STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

DEPARTMENT OF MANAGED HEALTH CARE

980 9th STREET

ROOM OF EXCELLENCE, 5th FLOOR

SACRAMENTO, CALIFORNIA

WEDNESDAY, AUGUST 16, 2023

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Jeff Rideout, MD, Chair

Abbi Coursolle

Paul Durr

Mark Kogan, MD (via teleconference)

Jarrod McNaughton

David Seidenwurm, MD

Mary Watanabe

Amy Yao

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Sarah Ream, General Counsel (via teleconference)

Shaini Rodrigo, Staff Services Analyst

Dan Southard, Chief Deputy Director

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

Elizabeth Landsberg, Director
Department of Health Care Access and information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

William "Bill" Barcellona
America's Physician Groups

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PROCEEDINGS

10:00 a.m.

CHAIR RIDEOUT: I would like to welcome everybody to today's Financial Solvency Standards Board meeting. I am going to cover a few housekeeping items and then I will do an official welcome, especially to our new members of the committee. These are a little bit long and we go through them but it is important that everybody knows.

The meeting is being conducted in a hybrid format with the opportunity for public participation in person or virtually through video conference or teleconference.

The women's and men's restrooms are located outside the conference room.

Please remember to silence your cell phones if you haven't done so already.

For our board members here in person, please do not join the Zoom meeting with your computer audio. I think we have all tested that a little bit. To ensure that you are heard online, and in the room, please use the microphone in front of you, this one, and push the button on your microphone to turn it on and off. The green light will indicate that it is on, the red light will indicate that it is off; and please remember to turn off your microphone when you have finished. Please speak directly into the microphone and move it closer to you if necessary to ensure everyone can hear you.

Questions and comments will be taken after each agenda item, first from the Board Members and then from the public. For those who wish to make a comment, please remember to state your name and the organization you are

representing. If any Board Member has a question, please use the Raise Hand feature or probably just raise your hand. All questions and comments from Board Members will be taken in the order in which the raised hands appear.

Public comment will be taken from individuals attending in person first. For those making public comment at the podium here in front of the room, please be sure to leave your business card or write down your name and title and leave it on the podium so that our transcriber can accurately capture your information. Those making public comments virtually, please use the Raise Hand feature.

For those joining online or via telephone, please note the following: Members of the public attending online, as a reminder you can join the Zoom meeting on your phone should you experience a connection issue. For the attendees on the phone, if you want to ask a question or make a comment, please dial *9 and state your name and the organization you are representing for the record. For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or leave a comment. To raise your hand, click on the icon labeled Participants on the bottom of your screen, then click on the button Raise Hand. Once you have asked your question and provided a comment, please click Lower Hand.

As a reminder, this committee is subject to the Bagley-Keene Open Meeting Act. The Bagley-Keene Act requires the Board meetings to be open to the public. As such, it is important that Board Members refrain from emailing, texting or otherwise communicating with each other off the record during the Board meetings because such communications would not be open to the public and would violate the Act. We also ask that you not use the Zoom Chat feature

as these comments or questions may not be viewable by the public.

Likewise, the Bagley-Keene Act prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if a majority of the Board Members emailed, texted, or spoke with each other outside of a public meeting about matters within the Board's purview. Such communications would be impermissible, even if done asynchronously. For example, member one emails member two, who emails member three. Accordingly, we ask that all members refrain from emailing or communicating with each other about Board matters outside the confines of a public meeting. So deep breath, that's all your housekeeping.

I would like to welcome you to this quarter's meeting. I think it is the first meeting we have been together in person since maybe last May so we will excuse any social faux pas that we might make. I think we all wore pants, which is good, and shoes, that's good.

I am Jeff Rideout, I am the new Chair for this committee, and I would like to first of all welcome two new Board Members. Jarrod McNaughton, to my right, is the CEO of the Inland Empire Health Plan; and Dr. David Seidenwurm is with Sutter Health, to my left. I would like to ask both of them to say maybe a couple of words about their background and then we will introduce the other Board Members.

MEMBER MCNAUGHTON: Thank you so much. It is a pleasure to be with you folks. Just looking forward to learning; and to learning more about the organization and the Board. Just very appreciative of the incredible relationship that we have with DMHC and the team here. For our organization, we are in the Inland Empire, which is San Bernardino and Riverside counties.

We serve about 1.7 million members there, so about one out of every three residents is a member of IHP. Prior to this role I was a hospital CEO, so I was on the provider side back at an academic medical center called Kettering back East. So, it is a pleasure to be with you folks today. Thank you for having me.

CHAIR RIDEOUT: Thanks, Jarrod. David?

MEMBER SEIDENWURM: Hi, I'm David Seidenwurm. Nice to meet everybody. I am a neuroradiologist with Sutter Medical Group and I am the CMO for our Sutter Physicians Alliance Medical Network, and I am the Quality and Safety Medical Director for Sutter Medical Foundation. I have been active in government affairs mostly through NQF processes and I have enjoyed participating in the diagnostic excellence program with the Gordon and Betty Moore Foundation. Happy to be here and happy to provide the voice of our constituents as well as the voice of independent clinicians, which I was for many years until we merged with Sutter.

CHAIR RIDEOUT: Next, if we could have Board Members introduce themselves. Abbi, start with you.

MEMBER COURSOLLE: Hi, I am Abbi Coursolle, she/her. I am an attorney with the National Health Law Program, we do health consumer advocacy, we are also part of the Health Consumer Alliance. Glad to be here.

MEMBER DURR: Paul Durr Sharp Community Medical Group, CEO. Thank you.

MEMBER WATANABE: Hi, good morning, Mary Watanabe, Director of the Department of Managed Health Care.

MEMBER YAO: Hi, this is Amy Yao, I am the Chief Actuary from Blue Shield of California.

CHAIR RIDEOUT: And I think we have one Board Member, Dr. Kogan, on virtually. Mark if you want to introduce yourself.

MEMBER KOGAN: Yes, thank you. Hi. I am Mark Kogan, I am a gastroenterologist in San Pablo, California. Apologize for not being there in person, but I am recovering from my first episode of COVID.

CHAIR RIDEOUT: Just one, that's pretty good.

MEMBER KOGAN: I thought I was immune, but I guess I wasn't.

CHAIR RIDEOUT: All right. And Mary is going to introduce the DMHC staff present here.

MEMBER WATANABE: Yes, just quickly, you will hear from most of these folks in just a minute. Dan Southard is our Chief Deputy Director. We have Pritika Dutt, our Deputy Director for the Office of Financial Review. Let me get this right here. Michelle Yamanaka is a Supervising Examiner in our Office of Financial Review. Sarah Ream is also joining virtually, she is our Chief Counsel. Jordan Stout, who most of you know, is helping with all of the logistics for this meeting and is a Manager in our Office of Financial Review. And Shaini Rodrigo is an Analyst in our Director's Office that is also providing administrative support. So I think that is everybody for the DMHC today.

CHAIR RIDEOUT: Great. I think we can move on to the second agenda item, this is the transcript of the previous meeting. Were there any corrections from committee members?

Hearing none, I will take a motion to approve.

MEMBER DURR: I'll motion to approve.

MEMBER YAO: Second.

CHAIR RIDEOUT: Any objections? Mark, on the phone, Mark

Kogan, you're okay?

MEMBER KOGAN: No objections, I approve.

CHAIR RIDEOUT: Okay, I think we will consider those approved.

And now we move on to the Director's Report. Mary.

MEMBER WATANABE: All right, good morning. I am going to try to navigate reading from my screen, I have a backup copy of my notes. I am still getting used to these in-person meetings and how to navigate so bear with me. I do want to start just by welcoming Jarrod and Dr. Seidenwurm, we are really excited to have you. We have had a lot of changes with our Board this year but we are really happy to have some some new input. I had a chance to meet with both of them in advance of the meeting and warned them to ask lots of questions if you don't understand things. I will just reiterate our ongoing commitment to making these really good meetings and providing information that is understandable, so always welcome to new ideas to update our reports and appreciate my team that is always very responsive to that.

So just a couple of quick updates on things that have been keeping the Department busy for the last couple of months. You should have probably received our Annual Report which we released at the end of June. I think the one statistic that I am probably the most proud of but also wears heavily on me is we now have about 30 million consumers in the health plans we regulate, that's three-quarters of the state. That is a significant amount of growth just in the nearly three years since I became the Director. We were somewhere hovering around 25 million for quite some time so that is a big responsibility. We have 143 health plans that we regulate and have licensed now at the Department. Not surprising, as we have talked about a lot in these meetings, most of that growth

is attributed to Medi-Cal so we have seen a lot of growth on the government side.

We also have had a lot of growth in the Department in our number of staff. It is a good thing we are teleworking because I don't know where we would put all of these people. And Dan is going to talk a little bit more about the growth in our department budget and our staff in just a minute.

Our Annual Report and an infographic is posted on our website so if you want to check that out. It is, I think, still linked under What's New, but you can also find it in our Report section.

I talked, I think at our last meeting, or maybe at the beginning of the year, how we have convened a Transgender, Gender Diverse and Intersex Working Group. The purpose of the working group is to make recommendations on a quality standard for patient experience to measure cultural competency related to the TGI community, and to recommend a trans-inclusive training curriculum that will be used by health plan staff that interact with consumers. This was a requirement of SB 923 that was delegated to the Department from our California Health and Human Services Agency. The working group has been very busy, they have met monthly five times so far this year. We will continue to meet throughout 2023 and into the first quarter of 2024.

In addition, the working group will be holding listening sessions, they are required to hold four across the state, so we are finalizing our logistics to hold listening sessions starting towards the end of September into October. The purpose is really to hear from our transgender community about their experience with the health care system. I will say that so far what we have heard is not good. It is some of the kind of worst patient experience stories I have heard so I will just note we have a lot of work to do in this space. But looking forward to

hearing from consumers and the recommendations from the working group on how we do a better job serving this community, but also around training and quality measurement.

Moving on to individual rates. So it is that time of year again, Covered California has made their announcement about preliminary health plan premium rates for 2024 citing an average statewide rate change of 9.6%, which is I think bigger than we have had for quite some time. Covered California in their press announcement cited some of the reasons for the increase were due to health care utilization following the pandemic, increases in pharmacy costs, inflationary pressures in the health care industry such as rising cost of care, labor shortages, and salary and wage increases.

Due to the structure of the Affordable Care Act subsidies and enhanced financial help the good news is most enrollees will not see any changes in what they pay for coverage in 2024. Costs obviously will vary based on the individual and family circumstances and income. But again, most families are receiving subsidies so there will not be a significant increase for them so that's really good news.

Covered California is also working to implement the new state enhanced cost sharing program that was part of the budget. This will strengthen the silver cost sharing or CSR plans, increasing the Silver 73 plans to the approximate of gold level coverage. The Silver 87 will be approximate platinum level of coverage, and Silver 94 plans already exceed the platinum level of coverage. Deductibles will also be eliminated in all three Silver CSR plans. So this will remove some of the financial burdens for folks enrolled in Covered California. Covered California estimates over 650,000 enrollees will be eligible

for these cost sharing reduction benefits so good news there.

The DMHC actuaries are currently reviewing 2024 individual rate filings. The proposed average rate increase for the 13 health plans in the individual market ranges from a decrease of .9% to 15%, with a weighted average rate increase of 10.4%. So we have got one more plan that we review as well as off-exchange so a little bit higher than Covered California.

Twelve plans offer products on-exchange. One plan, again, offers a product off-exchange. Exciting news, there is a new plan entering the individual market, Inland Empire Health Plan, participating in Covered California. I know this has been a long-hoped for entrance for IHP, so Jarrod, great work to you and your team. Excited to have you joining the individual market.

And then I think we talked about this previously, but Oscar Health Plan is exiting the individual market in 2024.

We have posted the 2024 individual rate filings on our website for public comment. We will wrap up our review, I believe Pritika, is it the end of September?

MS. DUTT: (Nodded).

MEMBER WATANABE: Okay. And then we will finalize those rates and we will have a full presentation on individual rates at the next Board meeting. Don't miss that meeting, there's a lot of exciting updates in November.

I would like to just take a minute to acknowledge our actuaries and our consultants that do the rate review. This is a very, very busy time of year, lots of long hours they are putting in. I think particularly given the rate increases we are seeing I really appreciate their thoughtful review and scrutiny of the rates.

I will just tell you, we have our two first requests to review large

group rate methodologies as well. I think AB 731 passed in around 2019 where plans file their rate methodology and contract holders can request a review. So we also are reviewing those along with the individual and small group rate filings. So busy times so thank you to our actuaries for the work they are doing.

My final update is on risk adjustment transfers. We will have a full presentation on this at the November meeting, but the information is out so I just wanted to give you a little bit of a preview. Just a reminder, the risk adjustment transfer program is intended to transfer funds from health plans or insurers with low actual actuarial risk to those with high risk. Risk Adjustment transfers represented an average of 10% of premium nationally in 2022. And for benefit year 2022, 1.32 billion was transferred between the California health plans and our insurers. Twelve health plans had to pay into the risk adjustment pool with Kaiser paying the most, I think it was 750 million. And then similar to previous years, the PPO plans ended up on the receiving end. And again, we will have more detail about all of this at the next meeting.

I think that is it for me. Pritika, did I miss anything?

MS. DUTT: (Shook head).

MEMBER WATANABE: Yes, so more information to come, yes. I think MLR we are doing today, but we will do more on rates and risk adjustment transfer at the next meeting. So with that, I am happy to take questions from the Board and then of the public.

CHAIR RIDEOUT: We will start with Board Members in the room. Any questions?

MEMBER DURR: I have a question, Mary. With regards to the rate reviews, how much do you wind up making any change or what is the impact

of the rate reviews when your team does that?

MEMBER WATANABE: Yes, and I can let Pritika add here. I think we have saved consumers, there is a ticker on our website. I want to say it is about 296 million overall in our rate reviews. You know, obviously when we find things that we think need to be adjusted there is a back and forth with the plans. If they make an adjustment to their rates, that's how we come up with that number. We can find rates to be unreasonable or unjustified. We have done that very rarely. And there is a notification process that has to happen if we do that. So historically, we have been very successful in negotiating with the plans to reduce their rates if we find something we think is unreasonable. Pritika, anything you want to add on the rate review?

MS. DUTT: We get a lot of data from the plans to support and justify their rate changes. So anytime, when we get the first initial package that starts it and our team goes back, asks for more detailed information. And probably Amy can attest to that, too. So we ask a lot of detailed questions. The rates are publicly available. The information that we get, we post them on our website, so the transparency helps there too. So in the beginning of our process when we started rate review we were getting a lot of changes in rates, like when we were getting plans to reduce rates. Now it is more like self-corrected. I think just the transparency has kept each plan like more competitive. They look at each other's rates and try to make sure that they provide a good, detailed explanation when they change rates.

CHAIR RIDEOUT: Jarrod.

MEMBER MCNAUGHTON: I am just curious. On the risk adjustment transfer, does that include the county-wide averaging that takes place

with DHCS? Do we report that to you folks for that or no?

MEMBER WATANABE: Commercial.

MS. DUTT: The risk adjustments that we present is just for the commercial market.

CHAIR RIDEOUT: Abbi.

MEMBER COURSOLLE: Mary, I was just wondering, and feel free to say it is too early. But if you can say anything more about the two large group plans that are going through the rate review process now.

MEMBER WATANABE: I am going to defer to Pritika. Is it too early to say anything about that?

MS. DUTT: Our process is still going on. Do you have any specific questions at this point?

MEMBER COURSOLLE: No, I was just wondering, you know. Well, maybe you can say a little bit more about the petition process and what that looks like to get the plans to your review.

MS. DUTT: Sure. A large group contract holder, when they receive their renewal notices, they have 60 days to file a request with the Department for their particular rate review. And they have to meet certain criteria. So they have to have more than 2,000 enrollees in that plan. And then also, if they did not get any claim information, if they had requested the plans to provide, they would qualify for that process. So the two we have, we can provide more information at the next meeting, because we should be wrapped up with those reviews. So in addition to the individual rates, we can provide a overview of that process.

MEMBER WATANABE: Abbi, maybe I will just add, I think it has

been pretty well documented in the media that we are seeing some significant increases this year. I don't think we have seen quite the high increases in the past couple of years, with COVID there has just been a lot of uncertainty, sSo we haven't had any requests yet. It is actually a little, we are kind of excited to test the process, even though it is a lot of work and it is new work. But I think we may see more of these requests coming from large group employers as they understand that this is an option, particularly given the significant increases and the pressures of labor costs and other inflationary factors.

CHAIR RIDEOUT: David, you had a question?

MEMBER SEIDENWURM: You mentioned some of the Covered California Silver plans with benefits structures similar to the Platinum plans and so forth. Can you explain the significance of that?

MEMBER WATANABE: Yes, and I will do my best; others can jump in if I if I get this wrong. But essentially there is additional money in the state budget to help to kind of offset some of the costs of cost sharing and premiums. And so basically, for the cost of a Silver plan you will be getting the benefits as if you were in a Gold or a Platinum plan, so you are getting better coverage, lower deductibles, cost sharing assistance. I think I am getting this right, someone jump in, if I am not. But I think that is really going to help to offset some of the out-of-pocket costs for consumers while giving them a richer benefit package. And so it is kind of a combination of the state subsidies with the federal subsidies.

MEMBER SEIDENWURM: And is that means is tested or generalized? Is that means tested or generally available?

MEMBER WATANABE: I have no idea. We could try to find out. I

will say I think we are going to try to have Covered California come back, if not in November, the first part of the year. And I know this is something that they are still working on the implementation as they head into their open enrollment, but we can certainly have them answer some more detailed questions about that. Yes, good questions.

CHAIR RIDEOUT: Mark, do you have a question virtually?

MEMBER KOGAN: I did, but I think it would be better answered in like three months at our next meeting when we have more information.

CHAIR RIDEOUT: Any other questions from Board Members?

Okay, I will turn it over for public questions for, first, folks in the room, and I see Bill coming up. Again, please identify yourself and your organization.

MEMBER WATANABE: Make sure the microphone is green.

MR. BARCELLONA: Good morning, Bill Barcellona, America's Physician Groups, APG. Nice to see everybody here and welcome to the new members. A few questions.

Mary, do you have an ETA on the benchmarking for the health equity and quality standards? Did I miss that? Have you selected?

MEMBER WATANABE: No, no. I don't have a big update on that but I will share. We have been having some conversations with the health plans in particular and the purchasers over the summer really to, I would say, for us to have a better understanding of the nuances of the benchmark and different approaches to that. We have started to have some additional meetings with other stakeholders on some options for that. I am still hoping to have a decision by the end of this summer. I know when we pick seasons that gives us a little bit

of wiggle room, so by next month. I will just say we are having some conversations about whether it makes sense to reconvene the committee and have a public forum to discuss the benchmarks. So more to come on that. But I think we have made some good progress on options and we are getting smarter. So more to come on that.

MR. BARCELLONA: Okay. Second area involves the collection of data by the Department around rate review. I have monitored these rate filings for some years and I find them useful to determine the different categories of provider rate trends. I think there's four or five provider rate trends in the filings. It is spread out over capitated providers, fee-for-service providers, facilities-based, that sort of thing. It would be really useful in the OHCA process if the Department would publish some type of summary information gathered from all of the premium charging plans that it regulates; so that we could have some public information that was actionable around provider rate trends, provider cost trends. Does that make sense to you?

MEMBER WATANABE: I think it does. I think, Pritika, you tell me. I think if you have thoughts about what else we can include. You have seen our typical presentations, what we will do next month. If there is something else specific to provider trends, happy to work with you on kind of what that would look like.

MR. BARCELLONA: I'll follow up with an email.

MEMBER WATANABE: Sure.

MR. BARCELLONA: On the categories out of the filings to show you. But I think that would be very, very helpful.

And then another point with regards to the Department's collection

of information. I know you have collected information on MSOs for some time. That is becoming more and more important based on what we are seeing in the draft OHCA regulations, for example. We probably should think about ways to pull more information out of DMHC filings around the MSO market to help inform the OHCA staff of where that market, how that market performs and the differentiation within the market between what I will call the independent MSOs versus the captive MSOs that are captive to single RBO organizations.

Okay, that's it. Thanks very much.

MEMBER WATANABE: Thanks, Bill. It's good to see you in person.

I will just note we have OHCA and HCAI staff attending today. We have been working very, very closely with them trying to share information and be as helpful as we can. So just know there is some good dialogue and communication happening there.

CHAIR RIDEOUT: Other questions or comments from the public in the room?

Hearing none, we will move to public comments from the phone. Do we have any?

MR. STOUT: None at this time.

CHAIR RIDEOUT: No public comments or questions on the phone. All right. I think that concludes our Director's remarks.

Next up we have an HCAI update and I think we have Vishaal Pegany here to do that and get us started. Vishaal, thank you for joining us today.

MR. PEGANY: Good morning. Today I will be providing some

updates on OHCA implementation. Before I launch into that, I want to share some facts about health care spending in California. Next slide.

I had spoken to this group before last year about OHCA implementation and we have some more substantive updates for you all today. So just before I launch into that I want to just remind everyone of HCAI's new mission statement, really incorporating affordability into its focus with the addition of the Office of Health Care Affordability.

The next slide also shows kind of our program areas. You know, historically, HCAI has been the hospital building department, focused on standards and seismic safety; and then also managing several data assets and workforce programs. And then affordability is the new pillar added to HCAI's program areas. Next slide.

I will be giving some some specific updates then also kind of giving some refreshers on some of our key provisions. Next slide.

You have all seen kind of similar charts like this about per capita spending in California. It reached about 10,300 in 2020, which was about a 4.8% average annual growth rate from 1991. The key goal of OHCA will be to slow this rate of growth while maintaining or improving the quality and equity of care. Next slide.

We have organized OHCA's activities in terms of what the statute requires, into these three components. One is to slow spending growth. Two, is to promote high value system performance. And lastly, assessing market consolidation. Next slide.

In terms of slowing health care spending growth, this activity involves OHCA collecting, analyzing and reporting data on total health care

expenditures.

The Office will develop a spending target methodology and proposed targets for spending growth. Initially there will be a statewide spending target for calendar year 2025. And then eventually the Office will set sector-specific targets, which are essentially more granular than the statewide target and could focus on certain regions or types of entities.

And then lastly, we will have a progressive enforcement approach, beginning with technical assistance, public testimony, and then escalating to performance improvement plans and financial penalties. Next slide.

So, I will leave this mostly here as a leave-behind because I will be delving into a more comprehensive update on the system performance activities. But the key one that I won't be covering today is the last pillar there about workforce stability. We do have several provisions related to monitoring the stability of the health care workforce. And then the next slide, please.

Similarly, for market consolidation I will be providing a more thorough update, but these are essentially kind of the key activities we have for assessing market consolidation. Next slide.

Moving on to our Health Care Affordability Board and Advisory Committee.

The next slide right here shows the key distinctions between our Board and our Advisory Committee. The Board is a decision-making board that sets the spending targets and approves key benchmarks such as alternative payment model or APM adoption. We also have an Advisory Committee that was convened recently by the Board. It also provides input and recommendations on several areas listed on the right. Next slide.

In terms of meeting cadence, the Board meets about every month and then the meetings are listed for the remainder of the year. The Advisory Committee meets quarterly and we will be meeting with them again in September and November. Both of these meetings are subject to the Bagley-Keene Open Meeting Act. Next slide.

So these are our Board Members, appointed by the legislature and administration, and some of our ex officio appointees.

And then the next slide also shows our Advisory Committee members. So, they are pretty, you know, spanning the various sectors of the health care system, payers, medical groups, consumer advocates, organized labor. So, we are excited to have that body convened. Next slide.

I will be updating you all on our cost and market impact review program. We have had several significant updates and have appreciated DMHC's partnership on providing technical assistance on this area.

This is just kind of a recap of the legislative findings that the statute had related to market consolidation in terms of escalating health care costs driven by by prices, higher prices, and underlying market conditions, particularly where there is a lack of competition due to consolidation.

Then consolidation can occur through mergers and acquisitions or affiliations involving a variety of entities, health plans, hospitals, physician organizations, PBMs or pharmacy benefit managers, and other health care entities.

And then as you all may know, it could be horizontal, vertical and across industry, et cetera. Next slide.

This is our, you know, our responsibility for reviewing and

evaluating consolidation, market power and other market failures involving the types of entities listed there. The overall intent is to increase transparency on transactions that may impact competition or affordability for consumers and purchasers. Next slide.

Just wanted to kind of recap in terms of what our CMIR program will do.

There is going to be a requirement for health care entities to provide notice to OHCA for any mergers, acquisitions, or affiliations depending on thresholds that are to be set in regulation. We just had our regulations workshop yesterday for the cost and market impact review, which those regulations have been out since July 31st and there's a public comment period concluding on August 31st. Those are proposed regs and they have the thresholds that will be required for filing.

Once OHCA determines that the notice is complete there will be a 60 day period, and we may not take the full 60 days. This is to assess whether the transaction rises to the level of a more comprehensive review, which is referred to as a Cost and Market Impact Review. If OHCA determines a transaction may negatively impact market consolidation -- market competition, excuse me, costs, access, quality and equity, we have those factors identified in our proposed regulations, we can conduct a Cost and Market Impact Review. And this effectively evaluates whether the transaction is in the public interest.

OHCA will put out a preliminary report of its findings, we will have a public comment period and then issue a final report. I do want to note we can't block the transaction, but we will increase transparency about its effects, you know, both positive and potentially harmful effects. We will work with other

regulators to address market consolidation, such as the attorney general's office; or if it involves a health care service plan, DMHC. Next slide, please.

So this is just a reminder, I am sure many of you already are tracking this. There's different entities within state government that track mergers and acquisitions, with CDI and DMHC when it involves health care service plans or insurers respectively, and the AG's office for nonprofit facilities. And they have other bodies of laws for other types of entities as well. Next slide.

These are the gaps that we are currently seeing in California's market oversight. They involve, you know, for-profit hospital facilities, physician organizations, and other types of entities such as private equity or MSOs or management services organizations. Then moving on to the next slide.

This is our timeline. As I mentioned, the workshop happened yesterday and then we will be reviewing comments received and then submit a package for consideration by OAL in October. The goal is to have the regulations in place before January so that we can begin receiving our first set of notices. Next slide.

And then I will turn it over to our Director Elizabeth Landsberg to cover the next portion.

CHAIR RIDEOUT: Welcome, Elizabeth.

MS. LANDSBERG: Thanks very much, Jeff. Thank you. Good morning, everyone. Elizabeth Landsberg with the Department of Health Care Access and Information. Sorry to be late. Appreciate Vishaal being here and so we are both happy to engage with you and answer questions. You have heard about the Board, you have heard about the Advisory Committee, and we will tell you a little bit about what we have been up to in terms of actually capturing total

health care expenditures, one of our new acronyms for today.

One of the three, those three interlocking goals that Vishaal showed you was around slowing spending growth, so we will move on to the next slide to show you some of the fundamentals.

One of the key tools and goals of the new Office of Health Care Affordability is transparency and data. So we will have new data, aggregate health care spending data, total health care expenditures. And this is a construct used in other states, of course, we are making it specific to California. But you can see here the elements included in total health care expenditures.

So first is all the fee-for-service or claims payments that are made. Also, of course, very important in California with our high level of capitation, to get non-claims-based payments, and we will talk a little bit about some examples there. And our all-payers claims database, and OHCA will together be working on those categories of non-claims-based payments. Very important to us that we are capturing consumer costs, so we will be getting all cost-sharing paid by members including deductibles, copays, and coinsurances. And so together those three main elements constitute total medical expenditures. You know, what are the providers and hospitals and clinics paying?

In addition, we will be capturing admin costs and profits from the health plans and insurers and together that makes up the total health care expenditures. So this is aggregate data that we will be getting from health plans and health plan insurers. We have a note at the bottom that will also be capturing pharmacy rebates as an important component of total health care expenditures. Next slide, please.

So again, the claims-based payments, it is important for us to try to

understand the different categories so again, we have been learning from other states. This is our recommended approach in terms of reporting on categories of claims-based categories. The different hospital claims, different categories of professional services, long-term care, retail pharmacy. We will only be collecting dental data insofar as it is provided by a health plan that also includes dental services. Okay, next slide.

And again, as I noted, it is important for us to capture the non-claims categories, so these give some examples: capitation, global budgets, supplemental payments in the Medi-Cal program. But we will be doing some deeper dives to really develop our methodology for the non-claims payments. I should note, we have a technical workgroup with some of the payers, so we are already talking to them about these pieces, how to categorize and make sure that the data collection works. Okay, next slide.

We did want to specify for you, and Vishaal may have covered this back in the fall, but which categories are subject to these new spending targets and this is all laid out in the statute. Health plans and other payers are covered.

The last box on the right, Fully Integrated Delivery Systems or SIDS -- FIDS, definitely not SIDS. FIDS is defined in the statute in such a way that we believe it only captures Kaiser Foundation Health Plan and Permanente Medical Group. So all the health plans and payers. And in the providers there are seven different categories of provider groups that are also subject to the spending targets, including physician organizations. We did have some discussion about what size of physician organization, so it is 25 or more or high cost outliers. Certainly health facilities and hospitals. This is more complicated to figure out the spending growth target measurement for the provider group, so

again, we are working through with both our technical work group on the payer side, and we will start conversations with folks on the physician organization and health system side. Okay.

When we do our baseline report and moving forward, these are the different categories or levels of spending that we will be reporting on. We will be reporting total health care expenditure at the state level. We think is very important to be measuring over time what's the health care spending in California at an aggregate level.

On a market level we will have a breakdown of Medi-Cal, Medicare and Commercial.

And then we will be tracking total health care expenditure at the payer level. So each individual health plan, whether it is a Medi-Cal plan, a Medicare Advantage plan or a Commercial plan. And again, those larger provider entities are subject to the spending growth targets and we are, again, working out the methodology as to how to track that, and that will be significantly more complicated.

Vishaal may have talked about this in the beginning. California has had the benefit of learning from other states were somewhat unique in our enforcement approach, our enforcement authority that is included in the statute. But we do want to be clear that the first time there would be enforcement is in 2028. The 2025 spending growth target is a baseline target. The first enforceable target is for the 2026 measurement year. We will be collecting the 2026 data on total health care expenditures and total medical expenditures in 2027 and taking all of that data in and analyzing it. The first time we would potentially have any kind of penalties would be 2028 but even that's unlikely.

You can see that box up in the upper right-hand corner, the progressive enforcement approach with four different steps, starting with technical assistance. We would want to very much sit down and work through the data with the entity, see if we got it wrong, see if there was something unusual that happened with the entity that year. Did they invest in a new data system? Was there something new like SOVALDI that happened or like a pandemic that happened?

We do have the authority to bring groups in for public testimony.

If after those two steps we find that there is a problem with meeting the spending growth target we can negotiate, work with them on a performance improvement plan.

And if that is not met, only then would we reach the financial penalty phase. Okay.

So again, the total health care expenditure data that OHCA is going to be capturing is aggregate data. W will then have California's all-payer claims database called the Healthcare Payments Data Program to do deeper dives and really look at claims. Once we identify a cost driver we can use the HPD to better understand. Mary thought it would be helpful for me to just give a very high level overview of the HPD today. And then if you are interested, as I hope you are, we can certainly have our our HPD folks come back and show off. I hope in the meantime that you will play around on the tool, it is pretty exciting.

So moving on again, HPD is California's all-payer claims database. We are collecting medical claims and encounter data, pharmacy claims, and then member eligibility and provider information. So a researcher will have the ability to, you know, take individual members and look at their claims, so we do have

files on individual members and on providers.

Our data sources are, again, from the commercial health plans. For Medi-Cal we are getting all of the Medi-Cal data, both fee-for-service and managed care data from the Department of Health Care Services, and we have had a really great partnership with them. They have been in partnership with us at the table as has Covered California. Of course, IHA has been a wonderful partner in giving us technical assistance, given their wonderful expertise. And then the Medicare fee-for-service data we are getting from CMS, sometimes a little slower than some of the other data. You will see we are still, for example, waiting for the last year of Medicare data.

The HPD uses the NAHDO Common Data Layout. So NAHDO is the National Association of Health Data Organizations. As we speak, our HPD team is actually in Boston for a conference there. So there is a wonderful collaborative of states that have stood up all-payer claims databases. We are on the board, we have advocating of late to include SOGI data in the in the Common Data Layout, sexual orientation, gender identity. But California has adopted the all-payer claims database common data layout, or CDL. Okay, so moving along.

The HPD statute that was adopted. We have been working on this project for five-plus years. The state of California has, of course, been talking about it for more than a decade. I am sure I have sat in rooms with Mary and Abbi and others at CHCF-sponsored forums about all-payer claims databases. So it has been a long time in the making. The statute required HCAI to be substantially, have the project substantially complete by July 1st of 2023, this year. That seemed a long time ago, back when it was a long time ago. The week of June 27th we released our first HPD snapshot to great fanfare among

data geeks, let us unite. So, we are really excited about it.

This just gives you a snapshot of the Snapshot. We literally have billions of claims data. This shows you that we have 2018, 2019, 2020 and 2021 data for, again, Medi-Cal, Commercial, and Medicare lives. So please do go to the Snapshot. We include a link there, hopefully you got this electronically, it should be pretty easy to find from our website. So, there's information, you know, the individuals by payer type, but then you can search. You can very easily pull up like the 25 most common procedures or pharmaceutical products or claims and you can sort it just by Medicare, just by Medi-Cal or just by Commercial. Again, this is just to whet your appetite. We can have someone come who knows the tool much better than I. Next slide.

Snapshot is out. Our next rollout will be in the next month or two, it will be HPD Measures, and our our data consultants tell us this is when it gets really exciting. This will have geographic breakdowns, it will have some demographic information, not as much as I would like, filters for up to 23 different measure categories. This will really allow us to access a lot more information. Next slide.

In terms of next steps, there is the data that's available. We are trying to publish as much as we can to make it available to folks. We have both an HPD Advisory Committee and a Data Release Committee. We are developing regulations, a draft of which has already been released on data release standards. We will have a application process for folks who want to get more granular data that is available publicly, and a Data Release Committee to review those requests. We expect to begin accepting requests for nonpublic HPD data after the first of the year in early, early 2024. We will have an enclave

where researchers and other data requesters can go in to access the data if their request is granted.

All right. With that, I am going to hand it back to Vishaal to talk about the performance work that we are doing.

MR. PEGANY: Thank you, Director. I will be giving an update on OHCA's health system performance activity. The purpose of these activities is to really implement the best ideas out there in terms of how do we reorient the health system towards greater value. We don't simply want a low-cost system, but we want a high-value system. If you could go to the next slide.

These are the focus areas we have in terms of being able to have. I will focus today on the first three, APM adoption, primary care and behavioral health spending, because we have some some statutory deadlines that happen sooner. We are still actively working on quality and equity measurement and workforce stability, it is just those are on parallel tracks.

Across these five areas there's various work being done on data definitions, measurement approaches and reporting.

For APM adoption, for example, the purpose would be to set a benchmark for APM adoption in terms of what share of total health care spending should be a value-based payment or alternative payment model payment.

And then for primary care and behavioral health, what share of health care spending should be allocated to primary care and behavioral health. For primary care in particular there has been a lot of work already being done by various groups EBGH, IHA, Covered California, so we have some lessons that we could leverage and have further traction in those areas. And behavioral health is going to be one that's going to take some time to really investigate

further. So if you could go to the next slide.

This is our timeline for the various work streams; I will focus on the three that I mentioned. We do have some deadlines in the statute and then we also have to seek board approval for these areas.

So just to highlight one set of activities: In spring 2024 we are going to need to define primary care definitions for those in terms of the types of providers, the settings in which they take place, et cetera. And then for APMs as well, there's frameworks out there such as the Health Care Payment and Learning Action Network framework, that no Milbank framework for non-claims-based payments. OHCA is going to catalogue all those. Once we define some common approaches towards measurement and reporting, then we are going to propose in summer of 2024, or no later than summer 2024, a potential benchmark value for primary care spending, and then also for an adoption goal for APMs as well. And then also for APM contracting standards. So this is essentially a set of best practices, model best practices for how payers and providers can engage in APMs, that will also need to be approved by the board by summer of 2024. And then, following board approval we would need to issue regulations for data collection. And then measure, collect and analyze and report on that data in our first annual report, which is due sometime in June 2027. So, for behavioral health the cadence is like an additional year out because that is a topic that needs further development. And then moving on to the next slide.

We are excited to have a work group, which is called the Investment and Payment Workgroup. They just had a meeting earlier this morning to provide stakeholder input on these three work streams. They will be having monthly meetings through the remainder of the year as well as into 2024.

The purpose is to get that stakeholder engagement so that OHCA can develop its recommendations for the benchmarks that will need to be approved by the board. And then you will see here on the blue box the diverse set of stakeholders we have engaged. Next slide.

This is just kind of a set of resources in case you are curious about our public meetings and then also we have the landing page with various resources that stay engaged with OHCA.

I think that wraps up our slides. We are happy to defer to the Chair for any follow-up questions.

CHAIR RIDEOUT: Thank you, Vishaal, and thank you, Director Landsburg.

Committee Members in the room, questions for HCAI and OHCA?

MEMBER YAO: Thanks, guys, for this. This is a lot and this is the first time seeing this so I am trying to absorb what this is. I always come back to the three circles that are your goals. For example, the Slow Spending Growth. And when I look at your timeline, setting up the target is all the way to 2028, it is still five years away. Do you have more specific goals during the five years? Let's say today's trend is 4.8. Are you going to try to bend the trend, measure your success by decreasing the trend by a half point? I see lots of activity goals, but I don't know what are the outcome goals.

MR. PEGANY: Yes, I could clarify that. The proposed target is going to be announced next spring, so by February of 2024 we are going to announce that target for calendar year 2025. The target is going to be sooner than you think. I think what you were getting at was the enforcement. That is going to be more in the future because of just simply due to the data lag in terms

of having a calendar year's data, close out and then receiving it and then analyzing it. But the target itself is going to be proposed in the spring and the board has to adopt it by June.

MEMBER YAO: So you have a target. So what happens if we cannot meet the target? If there is not enforcement, right?

MR. PEGANY: The first year is not enforceable for 2025. It is essentially kind of a first year, you know, performance measurement only, but the second year will be enforceable.

MS. LANDSBERG: We hope folks will take it seriously. So we do have this, you know. The target for measurement year 2025, as Vishaal said, will be set by the board this spring. We hope folks will take it seriously. And then 2026, that is an enforceable target. What we have heard from other states is it does start to come into the contracting conversation between health plans and health systems. That, you know, you can't go above this. You know, do we wish that the legislation had passed when the governor originally proposed it four years ago, five years ago, yes. But we are trying to work out the impacts because we know consumers are really struggling now.

CHAIR RIDEOUT: Jarrod.

MEMBER MCNAUGHTON: Thank you so much for coming today. Elizabeth, I know you shared with us at the Local Health Plans of California a few months ago and really appreciate that.

Just a couple of questions for you, two questions. First, do you see this as kind of going down the path of like the Maryland Total Cost of Care Model? Is that kind of where we are headed with the state? And secondly, for our organization, out of our 1.7 million members, about 700,000 of them are seen

by solo or small group practices. So, It is one thing to have the data, but for a physician practice, as an example, when you are out in the field, to understand the why. What are the pressures that the physicians are seeing in their offices with staffing, lease rates, equipment supplies; and how do you take in the why, not just the data?

MR. PEGANY: Yes, the Maryland model initially started as an all-payer rate setting model and they have moved to a total cost of care approach. But the state spending target programs are different in terms of types of entities involved, its plans, payers, providers, and employee-integrated delivery system. So it is not just hospitals but it is plans and medical groups as well. But it is similar in terms of tracking growth in spending so there are some similarities there.

MS. LANDSBERG: How important is the mic? Should I be talking into it?

THE REPORTER: Yes, please.

MS. LANDSBERG: Okay. feel free to boss me around, I take instruction well, usually. (Laughter.)

So, in terms of, you know, the reality on the ground for individual providers, I actually was at a CMA presentation, a CMA conference a couple of weeks ago, talking to doctors and saying, we hope we are in partnership with you because we know you care if your patients can't get access to care so we think this is an important shared goal.

You know, we also have to track the reality of what happens. So, you know, Massachusetts has been doing this for more than a decade. Many states set multiyear goals. Well, those multiyear goals don't anticipate COVID,

they don't anticipate the inflation rate, so it has been interesting to learn from our sibling states how they responded to things like inflation. So we know inflation, workforce shortages, are having a significant impact on those practices. I was actually just on a call about the distressed hospital loan program because, you know, hospitals are having a hard time affording, you know, traveling nurses and inflationary pressures on medical supplies and DME and the like. So, I think we will set a goal, it is a serious goal, and and we need to respond to what's happening in the economy and what's happening in life.

MEMBER MCNAUGHTON: Just a follow up question.

CHAIR RIDEOUT: Of course.

MEMBER MCNAUGHTON: Just a follow up question, Elizabeth. Will that goal be statewide or regional based on the regional variations that we see?

MS. LANDSBERG: Great question.

MEMBER MCNAUGHTON: Just as an example, for us with anesthesiologists as just an example, when you are out to the west, west of us in LA County, about every 15 to 20 miles that you move in the cost is about 100,000 more.

MS. LANDSBERG: Wow.

MEMBER MCNAUGHTON: So just to get them out into those regions we just have to pay more. And so I am just curious, how does that work with the regional variation?

MS. LANDSBERG: Yes, it is a great question. The first couple of spending target years, growth target years, are statewide. So the 2025 baseline, ’26 and ‘27. Starting for measurement year 2028 the board can choose, has the

authority to choose to have sector targets. Sector is defined pretty broadly in the statute; it could be geographic region. We know those of us in Northern California pay a lot more for health care than those of you in Southern California. And then, obviously, there are more granular regional variances. The board could also choose, for example, to have a different target for part of the health care system, like hospitals, for example.

CHAIR RIDEOUT: Other questions from Board Members in the room? David and then Paul.

MEMBER SEIDENWURM: So two questions. One is, when you talk about enforceable goals, are they enforced in real time or retrospectively? Is that up to you guys or is that in the statute?

MS. LANDSBERG: It is retrospective, yes. So we won't even, so that was the one slide we were trying to show that, for example, the first enforceable year is 2026. So spending growth from shouldn't, you know, grow more in that year than the targeted amount. We won't even have the data on total health care expenditures until 2027, probably by the fall of 2027. We will need time to analyze that, so it is retrospective.

MEMBER SEIDENWURM: Okay. Just speaking as a clinician, it would be great if somehow that information were provided in real time so you could adjust. It is very hard to work in these programs where they pay you next year for what you did last year.

MS. LANDSBERG: Absolutely, yes. So just just to note, the timing is such that the target will be set by June of the preceding year. So, for the 2026 measurement year, for example, the target will be set no later than June of 2025.

MEMBER SEIDENWURM: That's helpful, thank you. And then my

second question is related to the overall topic of consolidation, which was one of the three circles. When you were talking about looking at all the different parts of the market and all the different components of the market and geographical regions and whatnot, are you going to be using the same sort of HHI or some other metrics, same standard for each of the types of organizations, each of the geographies, or is that something that is going to be more ad hoc?

MR. PEGANY: Our proposed regulations propose a dollar threshold for whether you have to notice. So that's just for the notice. In terms of, for example, one of the factors is if you are an entity that has 25 million in revenue or assets. But then in terms of the actual analysis of market, you know, the effect on competition, we could look at HHI. That is not going to be the sole factor because there are some limitations with that, especially. It works well for horizontal integration but not not so much for vertical. And then we will look at other factors such as impacts to access and quality and equity as well.

MEMBER SEIDENWURM: So pretty flexible?

MR. PEGANY: Yes.

CHAIR RIDEOUT: Paul, you had a question?

MEMBER DURR: Yes. Thank you, guys, for being here. It is always so enlightening to learn more about the work that you are doing and the amazing opportunity that we have, but it is certainly a lot to take in.

My question was kind of going where Jarrod was going, which is about the payers to the individual physicians. Because I represent IPAs as well, an IPA physician group, that some of those physicians take Medi-Cal and some don’t. So when I think about the payer mix and the impact that has for different organizations that you are measuring from health cost. So some medical groups

don't take Medi-Cal, some do. And so are there cost differences in that regard that need to be factored in? Because I think of the patient, the equities you mentioned, you just referred to that, Elizabeth. I think the the equity of the patient population, the health equities of those patients that they are serving that makes it more challenging for them. So it is more costly to care for them in some way because of noncompliance with patients, versus if you just had a straight commercial, or an MA population. I know that's getting more into the weeds, but it speaks to the complexity of measuring one organization against another and expecting the same outcome with regards to that.

MR. PEGANY: Yes. I would clarify we are measuring spending growth for health care entities. They are being measured, assessed on their performance against themselves. We are not comparing Medical Group A and B in terms of a percentage growth rate. We are going to look at dollar amounts and we'd want to do that risk adjustment to account for the different populations. But it is essentially we are looking at year over year growth. We could definitely have some other state approaches and other models to look to, to be able to account for that.

MEMBER DURR: Just one comment. I think the year over year growth does make sense, but I think what you see is some of the older physicians who got into the practice of medicine because they believe in the heart of caring for the community, and recruiting new physicians to take their spot, becomes more competitive when you are competing against organizations that don't take Medi-Cal. And so for Jarrod’s point is that, you know, for me to recruit a primary care physician, I am going up against Kaiser and what other organizations that don't see Medi-Cal have. And trying to recruit those primary

cares, so my cost is going to go up more, maybe at a higher rate, in order to recruit those physicians in, which ultimately gets to the overall cost of care. So it is something to consider. I know, we are not going to solve it here but just considerations for that.

And the other thing it makes me think about is all of the other changes in health care that are happening with regards to other mandates from the state, which are great things. We were just talking earlier about the the new initiative that you are working on with regards to LBGT or that type of community, and how they are not getting the care that they deserve and need. And yet, if we do more for that, that's going to increase cost over and above what our trend rate is currently there. So just more factors to consider.

MS. LANDSBERG: Yes, no, I think that's all very helpful and when we were working on the legislation we heard from, you know, children's hospitals that said, you know. From a variety of different groups that say, we are taking care of sicker populations, or our costs are more expensive. We hope that, like Vishaal said, measuring your own patient population and your own spending over time will work. But if it doesn't, we -- so we have had conversations about what level of risk adjustment, if any, to apply. At this point we are leaning towards just doing age and sex and not doing other risk adjustment, partly out of concerns with the Medicare methodology and what's happened with kind of the raise to up-code, honestly. But we are certainly, again, open to having conversations with individual entities about what changed for them year over year and some of the things that you are talking about as mandates change, for example.

CHAIR RIDEOUT: Abbi.

MEMBER COURSOLLE: Well, thank you also from me for the

presentation, it is really great to hear about all the wonderful work you are doing.

I have two kind of technical questions about some of the components that go into the total health care expenditures. So first, on the Medi-Cal side I'm wondering, you mentioned, you are getting both fee-for-service and managed care data. I am wondering if that also includes carved out benefits like specialty mental health, dental? Okay, I see.

MS. LANDSBERG: Yes, it does, it does. When we were working on the legislation we got technical assistance. We had the hospital's weighing in on sort of some of that language and we did work closely with DHCS on hopefully getting the language right. The intent is to include all the carved-out benefits, supplemental payments with Medi-Cal, that we would, you know, likely get that from, directly from DHCS.

MEMBER COURSOLLE: Thank you. My second question is just sort of across the board, whether the expenditure data you collect will account for non-covered benefits at all. So, you know, benefits that people are paying for completely out of pocket. And especially, you know, you mentioned new mandates coming into effect. As new mandates come into effect and people now have coverage for benefits that previously they were paying for out-of-pocket, how you will take that into account?

MS. LANDSBERG: It is a great question, Abbi, and at this point, no, we won't cover non-covered benefits. And it is an important flag and if folks have different ideas of approaches, we'd love to hear from you. So the board has spent a fair amount of time talking about this. We all know there are people, you know, paying out of pocket for behavioral health care services. It has come up around dental, it has come up around long-term care services, it has come up

for -- sometimes we all know that consumers just get frustrated with their plans and pay for things out of pocket. Because we are getting the aggregate data from the health plans for both their costs and for consumer cost-sharing, we don't know a data source where we could get what folks are paying out of pocket. So if anyone here has an idea, you know, I think we are open. I don't know if we, we haven't really uncovered a data source, though, right, for that, Vishaal?

MR. PEGANY: No. There is survey data but not a comprehensive data source.

MS. LANDSBERG: You guys need a taller podium for Vishaal. (Laughter). You're heard just fine if I hold it up. Any other questions for us?

CHAIR RIDEOUT: Let's see. Mark, do you have a question, virtually? No. Okay. Other questions from the Board?

MEMBER YAO: I like numbers so I have a question. When you mentioned you guys picked the area of market consolidation as one area to go very deep, you mentioned because based on your study, it really has contributed to the high cost health care trend. Could you elaborate a little bit, because that's really not on our radar. You know, we do trend to all the time. So how much it has contributed to the health care trend? Because we see more concern about specialty pharmacy, for example.

MS. LANDSBERG: How much does consolidation contribute to --

MEMBER YAO: Yes, to the higher.

MR. PEGANY: We have shared with our board some of the findings in terms of independent physician practices, the shared grow declining, even just within the last couple, several years. This is more of a nationwide trend. And those being, those independent physician practices being acquired

by health systems or private equity, and that leading to higher prices and then that leading to higher intensity services being performed. And then for hospitals as well, you know, within market transactions, you know, hospital to hospital, or health system to hospital, those leading to higher prices as well. And some kind of mixed results on quality associated with those transactions.

MS. LANDSBERG: And I will just add, it is not an either-or. We know that specialty pharmacy is a huge cost driver. So I think the focus on market consolidation analysis shouldn't lead you to think we don't think there are other issues. Again, all three are very important. We think market consolidation, I mean, the stat that always sticks with me is when two hospitals, when there's a consolidation of hospitals, costs go up by 20 to 44% and quality stays the same or goes down. So we know consolidation is a significant driver, and we very much need to uncover what other significant cost drivers there are.

CHAIR RIDEOUT: Okay, I will move to questions from the public in the room.

MR. BARCELLONA: Bill Barcellona, APG. Thanks so much for the presentation. There is some overlap between the role of the DMHC in its monitoring of financial solvency and the role of OHCA and HCAI in containing costs. Particularly around the primary care market in California and across the nation right now we are seeing private equity, private equity's interest in primary care drying up rapidly across the country. I don't know if all of you are aware, here in California, Babylon, which is a British company, recently declared bankruptcy. Their first creditors' report will be published next week on the 24th of August. They have 100 million in assets and 500 million-plus in liabilities. And they were -- they had acquired two groups here in California and tried to make a

go in the Medicare, Commercial and Medicaid markets and it didn't appear to work out and they are leaving the US market.

There are three ways to finance or capitalize provider organizations and what we have seen historically, the good old fashioned way, the way the California delegated model started back in the ‘80s and ‘90s, was the use of capitation to retain earnings and reinvest in the infrastructure by the physicians who were the principles in those organizations. After the Affordable Care Act, the need for capitalization increased so dramatically that a lot of those organizations were not able to maintain financial sustainability and they had to look outside of themselves for additional capital. And then we saw the mergers with hospital systems across the state and there was rapid consolidation there, but that appears to have cooled off as well over the past few years.

And then more recently, we have seen the interest by private equity, in particular in acquiring small specialty practices and rolling them up, and then also in building primary care networks.

It is going to be interesting to see how OHCA approaches the standards around workforce stability and primary care investment as the capital funding market changes, to sustain physician organizations across this state and other states as well. We need to pay special attention, obviously, to sustaining primary care practices in the state. But the question remains, where is that money going to come from? I am not advocating for private equity, I am not defending private equity, but it just seems that our our interest in the private equity market here in California may be, well, maybe that ship has already sailed. That's really all I have to say about that. We need to figure out another way to sustain it.

The other thing, this nexus between the role of the FSSB and the Department here with OHCA and HCAI. When we look at quality outcomes and increasing equity and quality in the delivery of health care in the state, one of the things that we never really focus on when we look at networks is the stability of the providers within those networks. I am not talking about like the economic stability of primary care practices. I am talking about the turnover of providers within the networks themselves. You know, there are certain delivery models in this state, delivery system models, that have turnover rates of 20 to 40% annually. It is really hard for any type of organization, not just in health care but any type of organization in the economy, to maintain a high quality of services when you have tremendous turnover rates among your employees and your service-bearing providers. We don't grade. You know, here at the FSSB we don't grade the organizations that are monitored on the stability of their networks. And I think that's something that we should look at over the long term, because -- and it kind of goes to some of Paul's observations and Jarrod's earlier around the cost of maintaining the stability in those networks. Because if they are putting out a higher quality and they are maintaining access because they have stable providers in the network, that should be something that is credited to them.

CHAIR RIDEOUT: Thank you, Bill.

Are there other questions from the public in the room?

Are there any questions from the public online?

Okay, I think that will conclude this section. Thank you again, Director, and thank you, Vishaal.

We will move to the next item. Dan.

MR. SOUTHARD: All right, thank you. As noted earlier, my name

is Dan Southard, I am the DMHC's Chief Deputy Director. Today I am going to provide you with a brief overview of the DMHC's fiscal year '23-24 spending and position authority and then give a quick overview of our recently approved budget change proposals or BCPs. Next slide, please.

As you will see in the first bullet point there, the previous fiscal year, fiscal year 2022-23, the Department's spending authority was a little over $125 million and we had position authority for 605.5 positions.

That has grown by $36 million for a 29% increase in our spending authority for fiscal year '23-24, which is now at $161 million, and our position authority increased by 102 positions to 707.5. Next slide, please.

This slide shows a slow and steady growth up until '22-23 in the Department spending authority and position authority. We had a significant increase since fiscal year '22-23 where we have increased our spending authority by $58 million and our position authority by 191.5 positions. Next slide, please.

There were seven bills that were signed last fall that resulted in the DMHC requesting resources through budget change proposals. Four of these budget change proposals resulted in just a few positions each. However, the Suicide and Crisis Lifeline or AB 988 BCP resulted in the DMHC receiving an additional, excuse me, 7.5 positions. We received 9 positions to implement SB 923 for gender-affirming care. And the largest BCP this year was to implement SB 858, which was an increase in our civil penalties, and that resulted in the DMHC receiving 40.5 additional positions, with most of those being in the Office of Enforcement. Next slide, please.

The DMHC also had three workload BCPs approved this year for

Office of Legal Services, Office of Financial Review and our Office of Technology and Innovation.

THE Office of Legal Services BCP requested additional funding to address Department of Justice legal fees. The DMHC has been a party to a number of recent lawsuits where the Department of Justice has assisted the DMHC in defending these lawsuits. This BCP provided the DMHC the appropriate funding to reimburse the Department of Justice for their services.

More applicable to this board meeting is the Office of Financial Review workload BCP which resulted in 14.5 new positions for the Office of Financial Review. These positions were used to increase the frequency of financial examinations of health plans and risk bearing organizations. Historically, Michelle or Pritika if she is still available can correct me if I am wrong, but I believe our health plan financial examinations were on a five-year basis; and that will now move to three years with these additional positions. And the financial examinations of the risk bearing organizations, which was done once every eight years, will move to once every five years with this BCP approval.

And the final workload BCP was for the Office of Technology and Innovation which resulted in five new positions and funding to enhance our network security systems. I am sure you are all aware of some recent breaches of health care entities and so this is very important work for us at the DMHC. Next slide, please.

The DMHC also had three Spring Finance Letter BCPs. The first was a request for eight additional positions in our Office of Plan Monitoring to continue our behavioral health investigation work. In the 2020-2021 budget year

we received funding and two positions to initiate this behavioral health investigation work. We quickly realized that we underestimated that work and so this BCP was to right-size our positions to continue that work.

The second Spring Finance Letter BCP was accompanying trailer bill language that we drafted which would require health plans to utilize DMHC-developed enrollee facing standardized templates, which will include EOCs as Summary of Benefits. Our Office of Plan Licensing, in conjunction with our Office of Legal Services will be working to standardize these templates over the next few years. Once completed, this will benefit enrollees when they change health plans or coverage types as the documents provided to enrollees will be consistent from plan to plan.

And our last Spring Finance Letter was for position authority for the OFR and OTI workloads BCPs I described earlier. When we first presented these workload BCPs, the Department of Finance was concerned about our vacancy rate. Since we jumped about 100 positions last fiscal year, it took us some time to fill those positions and so our vacancy rate in the fall of last year was around 22%. And so the Department of Finance gave us this spending authority in the governor's January budget, but didn't give us the position authority. They wanted to see us bring down our vacancy rate. Which we worked across all of our programs very hard throughout the fall and early spring, got that down below 10%, and then the Department of Finance allowed us to move forward with the position authority with a Spring Finance Letter BCP.

And that concludes by presentation, next slide. More than happy to answer any questions.

CHAIR RIDEOUT: Thank you, Dan.

Questions from committee members? Jarrod.

MEMBER MCNAUGHTON: Dan, I'm sorry, I don't know what BCP is.

MR. SOUTHARD: I'm sorry, budget change proposal.

MEMBER MCNAUGHTON: Okay.

MR. SOUTHARD: Or BCP.

MEMBER MCNAUGHTON: Thank you. I'm sorry, I'm just --

MR. SOUTHARD: It's an acronym.

MEMBER MCNAUGHTON: That's good to know. I am just curious, given the presentation we just heard about cost control for all of the providers, physicians, health plans or whatnot, we get excited every year when we get a 3 to 4% increase from DHCS for rates, knowing that the FTE count, for us, has substantially increased as well because of all of the things that are in the new contract coming, all of that kind of stuff. How does that work on the regulator side within the state budget piece of that cost control as well? How does that, how does that work? I am just curious.

MEMBER WATANABE: Maybe let me make sure I understand. As we add positions we get funding to support those positions as well, so that's part of the budget change proposals. Basically, our budget asked to say, as part of new legislation or increase in our workload we need more people to do the work, and so we put together a budget change proposal to say, here's the additional work we are going to do, we need eight new people, or however many, and this is the funding, so it gets added to our budget. But then we develop our budget for the department and that's what informs our assessments, so your assessments go up as we grow. We are funded through assessments on the

health plans, we don't have any general fund. It is all part of the puzzle, really, because as our assessments go up that also adds to your cost. Does that answer your question in a roundabout way?

MEMBER MCNAUGHTON: That's what I was getting at.

MEMBER WATANABE: Yes.

MEMBER MCNAUGHTON: Is just to make sure that with the presentation we just heard about the cost controls that are trying to happen within the state, that as we add to the totality of the health care system, on the regulator side, on the provider side, all of that, it would just be interesting to see what does that look like in the future. And I don't have a clue what it will look like but it will just be fascinating to watch that, because I think all of us will be in the same canoe together trying to figure out how to slow down that growth spending, whether it is with an assessment fee, whether it is with a licensing fee, whatever it might be. And we are starting to see some of our providers, in fact I just had a provider reach out to me this week, around even making decisions on not having certain third party deemed agencies provide their oversight for site audits and whatnot and doing a direct delegation oversight with us because they want to save dollars. And so all of those different components will be fascinating to see over time how that plays into what we just heard from the HCAI folks.

MEMBER WATANABE: I think as Paul mentioned too, there's been a lot of new mandates, new requirements. And so all of those new requirements, those are new requirements on the health plans, new requirements for us to oversee the plans to make sure they are doing that correctly. So I think, you know, we have seen a lot of just growth in the health care system and that's feeding into our growth as well. I will say, I think just as a

result of of our vacancies and some of the cost savings we had a result of that, our assessments actually were flat when we normally would have seen probably a pretty significant increase. So again, I think it is something we are always very mindful and thoughtful about. But yes, a lot of our growth really has been related to new legislation and new requirements.

MEMBER MCNAUGHTON: I was just going to say huge kudos for the below 10% vacancy. If you have secrets on how you're doing that we would love to learn because that's pretty, that's great.

MEMBER WATANABE: I have to give credit to our administrative team. There are no bad ideas when it comes to hiring ideas. We have been doing virtual hiring events, getting really creative about leveraging social media. So again, I think we are all looking for creative ways, but it is a challenge. And I think, you know, we are competing with the private sector as well. We have got a lot of advantages to working for the state, but I think we are all experiencing that challenge.

CHAIR RIDEOUT: Other questions from committee members for Dan?

Questions from the public in the room?

Anyone online from the public have a question?

Okay, so I think we conclude that section.

We are moving on now to our regulations update with Sarah Ream and I think, Sarah, you're virtual; is that correct?

MS. REAM: I am, good morning. Nice to see everyone virtually. I wish I could be there for our inaugural in-person, but my luck ran out also with COVID and I got it for the first time ever, last week, so just recovering there.

Dodged a bullet for quite a while but I guess time to pay the piper.

I am going to be giving an update on regulations that we have either in formal rulemaking or far along in the process; and then I am also going to be giving you an update just on where we are with implementation of SB 510, which regards COVID-19 testing, vaccinations and therapeutics. Next slide, please.

So first I am going to be talking about regulations. The two regulations we actually have in formal rulemaking. A space makes all the difference here. It actually should say “In Formal Rulemaking” rather than we have “Informal” on this slide. So, we have two regulations that are in the process of becoming regulations. They are in that formal public notice, public comment period process before we can actually adopt the reg.

We have first the average contracted rate reg. This reg adds an adjustment for inflation to the amount that a plan has to pay a non-contracted provider who delivers covered services to an enrollee in a contracted facility. This is this AB 72. Non-emergency services that are provided by an out-of-network anesthesiologist, radiologist, whomever, to an enrollee who is in a contracted facility. We have had two comment periods for this regulation. We are going to be submitting the final reg package to the Office of Administrative Law in the next several weeks. I am happy to report this one is extremely close. The Office of Administrative Law then has about 30 days to review and hopefully approve that reg. So this one I feel like the finish line is definitely in sight on this regulation package.

The second regulation that we have in formal rulemaking is the mental health/substance use disorder coverage requirements under SB 855. SB

855 was enacted a couple of years ago in 2020. This reg, the most recent comment period closed on July 31st. We are reviewing all those comments. We think we are going to likely need a third comment period, we are going to be making a few tweaks to the language, so that comment period will start in a couple of weeks. Again, this is a big package. We have had a tremendous amount of public interest, stakeholder interest in this reg, so we are making sure we are being very thoughtful about the language of this reg and we want to make sure we get it right, so that's why we are going to be having a third comment period on this one. Hopefully that will be the last comment period, then we can finalize the regulation and move it over to Office of Administrative Law to get that done by the end of the year. Actually, it needs to be done earlier than the end of the year. I believe it needs to be finished by November, if I am remembering that correctly. Next slide, please.

And then we have regulations that are forthcoming and I have included here the reg packages that are furthest along in the process. We have a whole cache of regs we are working on. My team is, they are just very, very busy. So much going on here. But let me talk about these three topics, these are the ones that are furthest along.

First, we have fertility preservation, also called iatrogenic infertility. This regulation will implement SB 600 back from 2019. The bill will clarify that standard fertility preservation services -- the bill, excuse me, clarified, the bill did do this. Clarified that standard fertility preservation services are basic health care services that plans must cover. The regulation will specify and clarify how plans must cover those services, when they must cover those services, the extent to which they must cover those services. We have had probably almost

as much interest in this regulation as we did for the SB 855 reg so we have had some very robust stakeholder conversations as we were developing the reg. We are hoping to start the formal rulemaking on this one very, very soon, we are really almost ready to go with it, and so that you should be seeing that in the next month, month and a half. We plan to get that one going before the end of summer.

The next one we have far along is the general licensure regulation, we also call this the risk reg. The current version of this reg requires any entity that accepts any amount of global risk to either obtain a health plan license or an exemption from licensure. So we have had a phase-in period, I think I have talked about this before. We had a phase-in period for compliance with this regulation. The phase-in period was intended, we had intended to have it end, I want to say, back in 2019 or early 2020. COVID happened, the world got upended, so we have extended that phase-in until the time when we have actually promulgated an updated reg to make it clear as to when an entity needs an exemption versus a license. Just to make the whole universe a little clearer for everyone involved. So we are taking what we have learned and we are revising the types of risk and levels of risk that an entity will qualify an entity for exemption or licensure. We are still working through some of the details on this reg. I think the last time I spoke at FSSB I said we had a target for starting formal rulemaking this summer. However, now it looks like it is going to be more towards the fall because summer is quickly slipping away and here we are. I think it will be -- look for that one to come out this fall, is where I think that we will be ending up with that one.

Finally, a rate review. So large group rate review and individual

and small group rate reporting. These regs have also been, we have been working on these for quite a while. Larger group rate review, we shared a draft with stakeholders some time ago and got some good feedback so we are planning to start formal rulemaking on this one by the end of the year. Regarding the individual and small group great reporting, DMHC has a temporary waiver to issue guidance via APL versus guidance via a regulation and that temporary waiver goes through the end of this year, through the end of 2023. So based on that waiver, last year DMHC issued an All Plan Letter outlining information plans have to include in their annual aggregate rate filings for the small and individual markets. The waiver gives us time to tweak our guidance to make sure that we are getting meaningful, accurate data before we memorialize that guidance in a regulation so we are working on that now. And for this reg we plan to start formal rulemaking either towards the end of this year or early into the beginning of 2024. Next slide, please.

Turning now to SB 510 and coverage of COVID-19 services. As we have talked about before, plans must continue to cover these services with no UM, no cost-sharing, and enrollees can go in or out-of-network to access those services. The only change that is going to occur will happen in November of this year and in that case if an enrollee goes out-of-network they can be charged cost-sharing. That's the only change that we are going to be seeing with respect to coverage of these services. Other than that, if an enrollee goes to -- currently, if you go in or out-of-network an enrollee can get these services, no cost-sharing, like I said, no prior auth, nothing. Come November though, if an enrollee decides to go out-of-network, then they will be able to be charged cost-sharing. I don't know if all plans will charge cost-sharing what they may. I would reference you

to APL 23-017, that really breaks down exactly what the requirements are now and what they will be going forward. Next slide, please.

And then finally, with respect to SB 510. Wanted to give you an update on the status of the CAHP lawsuit that had challenged SB 510's requirements that health plans retain the risk for COVID 19 testing unless the plan had, and the provider had specifically negotiated and passed that risk on to the provider. The trial court denied CAHP's request, so essentially CAHP did not prevail at the trial court level. However, CAHP has appealed to the Court of Appeal. So the case is not, you know, it's not over until it's over, in this instance, so we are waiting to see what happens with that appeal before DMHC steps in and directs the plans to reimburse the providers. Our hope is that plans will be doing so on their own accord at this point. But what we are worried about is if DMHC comes in and says plans, you must reimburse the providers now, well then if the Court of Appeals says something different and rules in CAHP's favor then we are going to have to go back and CAHP plans could then maybe recoup that. It seems like it will take a complicated situation and make it simply that much more of a complicated mess. So for the time being we are just sitting status quo, waiting to see what the Court of Appeal does.

I believe that's my last slide. It is. I am happy to take questions or provide more information.

CHAIR RIDEOUT: Thank you, Sarah, especially under the circumstances. Any questions from committee members? Abbi.

MEMBER COURSOLLE: Thank you, Sarah and hope you are feeling okay. I just had a question about the SB 510 update you provided. I think I may have asked this before so forgive me if I am making you repeat yourself.

But given the change or the potential change for accessing COVID services out-of-network starting in November, will plans have any kind of noticing requirement to consumers? Will they be required to provide more information about which providers are considered in-network or out-of-network for those services? Because I don't think that's something consumers have been paying attention to up until now since there's no real differentiation from their point of view and so I am just worried that people could start facing significant billing with this change coming up.

MS. REAM: No, thank you for that question. That's an excellent question and a great point and something we are aware of. We are talking internally about how to -- how do we strike a balance between we don't want consumers to be overwhelmed with information. This stuff is already so convoluted and it is so -- I know, just as an aside, my mom also has COVID and my dad went -- she's fine, she is the healthiest person on the planet, honestly. My dad went to pick up some some tests for her and he was shocked and appalled that Medicare Advantage that testing, over-the-counter testing is no longer covered, he thought that was horrible. But it is just the landscape is so confusing. I think to a certain extent that we we want to make sure that whatever we require the plans to do it is very clear and concise and enrollees understand that, to your point, you may still go out-of-network, but you may be charged. So that's something we are still talking about internally and we will likely be looking to stakeholders for assistance in what to do there. Appreciate that.

CHAIR RIDEOUT: Other questions from committee members?

MEMBER KOGAN: Yes, I have a question.

CHAIR RIDEOUT: Mark Kogan, there you go.

MEMBER KOGAN: I have just a, it is more a comment than a question. I understand why the Department is saying what it is saying, but it is really disturbing and difficult when the health plans are refusing to pay for these services and it's the patients that are suffering because of this. It seems to me if they, if they have a order that's in place right now, even though they are re-appealing but I think that order is still in place, I don't understand why the health plans shouldn't be forced to pay. And they can always try to recoup the money in that direction as opposed to in the other direction. It is just, you know, the patients and the physicians and the pharmacies and everyone else that are getting caught in the middle here.

CHAIR RIDEOUT: Sarah, do you have a comment on that?

MS. REAM: Sorry. I definitely hear you on that one. That's something we can take back. I mean, we are actively discussing how to navigate this sort of temporary situation that we are all in while the appeal is pending. So, take that back.

MEMBER WATANABE: Yes, and maybe I will just jump in here. This is something Sarah and I have talked about almost from the beginning of the requirements on the plans to cover COVID testing and vaccines. I think that the challenge we have is if CAHP were to prevail, the recoupment process could potentially be even more disastrous. And so I think that's -- that's the things, you know. We weigh this and we are kind of leaning towards let's wait and see how this all plays out. But definitely understand the concerns and the disruption and challenges this has created.

CHAIR RIDEOUT: Okay, any other committee questions, committee member?

Okay, questions from the public in the room? One here.

MR. BARCELLONA: Hey, it's Bill Barcellona from APG. On SB 510, I understand the department's position and I appreciate everything the Department has done in this litigation. This has been a long haul for APG as well as a party to this litigation. I would ask the Department to strongly consider the application of interest for the unpaid amounts. We requested this in a letter to the Department several months ago. The health plans chose to appeal a very well-reasoned decision by the superior court so that's a risk they took. We don't expect the court of appeals to do anything different than the trial court did but, you know, I understand the department has to be cautious in that regard. But I do think that when and if this is resolved, finally, the Knox-Keene Act requires the payment of interest on these past due amounts, and that's very important for the financial solvency of these organizations that have borne the unilateral risk shifting by the health plans.

On the other topic of the general licensure regulation. Sarah, thanks for your report. Always looking forward to seeing that general licensure regulation reissued. I do want to ask one more time that when you do get ready, that you would circulate it in draft form before you start formal rulemaking so that the affected parties in California can at least review it and provide some further comment to the department. Thank you.

CHAIR RIDEOUT: Thanks, Bill.

Any other comments or questions in the room?

Do we have comments or questions from public on the phone?

Seeing none. All right, we will continue to move on. Pritika, you are up for the MLR discussion.

MS. DUTT: Thank you, Jeff. Good morning., I am Pritika Dutt, Deputy Director of the Office of Financial Review at the DMHC. I will provide you an overview of the 2022 Annual Federal Medical Loss Ratio, or MLR, Reports that was due from health plans on July 31, 2023. For details related to this presentation, we did include a handout. The report is called “Federal Medical Loss Ratio Summary for Reporting Year 2022.” That report includes on 2021 and 2022 MLR reports that we received from the various health plans.

Federal laws require health plans that sell health care products directly to enrollees and employer groups to spend a certain percentage of their premium dollars on health care expenditures or medical expenses. The Medical Loss Ratio requirement went into effect for reporting year 2011. Health plans in the individual and small group market are required to spend 80% of their premium revenue on medical expenses; and for plans in the large group market the requirement is 85%. So in the large group market, 85 cents of every dollar needs to be spent on the provision of health care services. If plans fail to meet this requirement, they have to pay a rebate to the enrollees or employer groups. For rebate purposes, MLR is based on a three-year average. For example, for reporting year 2022, the MLR and rebate calculation is based on the three-year average of a health plan’s premium and medical expenses that includes 2020 data, 2021 and 2022.

Page 2 of the report shows the MLR for the plans in the individual market so I will quickly summarize that here. As I mentioned earlier, the Federal MLR reporting requirement for the individual market is 80%. The MLR for the 12 plans in the individual market range from 84.2% to 101.3%. And no rebates were paid for the individual market.

For the 2021 Federal MLR reporting year we had the same 12 plans in the individual market and the MLR ranged from 81.7% to 99.9%. And again, no rebate was paid for reporting year 2021.

Page 3 of the handout shows the MLR for the health plans in the small group market. For the small group market, the MLR requirement is 80%. For the 14 plans in the small group market, MLR ranged from 78% to 99.2%. Two health plans, Anthem Blue Cross and United Healthcare Benefits Plan reported MLR below 80% and are required to pay rebates to the enrollees totaling $77.9 million. Anthem will have to pay rebates totaling $62.9 million and United Healthcare Benefits Plan we will have to pay $15 million. And I said, will have to pay, because those rebates are due on September 30 of this year.

For reporting year 2021, there were 13 plans in the small group market, and MLR ranged from 77.3% to 96.6%. Three plans, Anthem Blue Cross, Health Net and United Healthcare Benefits reported MLR below 80% in 2021 and they were required to pay rebates to enrollees totaling $98 million. Anthem paid rebates of $75.9 million, Health Net paid $11.7 million, and United Healthcare Benefits paid $10.4 million.

The table on the next page, or page 4, shows the MLR for full service plans in the large group market. We had 22 plans that offered products in the large group market; and all of them met the MLR requirement of 85%. The MLR in the large group market ranged from 87% to 113.3%. All plans met the MLR requirement, as I said, and no rebates were paid.

In 2021, the MLR in the large group market for full service plans ranged from 86.1% to 111.8%. And again, no rebate was paid. The plans with the higher rebates are those Medi-Cal plans that offer in-home support services

products to enrollees so they tend to have higher MLR.

Table 4 on page 5 of the handout shows the MLR for the four specialized health plans that are subject to federal MLR reporting requirements for their large group products. Three plans reported MLR below 85% and paid rebates totaling $2.3 million. Managed Health Network reported an MLR of 82% and paid $60,000. Optum Health Behavioral Solutions of California, or US Behavioral Health Plan, reported an MLR of 71.7% and paid rebates of $1.8 million. Optum Health Physical Health of California, or ACN Plan, reported an MLR of 69.6% and will pay rebates of $361,000.

For the 2021 Federal MLR reporting year we had the same four specialized plans that were subject to the reporting requirement and MLR there ranged from 70.4% to 90%. Two plans reported MLR below 85% in 2021 and paid rebates totaling $1.9 million. That was Optum Health Behavioral Solutions of California, they reported an MLR of 70.4% and paid rebates of $1.8 million; and Optum Health Physical Health of California reported an MLR of 81.1% and paid rebate of $101,000.

This chart here shows the total rebates paid since 2011. The health plans have to issue rebate checks by September 30, 2023 for reporting year 2022. Rebates may be issued in a number of ways. Enrollees could receive a check in the mail, a deposit into the account used to pay the premiums. For example, if they were paying from a credit card then they will get a payment there, or a direct reduction in future premium.

We just received the filings on July 31 so my team is still reviewing the information that we received. These are just preliminary information that we have received so there may be some changes. But like I said, if there's any

substantial changes we will report to the Board at the next meeting.

Any questions?

CHAIR RIDEOUT: Paul.

MEMBER DURR: Pritika, thank you, great summary, as always. My question is on the rebates. How sure are we that the rebates actually get there? I am thinking of unclaimed property, right? So you issue a refund but, you know what, no one claims it, it then comes to the state over time. But it just makes me think, does the consumer even know that they are due this refund and just if they actually get it? I don't know of any way you would have to prove that unless you audited them to see that they were, you know, the liability was coming off their books.

MS. DUTT: The health plans are required to pay the rebates by September 30 of each year. So, if they are unable to find an enrollee, let's say they drop off or their address changed, they have to go through the state escheat process. You know, they have to keep trying to find the enrollee. They have to make the best effort. And that's something that CMS tracks as well and we have had conversations with them before about that, like, you know, if a plan has unpaid liabilities on their books. They do track that. And then we do follow up with the plans whether they made the best effort to find these enrollees.

CHAIR RIDEOUT: Abbi.

MEMBER COURSOLLE: Thanks, Pritika. I am just wondering, especially looking at the specialized health plans, the large group market, and seeing the same two plans with not meeting the MLR targets two years in a row, and in fact, Optum Health Physical Health, their MLR going down even further from 2021 to 2022. Is this something that the Department tracks for potential

enforcement action or what does that look like when you have this problem repeating over multiple years?

MS. DUTT: So, if we were talking about full service plans I would have said we track that through our rate review process and then this is something that we would have asked questions around that. But for specialized plans, right now our teams are going to be doing a thorough review; because like I said, we just received the report two weeks ago. So we are doing a thorough review and we will be checking with the plans, what they are doing to correct that, get out of that rebate situation. The tricky part for specialized plans are the low premiums. Sometimes it gets hard for them to meet that because, again, I think this is something we run into with the dental plans where the premium is small, they still have those same admin costs. But we will be working with these plans to see what they are doing.

CHAIR RIDEOUT: Other questions from committee members?

Questions from the public in the room?

Questions or comments on the phone?

Seeing none, thank you Pritika, we will move on.

MS. YAMANAKA: Thank you, Jeff. Good morning. It's 11:59 so I beat the afternoon. (Laughter.) Michelle Yamanaka, Supervising Examiner in the Office of Financial Review. I am going to begin my presentation with a summary of the RBO reporting requirements for the new FSSB Members, and a refresher for the continuing members.

To be classified as an RBO there are four requirements that an entity needs to meet. The first is a structure requirement. The entity needs to be a professional medical corporation, a medical partnership, a medical foundation,

or any other lawfully organized group of physicians that arranges or provides for health care services. They contract with a health care service plan or arrange for health care services with health care service plan enrollees. They receive compensation for those services on a capitated or fixed periodic payment basis and they are responsible for the processing and payment of claims. When an entity meets these four requirements they are classified as an RBO, and they are required to meet the financial reporting and grading criteria requirements. For financial reporting, we have been receiving financial information since 2005.

In October of 2019, the regulations were revised to strengthen the financial solvency requirements and the Department's oversight of RBOs. RBOs are required to file quarterly and annual survey reports, which are financial statements. Quarterly reports are due 45 days after the RBOs' quarter-end, annual reports are due 150 days after the RBOs' fiscal year end. Annual reports are based on the RBOs' annual audited financial statements.

The grading criteria that RBOs are required to meet, there are five of them.

The first is the tangible net equity or TNE requirement. The minimum is the greater of 1% of annualized health care revenues or 4% of annualized health care expenses.

The second is the working capital requirement, which must be positive.

Third is cash-to-claims. The RBI needs to have sufficient cash and health plan capitation receivables that are collectible within 30 days to cover their total claims liability.

The fourth is the claims timeliness requirement, which is 95%.

And the fifth is an approvable IBNR, incurred but not reported, methodology.

If an RBO fails to meet one or more of the grading criteria, a corrective action plan or CAP is required. The CAP includes financial projections and assumptions to show how the RBO will attain and maintain compliance with the grading criteria. The CAP process is a collaborative process between the RBO, its contracting health plans, and the Department.

The provider solvency quarterly updates to the FSSB provide information regarding the RBOs' latest reports filed with the Department. I will provide you with an update regarding the quarter ended March 31, 2023 submissions. Next slide, please.

We received 211 RBOs that were required to file reports with the Department. There were 8 RBOs that began reporting this period and 7 RBOs that were deactivated and did not report this period, with a net increase of 1 RBO.

We received 200 annual survey reports for the fiscal year end 2022. A majority of those were received on May 31. There is one RBO on our non-filer list.

We received monthly financial statements from 10 RBOs as a requirement of their corrective action plan.

As of quarter end March 31, 2023 we have 13 RBOs on CAPs, which I will present more information in a later slide. Next slide, please.

The most recent data is in the last column of this table that contains the information for quarter end March 31, 2023. This chart shows that 198 RBOs, or 94% of them, reported compliance with all grading criteria. This

includes 7 RBOs on our monitor closely list. There are 13 RBOs or 6% of the RBOs that reported non-compliance with the grading criteria. We have 13 RBOs on corrective action plans. Two of those RBOs have two active corrective action plans, which brings our total CAP count to 15 CAPs that we are monitoring. Next slide, please.

There was a significant decrease of the number of CAPs from the previous reporting period, December 31, 2022. After review of those financials, 3 RBOs accounts were deactivated, and the remaining RBOs obtained compliance with all grading criteria. This provides us with 10 continuing CAPs from the previous reporting period, and 5 new CAPs as of March 31, 2023. Of those 10 CAPs, 9 RBOs are improving from the previous quarter, 1 RBO did not meet its CAP projections. We are continuing to monitor and working with the health plan and the RBO to extend the compliance date of that CAP. Of those 15 CAPs, all are approved. For more information there is a handout that lists the 15 CAPs, and it is sorted by management services organization or MSO. It includes the contracting health plans, enrollment by ranges, the quarter the CAP was initiated, compliance status with the approved CAP, and the grading criteria deficiency. Next slide, please.

Looking at the grading criteria. We compiled the TNE data from the quarterly survey reports, we use TNE and required TNE to calculate this ratio. RBOs reporting less than 100% of TNE to required TNE were non-compliant with the grading criteria. At March 31, 137, or 65% of the RBOs, reported TNE with more than 500%. For RBOs reported non-compliance with the TNE grading criteria, 3 of those 4 RBOs had less than 10,000 lives, and 1 RBO was in the over 100,000 range. Next slide, please.

Relative working capital. We calculated the relative working capital by taking the comparison of current assets to current liabilities. This shows the number of times the current assets cover the current liabilities. At March 31, over 99% of the RBOs were able to cover their current liabilities with a ratio of over-one. There were 2 RBOs that reported non-compliance with working capital; and both of those RBOs had less than 10,000 lives assigned to them.

Moving on to the cash-to-claims ratio. This ratio is calculated by the amount of the RBOs cash and its health plan capitation receivables that are collectable within 30 days and divide that by the total claims liability. The minimum requirement is .75. This slide shows that there are 2 RBOs that reported non-compliance with the cash-to-claims ratio, and both of those RBOs had less than 10,000 lives assigned to them. Five RBOs were compliant, but did not have a dollar of cash to cover each dollar of total claims liability. And a majority of the RBOs had sufficient cash reserves to cover their claims liability. Next slide, please.

Claims timeliness. The requirement is 95%. There were 4 RBOs that reported non-compliance with claims timeliness. One RBO had less than 10,000 lives assigned to them, 2 RBOs had 10,000 to 25,000 lives assigned to them, and 1 RBO had over 100,000 lives assigned to them.

Moving on to enrollment. This slide represents the enrollment information reported by RBOs. As of March 31, there were approximately 9.4 million enrollees assigned to the RBOs reporting to the Department. This is an increase of approximately 187 RBOs from the previous reporting period. The increases are in all lines of business, with the majority of the increase in Medi-Cal enrollment. Next slide, please.

The RBOs that have Medi-Cal enrollment, we look at those RBOs that have Medi-Cal lives assigned to them. At March 31 there were approximately 5.6 million lives assigned to 84 RBOs. This represents 59% of the total lives assigned to those RBOs. Seventy-one of the 84 had no financial concerns, 5 of the RBOs were on our monitor closely list, and 8 RBOs were on corrective action plans. Next slide, please.

Continuing with Medi-Cal enrollment. We took the top 20 RBOs that had more than 50% of the Medi-Cal lives assigned to them. There were approximately 4.2 million enrollees assigned to these 20 RBOs, and this is approximately 45% of the total lives assigned to the 20 RBOs. Of those 20, 16 had no financial concerns, 2 were on our monitor closely list, and 2 are on corrective action plans. Next slide, please.

At the last FSSB meeting there were questions regarding the information that we provide or post to the DMHC website, so we are going to navigate and show you where the information can be found.

So, we are going to go to the DMHC website.

In the menu bar we are going to select Data and Research.

And then we are going to select Data & Research again. Oh, you are ahead of me sorry.

And then we are going to scroll down to the Financial Information section and select Risk Bearing Organization.

In this section there are five areas that we post information and we are going to go over each one.

Let's start with the Financial Surveys Received and let's select the reporting period January to March 31 of 2023. And this provides information

regarding all of the RBOs that filed and the grading criteria that they posted and if a corrective action plan is required. Okay.

The next is going back to Compliance Statements. As of October 2019 we no longer receive compliance statements. Previously, RBOs that had less than 10,000 lives could attest the compliance with the grading criteria through this compliance statement. But as of October 2019, all RBOs were required to file quarterly survey reports. Okay. So you can see 2019, that was the last filing that we received and it goes backwards from there.

The Non-Filing RBOs is next. This lists all the RBOs that have not filed or reopened their survey reports. As of January through March 2023 there is one RBO on there that reopened their report.

The next is going back to the Summary of Comparative Aggregate Data, which summarizes the grading criteria and CAP data for all RBOs. And we will select January through March 2023 and then it goes to show the number. It goes through all the grading criteria, the RBOs, as well as the number of CAPs that are submitted. Okay.

And the last is the Statement of Organization Information. This comes with the annual survey report and it includes -- and we will go to the year 2022. It includes information such as the model type, the number of lives assigned to those RBOs, it is in ranges, the counties the RBO serves, the MSO information, dispute resolution information, the contracted health plans, and the number of PCP and specialists in employment or under contractual arrangement.

So there is a lot of information posted that we put on our website and this is where you can locate the information. And that does it for my presentation. Any questions?

CHAIR RIDEOUT: Thank you, Michelle.

Any questions from Board Members? David.

MEMBER SEIDENWURM: It seemed as though there were similar numbers of non-compliant organizations in the various categories, in the less than 10,000 and greater than 100,000. Are they the same ones? In other words, are they clustered or are they independent?

MS. YAMANAKA: I have to go back and look, but the handout will show us sometimes that the RBO may be on a corrective action plan for more than one grading criteria, so it is very possible. I could go on take a look, and then I can let you know.

CHAIR RIDEOUT: Other questions? Paul.

MEMBER DURR: Yes, I think it is great to see the improvement. Nice summary, Michelle, and I liked the tutorial, that was really helpful. That was really good so thank you. But my comment is on the noted improvement on the summary of number of RBOs on CAP and it has quite nicely decreased and showing the efficiency of the groups that you are with, are watching.

My other thought or question is on the three that dropped off. Did they have many lives associated with those three? Because I think you said three deactivated.

MS. YAMANAKA: Sure. They had less than 10,000 lives. They were very, very small. Very small, yes.

MEMBER WATANABE: If I could just make a comment. Michelle, I was like trying to remember. I think we have had more than 20 RBOs on a corrective action plan for like five-plus years. Because I remember when the number went up and we were very concerned.

MS. YAMANAKA: Yes.

MEMBER WATANABE: Kudos to everybody for that going down. I will just say I was kind of going through the attachment to see if I could figure out who these two entities are that are on the naughty list. (Laughter.) You can probably back into it based on the categories.

MS. YAMANAKA: Yes.

CHAIR RIDEOUT: Abbi.

MEMBER COURSOLLE: I am sure you have told us about this before but I was wondering if you could just refresh my memory about sort of how you determine which RBOs are in the monitor closely category that are not quite at the CAP level yet.

MS. YAMANAKA: Sure. So, every quarter when the financials come in there is a look-back to see the trending over several periods. Got to hand it to the examiners, they take a look at this information and they know the RBOs. And so when there's, there's certain things that we also look for that drawl concern. Continued net losses, you know, they look at the claims timeliness, they look at the IBNR. There's just certain areas. Or even if the RBO changes their MSO. There could be a possibility when you have that transition, sometimes it is just not smooth. So there's just certain areas that they look at. And when they see those types of concerns then they will put them on the monitor closely list. We know who is on that monitor closely list so if we hear anything in the industry, oh, it rings a bell, we better go take a look, news articles. But then also when the financials come in, the priority of those monitor closely. Because we have 200, over 200 RBOs that file. So the first are the corrective action plans, RBOs on corrective action, next are the monitor closely list, and

then everybody falls into suit. So they just moved up as a higher priority of things to look for, yep.

CHAIR RIDEOUT: Other questions from Board Members?

MEMBER KOGAN: Yes.

CHAIR RIDEOUT: I'm sorry, Mark, go ahead.

MEMBER KOGAN: Yes, no problem, sorry. The question, which I think I asked the last time too and I apologize, but I don't really remember the answer. I think on one of the later slides, there's at least one risk bearing organization that has not fulfilled the corrective action plan for about the last four quarters. I guess my question is a more of a general question, not for them specifically, but in general what do you do when despite the plan they are just not meeting the goals or not improving at least?

MS. YAMANAKA: That's very important to us is, are they improving? It may be a slower improvement than they anticipated, but that's one of the things that we definitely look out for. Our first course of action is when we do see an RBO that is not meeting its approved projections we have a discussion with the RBO. And if necessary, we also have a discussion with the health plan to find out what the health plan is doing to oversee and if they have concerns as well. In addition to that, then we also ask the RBO, okay, if you are not going to be able to meet your CAP compliance date what would you need to do in order to meet your CAP compliance date and how long will it take? So those are the kind of things that we ask for and work with the RBO first. As we continue, if things do not get better, we have two courses of action that we can take. We can freeze the enrollment where the RBO is no longer able to receive enrollees. Or we can require the health plans to de-delegate the risk where they can no longer accept

that claims risk and so it is very difficult for the RBO at that point.

When we come to that crossroads with those two options to freeze or to de-delegate, we take that very seriously because the enrollees, you know, they see their doctors and we just need to make sure that the enrollees are taken care of. So that's one of the things that we look at if we need to take that action. But at some point, if the RBO is not able to fulfill their obligations, you know, we have in the past and we may have to go down that road. But again, it is something that we don't take lightly.

MEMBER KOGAN: Thank you.

CHAIR RIDEOUT: Okay, questions from the public, any comments in the room? Bill, you should sit in the front row.

MR. BARCELLONA: Guess what, it's Bill Barcellona, APG. Thanks for the report. The data gets better every year, really appreciate that.

I had a question and follow-up around the Babylon bankruptcy. And I don't know if you can answer it but other staff at the Department may. As a result of this bankruptcy are we seeing any disruption of enrollees? Are they being transferred to solvent providers or is that even an issue in this bankruptcy proceeding? What do we know?

MS. DUTT: So, Bill, we had a call with the RBO and the plan last week, it is Meritage Health Plan and Meritage Medical Network, so we are working with them. From our understanding, those two entities are not part of the bankruptcy, they are still meeting the grading criteria. We are working with them closely. We just got an update from them earlier this week so we continue to have conversations with them. The plan is a restricted plan and Meritage is an RBO. So we can work with the full service plans that contract with those entities

to monitor this plan and the RBO closely. But we are tracking the situation very closely.

MR. BARCELLONA: Okay. So there's no change in the plan-to-plan contracting between parent plans and the RKK?

MS. DUTT: Nothing that we have heard of right now. We have received some questions that we are researching. Since Sarah just got back from vacation I have some questions that I need to run by her. But we are looking at the situation closely and see what Meritage is doing, what their next step is. We are trying to get updates from them quickly.

MR. BARCELLONA: All right, thank you very much.

CHAIR RIDEOUT: Thanks, Bill.

Questions from the public on the phone?

None. Okay, folks, we are in the home stretch. We have the health plan quarterly update from Pritika next.

MS. DUTT: The purpose of this presentation is to provide you an update on the financial status of health plans at quarter ended March 31, 2023. All licensed health plans are required to submit quarterly and annual financial statements with the DMHC. Additionally, we get monthly financial statements from plans who are newly licensed, and from plans whose TNE falls below 150% of required TNE, and TNE is tangible net equity. Or if we have concerns with the health plan’s financial solvency, we place them on monthly reporting as well.

We also included a handout that shows the enrollment at March 31, 2023 and TNE for five consecutive quarters from March 31, 2022 through March 31, 2023. This quarter we added working capital information as well as cash-to-claims for all the licensed health plans. The information is broken into three

categories looking at full service, restricted full service and specialized plans.

As of July 6, that's when we pulled this data here, we had 144 licensed health plans. We are currently reviewing 10 applications for licensure. We just got one yesterday, one more yesterday. We have 5 full service and 5 specialized. Of the 5 full service, 2 are seeking licenses for restricted Medicare Advantage, 2 for Medicare Advantage where they will contract directly with CMS and market to the beneficiaries directly, and 1 is looking to get into the Medi-Cal space. And then for the 5 specialized plans, 3 are looking to get licensed to offer employee assistance program benefits, and 2 for dental.

And since the last time we met, the last time we had the slide presentation here, we licensed 3 health plans. All 3 offer MA products. Two plan to contract directly with CMS and offer products for benefit year 2024, and one plan is a restricted Medicare Advantage plan. And those plans are Alignment Health Advantage Plan, which was licensed on April 27 2023 as a Medicare Advantage plan; Guidant Health Plan licensed on May 25 2023, it is a restricted Medicare Advantage plan, and then Champion Health Plan of California that got licensed on June 19, 2023 as a Medicare Advantage plan and they plan to offer services for end-stage renal disease. And then we also had one plan that surrendered its license, Evolve Vision, Inc., they surrendered their license on June 6, 2023. So it was pretty busy.

At March 31, 2023 there were third 30.47 million enrollees in full service plans licensed with a DMHC. Our total commercial enrollment includes HMO, PPO/EPO and Medicare supplement. As you can see on the table, compared to the previous quarter, the total full service enrollment increased, and that was largely driven by the increase in Medi-Cal enrollment, as you will see on

the following slides.

This slide shows the makeup of the HMO enrollment by market type. HMO enrollment in all markets remained consistent compared to previous quarters.

This slide shows the makeup of the PPO/EPO enrollment. As you can see on the table, PPO/EPO enrollment decreased slightly. And we are making changes to our financial reporting template, so we are going to further get more detailed enrollment information probably in the next six months or so.

This table shows the government enrollment, which is Medi-Cal and Medicare. Overall government enrollment increased. Medi-Cal enrollment increased by 624,000 lives and Medicare Advantage enrollment increased by 112,000 lives. Again, this enrollment information is capturing information from March 31, 2023, so it does not account for any of the changes that may be happening right now with the Medi-Cal redetermination.

There were about 4 million enrollees enrolled in the closely monitored full service plans. Of the 29 closely monitored full service plans, 14 are restricted licensees, which includes 3 restricted Medi-Cal plans, 9 restricted Medicare plans, and 2 restricted commercial plans, and those 14 plans had 299,000 enrollees. The total enrollment for the five specialized plans is 283,000 lives, which consists of 1 vision plan, 2 behavioral and 2 dental plans.

And we were busy. I think this is the largest number of plans that we had report TNE deficiencies since we started presenting at FSSB Board. We had 5 health plans that did not meet the Department's minimum financial reserve or tangible net equity requirement. All licensed health plans with the DMHC must meet the TNE reserve requirement described in California Code of Regulations

Section 1300.76. TNE is defined as a health plan's total assets, minus total liabilities reduced by the intangibles, which includes any startup costs, goodwill, et cetera, and unsecured obligations of officers, directors, owners, or affiliate receivables are deducted from TNE as well if they are not as part of normal course of business. And any debt that is properly subordinated may be added to the TNE calculation, which serves to increase the plan's TNE.

So the first plan that was TNE deficient was Access Senior HealthCare. Access Senior HealthCare reported TNE deficiency starting with December 31, 2022 financials through March 31, 2023. Their TNE deficiency resulted from year-end audit adjustments. The plan's parent infused additional capital, which cured the TNE deficiency in April 2023. So Access Senior is a restricted Medicare Advantage plan; it is smaller with 2400 lives.

And then Brandman Health Plan, you probably have seen them, they are a frequent flyer here. (Laughter.) So Brandman Health Plan reported TNE deficiency since May 31, 2022. The deficiency still continues. They are in the process of correcting the TNE deficiency through a subordinated loan agreement from its parent. So my team is currently looking at the filing. Before we allow any plan to make adjustments to TNE through a subordinated loan we ask the plan to submit all the documentation for the Department's review. If everything looks okay, then we will allow the plan to include that amount in their TNE calculation. And then Brandman was licensed as a Medicare Advantage plan, but currently has zero enrollment or no lives.

And then For Your Benefits, Inc. For Your Benefits reported TNE deficiency for the quarter ending March 31, 2023. The plan was in the process of going through a change in control when the TNE deficiency happened. But they

received a cash infusion from the new parent in May and they are currently compliant with the TNE requirement.

So we have LifeWorks that also reported a TNE deficiency starting with December 31, 2022 financials; and for March 31st quarterly they were also non-compliant. The plan received capital contributions from its parent entity and reported compliance with the TNE requirement for month ended June 30, 2023.

As you may recall, I mentioned earlier that we do get monthly financials from some of the plans that are either newly licensed, we have financial concerns with, or whose TNE is below 150%. So all these plans that are TNE deficient do more frequent reporting with the Department, including monthly financials. We receive projections from them and frequent updates.

The last plan on our list here is Medcore HP. As a result of the plan's year end December 31, 2021 audited financial report's adjustments, Medcore HP reported TNE deficiency going back to December 31, 2021, all the way through March 31, 2023. As of now the plan has not cured -- let me come back here. The plan cured its TNE deficiency and reported access TNE for month ending April 30, 2023 and May 31, 2023. The plan received a cash infusion in April and they were able to resolve their TNE deficiency.

All these plans, like I said, are on monthly reporting and we are monitoring them very closely.

This chart shows the TNE of health plans by line of business. A majority of the health plans with over 500% of required TNE are specialized health plans, because the required TNE is much lower for specialized health plans as compared to full service plans. So for specialized plans, they are required to maintain the greater of $50,000 or a percentage of their revenue or a

percentage of expenses, the greater of the three. So starting with $50,000, right. And for full service plans the plans have to maintain the greater of $1 million or a percentage of their premium revenue, a percentage of their medical expenses. Next slide.

This chart shows the TNE of full service plans by enrollment category. Sixty-three health plans, or half of the total licensed full service plans, reported TNE of over 250% of required TNE. The health plans below 150% of TNE are required to submit monthly financial reports to the DMHC.

This chart shows the breakdown of the 26 full service plans in the 150% to 250% range. Like I mentioned earlier, if a plan's TNE falls below 150% the plan is placed on monthly reporting. And we also place plans on monthly reporting if we observe a declining trend in their financial performance, their TNE is going down, net income, enrollment. If we see something in the news that raises concern, we may monitor them closely as well.

And this chart shows the tangible net equity of full service plans by quarter. This chart pretty much summarizes the handout when you look at the five quarters there. So if you wanted to look at more detailed information you can look at the handout and you can see like where each plan is.

This chart shows the working capital for full service health plans by enrollment as of March 31, 2023. Working capital measures the health plan's ability to cover or pay its short-term obligations, or those payables that are due within the year. Working capital also measures the plan's liquidity and short-term financial health. On the previous slide you may have noticed that we had 60 full service plans with TNE of over 250%. However, there were only 14 plans that had two and a half times more current assets than what they owe in current

liabilities. So 13 of those plans were in the smaller, so I am looking at the working capital, up over 2.50. So 13 of those plans were small with zero to 50,000 lives.

And this slide shows the cash-to-claims ratio for full service plans by enrollment. This measures the plan's ability to pay its claims, so this should be cash-to-claims and payables. So here we look at the cash and short-term investments, so cash and cash equivalents, and short-term investments that are available at a health plan to cover its payables of claims, capitation payables, so those claims and payables that are due in the short-term. Nineteen plans reported cash-to-claims of less than 1, so that means that they do not have enough cash. So, if everything were to be due today, they don't have enough cash to cover that.

That brings me to the end of the presentation. With that I will take any questions.

CHAIR RIDEOUT: Thank you, Pritika.

Questions from Board Members?

MEMBER DURR: Just one question. Do you have any idea what the impact of Medi-Cal redetermination is going to be? It has already started, obviously. That could make a big difference in the enrollment numbers. Just thoughts if you had any preliminary data on that?

MS. DUTT: I do not but I would look to my left here and maybe Jarrod could. Jarrod, do you want to?

MEMBER MCNAUGHTON: Sure, I would be happy to. Thank you. Thanks, Pritika, that was great.

Yes, we are kind of seeing an interesting thing happen right now,

Paul, that the first month in July, for our organization, we actually saw a less increase, a less amount of increase than we actually thought on the redetermination front. Meaning that the total number that was coming off the plan was actually less than what we thought was going to happen. We only lost about 4,000 or so members. And that was really due to the high enrollment so the enrollment made up for the loss.

Then in August, our two counties along with some other counties across the state, there was a procedural issue that was a problem. That a 10 day notice was not sent out per statute. That at 10 days of disenrollment, that those notices weren't sent out. And so those, all of those were placed on hold so we actually gained membership in August.

So we know that what's coming in September is the makeup now for August and September. And so we will have a little bit of a better idea, I think, September 1 when we see those numbers. There were literally almost bets in our office between finance and strategy on a loss of 200 to 400,000 members for the entirety of the 12 month period of our 1.7. But we will just have to see how that plays out. I really applaud the counties for the work that they are doing to really get the word out across the state and I think that that's helping to just augment some of the numbers that we expected to lose. So I don't know if that helps give you a little bit of a flavor, but we will know more here in a few weeks.

CHAIR RIDEOUT: Amy.

MEMBER YAO: I have a question, Pritika. How concerned are you guys on this cash-to-claims ratio or the working capital? Do you have some historical data? I know lots of companies are facing some cash flow issues.

MS. DUTT: We have financials on all the plans, which are publicly

available, unlike the RBO information. The health plans, as soon as the financials come in, we publicly post them. So we are tracking. That's something that my team looks at. When the financial statements come we look at various financial ratios, getting a little nerdy here. But we do look at, we do conduct detailed analysis on the financials. Like I said, if we have concerns then we place them on our watch list. We start having conversations with a plan earlier, we don't wait for a plan to go TNE deficient. We ask for projections. We also look at the long-term investments in addition to, you know, in addition to the short-term investments, right. So what is available to the plan long-term. Because there is a cost to breaking those long-term investments but we also look at what is available.

CHAIR RIDEOUT: Other questions?

MEMBER WATANABE: Jeff, if I could just make a quick comment on the redetermination. I think it is our plan to try to have DHCS come to the next meeting. We will have the financial summary for the Medi-Cal managed care plans as we do every other meeting, and I believe, someone can correct me if I'm wrong, but I think I saw that DHCS has created a dashboard related to the redeterminations too. So there is some information publicly that is being updated on how that's going. But we will look forward to hearing more about that. Hopefully they can attend in November. And then probably the next meeting, the first part of 2024 will be Covered California. We'll hear how their open enrollment went and how the numbers kind of landed.

CHAIR RIDEOUT: Great, thank you.

Questions from the public or comments in the room?

Anyone on the phone?

Okay, thank you, Pritika.

We have the meeting dates set for 2024. I think there's a slide available. Yes. So, for committee members and the public, these are the confirmed dates next year.

MEMBER WATANABE: They are technically proposed. Jeff and I have validated that our calendars look good. (Laughter.) Now it is for the rest of you to just double-check. If there's any, you know, significant conflicts, let us know between now and the next meeting. But we like to kind of preview them in the summer, finalize them at the last meeting of the year. So far we don't see any significant conflicts.

CHAIR RIDEOUT: And those will all be in-person, we hope.

MEMBER WATANABE: It will be in-person. However, there is a bill that would allow us to go back to virtual meetings for Bagley-Keene meetings. So depending on the outcome of that bill, there is a chance that starting in 2024 we would go back to virtual options or can have the discussion about hybrid or how we want to do that. So more to come depending on the outcome of that legislation.

CHAIR RIDEOUT: Next we take public comments on any items not on the agenda.

Hearing none. Nobody on the phone? Okay.

We will move on to agenda items for future meetings. Any comments from committee members first about additional items to consider? There was a list in the transcript, I think.

MEMBER WATANABE: There is. We have been kind of keeping a running list of things that were raised. As we have kind of been onboarding a

number of new Board Members we wanted to kind of let everybody get settled. We had a number of things in the queue that we needed to present too. So we will certainly revisit the items that were in the transcript. But if there's other things you would like to hear about at upcoming meetings, let us know.

CHAIR RIDEOUT: Okay. And the last thing is just closing remarks. I should have said this at the beginning, but a thought for all of our friends in Hawaii. That's horrific what's happening there. And thank you for tolerating me as your Chair at least once. (Laughter.)

MEMBER WATANABE: You did great.

CHAIR RIDEOUT: All right. Any other comments for the good of the order?

MEMBER DURR: You know, Jeff, I just couldn't help but notice the core values in back there of DMHC, and it really speaks to the leadership. For those of you that can't see it, it says, integrity, leadership, commitment to service. And I think what my experience on this board has been, one, that we have elevated that with your role, Mary and team; and it is a compliment to you and the whole DMHC team. Your commitment to living those core values, because I think we see it. We ask a lot of questions, we probe, we push, but you are living those values and I just wanted to compliment you on that.

MEMBER WATANABE: Thank you, I love to hear that. I will tell you that I started eight and a half years ago. We were finishing up our strategic planning process and we had a lot of discussion about the values. Integrity is one that resonates with me because we aren't always going to agree. We have really smart, passionate people. And you all know I have assembled this amazing leadership team that really exemplifies those core values. I often say

customer service instead of commitment to service, because I have been passionate about customer service my entire life and it is important to me that we are transparent and we have the dialogue and the conversations whether we agree or not.

I will warn you that we are going to start a new strategic planning process, hopefully by the end of this year going into next year, so we will be probably revisiting our mission, our core values, I keep thinking about what else we would either replace or come up with because I think they are -- other than I probably would say customer service because I misstate that frequently.

But anyway, I really appreciate that and kudos to my team because, you know, it is a team effort. Thank you.

CHAIR RIDEOUT: Nice way to finish. A motion to adjourn, perhaps?

MEMBER DURR: Motion to adjourn.

MEMBER KOGAN: Second.

CHAIR RIDEOUT: We are adjourned. Thank you very much.

(The meeting was adjourned at 12:427 p.m.)

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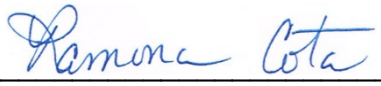
CERTIFICATE OF REPORTER

I, RAMONA COTA, an Electronic Reporter and Transcriber, do hereby certify:

That I am a disinterested person herein; that the foregoing Department of Managed Health Care, Financial Solvency Standards Board meeting was electronically reported by me and I thereafter transcribed it.

I further certify that I am not of counsel or attorney for any of the parties in this matter, or in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 28th day of August, 2023.



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