Financial Solvency Standards Board Meeting
October 17, 2018
Meeting Minutes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Jeffrey Conklin, Adventist Health Plan
Dr. Larry deGhetaldi, Palo Alto Medical Foundation
Paul Durr, Sharp HealthCare
Richard Figueroa, The California Endowment
John Grgurina, Jr., San Francisco Health Plan
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
Wayne Thomas, Chief Life Actuary, Office of Financial Review
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

Chairperson John Grgurina called the meeting to order and asked the Board members to introduce themselves. Mr. Grgurina asked for a moment of silence for former chair of the Managed Risk Medical Insurance Board (MRMIB) and long-time public servant, Cliff Allenby, who passed away this year.

2) Minutes from July 17, 2018 FSSB Meeting

Mr. Grgurina asked if there were any changes to the July 17, 2018, FSSB meeting minutes. Meeting minutes were approved with a change noted by Dr. Larry deGhetaldi on page 9 of the minutes.

3) Director's Remarks

Director Shelley Rouillard introduced new board member Richard Figueroa. Mr. Figueroa is the Director of Prevention and the Affordable Care Act for the California Endowment. He served in the California Governor's Office where he was a Deputy Cabinet Secretary and Health Care Advisor to Governor Arnold Schwarzenegger and as

Deputy Legislative Secretary for Governor Gray Davis. He has also served as a Board member or staff for the MRMIB for 15 years.

Ms. Rouillard provided an update on the three health plan mergers currently under review by the Department. The DMHC held public meetings for the Optum/DaVita and CVS/Aetna mergers in the spring of this year. The Department of Justice (DOJ) approved the CVS/Aetna merger last week, which included a requirement that Aetna divest its Medicare Part D prescription drug business. The DOJ also approved the Cigna/Express Scripts merger on September 17, 2018.

Ms. Rouillard mentioned Assembly Bill (AB) 595 and the impact it will have on the Department's review of mergers. AB 595 by Assembly Member Jim Wood was signed by the Governor and takes effect January 1, 2019. AB 595 codifies the Department's existing practice of holding a public meeting to allow for public comment on the merger. It also grants new authority to the Department to assess the impact of mergers on the health care market and to disapprove a merger that would substantially limit competition in health plan products or would create a monopoly in California. Additionally, it requires the Department to obtain an independent analysis of the impact of the transaction on market competition. The Department does not have a statutory timeframe for reviewing mergers. However, if any mergers are still under review after January 1, 2019, the Department will apply the new requirements of AB 595.

Ms. Rouillard provided an update on undertakings associated with prior health plan mergers. For Blue Shield's acquisition of Care1st, the Department required Blue Shield to invest $50 million to develop an industry solution to the provider directory problem. Blue Shield contracted with the Integrated Healthcare Association (IHA) to develop the provider directory utility. IHA is currently engaged in a soft launch of the Utility with three large health plans and several provider groups participating. Blue Shield and IHA have executed the final phase of the contract, which runs through the end of 2022.

In regards to Health Net's encounter data initiative, Health Net has made some grants to provider organizations to assess their capabilities around encounter data and the results of these assessments should be available by the end of the year.

Ms. Rouillard provided a follow-up to the presentation at the July meeting by Don Crane from America's Physician Groups (APG) and the three requests he made of the Department. The first request was to expand the capitated integrated model to areas where it doesn't exist in California with the goal of focusing on value. The second request was to allow sophisticated medical groups to contract directly with employers. The final request was to work more closely with the DMHC to develop a better health care delivery system in California. Ms. Rouillard reminded the Board that, in 2014, APG requested the Department enact a regulation that would allow medical groups to contract directly with employer groups. Over the past four years, the Department has discussed this issue extensively with the Board and APG. The Department's decision was to issue the general licensure requirements regulation that is currently going through the administrative process. The DMHC will be meeting with APG in the next week to address some of the other issues.

Ms. Rouillard provided the following update regarding regulations:

- AB 72, Average Contracted Rate (ACR) Methodology. AB 72 was enacted to end the practice of surprise balance billing for non-emergency services. The regulation creates a methodology for determining the default reimbursement rate for noncontracting providers who provide services in contracting facilities. The regulation was approved by the Office of Administrative Law (OAL) on September 13, 2018 and will take effect on January 1, 2019. AB 72 also created the Independent Dispute Resolution Process (IDRP) for providers who are unsatisfied with a health plan's reimbursement. Since the provision went into effect on September 1, 2017, the DMHC has received 36 IDRP applications. Of these applications, 72 percent were for anesthesiology services, 14 percent for pathology services, 8 percent for ambulance services and the remaining were for other services. About half of the cases were closed because they were non-jurisdictional or ineligible for IDRP. The other half are awaiting the health plan's response. To date, no applications have gone through the formal IDRP.
- General Licensure Requirements or Risk and Restricted Licenses. This regulation codifies the DMHC's practice regarding the types and levels of risk that require Knox-Keene licensure. The final regulatory package was submitted to the OAL on August 24, 2018. The OAL disapproved the regulation package on two grounds. First, the Department of Finance needs to sign off on the form that evaluates the economic impact of the regulation. Second, the section on exemptions lacked sufficient clarity. The Department has 120 days from October 8, 2018 to revise the regulation, hold a 15-day public comment period, and resubmit the regulation to the OAL.
- Cancellations, Terminations and Non-renewals of Coverage. This regulation updates and clarifies the requirements health plans must meet in order to terminate coverage for nonpayment of premiums. The DMHC is currently reviewing the public comments from the 45-day comment period and anticipates holding a second comment period in the future.
- Risk Bearing Organizations (RBO) Financial Filing Requirements. This regulation updates the financial requirements for RBOs to better address the changing nature of the relationship between RBOs and health plans, including sub-delegated entities, and establishes minimum TNE requirement for RBOs. The Department is currently reviewing comments from the second comment period which ended on September 28, 2018. The Department has not determined yet if there will be another comment period.
- Senate Bill (SB) 1052, Standard Drug Formulary Template. SB 1052 required the DMHC and the California Department of Insurance (CDI) to develop a standard formulary template for plans and insurers to use. The DMHC has filed the proposed regulation with the OAL and is currently holding a 45-day comment period, which will end on November 13, 2018. There will also be a public hearing on this proposed regulation on November 13, 2018.

Discussion

Dr. deGhetaldi asked about the status of the regulatory or legislative approach to protecting California consumers in regards to short-term policies and Association Health Plans (AHPs). Ms. Rouillard stated there were two bills signed by the Governor this year to address these issues. The first one prohibits the sale of short-term limited duration insurance (STLDI) in California and the other bill prevents sole proprietors and small employers from joining an AHP for the purpose of gaining large group coverage.

4) Department of Health Care Services Update

Lindy Harrington, Deputy Director, Health Care Financing, Department of Health Care Services (DHCS), provided an update on the Adult Expansion Medical Loss Ratio (MLR) Risk Mitigation. Ms. Harrington explained the Adult Expansion MLR Risk Mitigation was previously referred to as the Affordable Care Act (ACA) Optional Expansion MLR. However, due to the change in the federal regulations requiring MLR calculations for all populations, this name more accurately references the risk mitigation associated with the adult population.

The current Adult Expansion MLR Risk Mitigation applies to contracts from January 2014 to June 2016. The MLR is calculated for two periods. The first is an 18 month period from January 2014 to June 2015 and second is from July 2015 to June 2016. However, in June 2018, the Centers for Medicare and Medicaid Services (CMS) notified DHCS that the requirement will also extend to the contract period of July 1, 2016 to June 30, 2017. CMS felt this requirement was needed because DHCS continues to use a blend of data that is not completely based on the health plan's actual experience.

Ms. Harrington provided the following summary detailing how the risk mitigation works while this requirement is in place:

- If the MLR is less than 85 percent, the plan would return the difference between the actual amount and the 85 percent calculation.
- If the MLR is between 85 percent and 95 percent, there is no risk adjustment.
- If the MLR is above 95 percent, DHCS will make additional payments for the difference between the actual amount and the 95 percent.

DHCS worked with CMS on the MLR calculator for the first 30-month time period from January 2014 to June 2016, but DHCS did not receive approval from CMS until December 2017. In January 2018, DHCS sent out a supplemental data request to the health plans in order to get the data required to do the calculation. All of the Medi-Cal Managed Care Plans submitted their data in April 2018 and DHCS has worked with the plans to make adjustments, as needed.

DHCS has begun sending determination letters to the Medi-Cal Managed Care Plans. Most health plans are going to have to submit money back to the state, which will ultimately be returned to the federal government. There are a couple of plans that fall

into the no-adjustment category and one health plan will be receiving funds back. DHCS estimates that for the 30-month period, approximately $2.4 billion will be returned to the federal government.

Ms. Harrington also provided an update on the directed payment program. She reminded the Board that under the Medicaid Managed Care Final Rule, pass-through payments are impermissible. However, CMS allowed for a 10-year phase down. For fiscal year 2018-19, DHCS will continue pass-through payments associated with SB 239, known as the Hospital Quality Assurance Fee (HQAF) program, which requires health plans to spend those dollars on hospital services. DHCS will also continue payments as required by SB 857, which provides a specific level of funding for the Martin Luther King, Jr. Community Hospital.

The Final Rule allowed for some exemptions for directed payments, including value-based purchasing models, delivery system reform, performance improvement initiatives, and setting minimum or maximum fee schedules. All of these allowable directed payments require CMS approval prior to implementation.

Ms. Harrington explained the goal of the directed payment programs, combined with the pass-through dollars for the HQAF program, was to maintain the level of funding the industry received prior to this regulation. The focus of these programs is to maintain or improve quality and access to care, as well as to improve encounter data reporting. Encounter data is very important to DHCS, but sometimes, in capitated arrangements, the providers lose the incentive to provide clean, detailed encounter data.

Ms. Harrington reviewed the details of the three directed payment programs for hospitals:

- The Designated Public Hospital (DPH) Directed Payment Program, also known as the Enhanced Payment Program (EPP), is for the county DPHs and the University of California (UC) systems. There are five separate classes of providers for this provider pool of payments. The proposed amount for this program is $1.5 billion annually.
- The Designated Public Hospital Quality Incentive Program (QIP) is also for the DPHs and UCs. The hospitals are required to report on at least 20 of 25 quality metrics. There is a single class of providers for this pool of payments and the proposed amount is $640 million for 2017-18 and $668 million in 2018-19.
- The Private Hospital Directed Payment Program provides a single pool of funding for private hospitals. For this pool, the proposed amount is $2.1 billion in 2017-18 and $2.3 billion in 2018-19.

For all of these programs, DHCS develops a proxy per member per month (PMPM) based on the projected expenditure levels and then adjusts the proxy PMPM based on actual experience.

Ms. Harrington explained there was concern that a risk component would be added to the process. DHCS worked with CMS to create a pooled approach, which allows

payments to happen after the fact and maintain a level of no risk for the hospitals and the health plans. Because of the challenges with encounter data, DHCS split the pools into two six-month pools to allow the hospitals and health plans more time to work together to make sure DHCS has the most accurate data available when they do the calculations.

CMS has approved the 2017-18 proposals and they are continuing to review the 2018-19 proposals. DHCS submitted another round of responses recently and anticipates further conversations with CMS shortly. She said there were no concerns around the concept and their conversations would be about the more technical aspects of the proposals.

Ms. Harrington also discussed the Proposition 56 Physician Directed Payment Program, which provides direct payments to primary care physicians, specialty physicians, and mental health outpatient providers through risk-based payments to Medi-Cal Managed Care Plans. There is no pooled amount for this program and payments are based on utilization. In 2017-18, the payment was $325 million. In 2018-19, the payment grew to $1.3 billion.

Discussion

Mr. Figueroa asked how the MLR calculations fit into DHCS's ongoing rate development process. Ms. Harrington responded DHCS has continued to make adjustments as they have moved through the rate-setting process. They didn't have experience to set the first rates so they used information from the low-income health program experience, as well as research and data about the population. The number of enrollees was significantly more than anticipated and their actual expenditures and utilization tended to be lower cost than anticipated. As DHCS has moved through the rate-setting process they've blended in experience and as a result have seen rates drop for that population. The rates for the 2018 period are set 100 percent on health plan actual experience and follow the same process as for all other rate cells.

Dr. Jeff Rideout commented the federal government extension of the MLR requirement seemed unusual until you actually look at the results. He asked if there was more context for this request. Ms. Harrington responded CMS was late in approving the calculator so they had not yet seen the results of the 30-month calculation. DHCS continued to use a blend of actual health plan experience and initial assumptions of what utilization would look like, so CMS felt it was appropriate to continue the risk mitigation calculator.

Amy Yao said even if you have the actual experience it is going to fluctuate. She asked if Ms. Harrington thought the federal government would continue this MLR requirement beyond June 2017. Ms. Harrington responded CMS sent a letter stating they were requiring it for 2016-17 and were continuing to review it for 2017-18. She noted that for 2018-19, CMS will have the results of the 30-month MLR calculation and will be able to see that the rates have stabilized for the most part. However, CMS has indicated the

requirement will likely continue for 2017-18, but DHCS has not received anything formal from CMS.

Dr. deGhetaldi said from his perspective as a County Organized Health System (COHS) board member, the period from 2014 to 2017 was a time of plenty, when most organizations were below 85 percent MLR and some were even paying back the federal government. There is pressure on these organizations to increase rates to their physicians and providers. However, he expressed concern about a sustained rate they can forecast.

Ms. Harrington responded that whether or not the MLR is in place, DHCS will continue to set rates that are fairly stable and based on the actual experience of the health plans. For this population, there were significant rate decreases from 2014 to now. However, from a rate-setting perspective, rates have stabilized and DHCS is not continuing to see significant decreases in those rates. This means the actual experience is coming in line with the rate-setting process. DHCS also continues to collect data from the health plans on their contracting trends for consideration in the rate-setting process.

Jeffrey Conklin asked if the plans' MLRs information was public. Ms. Harrington said she was unsure if there were plans to publicly post the information. However, DHCS will provide the information, if requested.

Mr. Conklin stated from his experience, the Medicaid Coverage Expansion (MCE) consumers are starting to understand their benefits and consume services differently, changing the cost profile. He asked if DHCS is seeing this in their data. Ms. Harrington stated DHCS is continuing to monitor the actual experience and is seeing less volatility in utilization. The MCE population is starting to look more like other populations.

Dr. Rideout stated he assumed there was no downside or upside cap on the payback. Ms. Harrington confirmed there was not.

Ms. Yao asked for clarification about which entity pays the plan with the MLR above 95 percent. Ms. Harrington explained the plans have a contract with DHCS, so regardless of who funds it, DHCS submits the payment to the plan. For the first 30 months, the Adult Expansion was 100 percent federally funded. However, starting in 2016-17, it was funded by both a Federal Medicaid Assistance Percentage (FMAP) and a state share so the plan payment for the 2016-17 time period would be funded by the state and federal government.

Mr. Grgurina stated most plans estimated this was going to happen and put dollars aside in a liability account that wasn't counted in their reserves. The question is what did the plans estimate they would have to give back and what was the final number. He has heard some plans are very close and his plan is hoping for the same result.

Dr. Rideout commented the funds going to the hospitals compared to those going to the physicians seemed disproportionate. He noted that in other states, like Oregon, there is a required amount for primary care of up to 15 percent of the total, which seems to lead

to direct improvements in the health of members, including Medicaid members. He asked for the logic behind the balance of payments. Ms. Harrington responded the directed payments are intended to replace the existing funding the hospitals receive. The hospitals are providing the non-federal share for most of those programs, either through fees or intergovernmental transfers. With the physicians, DHCS had a new revenue source and wanted to ensure the funding made it to the providers themselves and to incentivize proper reporting of encounter data.

Dr. deGhetaldi stated these funds are important to physicians. He hopes one day the Medi-Cal fee schedule is abandoned and the Medicare fee schedule is adopted for both the hospitals and physicians of California. He noted that when physicians see a Medi-Cal patient and receive 100 percent of Medicare, it is a game changer and if Proposition 56 funding can accomplish this, it is a great thing.

Dr. deGhetaldi expressed concern about a CMS proposal for 2019 that would collapse the four main Evaluation and Management (E&M) codes into one. He asked if this proposal will affect the Proposition 56 funding for the common E&M codes. Ms. Harrington said it hasn't happened yet, so she can't speak to the impact.

Mr. Grgurina reiterated that these dollars were provided particularly to public hospitals and UCs to be able to serve low-income patients and those are desperately needed funds. Mr. Grgurina complimented DHCS for their work over many months with CMS to develop this approach, which provides critical funds to hospitals in a way that seems equitable. Ms. Harrington said DHCS appreciates the valuable input it has received from the Medi-Cal Managed Care Plans, who worked alongside DHCS.

Ms. Yao asked if there were any updates on the timing of the Medi-Cal procurement coming up next year. Ms. Harrington responded she did not have any updates, but there is a procurement schedule on the DHCS website.

5) Legislative Update

Mary Watanabe, Deputy Director, Health Policy & Stakeholder Relations, reviewed several bills signed by the Governor this year that the Department is implementing, including:

- AB 1092 (Cooley) permits vision plans to use a statistically reliable method to investigate suspected fraud and recover overpayments. Vision plans must meet certain requirements, including limits on the look-back period, notification requirements for providers, and procedures for contesting overpayments.
- AB 1860 (Limón) extends the sunset date from January 1, 2019 to January 1, 2024 for cost-sharing limits on individual prescriptions of a 30-day supply of an oral anticancer medication. It also increases the monthly cost-sharing limit from $200 to $250, which is consistent with some of the requirements in AB 339 (Gordon, 2015).

- AB 2193 (Maienschein), effective July 1, 2019, requires health plans to develop a maternal mental health program to promote quality and cost-effective outcomes and to provide this information to providers. It also requires providers of prenatal and postpartum care to screen for maternal mental health conditions. Ms. Watanabe will be working with stakeholders to implement this bill.
- AB 2499 (Arambula) maintains the federal MLR requirement that was in place January 1, 2017. Currently, existing law is tied to federal law and this bill allows California to maintain the MLR requirements regardless of what may happen at the federal level.
- AB 2674 (Aguiar-Curry) requires the DMHC to review, annually, complaints from providers alleging unfair payment patterns by health plans. It also gives the DMHC authority to investigate, conduct audits and take enforcement action.
- AB 2863 (Nazarian), effective January 1, 2019, prohibits plans from requiring a cost-sharing amount for a prescription drug that exceeds the retail price. Pharmacists must inform customers if the retail price is lower and report to the plan if the retail price is paid so the payment can be applied to the deductible and out-of-pocket maximum.
- AB 2941(Berman) requires plans to ensure continued access to medically necessary health care services when enrollees are displaced by a state of emergency. It also requires health plans to file a plan with the DMHC within 48 hours of a state of emergency declaration.
- SB 910 (Hernandez) amends the Insurance Code to prohibit the issuance of STLDI in California. It also amends the Knox-Keene Act to remove all references to STLDI.
- SB 997 (Monning) removes the sunset date and makes permanent the existing requirement that health plans' networks include one primary care physician per 2,000 enrollees.
- SB 1021 (Wiener) extends the sunset to January 1, 2024 for cost-sharing limits on a 30-day supply of individual prescription drugs. It also prohibits utilization management policies that rely on a multi-tablet regimen instead of a single tablet regimen for the prevention of AIDS/HIV.
- SB 1375 (Hernandez) clarifies that small employers, large employers, and individuals remain subject to the rules of their respective markets regardless of their membership in an AHP.

Ms. Watanabe also described three bills with the most significant workload for the Department.

- AB 315 (Wood) establishes the following requirements related to pharmacy benefit managers (PBMs):
    - DMHC Task Force. AB 315 requires the DMHC to convene a task force by July 1, 2019 to determine if plans or their contracted PBMs should report

additional information to the DMHC, including rebates, wholesale cost, payments to pharmacies, or exclusive arrangements. This information would be in addition to the reporting requirements on prescription drug pricing in SB 17 (Hernandez, 2017). The DMHC will convene the task force next summer and submit a report with recommendations to the Governor and the Legislature by February 1, 2020.

- Contracting Requirements. Effective January 1, 2020, there are new contracting requirements for PBMs and plans, including good faith and fair dealing clauses, and requirements that PBMs inform pharmacists of their rights as a provider, including the Provider Bill of Rights, and their right to submit complaints to the DMHC. PBMs that contract with health plans will also be required to register with the DMHC, similar to the RBO process.
- Pilot Project. Effective January 1, 2020, in Riverside and Sonoma counties, plans or their PBMs cannot restrict prescription drug quantities dispensed at retail locations, if they offer a larger quantity, either by their pharmacy owned or controlled by the plan or the PBM. Plans will report changes in utilization resulting from the pilot project and the DMHC will issue a report by the end of 2022.
- Business and Professions (B&P) Code. There is a requirement in the B&P Code similar to AB 2863, which requires pharmacists to notify consumers if the retail price for a prescription drug is lower and apply that to the deductible and out-of-pocket maximum. There are also contracting requirements, similar to those for Knox-Keene plans, that apply to self-funded plans or Employee Retirement Income Security Act (ERISA)-governed plans. The B&P Code includes a new requirement for PBMs to disclose various pricing information and rebate metrics, which are generally proprietary, if requested.

- AB 595 (Wood) expands the DMHC's oversight of mergers, primarily to conduct an independent impact analysis, issue a statement describing the transaction, and hold a public meeting. AB 595 also gives the Department new authority to disapprove these transactions based on anti-competition findings. It also makes the merging health plans responsible for the costs of the analysis and the public meeting.
- SB 1008 (Skinner) was discussed at the April 2018 FSSB meeting in relation to a presentation on dental MLR data. At that time, the bill included a dental MLR requirement, which was later removed and the final bill focuses on dental plan disclosures. Starting either January 1, 2021 or 12 months after the DMHC promulgates regulations, plans that cover dental services will be required to use a uniform benefit and coverage disclosure matrix. The matrix will include annual deductibles; benefit limits; coverage for categories like preventive and diagnostic services, basic services, major services, and orthodontia; reimbursement levels; cost-share for services; waiting periods and examples to illustrate coverage of commonly used benefits. Ms. Watanabe will be working with the Department's stakeholders on the development of the matrix.

Ms. Watanabe also discussed two bills that do not directly impact the Department. AB 1810 (Committee on Budget) established a Council on Health Care Delivery Systems. Additionally, it charges Covered California with developing options for providing financial assistance to low- and middle-income Californians and charges the Office of Statewide Health Planning and Development (OSHPD) with developing a Health Care Cost Transparency Database. AB 2472 (Wood) also requires the Council to analyze the feasibility of a public health insurance option.

Ms. Watanabe stated the next step will be to start mapping out the DMHC's implementation plan and to work with the plans and stakeholders. The Department will report more information to the Board on a number of these bills in the coming year.

Discussion

Dr. Rideout asked if the provisions of AB 595 extend to RBOs, which are technically not full-service health plans. Ms. Rouillard responded they could. Dr. Rideout asked if a transaction like the Optum/DaVita merger would count. Ms. Rouillard stated it is really up to the Director to determine what qualifies. There are a lot of characteristics the Department has to evaluate, like the size and scope of the transaction. Ms. Watanabe noted one of the characteristics would be a significant amount of assets.

Dr. Rideout noted when looking at competitive behavior, what counts as a major transaction might be defined more by the local market than statewide. Ms. Rouillard confirmed this was correct.

Mr. Grgurina asked if there was a wind-down period for an employer or an individual that has purchased STLDI so they're not suddenly without coverage on January 1st. Ms. Watanabe stated there have never been any STLDIs under the DMHC's jurisdiction and these have been under the CDI. There also have never been any AHPs. Ms. Rouillard noted there are Multi-Employer Welfare Arrangements (MEWAs) under the CDI that are allowed to continue, but no more are allowed to form.

Mr. Figueroa added that MEWAs tend to be in a single industry while an AHP may have a mix of individuals and small employers across different industries, like in a chamber of commerce. MEWAs are single-industry reliant, like automobile dealers and certified public accountants (CPAs). There are also two agricultural MEWAs. There are MEWAs that have been around for 25 years and California hasn't allowed any new ones to form for 25 years. This is more of a technical clean-up bill to make sure no new ones could form other than the very narrowly tailored organizations that currently exist.

6) 2019 Rates in the Individual Market

Pritika Dutt, Deputy Director, Office of Financial Review, provided an overview of the 2019 rates for the individual market, including a review of the rate-setting timeline. The rates were finalized on October 1, 2018 and will go into effect on January 1, 2019. Open enrollment began on October 15, 2018.

Ms. Dutt provided an overview of the DMHC's rate review process. Department actuaries review the rate filings to determine if the proposed rate increases are justified. The DMHC does not have the authority to approve or deny rate increases. However, the DMHC does review rates to ensure they are reasonable or justified.

Ms. Dutt provided the following summary of 2019 rates in the individual market:

- The statewide average increases for Covered California plans ranged from a decrease of 1.19 percent to an increase of 10.2 percent. The weighted average increase across all plans was 8.7 percent.
- The key drivers for rising rates in 2019 include:
    - Medical cost trends
    - Changes in risk adjustment
    - The federal decision to eliminate the individual mandate penalty, which increased rates by an average of 3.5 percent across all plans
- Outside of Covered California plans, Sutter Health offers an off-Exchange individual product with a projected enrollment of 3,300 enrollees and an average annual increase of 14.9 percent.

Discussion

Mr. Conklin noted the larger plans had rate increases of about 7.5 to 9.8 percent. He asked if the Department published information about the profitability of these plans. Wayne Thomas, Chief Life Actuary, Office of Financial Review said all plans met the MLR target of 85 percent. There was probably some profit, but it's pretty slim. Ms. Dutt added the plans that are subject to the MLR requirement have to submit annual reports, which show the profitability for each plan and product line. All of the financial statements and rate filings are available on the public website.

Dr. Rideout stated over the last few years, organizations that had lower rate increases tended to use integrated care delivery networks. However, this data seems to show the opposite. He asked if there was any explanation for this or if it could simply be attributed to the risk profile changing. Ms. Rouillard responded that with the individual mandate going away and a 3.5 percent impact to the rates, bigger plans may be projecting they are going to lose younger, healthier members more than other plans.

Dr. deGhetaldi stated the presentation does not show the geographic variation and requested that this information be presented in the future. He said there is a one-plan county that had a 25 percent increase two years ago and a 16 percent increase this year. Specifically, he would like to know how the loss of competition and plan choice impacts rates and why in some parts of California there is double inflation. He said the Board needs to understand the geographic variation because it is harming some consumers.

Ms. Yao said Blue Shield does not have an integrated system and has the only broad Preferred Provider Organization (PPO) network on the Exchange. Blue Shield has seen adverse selection in the marketplace and this may be one of the reasons their rate increases might be higher than average. Ms. Yao also noted nationwide rates have decreased by 1.5 percent. Her team looked into this and found that last year when there was a lot of uncertainty, in many states, plans overpriced. She said she was grateful the DMHC and Covered California have done a good job with rate review to assure California is being reasonable and not just reactive or overcharging consumers.

Mr. Figueroa noted Covered California posts a comprehensive set of documents, including charts with rates by region, for anyone who wants more information about the regional variation.

Ms. Rouillard acknowledged Mr. Thomas, the DMHC's rate review team, and the DMHC's contracted actuaries for doing a good job on rate review and making sure the Department understands the reasoning behind the rates.

Mr. Grgurina noted the overall weighted average is 8.7 percent and while no one wants to pay an increase of 8 or 9 percent, plans have to back out that piece of uncertainty with the individual mandate penalty being removed. There were also changes in the risk adjustment and cost sharing last year. He complimented Covered California for keeping the market as stable as possible, given all of the changes at the federal level.

7) 2017 Federal Medical Loss Ratio Summary

Ms. Dutt provided an overview of the 2017 Federal MLR reports. Federal law requires health plans that sell products directly to enrollees and employer groups to spend a certain percentage of their premium dollars on medical expenses, as well as quality improvement efforts. For the individual and small group markets, plans are required to spend 80 percent and for the large group market the requirement is 85 percent. If plans fail to meet the MLR requirement, they must issue rebates to the enrollees or employer groups. Rebates can be issued in a number of ways. Enrollees can receive a rebate check in the mail or the plan can deposit the rebate into the enrollee's account to be used to pay their premiums or reduce future payments. For rebate purposes, the MLR is based on experience over three years. For reporting year 2017, the MLR and rebate calculation is based on the health plan's accumulated premium and medical expenses for 2015, 2016, and 2017. As Ms. Watanabe discussed, AB 2499 goes into effect January 1, 2019 and codifies the federal MLR and rebate requirement into state law.

Ms. Dutt reviewed the key findings:

- The MLR for the 12 plans in the individual market ranged from 83.5 percent to 110.5 percent.
- The MLR for the 11 plans in the small group market ranged from 77.5 percent to 98.5 percent. Two plans, Anthem Blue Cross and Blue Shield, reported MLRs below 80 percent and were required to issue rebates to enrollees or small employers by September 30, 2018. Anthem Blue Cross reported a MLR of 77.5

percent and paid rebates of $53 million. Blue Shield reported a MLR of 79.3 percent and paid rebates of $19 million.

- The MLR for the 21 plans in the large group market ranged from 85 percent to 117.6 percent.
- Four specialized plans are subject to the MLR requirement. One specialized plan, OptumHealth Behavioral Solutions of California (OptumHealth), reported a MLR of 29.7 percent and did not meet the MLR requirement of 85 percent for the 7,189 direct contracted lives. OptumHealth has an additional 1.5 million enrollees, where they act as subcontractors to full-service health plans to provide behavioral health services. OptumHealth is not subject to the MLR requirement for the subcontracted lives. OptumHealth has been paying rebates since 2014 and their number of direct contracted lives has decreased.

Ms. Dutt noted in 2011 there were 7 specialized plans subject to the MLR reporting requirement. Of these, four plans continue to report, but have seen a decline in total direct enrollment. Two plans have changed their business models to act as subcontractors to full-service plans and one plan has gone out of business.

The rebates paid by health plans have fluctuated over the years. Health plans set their rates based on historical claims cost and utilization data with the goal of meeting the MLR requirement. The DMHC rate review team also looks at rate filings from plans to see whether plans are projected to meet the MLR requirement. However, medical expenses are driven by how much enrollees utilize health care services, which may vary from year to year. As such, some plans go over the minimum MLR requirement and some plans do not meet the MLR requirement and must issue rebates.

Discussion

Mr. Grgurina asked for clarification about how the MLR is calculated. Ms. Dutt responded the MLR is a three-year accumulation of premium revenues, not an average.

8) Financial Summary of Medi-Cal Managed Care Health Plans

Ms. Dutt provided an update on the Financial Summary of Medi-Cal Managed Care Plans for the quarter ending June 30, 2018. The report highlights enrollment and financial information for Local Initiatives (LIs), County Organized Health Systems (COHS), and Non-Governmental Medi-Cal Plans (NGMs) with greater than 50 percent Medi-Cal lives.

Local Initiative Health Plans:

- The nine LIs serve over 5 million Medi-Cal beneficiaries in 13 counties.
- From April 2018 to June 2018, LIs reported total net income of $30 million.
- The tangible net equity (TNE) to required TNE ranged from 448 percent to 789 percent, indicating profitability for LIs has declined over the last few quarters.

- San Francisco Health Plan (SFHP) reported TNE greater than 1,000 percent for all quarters in 2017. However, the plan's TNE has declined to 777 percent as a result of net losses in 2018.

County Organized Health Systems:

- The five COHS that report information to the Department serve approximately 2 million Medi-Cal beneficiaries.
- From April 2018 to June 2018, COHS reported total net losses of $60 million.
- The TNE to required TNE ranged from 818 percent to 1,204 percent.
- Partnership HealthPlan reported net losses for five consecutive quarters and Central California Alliance for Health reported net losses for three consecutive quarters. Both plans attribute their losses to rate cuts for the MCE lives.

Non-Governmental Medi-Cal Plans:

- The seven NGM plans serve 3.3 million Medi-Cal beneficiaries in 31 counties. As of December 2017, there were two new NGM plans, Aetna Better Health of California and UnitedHealthcare Community Plan of California.
- From April 2018 to June 2018, NGM plans reported total net income of $65 million.
- The TNE to required TNE ranged from 207 percent to 4,795 percent.
- UnitedHealthcare Community Plan reported 4,795 percent TNE due to a cash infusion of $50 million from its parent company.
- Community Health Group reported a net loss of $95 million for the quarter, dropping the plan's TNE from 1,400 percent to 1,180 percent. According to the plan, this is a result of the plan paying back DHCS for not meeting the MLR requirement of 85 percent.

In conclusion, Ms. Dutt said Medi-Cal Managed Care plans continue to meet the minimum TNE requirement. Enrollment increased significantly from 2014 to 2016, but slowed in 2017 and 2018. Overall, premiums and expenses have stabilized compared to the significant growth from 2014 to 2016. Net income has significantly decreased and a few plans have reported net losses in recent quarters, resulting in decreases in TNE. There are also a few plans projecting net losses for the 2018-19 fiscal year, which would further decrease their TNE.

Discussion

Mr. Grgurina stated SFHP's policy is to limit their reserves to two times capitation premiums. When the plan goes above this limit, those dollars go back into the provider community to improve Healthcare Effectiveness Data and Information Set (HEDIS) scores, to improve access to its members, and to improve services from its hospitals. This is referred to as a strategic use of reserves. When SFHP does this, it pushes the plan into a loss position. SFHP's percentage of TNE has gone down over the last few

quarters because those dollars are being spent to improve services to the community. SFHP is choosing to do this because they are comfortable with their reserve.

Dr. deGhetaldi asked if these are typically one-time investments and not an ongoing rate increase. Mr. Grgurina confirmed they are one-time investments and are not rate increases. The concern is if you make a rate increase, then the plan has to lower it later on.

Mr. Grgurina commented that his plan is seeing membership in Medi-Cal going down because the economy is improving and minimum wage is going up. At some point this is going to come to an end when there is a tougher economy. When this happens, the plan's board will probably no longer have the ability to pass the strategic use of reserves. The Finance Committee and Governing Board of his plan have spent extensive time discussing how the plan can improve services to the city in a way that is financially responsible.

Dr. deGhetaldi expressed concerns about Alameda Alliance for Health, which experienced troubles a few years back. He questioned whether part of its improvement was due to better reimbursement under the Medi-Cal coverage expansion and not a true structural improvement in performance. Ms. Rouillard said she shared this concern and has met with the leadership of the plan. She also noted that, like a lots of plans, there are quarters where there are losses and quarters where they are more profitable. A lot of this has to do with how and when DHCS pays their rates. Ms. Rouillard stated she's not concerned right now, but the Department will be watching the plan.

Ms. Dutt noted the Department attends the board meetings for the governmental plans and hears about what's going on in the community with their provider contracts and financial concerns regarding their budgets.

Ms. Yao noted the COHS net loss of $60 million is concerning, but the TNE level is still very healthy. She assumes most plans had strategies similar to SFHP to invest in the community.

Mr. Figueroa noted that for LIs, the TNE tended to be mostly between 400 and 600 percent, but the COHS had significantly higher TNE. The TNE of NGM plans seemed to be all over the map, as well. He wasn't sure if this had to do with the way they were governed or the tendencies of the Board. He commented that the variation between the different types of plans was interesting.

Mr. Grgurina said these organizations serve different populations. The COHS have the long-term care and dual-eligible population, while the two-plan models do not have those populations unless they're in the Coordinated Care Initiative. When a plan has those two populations, the risk is different and there are tremendous dollars flowing to the plan. If SFHP were to add the dual-eligible and long-term care populations, revenues would more than double instantly.

Dr. Rideout asked Ms. Rouillard if TNE can ever be too high. Ms. Rouillard stated this is something the Department has looked at before, but the Department doesn't have a specific limit for TNE. Ms. Dutt noted the Department looks at other financial metrics in addition to TNE, like how much cash a plan has on hand and what their asset composition looks like.

Dr. deGhetaldi commented in 2014 younger, healthier people went into Medi-Cal and the risk profile went down. The opposite is happening now since those people are leaving Medi-Cal and there has been an increase in emergency department visits and overall utilization. As a result, the risk profile is worsening. He said if this continues, the Board should be mindful of the demographic shift that's occurring, which could hurt the plans.

Dr. Rideout asked about how to interpret TNE for different types of plans. For example, given the information Mr. Grgurina shared about the populations served by COHS versus LIs, how would the Department interpret the TNE of a major COHS, like Partnership HealthPlan, coming down to levels that are more like those of LIs. Ms. Dutt stated when the Department sees a decline in a trend, even if the TNE is high, the Department gathers additional information from the plan. The Department looks at how rate decreases have impacted their TNE and if the plans are making community investments.

Dr. Rideout asked if the Department should be telling the Board about these types of things or if these were just interesting observations on a chart. Mr. Grgurina commented that the Department should ask the plans for additional information. He said that when his plan came up with their policy, they did empirical research to find out what should be the upper end of reserves. Other states hired actuaries and they reported there wasn't an upper end, but there was a range. SFHP is very capitated and its TNE is about $12 to $14 million. This equates to about a week's worth of expenses, so their reserves are much higher. Mr. Grgurina stated it really comes down to the boards of these plans and where they feel comfortable with their reserves. Second, it's a question of the plan's history. Some of the COHS almost closed a long time ago and many of them remember that experience and may be more comfortable with a higher reserve.

Additionally, Mr. Grgurina advised Dr. Rideout to interpret the data with caution. He noted that in the case of Alameda Alliance when the Department stepped in, TNE was below 100 percent and now it is several times that. Like all health plans, Alameda Alliance still needs to evaluate the reasons it is in a loss position. However, given where their TNE levels are right now, they have room to maneuver.

Ms. Yao stated her plan has seen an increase in Medi-Cal utilization because of the population risk deterioration, especially in the adult population. She stated her plan has come to the same hypothesis that healthy people went back to work. Her plan is also seeing an increase in maternity.

Mr. Grgurina said many of the Medi-Cal plans are seeing utilization increasing, particularly for the Medicaid expansion population. This is also the reason DHCS set

rates based on the plan's own experience. Part of the difficulty plans face, is that DHCS is looking at the actual experience, but it's going back almost two years. If a plan sees utilization go up, it's made up two years later.

Dr. deGhetaldi stated COHS are sole community providers, with higher risk, which is why their TNE has been higher. He agreed with Dr. Rideout that Partnership HealthPlan gave a great gift of covering the entire northern third of the state. However, the Board needs to make sure they remain stable because they are the sole community provider for several counties. Ms. Rouillard stated they are the sole providers for 16 counties. Mr. Grgurina noted Partnership HealthPlan has also been reinvesting in the community.

Mr. Figueroa asked Mr. Grgurina if the excess dollars SFHP is reinvesting in the community are captured in audited financials as costs for those years and then getting incorporated into ongoing rates. Mr. Grgurina stated the use of strategic reserves counted towards the medical loss ratio, but they typically do not build up the plan's rate in Medi-Cal. There is a specific part of the rate development template where DHCS asks what kind of special things a plan is doing and where those dollars are going. DHCS then decides if they're going to build it into the plan's rates or not. However, the plan must demonstrate the investments are ongoing and that there will be future savings.

Ms. Yao commented that she thought there was a rate-setting task force on this topic and one of the recommendations is about how to count this as part of the rate-setting process. Mr. Grgurina responded there is workgroup with DHCS and Mercer on shared savings. He explained that the central question is about how plans can do innovative things and share some of those savings with the State. Currently, if a plan realizes savings, the plan will only have them for a year or two.

9) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, provided an update on the financial solvency of RBOs for the quarter ending June 30, 2018:

- 188 RBOs are required to file financial information with the Department and all RBOs are required to file annual reports. To date, four RBOs submitted their annual reports for the fiscal years ending March 31, 2018 and April 30, 2018. The remaining RBOs will be filing their financial reports, which are due 150 days after their fiscal year ends.
- 136 RBOs filed quarterly financial survey reports and 52 RBOs filed compliance statements. Nine RBOs filed monthly financial survey reports as required by their corrective action plan (CAP).
- 173 of the reporting RBOs reported compliance with the solvency criteria including:
    - 37 RBOs were in the Superior category, of which 1 RBO was on a CAP.

  - 84 RBOs were in the Compliant category, of which 5 RBOs were on a CAP and 5 RBOs were on the monitor-closely list.
  - 52 RBOs filed compliance statements.
- 15 RBOs reported non-compliance.
- There were 21 RBOs on a CAP, which represents 11 percent of all RBOs. Of these, 11 of the CAPs continued from the previous quarter and the RBOs are meeting their approved projections. Two RBOs are not meeting their approved projections. There were 8 new corrective action plans as a result of the June 30, 2018 filings.
- Of the 21 CAPs, 14 have been approved, 5 are in progress, and 2 CAPs will be closed due to the enrollees being removed from the RBOs.
- There were 88 RBOs with Medi-Cal enrollment covering approximately 4.1 million enrollees.
  - The top 20 RBOs served approximately 3.1 million Medi-Cal lives. Of these, 16 have no financial concerns and 4 were on a CAP.
  - The remaining 68 RBOs served approximately 1 million Medi-Cal lives. Of these, 57 have no financial concerns, 9 were on a CAP, and 2 were on the monitor-closely list.

Ms. Yamanaka stated the Office of Financial Review has 24 audits planned for 2018, of which 6 have been completed, 12 are in progress and the remaining 6 have been scheduled.

Discussion

Dr. Rideout noted DaVita Medical Associates is on a corrective action plan. He asked if this information factors into merger decisions. Ms. Rouillard responded everything known about the plans is taken into consideration during the review of mergers. Dr. Rideout noted that capital could be a good thing to consider.

Ms. Rouillard noted there are 21 RBOs on corrective action plans. This is the most the Department has ever seen. This is very concerning given the events of the last year involving medical groups and reports of questionable activities.

Ms. Yao commented the number of noncompliant RBOs is concerning and asked if there are any trends. Ms. Yamanaka said there are a variety of reasons and there is not just one indicator.

Paul Durr asked if there was adequate staffing to review the CAPs and monitor the groups. He noted some of the RBOs have been on CAPs for a while. He expressed concern about the longevity of the RBOs and noted that something could happen quickly that disrupts care delivery for those members. Ms. Rouillard responded she

shared this concern and the Department is also looking to the plans to help identify groups they may have concerns about and for the Department to focus on.

Dr. Rideout added the plans are closely looking at this because they have concerns that if a RBO isn't viable, the plan will have to work out where to move those members.

Mr. Figueroa asked if Medi-Cal enrollment was just one of many different contributing factors or if there was a preponderance of RBOs with heavy Medi-Cal enrollment on CAPs. Ms. Yamanaka stated the majority of enrollment is not Medi-Cal. About half, or 13 of the 21 RBOs on CAP, have mostly Medi-Cal enrollment.

10) Health Plan Quarterly Update

Stephen Babich, Supervising Examiner, Office of Financial Review, presented the health plan quarterly update.

- There were 125 Knox-Keene licensed plans, including 78 full-service health plans and 47 specialized plans.
- Enrollment in full-service plans is 26.5 million lives, an increase of 1 percent from last year. This is an all-time high and is largely driven by commercial enrollment.
- Commercial enrollment increased nearly 2 percent in the last year. There were 10.73 million lives in HMOs, a 4 percent increase from a year ago. There were 2.73 million lives in PPOs, a decrease of 7 percent from a year ago.
- Medi-Cal enrollment decreased by 1.2 percent over the last year while Medicare enrollment increased over 6 percent, likely due to the aging Baby Boomer population becoming eligible for Medicare. Since 2015 to 2018, there has been a 15 percent increase in Medicare enrollment.
- There were 20 full-service plans with 620,000 lives on the closely-monitored list, compared to the 23 plans in the previous quarter. Of these, 12 were Medicare Advantage (MA) plans, 5 were commercial plans, and 3 were Medi-Cal Managed Care Plans. Most of the plans are in the MA market, which has a lot of new entities with inherent risk and typically low enrollment. In addition, there were three specialized plans with 200,000 lives on the closely-monitored list.
- There was one TNE deficient plan, which was a MA Plan with about 15,000 lives.
- There were 24 plans on CAPs, including 10 in progress, and 14 pending approval as of September 19, 2018. Most of these are as a result of claims reviews.

Mr. Babich stated there were 15 examinations in progress, and 32 planned for fiscal year 2018-19.

Discussion

Ms. Yao asked if the Department breaks down PPO enrollment by line of business. Ms. Dutt stated that the information is available on the Department's website.

Ms. Yao stated that she suspects the decrease in PPO membership was due to the individual line of business, which has been shrinking for Blue Shield. Mr. Babich stated that PPO individual enrollment is at 826,000 lives, which is down from 852,000 in the last quarter. For the quarter ending December 31, 2017, enrollment was slightly over one million, which equates to about 175,000 live lost over six months.

Mr. Grgurina requested that in future reports the PPO/Exclusive Provider Organizations (EPO) information to be broken out by market segment similar to HMO so the Board can see the individual trends. Mr. Babich said this could be done.

Dr. Rideout asked if this is all fully insured PPOs. Ms. Rouillard responded this was correct and enrollment reflects only the PPOs the DMHC regulates.

Dr. deGhetaldi stated that in the last meeting IHA's presentation demonstrated that MA provides higher quality as compared to fee-for-service. He asked if there were any specific characteristics of the struggling MA plans. Mr. Babich said he attributes most of this to small size. Many MA plans were first an RBO and are used to operating on a thin margin and are not used to keeping 1,000 percent of TNE around.

Dr. Rideout asked if the Board would be able to see issues with limited Knox-Keene licensees in the Department's reports. Mr. Babich said they should and that 6 of the 12 MA plans on the closely-monitored list are restricted licensees. Dr. Rideout asked if these plans could be highlighted in the future.

Mr. Grgurina noted that in previous years the number of examinations were around 46 to 48. However, in this current year the Department is projecting 60 examinations. He asked if there is a particular reason for this and if this was going to become the new norm. Mr. Babich responded there is some variability in the number of planned examinations and not every plan is on a three-year cycle. For example, vision plans, by statute, must have routine examinations every five years. There are also non-routine examinations that could come up suddenly and have to be addressed immediately. Ms. Dutt noted some examinations will start closer to the fiscal year end and will go into the following year, so they will be counted in the next fiscal year.

11) Public Comment on Matters not on the Agenda

Mr. Grgurina asked for public comment on items not on the agenda. There was no public comment.

12) Agenda Items for Future Meetings

Mr. Grgurina asked for agenda items for future meetings.

Ms. Yao asked if the consulting actuaries could do another presentation on the national trends in individual and small group rates.

Mr. Figueroa asked if there has ever been a presentation to the Board about the differences between CDI's risk-based capital and TNE. Ms. Rouillard responded there was a presentation to the Board on the topic about four or five years ago. She said former Board member, Ed Cymerys of Blue Shield, did a good job of describing it, but at the time the Board decided to stay with TNE. Mr. Figueroa clarified he was not suggesting the Board change anything, but depending on who is elected, they may want some sort of universality of financial metrics.

Mr. Conklin stated he was interested in follow-up conversations surrounding APG and Management Services Organizations (MSOs).

Dr. deGhetaldi stated that a few years ago the Board looked at the new Accountable Care Organizations (ACOs), Medicare ACOs, and Pioneer ACOs. There is a new ACO rule that is going to accelerate the movement over the next five years to higher levels of downside risk for organizations in a Medicare ACO. He expressed concern about the rule and suggested the Board revisit whether they need to supervise Medicare ACOs.

13) Closing Remarks/Next Steps

The meeting was adjourned at 12:16 p.m.