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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 held on November 9, 2004.

I. Opening Remarks and Adoption of Meeting Minutes

The meeting minutes summary from the October 5, 2004 Board meeting was unanimously approved by the Board members.

II. Department Overview of the Revisions to the Regulatory Text

Following the Department's overview of its revisions to the SB 260 regulatory text and the some general observations from the Board members, public comment was solicited on the following topics.

A. Cash to Claims Ratio

1. Medical Group's perspective.

CAPG presented an expert, Mark Abernathy, CPA, of Navigant Consulting, to offer public comments on the need and appropriateness of a cash ratio. The expert preferred the use of a current ratio, which is a ratio of current assets to current liabilities, over a cash ratio. Generally, the effectiveness of a cash ratio varies depending on the amount of capitation versus the amount of fee-for-service business within a medical group. If a medical group has a high amount of fee for service business, then the usefulness of a cash ratio diminishes. A cash ratio only offers a snap shot of the financial stability of the medical group. For example, a late cap payment could lead to an artificially low ratio while an early payment can lead to an artificially high ratio. A cash ratio could have a greater impact on a medical group that is based on a staff model since it incurs costs before getting paid.

Another concern of the expert with the cash ratio is what is considered cash in the calculation of the ratio. Accounts receivable should be included as cash. Excluding accounts receivable is not fair because the obligation to pay a claim may not be incurred until 60 days

after the date of service. However, stale accounts receivable are not likely to be paid and should not be included in a cash ratio. Also, what would be an appropriate cash ratio was not given, although a 1:1 ratio would be problematic if the standard is not phased in.

The expert did acknowledge that reliance solely on net-worth (positive tangible net equity) could be problematic. For example, if a risk bearing organization only maintained a net-worth of $1.00 or if its net-worth included a computer system that had little value outside the medical group's practice, would the current TNE criteria be sufficient to ensure that the entity could pay its claims timely. The liquidity of an asset included in a group's net-worth is an issue because you need cash to pay claims and an asset may not be easily converted to cash. As such any early warning system should be designed to identify troubled medical groups, including, for example, those in recent years that filed for bankruptcy protection.

General Medical Group comments included the position that the cash ratio is meaningless and that a current ratio is preferable. An indicator that a medical group is having problems is when the group stops paying claims timely. Another early warning sign is industry "noise" regarding a medical group's financial stability. It was also stated that when medical groups encounter financial difficulties, they could destabilize quickly. If a cash ratio is used, medical groups would need to be given time to meet any required level. Medical groups would need to be given time to revise their business plans to meet the cash ratio requirements. A cash ratio requirement could discourage medical groups from making equipment purchases (for example, a computer system) because it would impact their cash ratio, although giving the medical group the opportunity to inform the DMHC of the pending purchase could lessen this problem.

2. Health Plan Perspective.

SB260 includes four specific measures. If those prove insufficient, the addition of another measure can be readdressed at a later date. The current financial condition of risk-bearing organizations may not warrant the inclusion of additional criteria.

B. Corrective Action Plan Timelines

1. Medical Group Perspective. Medical groups would like the time limits for developing a corrective action plan increased from 15 days to 30 days, since the medical group is the entity that is developing the corrective action plan. This could be accomplished by cutting 7 and 8 days from the two health plan reviews.

2. Health Plan Perspective. The health plans are supportive of the new timelines. The regulations should not be overly proscriptive in regards to time frames for correcting deficiencies . Also, if a health plan and a medical group agree to a corrective action plan, then there does not appear to be a need for an external party review.

C. Confidentiality

Medical Group Perspective. Concerns were expressed regarding the stability of the system. The disclosure of certain items would be anti-competitive. Presently, at the Director's sole discretion, the regulations allow for the disclosure of confidential information. The regulations should limit the circumstances under which the confidential information would be disclosed. Disclosing information regarding whether a standard was met/not met appeared acceptable.

Health Plan Perspective. Health plans were supported of the Department's new approach to disclosure.

III. Closing Remarks/Next Steps

The DMHC would like to finalize the preliminary draft of the revised SB 260 regulations by the end of the year so the regulation test can be submitted to OAL, to commence the formal rule-making process, in January of 2005. After the next FSSB meeting was confirmed for December 14, 2004, at the Sheraton in Sacramento, the meeting was adjourned.