
Michelle Yamanaka, Supervising Examiner, Office of Financial Review

Department of Health Care Services (DHCS) Staff Present:
Lindy Harrington, Deputy Director, Health Care Financing

1) Welcome & Introductions - Agenda

Chairperson Betsy Imholz called the meeting to order.

2) Minutes from October 18, 2017 FSSB Meeting

Ms. Imholz noted there was one correction to the minutes. The minutes mistakenly referred to John Grgurina as Dr. Grgurina. Ms. Imholz then called for a motion to approve the minutes. Meeting minutes were approved with the noted change to Mr. Grgurina's name.

3) Director's Remarks

Director Shelley Rouillard provided an update on recent federal activities impacting health care. On January 22, 2018, Congress passed, and the President signed, the continuing resolution to extend the Children's Health Insurance Program (CHIP) program for 6 years, until 2023. The continuing resolution also included suspension of the health insurer's annual fee until calendar year 2019, and suspension of the "Cadillac tax" on high cost employer health coverage to December 21, 2021.

In addition, the administration released proposed rules regarding Association Health Plans (AHPs), which would allow individuals and small group employers to group together to self-insure or purchase large group insurance. Ms. Rouillard noted Gabriel Ravel would be presenting more detail on the proposed rule.

Ms. Rouillard discussed the January 10, 2018 release of Governor Brown's budget for Fiscal Year (FY) 2018-19. She provided the following highlights related to health care:

- While there have been proposals to repeal or replace the Affordable Care Act (ACA), Congress has not acted on anything. Consequently, the budget assumes existing state and federal laws are still in place.
- Many of the program reductions implemented during the Great Recession have been restored, including most of the optional benefits in the Medi-Cal program as well as dental benefits for adults.
- Proposition 56 Tobacco Tax funds will be used to increase payments to physicians and dentists in the Medi-Cal program.
- The budget includes an additional $169.4 million to support new growth in the Medi-Cal program compared to 2016 and $64.5 million for a 50 percent rate increase for home health providers who serve children and adults.

Ms. Rouillard provided the following update on the DMHC proposed budget for FY 2018-19:

- The DMHC's proposed budget is $79.2 million and 451 authorized positions. Salaries and benefits comprise about 70 percent and the rest is for operating expenses.
- The proposed budget includes the following two Budget Change Proposals (BCPs):
    - The first BCP would convert $529,000 in limited-term funding to ongoing funding for oversight and compliance work related to the Federal Mental Health Parity and Addiction Equity Act (MHPAEA). The limited-term funding was initially granted for two years but not all of it has been spent. This BCP would allow the Department to use the funding in the coming year.
    - The second BCP requests one actuary position and funding for a consultant to implement Senate Bill (SB) 17, which creates greater transparency in drug pricing.

Ms. Rouillard stated the current year assessment for health plans is $1.70 per enrollee for full service plans and $0.45 per enrollee for specialized plans.

Ms. Rouillard acknowledged many may be wondering what is happening with the DMHC's investigation into alleged wrongdoing at SynerMed and Employee Health

Systems (EHS), a medical group serving primarily Medi-Cal beneficiaries primarily in Los Angeles, the Inland Empire, San Diego, the Central Valley and Sacramento. Ms. Rouillard stated because there is an ongoing investigation, she cannot share a lot publicly. However, some information has already been shared publicly in the media, so she will talk about what is already in the public domain.

In October, the DMHC received a whistleblower complaint alleging SynerMed improperly denied care to thousands of patients and falsified documents to hide it. Some of the medical groups that contracted with SynerMed began the process to terminate their contracts and in early November, SynerMed's Chief Executive Officer (CEO) sent an e-mail to SynerMed employees saying the company would shut down in 180 days. EHS was one of the medical groups that terminated its contract with SynerMed.

In December, the DMHC received a second whistleblower complaint involving both SynerMed and EHS alleging "economic profiling" of physician specialists. The complaint alleged SynerMed was suppressing high cost physician specialists in its portal used by primary care physicians (PCPs) to identify specialists to whom they could refer their patients.

The DMHC has subpoenaed documents from SynerMed and EHS based on the whistleblower complaints and is in the process of reviewing those. After verifying the complaint, the DMHC issued a cease and desist order to nine health plans that were contracted with EHS, directing them to terminate their contracts that assign risk to EHS and requiring the health plans to file a transition plan with the DMHC that included a timeline for the orderly removal of enrollees from EHS. The transition plans were due to the DMHC on January 3, 2018, and all nine health plans have filed them. The order also required the plans to file a final "proof of compliance" with the cease and desist order by February 5, 2018.

The DMHC has been coordinating very closely with the Department of Health Care Services (DHCS) on this matter to ensure as smooth a transition as possible for the approximately 600,000 Medi-Cal beneficiaries in EHS. DHCS issued its own Corrective Action Plan (CAP) on the affected Medi-Cal health plans that included termination of their contractual relationship with EHS, among other activities.

Meanwhile, EHS engaged counsel who contacted the DMHC requesting a meeting to discuss EHS' concerns. That meeting occurred on January 4, 2018. All the affected health plans have filed their block transfer filings and some of the health plans have completed the transition of members to other medical groups.

Ms. Rouillard provided an update on the Provider Directory Utility project. The Integrated Healthcare Association (IHA) issued a request for proposal (RFP) for the database vendor on January 3, 2018 and proposals are due January 26, 2018. The vendor finalists will make presentations to IHA and to the Utility Management

Committee, which is made up of a broad range of stakeholders, including Mary Watanabe as the DMHC representative. IHA anticipates selecting the vendor in March.

In addition, IHA plans to launch a pilot with a couple of plans and several provider organizations by the end of 2018, with full deployment in 2019. There will be extensive user testing prior to the full launch. Blue Shield and IHA are working out the final details of Phase II of the contract which will last through January 2019.

Ms. Rouillard stated she expects the Utility will be able to support many elements of SB 137 compliance, but the health plans, ultimately, will still be responsible for overall compliance. For example, the Utility will support notifications to providers to validate information and will facilitate processing of submitted updates. The Utility will be able to flag providers who have not responded to requests but it will be the plans' responsibility to remove providers from its directory. Plans will be responsible for maintaining an online provider directory, updating it weekly and ensuring the directories are searchable by key categories. The Utility will support standardized data definitions across health plans and ultimately, the goal is to reduce the burden on both plans and providers to update provider information.

Ms. Rouillard provided an update on Health Net's Community Investment Advisory Committees. She indicated that as of the end of 2017, Health Net awarded more than $5.5 million in grants to 31 health care and community based organizations throughout California for the following activities:

- To help individuals retain and understand how to use their health coverage, improve the quality and availability of health care, and enhance health outcomes.
- To help recruit, retain and train physicians and medical assistants working in areas with provider shortages, specifically in Los Angeles, the Central Valley and the Inland Empire.
- To address the immediate needs of providers to improve systems to be able to improve the collection and reporting of encounter data.

In addition, Health Net awarded a grant to IHA to conduct a market assessment of provider organizations and practice management entities as to their system capabilities and staff readiness to improve Encounter Data completeness and accuracy. That project is underway.

The Health Net Infrastructure Investment Committee met for the first time on October 2, 2017. This Committee, chaired by Sandra Shewry of the California Health Care Foundation (CHCF), is charged with advising Health Net on capital investments for healthcare infrastructure and care delivery improvements in the Medi-Cal program. The next meeting is scheduled for March 7, 2018.

Ms. Rouillard also indicated that Blue Shield gave $35 million to its foundation at the end of December. This was a result of undertakings DMHC negotiated during Blue Shield's acquisition of Care1st.

Lastly, Ms. Rouillard provided an update on a couple of regulation packages. A regulation defining risk and codifying the DMHC's practice for issuing restricted licenses was filed with the Office of Administrative Law (OAL). The first public comment period ended on December 11, 2017, and DMHC is in the process of analyzing the comments. It is anticipated that there will be another public comment period in the next month or so. The other regulation package is related to Assembly Bill (AB) 72. This regulation will standardize the average contracted rate methodology and will be filed with OAL later this week.

Discussion

Ms. Imholz asked if consumers denied access to specialists had received notice as part of the SynerMed investigation. Ms. Rouillard said she could not comment since it is part of the ongoing investigation. However, the Health Consumer Alliance, an entity contracted with DMHC to provide consumer assistance, reported they received some access complaints. Ms. Imholz stated it is concerning that thousands of people, especially low-income people, did not have access to specialists.

4) Association Health Plans

Gabriel Ravel, General Counsel, provided an overview of the AHP proposed regulations starting with background information on the Executive Order that preceded the proposed rule. In October 2017, President Trump issued Executive Order 13813, which, among other things, directed the United States Department of Labor (DOL) to consider promulgating regulations to facilitate the purchase of insurance across state lines by allowing more employers to form AHPs. These are entities that are allowed under the Employee Retirement Income Security Act (ERISA) to band together to either purchase coverage or to self-insure as one employer. On January 5, 2018, the DOL published proposed rules for a 60-day public comment period in response to this Executive Order. The public comment period ends on March 6, 2018 and the DOL will finalize the rule at some point in the future.

Mr. Ravel reviewed the existing law related to AHPs and the key elements of the proposed rule. ERISA, administered by the DOL, regulates employer benefit plans including both insured and self-funded plans. Under ERISA and subsequent case law, there are complicated rules regarding the extent to which states are permitted to regulate these relationships. Generally, states are permitted to regulate the business of insurance. To the extent an employer purchases coverage from an insurer, the state can regulate the terms of that coverage but are very limited in their ability to regulate the employers themselves. Current law allows employers to form AHPs, including self-insured health plans, but the proposed rule would significantly expand their ability to do so.

The proposed rule would allow an association made up of employers in a single industry, regardless of geographic location of the employer, to count as a single employer. This could include a nationwide plan. It would also allow an association of employers in a specific geographic area, including a metropolitan area that might cross state lines, to count as a single employer.

Additionally, the proposed rule would relax existing requirements related to commonality of interests. Currently, in order to form an association, a group of employers has to have a common interest besides just providing benefits to its employees. The proposed rule would allow an association to form exclusively for the purpose of providing health benefits to the member's employees.

The proposed rule would allow sole proprietors to count as an employer and employee and would be eligible to join an association. This is a significant change from current law that requires an employer to have at least one common law employee in order to be considered a group.

There are a number of provisions related to nondiscrimination, such as prohibiting associations from discriminating based on health factors in either the provision of benefits, membership, or premiums. There are also a number of organizational rules. For example, an association has to be controlled by its members and not by a third party.

Mr. Ravel stated the DMHC is considering whether to issue comments on the proposed rule and is analyzing the extent to which the rule might impact the DMHC's jurisdiction. Initial policy concerns include:

- The proposed rule seeks to expand the use of AHPs, which are a type of multiple employer welfare arrangement (MEWA). Historically, MEWAs have been a vehicle for defrauding employers, plans, and beneficiaries. This was a significant enough problem that, in 1983, Congress amended ERISA to allow for state regulation of certain types of MEWAs. The California Department of Insurance (CDI) regulates self-funded MEWAs, of which there are currently five operating in California. To the extent this expands their use, there could be a potential for abuse.
- Concerns about the segmentation of the risk pool. The proposed rule, as written, would not prevent the formation of associations designed to attract healthier individuals to these associations. However, to the extent healthier people move to these associations, those left in the individual and small group markets would be sicker and higher risk, which could lead to premium increases and deterioration in those market segments. DMHC is still analyzing whether state law would prevent this practice.

Discussion

Dr. Jeff Rideout asked Mr. Ravel to describe the extent of CDI's regulatory authority over existing MEWAs. Mr. Ravel stated it appears to be a filing requirement of financial standards. However, in 1995 the Legislature enacted a ban on new MEWAs forming in California so unless they came in or were grandfathered before that time, there are not supposed to be new ones forming.

Amy Yao strongly supported the DMHC's concerns, especially the impact to the risk pool. Given the end of the individual mandate and the uncertainty around the ACA, this will just create additional uncertainty and destabilize this new market. She added that if the rules are different from existing markets, it will create adverse selection. She is also concerned about the geographic changes since they could only pick low cost areas to cover. There is a lot of potential for gaming. From an actuarial perspective, she is extremely concerned about the gaming that adverse selection potentially could create for the ACA market. She suggested the rules should be the same as the ACA to prevent gaming and there should be financial solvency requirements so consumers are not left with unpaid bills.

Dr. Larry de Ghetaldi asked for confirmation that the DOL regulations would expand the number of Californians covered by an ERISA type of arrangement. Mr. Ravel responded yes, that is the design. Dr. de Ghetaldi expressed concern about ERISA-sponsored plans that have fewer consumer and provider protections such as network adequacy, denials of bills, timeliness of payments, oversight of financial solvency, and access standards. He worries California is going to go backwards in protecting providers and patients as the ERISA-sponsored plans grow in the number of covered lives. California has led the nation and should mitigate any backward movement.

Dr. Rideout asked who would be the best state authority to weigh in on preserving these protections. Mr. Ravel responded DMHC is well-positioned to do so, as is CDI.

Jeffrey Conklin asked if an association capitates downstream, does that give DMHC any purview now and going forward. Mr. Ravel responded it is still somewhat of a gray area. DMHC's position in the past would be that, depending on the nature of the capitation, the DMHC would have jurisdiction over the entity that is receiving the capitation.

Bill Barcellona, representing America's Physician Groups (APG), encouraged DMHC to carefully review the leased network filings by health plans to determine whether or not any of the plans participating in the self-funded market are leasing their networks to the five remaining MEWAs. The CDI has jurisdiction over the MEWAs, but there is a long-standing practice of contracting between providers and health plans in California where providers are leased to self-funded networks. If DMHC can determine if this is happening with its regulated entities, it would be useful to know and could also be helpful for the Department's comments.

Tam Ma, representing Health Access California, stated her organization shares many of the concerns Mr. Ravel and others raised about the proposed rule, particularly given the history of these plans when more were allowed to exist in California. Consumers signed up expecting they had health coverage only to find out that they did not. Ms. Ma also expressed concern that the proposed rule would de-stabilize the individual and group market and skim healthy lives from them. As such, her organization is following this proposal very closely and is interested in the final outcome. In addition, they are interested in what opportunities might be available for the State to further regulate.

Ms. Yao asked if an association files a form outside of California, but they offer the benefit in California, whether California would have the authority to impose any California rules for that association. Mr. Ravel responded that according to the letter of the Insurance Code, any coverage that is offered via an AHP to anyone inside California would be subject to the CDI's regulation. However, there is a lot of uncertainty with the new proposed rule.

Paul Durr asked if DMHC is coordinating efforts with other states to have a more coordinated approach. Given how California is being viewed from a national level, especially by those in Washington, it could be seen more favorably if California's comments aligned with other states. Ms. Imholz added she is a consumer representative at the National Association of Insurance Commissioners (NAIC), where they have weighed in on this issue previously and certainly will again. The consumer representatives will be presenting the NAIC with ideas and she would be happy to share these ideas with DMHC, which does not formally participate at NAIC.

Dr. de Ghetaldi stated it was recently learned that seven percent or so of Covered California's individual and small group market flow into the risk adjustment transfers. It is a big number but fair from a policy perspective that the risk is spread. If, in aggregate, the individual mandate repeal and AHPs remove lower risk patients from that risk pool, premiums will go up and the risk adjustment transfers don't necessarily change. The Covered California premiums will rise and the aggregate impact is it will cost more. He asked for clarification on whether the AHPs will be exempt from participating in the risk adjustment transfer obligation. Ms. Imholz responded this was correct.

Joe Parra stated that he and other legislative staff would like to see the DMHC's comment letter and would be interested in a briefing.

5) Department of Health Care Services Update

Lindy Harrington, Deputy Director, Health Care Financing, DHCS, provided an update on implementation of the financial items of the Managed Care Final Rule. She reminded the Board that under the Managed Care Final Rule, the Centers for Medicare and Medicaid Services (CMS) has disallowed pass-through payments. They have allowed for a phase down of those dollars in California. DHCS, in consultation with the hospitals and other stakeholders, developed a number of directed payment proposals to

replace the hospital financing activities and ensure funding levels are maintained for those facilities in California.

Ms. Harrington reviewed the various directed payment proposals sent to CMS, including the Public Hospital Directed Payment Program, the Public Hospital Quality Improvement Program, the Private Hospital Directed Payment Program, and the Proposition 56 Enhanced Payment Programs for physicians and dental.

Ms. Harrington stated DHCS continues to work with CMS on final approval of the directed payment proposals. CMS is supportive of the approach and DHCS is working with them on the more technical aspects. The latest round of comments went back to CMS on January 19, 2018 after a delay due to the minor shutdown of the Federal Government.

Discussion

Ms. Yao asked if the payment was prospective or retrospective. Ms. Harrington responded it will be a retrospective payment based on actual utilization. From CMS's perspective, the payment will be based on the encounter data that is submitted, which will incentivize timely and accurate submission of encounter data. There will be workgroups with both the private and public hospitals and the health plans to work on improving encounter data submissions. The state will do the calculations and then inform each health plan of what the payment to each of the hospitals will be.

Dr. de Ghetaldi asked if the total dollar amount on the private and the public side is changing. Ms. Harrington indicated that the pool amounts presented are what DHCS is estimating for the first year. DHCS will continue to estimate those pools each year going forward. Depending on the available funding, DHCS can reestablish those pool amounts each year.

Dr. de Ghetaldi asked if an individual hospital can predict somewhat accurately whether there is going to be a distribution reallocation because these dollars are very important to hospitals. Ms. Harrington responded the distribution would be based on their actual utilization so hospitals should have a sense of what the distribution will be unless there is a significant change from historical utilization.

6) National Trends in Individual and Small Group Premiums

Brian Stentz, Lewis & Ellis, Inc., presented an overview of how California rates in the individual and small group market compares to other states in several areas, including overall rate increases and their drivers, comparison of final rates, number of carriers per rating area, and risk adjustment. Mr. Stentz noted the sample states that were included in the presentation for comparison purposes were based on what was presented to the Board last year.

Mr. Stentz explained they used the federal Unified Rate Review Template (URRT) to do the analysis because every health plan in each state is required to file and show every rate increase. It includes information on the development of premiums, trends, administration expenses, and profit margins. It also includes information for on and off exchange products and various product types.

Mr. Stentz made the following observations about the individual market:

- California's average rate increase in the individual market was 20.8 percent, which was higher than last year when the average increase was 13.8 percent. This was likely due to the lack of funding for cost sharing reductions (CSRs).
- The overall average rate increase in the individual market for the sample was 30.8 percent, which is higher than it has been in the past. The overall average rate increase for all states was 28.9 percent.
- Compared to other states in the sample, California had the lowest average rate increase in the bronze and gold tier and the second lowest increase in the silver tier. California also had the second lowest increase in the platinum tier compared to the states in the sample that offered a platinum plan.
- Most states had plans file two silver tier rates, one with CSRs funded and one without CSRs funded. The impact ranged from zero to 40 percent with an average rate increase of five to ten percent associated with CSRs.

Mr. Stentz noted the following observations regarding the small group market:

- California had the lowest average rate increase in the small group market among the states in the sample. The average increase of four percent was consistent with the increase last year, which was impressive considering trends of five to six percent.
- The overall average rate increase in the small group market for the sample was 5.8 percent compared to the nationwide average of 6.7 percent.
- California had the lowest average rate increase across all metal tiers compared to the states in the sample.

Mr. Stentz stated there are a number of typical rate increase drivers, such as updated experience, medical trends, anticipated population changes, profit margin, administrative expenses, and benefit design changes. He noted the administration, profit and risk margins are relatively consistent with last year.

Mr. Stentz also discussed the unique drivers of rate increases in 2018. CSR funding was the biggest issue and had a major impact on silver on-exchange plans. In addition, there were numerous threats to eliminate the individual mandate. However, most states did not allow plans to increase their trends for this issue because it hadn't been

finalized. This will be an issue for 2019 rates now that the individual mandate has been eliminated for the coming year.

Another unique rate driver for 2018 was the ACA issuer fee, which was not required in 2018. Carriers increased rates by two to three percent due to the additional administrative cost. There were also changes to the risk adjustment formula and the child age factors that had a minor impact on rates.

Mr. Stentz discussed the trend comparisons for medical, pharmaceutical and total trend. California's total trend in the individual market was 7.3 percent, slightly lower than the national average of 7.8 percent; the medical trend was 6.1 percent, slightly lower than the national average of 6.7 percent; and the pharmaceutical trend was 13.6 percent, higher that the national average of 12.4 percent. For the small group market, California's total trend was 5.5 percent, slightly lower than the national average of 6.1 percent.

Mr. Stentz noted some concern with California's administrative expenses in the individual market as a percent of premium (9.2 percent) as it was the highest of the states in the sample. However, California had the lowest per member per month (PMPM) administrative expense ($47.37). In the small group market, California also had the highest administrative expense as a percent of premium (14.5 percent) and PMPM administrative expense ($69.60). He speculated this could be due to California's high cost of living and taxes.

Mr. Stentz also reviewed the profit margin in the individual and small group market and noted the companies in California are pretty aggressive compared to nationwide. California had the lowest profit margin in the both the individual (0.7 percent) and small group market (1.4 percent). This is likely due to the amount of competition in the market as other states have fewer carriers.

Mr. Stentz compared the on-exchange rates for a 21 year old by market and metal tier. He noted this information was adjusted for cost of living by applying the consumer price index (CPI) for health services. California had the lowest average premium in the individual market in all metal tiers except platinum. California had the second lowest average premium in the platinum tier compared to the states in the sample that offer a platinum product. He said the low rates may be due to the large number of people enrolled on the Exchange and the numerous products offered. California also had one of the lowest rates in the small group market. However, the small group market on the Exchange does not have a lot of people enrolled in it.

California also had the highest average number of carriers offered per area with an average of 3.4. Many states only have one or two carriers in each region. California had some of the lowest rate increases in the country, likely due to competition and an effective rate review process. Similarly, the small group market had an average of 3.1 carriers per area where most other states had one carrier per area. He noted there are a lot of carriers off-exchange but few are participating on-exchange.

Mr. Stentz concluded by reviewing the risk adjustment transfers for California. California received $785 million in the individual market, which was the second highest among all states. On a per capita basis, it equates to 7.8 percent as a percentage of premium, which is lower than the national average of 10.7 percent.

Discussion

Dr. de Ghetaldi asked if there was a correlation between the number of carriers and the amount of the risk adjustment. Mr. Stentz responded there is not necessarily a correlation because it is based on whether you have one carrier that is farther away from the average. Some carriers are getting higher transfers because they are getting sicker enrollees.

Dr. de Ghetaldi asked if poverty is a risk factor in the risk adjustment calculation and whether it is something that should be adjusted for. Ms. Yao said poverty is not a driving factor.

Dr. de Ghetaldi asked if the risk adjustment system uses the same codes as Medicare. Ms. Yao responded it is a different model calibrated for the commercial population with different weights for different diseases.

Ms. Yao stated it appears California's individual and small group market is fairly stable compared to other states that appear to be wild and unstable, especially in pricing. The goal is to keep the market stable and the discussion about AHPs will distract from the dynamics in California. It will be important to limit the AHPs.

Ms. Yao also mentioned the proposal to increase administrative expenses up to 50 percent. Based on the information presented, 14 percent seems reasonable. Increasing it over 14 percent will create inequities among carriers.

Ms. Imholz suggested adding benefit design to the list of drivers. There has been a lot of work with Covered California to not make dramatic changes to the standard cost sharing designs from year to year.

Ms. Imholz also noted California's pharmaceutical trend is twice the medical trend and higher than at least some of the states. She asked if Mr. Stentz had any thoughts about why it is that way in California. Mr. Stentz said when they see a disparity like that, they will usually ask for support for the pharmaceutical trend, which DMHC and CDI likely did.

Mr. Conklin asked for clarification regarding which states were included in the sample for comparison. Mr. Stentz responded they were selected because they were used in the prior presentation. Mr. Conklin suggested using states that were more comparable to California next time. Mr. Stentz stated that could be done because they do have access to the URRTs for other states.

Ms. Imholz stated in her review of the URRTs, a lot of the information was deleted and not available publicly. She asked Mr. Stentz if he believed he had access to sufficient information. Mr. Stentz responded he is a little uncomfortable with the minimums and maximums but they did a lot of analysis and he is comfortable with most of the data.

Ms. Yao asked if he was aware of any states that loaded the higher CSR rate to their bronze plan. She heard some states were considering this because they were concerned their members would migrate to a bronze plan with a very high deductible. Mr. Stentz said he believed some states did, but none that he works with. Ms. Yao noted her plan saw quite a bit of migration to the bronze plan and there may be complaints when the members start accessing care even though the coverage was free for many of them.

7) Legislative Update

Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations, presented an overview of DMHC's current legislative implementation activities.

SB 546 was signed by the Governor in 2015. It requires large group plans to file aggregate rate information with the DMHC annually starting October 1, 2016. It also requires employers to include information in their notices to large group employers comparing the premium increase to the average rate increase for both CalPERS and Covered California. Additionally, DMHC is required to hold an annual meeting to discuss the rate changes and allow for public comment. The next annual meeting will be held on February 7, 2018 in San Francisco. Findings from the 2017 filing will be presented to the Board in April.

Ms. Watanabe reviewed several bills signed by the Governor last year that the Department is implementing, including:

- AB 156 (Wood) sets the open enrollment periods for the individual market starting in 2019.
- Beginning July 1, 2018, AB 1048 (Arambula) allows pharmacists to dispense opioids as a partial fill if requested by the prescribing physician or the consumer. Beginning January 1, 2019, health plans are required to prorate the cost sharing.
- AB 1074 (Maienschein) clarifies that Qualified Autism Service (QAS) professionals and paraprofessionals may be employed by a qualified entity or group. It also deletes the requirement that these providers be vendored by a regional center and permits QAS professionals to supervise paraprofessionals when appropriate.
- Beginning January 1, 2018, SB 133 (Hernandez) expands the existing continuity of care protections to patients in the individual market, when their health plan withdraws from the market. It also requires information about continuity of care to be included in the termination of coverage notice.

Ms. Watanabe also described the implementation of SB 17 (Hernandez), which is the bill with the most significant workload for the Department this year. SB 17 provides transparency related to prescription drug costs. Beginning October 1, 2018, health plans in the individual, small group, and large group market will report information to DMHC annually on the 25 most frequently prescribed drugs, the 25 most costly drugs by total annual spending, and the 25 drugs with the highest year-over-year increase in total annual spending. An annual report will be provided to the Legislature beginning January 1, 2019.

There are additional reporting requirements for large group plans that will be included in their annual aggregate rate filing. The DMHC is working collaboratively with the CDI and will be meeting with plans regarding filing requirements. Along with large group aggregate rates, prescription drug cost information will be shared at the DMHC annual meeting starting in 2019.

In addition, beginning January 1, 2018, drug manufacturers are required to provide a 60-day advance notice to public and private purchasers when certain thresholds have been met. Beginning January 1, 2019 drug manufacturers must report additional requirements to the Office of Statewide Health Planning and Development (OSHPD). DMHC is working closely with OSHPD to make sure the information that DMHC is collecting is comparable to the information OSHPD is collecting.

Discussion

Ms. Yao asked if the member must have a qualifying event in order to enroll during one of the On-Exchange special enrollment periods. Ms. Watanabe said she was not sure and indicated staff would follow up on the question. However, she believed the intent was to make available a three-month open enrollment period.

Dr. Rideout stated not all drugs are bad and not all drugs that are expensive are bad. He encouraged DMHC to use the limited amount of information available to try to separate those drugs that are offsetting other costs from those that are just contributing to them and leading to premium increases. Ms. Watanabe agreed and said it would be something to consider once the data comes in.

Dr. de Ghetaldi said IHA is testing three pay-for-performance measures on opioid prescribing in 2018 that should be a useful tool for medical groups to manage and understand this kind of variation.

Ms. Imholz stated Consumers Union is very excited to see the rollout of SB 17. She understands the legislation is not simple, but looks forward to working with DMHC on it.

8) 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 September 30, 2017:

- 184 RBOs filed financial information with the Department and all were required to file annual survey reports based on audited financial statements.
- 17 RBOs were required to file annual survey reports for the fiscal year end 2017. Of those, 16 have filed and there was one non-filer.
- 135 of the 184 RBOs were required to file quarterly financial survey reports and the remaining 48 RBOs filed compliance statements attesting to meeting or not meeting all of the financial solvency criteria. There was one non-filer.
- Five RBOs filed monthly financial survey reports as required by their CAP.
- 183 of the reporting RBOs reported compliance with the solvency criteria, including:
    - 40 RBOs, or 22 percent, were in the Superior category.
    - 92 RBOs, or 50 percent, were in the Compliant category, of which 8 RBOs were on a CAP and reported meeting the solvency criteria and 11 RBOs were on the monitor-closely list.
    - 48 RBOs, or 26 percent, filed compliance statements.
    - 3 RBOs, or 2 percent, reported non-compliance.
- There were 13 active CAPs for 12 RBOs. There is one RBO that has two CAPs. Of those, 6 CAPs are approved, 2 CAPs are currently under review, and 5 CAPs have been completed – Asian American Medical Group, Chinese Community Health Care Association, Imperial Health Holdings, Marin IPA, and Maverick Medical Group.
- There were 88 RBOs with Medi-Cal enrollment covering approximately 4.3 million enrollees.
- The top 20 RBOs served approximately 3.3 million Medi-Cal lives. Of these, 16 have no financial concerns, 1 was on a CAP, and 3 are on the monitor-closely list.
- The remaining 68 RBOs served approximately 1 million Medi-Cal lives. Of these, 58 have no financial concerns, 5 were on a CAP, and 5 were on the monitor-closely list.

Ms. Yamanaka stated the Office of Financial Review has 24 audits scheduled for 2017, of which 14 have been completed and the last 10 are nearing completion.

Discussion

Dr. Rideout stated IHA is tracking well over 300 provider organizations and some with multiple organizations resulting in about 780 health plan provider organization contracts. He asked for confirmation that the 88 RBOs DMHC is tracking, which would have multiple provider organizations, account for about 4.2 million managed Medi-Cal lives.

This would imply there are 8 to 10 million that are not in RBOs. Ms. Yamanaka responded this was correct.

Dr. Rideout added IHA's data indicates about 30 percent of Medi-Cal enrollment is in Los Angeles County and well over 50 percent of these enrollees get their care through an integrated medical group of some type. It appears integrated groups are seeing a lot of Medi-Cal enrollees and a lot of commercial enrollees, which is a difference from a few years ago. Ms. Yamanaka responded this was correct.

Ms. Rouillard clarified not all medical groups are RBOs. To be an RBO, certain criteria must be met and some of the groups IHA is tracking do not meet the criteria, which is why the numbers are so different.

Mr. Durr commented on the increase in the superior rating of the RBOs, which is quite significant compared to the quarter ending December 31, 2016. Only 13 percent were previously in the superior category compared to 22 percent in the most recent quarter. That is a significant jump and a complement to understanding more of what risk arrangement is and better performance by those delegated groups.

Ms. Imholz asked if Ms. Yamanaka could explain what the compliance statements mean. Ms. Yamanaka responded there are two types of filings that an RBO can file based on the number of enrollees the RBO had for a previous fiscal year. If they have under 10,000 lives, they can file a compliance statement attesting they meet the solvency criteria. If they are not compliant with one or more of the solvency criteria, they are required to file the quarterly survey report, which is filed by all groups with more than 10,000 enrollees. Ms. Imholz asked if it was a self-attestation for smaller groups. Ms. Yamanaka responded that was correct.

Director Rouillard asked how often the smaller groups admit they are not compliant. Ms. Yamanaka responded it is rare, maybe a few per year. However, DMHC also looks at their annual financials each year.

9) Health Plan Quarterly Report

Stephen Babich, Supervising Examiner, Office of Financial Review, presented the health plan quarterly update for the third quarter of 2017:

- There were 75 full-service health plans and a total of 123 Knox-Keene licensed plans.
- Enrollment in full-service plans was 26 million lives, an increase of 2 percent from 2016. The increase was driven by the government lines, where there was an increase of 3.5 percent versus half of one percent in the commercial market.
- Government enrollment and commercial enrollment each represent 13.16 million lives.

- There were 23 plans on the closely-monitored list with 1.75 million lives compared to 24 plans with 14 million lives last year. This demonstrates that smaller entities are struggling as opposed to the larger entities that were struggling last year.
- There were three Tangible Net Equity (TNE) deficient plans, including a specialized dental plan and two full service plans. The two full service plans resolved their deficiency. The specialized dental plan, Dedicated Dental Systems, remains.
- There were 25 plans on CAPs, including 14 in progress and 11 pending approval.

Discussion

Ms. Imholz said the Board is primarily concerned about solvency, but asked about plans that are far above the TNE requirements. Mr. Babich responded the evaluation of TNE was complex. Pritika Dutt, Deputy Director, Office of Financial Review, indicated some plans compete in the commercial market while others cannot. Those that cannot must maintain a higher reserve. The minimum amount of TNE will also vary depending on the plan's contracts and the risk that is passed along. Fee-for-service contracts pose a greater risk and as a result, the plan's TNE requirement will be much higher. Ms. Dutt reminded the Board about the Medi-Cal Managed Care report presented at the last meeting which shows a plan's TNE as only one criteria DMHC reviews. The DMHC's review includes other criteria such as cash on hand and net worth compared to exposure from claims. Ms. Imholz said from the consumer's perspective, there is always a concern there is too much surplus when the plan should be putting excess funds into reducing rates or other expenses.

Mr. Barcelona asked why DMHC no longer publishes information characterizing full service health plans as restricted or limited licensees. Ms. Rouillard responded she was unaware of the change and it could be an oversight caused during the refresh of the DMHC website. She indicated staff would look into it.

10) Public Comment on Matters not on the Agenda

Ms. Imholz asked for public comment on items not on the agenda. There was no public comment.

11) Agenda Items for Future Meetings

Ms. Imholz asked if there were any agenda items for future meetings.

Dr. Rideout suggested sharing information related to IHA's upcoming release of its Regional Health Care Cost and Quality Atlas.

Dr. de Ghetaldi suggested discussing the County Organized Health System (COHS) and the Local Initiatives (LI) and to discuss whether TNE is the right value and if 100 percent of TNE is the correct benchmark. He indicated the plans feel 100 percent is inadequate.

Ms. Yao said there has been a lot of information in the news regarding the raises being too high in Medi-Cal. It would be helpful to learn more about where we are headed with Medi-Cal rates.

Ms. Imholz stated she would like to continue to have an agenda item related to federal updates.

12) Closing Remarks/Next Steps

The meeting was adjourned at 12:17 p.m.