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Date: March 16, 2001

To: ALL INTERESTED PARTIES

From: Department of Managed Health Care

The following is a brief summary of the comments and events that occurred during the Financial Solvency Standards Board (FSSB) meeting on December 19, 2000.

I. Introduction: Opening Remarks by Scott Syphax, Chair.

The purpose of today's meeting is to consider the amended draft regulation language prepared in response to the Board's November 28, 2000 directives. The Board will proceed section by section, requesting comment from the Board members and the public.

II. Discussion of the revisions to SB260 Draft Regulations.

A. The draft regulations have been pared down to focus on the most critical issues.

1. The definition for a "corrective action plan" and "proprietary information" have been deleted. The definition for "risk sharing arrangement" and "lawfully organized group of physician" was modified.

Public Comment :

Health plan focus: (1) the definition of the "external party" is no longer necessary; and (2) the definition of "risk-shifting arrangement" should include the term "financial risk."

Provider focus: (1) the definition of lawfully organized groups of physicians is too narrow and directed almost exclusively toward medical groups and IPAs and does not include all contracting entities operating under MSO and foundation models.

2. Under plan reporting, specific data elements were identified from CALINX. The data elements should include the amount of capitation to be paid and the time for reporting should be accelerated to the 10th of the month.

Public Comment.

Consumer focus: (1) the timelines need careful consideration so that the timelines for switching primary care doctors within the plan network is not increased.

Health plan focus: (1) health plans may have difficulty providing payment information by the 10th of the month; (2) the data elements should reflect that the information should be transmitted “if known”; and (3) the data elements requirements should be phased in.

Provider focus: (1) providers receive two reports each month, which do not agree and cause an administrative burden to reconcile; and (2) patient identification numbers are crucial and have been omitted.

3. The Board moved by acclamation, to adopt the 10th of the month as the plan reporting date. It also required that patient identification numbers and addresses, capitation amounts, and the third-party coverage information, if known, be included in the data elements.

4. Electronic transmission should be the standard unless the parties agree to a different medium of transmission. The next section is the matrix of responsibility that identifies which expenses are the responsibility of the plan and the organization.

Public Comment.

Provider focus: (1) you need to include information on the base population to which the actuarial information relates to insure that it is geographically relevant; (2) the inclusion of actuarial information is very important to providers; and (3) you should consider including administrative cost language in the matrix.

Plan focus: (1) there needs to be a distinction between major benefit types and individual products; (2) a category of benefit plan might work better than by individual benefit plan.

A motion to add the words “by benefit plan” after the phrase, “Identification through a matrix of responsibility” was amended to read “Actuarial methods employed in determining the rate by benefit plan type, including the utilization and unit cost assumption.” The Board unanimously approved this motion.

5. Timeframe of 120 days for provider reporting was discussed. It was noted that the provider financial reporting would be based on estimates because plans are not required to make their final risk pool payment until 180 days after the close of the fiscal year.

Public Comment.

Provider focus: (1) quarterly reporting requirements of plans and providers should be consistent; (2) plans should be required to explain the basis for each deduction in sufficient detail to allow providers to verify the accuracy of the deduction; and (3) audited financial statements should be due 180 days after the close of the fiscal year.

6. Provider reporting starts with the first quarter of 2001. The report is due within 45 days of the close of the quarter. Reporting must include information on the inventory of existing claims.

Public Comment.

Health plan focus: (1) strongly recommend maintaining the current reporting timelines.

Provider focus: (1) reporting for IBNR claims should be limited to those that were processed or adjudicated; (2) reference to claims “received” should be deleted and the

statutory language, “reimbursed, contested or denied” retained; (3) due to the complexity of the reporting requirements, the initial reporting periods should be extended by a quarter; and (4) the standard for timely payment of claims should track with HCFA requirements (95%).

A motion to maintain the draft regulations’ current reporting dates was approved by a unanimous vote of the Board. The Board also adopted the provider suggestion to delete claims “received.”

7. The need to further define the term “at all times” was discussed. The Department was inclined to leave the term unrestricted to reduce the opportunity for manipulation.

Public Comment.

Health plan focus: (1) if you add any additional qualifiers to the term “at all times” it no longer means “at all times.”

Provider focus: (1) at all times is sufficient otherwise it is fuel for litigation, however if a provider net equity is not positive at a particular moment it does not mean that the entity is not viable.

A motion to adopt Option I relating to the definition of “at all times” was adopted by unanimous vote of the Board.

8. Annual reporting for providers is due 180 days after the close of their fiscal year that began in the year 2000. The term “principal officer” was amended to read the “CFO” or “CEO” of the organization.”

9. A discussion concerning phase-in period for audited financial for small groups was discussed.

Public Comment.

Consumer focus: (1) they recommend against adopting a phase-in period for audited financial statements.

Provider focus: (1) they recommended a one year phase-in period for audited financial statements for all groups.

A motion to adopt a one-year, phase-in period for medical groups with less than 10,000 covered lives was approved by a majority of the Board.

10. The requirement for a “redacted copy of a management letter” was discussed. A motion to strike the requirement was adopted by a majority of the Board.

11. Drafting of the “Statement of Organization” was discussed. Some Board members considered that it would be an impossible to provide a list of every plan contractor. A motion to strike the requirement that plans identify “all the entities with which you contract” was approved by a majority of the Board.

12. Reporting of deficiencies was discussed. The language was changed so that notification within five days of any event that might materially alter the financial situation or solvency of the group. It was suggested and adopted that the word “might” be deleted.

A motion to strike the examples of reporting situations relating to changes that may effect a provider group’s solvency was approved by a majority of the Board.

Public Comment.

Provider focus: (1) the standards for “material” should be consistent with GAAP.

13. Plan reporting was discussed. The main revision was to specify a start date of April 1, 2001 for the reporting requirement.

14. Confidentiality concerns were discussed at length. The definition of “proprietary information” was deleted. The revised regulation restated the statutory language of SB 260. A discussion of the intended confidentiality protections to be afforded provider submissions was entertained. The focus was on two competing interests: (1) the need to maintain the integrity of the plan/provider contracting process and (2) the public’s right to know.

A motion to maintain the current draft regulatory language on confidentiality restating the statutory provisions of SB 260 was adopted by a unanimous vote of the Board.

15. The provision providing a safe harbor for health plans was deleted.

III. Third Session: Financial Solvency Standards Board Reporting Requirement.

The Board noted that the Director’s involvement in the ongoing discussions and development of the emergency regulations. It was determined that the Director had sufficient information on the Board’s recommendation relating to the appropriateness of different risk-bearing arrangements between plans and risk-bearing organizations and the appropriateness of the four specific solvency standards prescribed in SB 260. While it is feasible to require insurance coverage for risk-bearing organizations, additional substantive study is necessary to determine whether insurance should be mandated.

IV. Fourth Session: Closing remarks were made by Chair Scott Syphax.