DEPARTMENT OF
Managed
HealthCare

Financial Solvency Standards Board Meeting
November 13, 2014
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Ann Pumpian, Chairperson, Sharp HealthCare
Edward Cymerys, Healthcare Consultant
Dr. Larry de Ghetaldi, The Palo Alto Medical Foundation
Jacob Furgatch, AltaMed Health Services
Betsy Imholz, Consumer Union
Deborah Kelch, Alternate, Kelch Policy Group
Dave Meadows, Liberty Dental Plan
Shelley Rouillard, Department of Managed Health Care
Dr. Rick Shinto, Alternate, InnovaCare Health, Inc.

Department of Managed Health Care (DMHC) Staff Present:
Stephen Babich, Supervising Examiner, Division of Financial Oversight
Pritika Dutt, Examiner, Provider Solvency Unit
Gil Riojas, Deputy Director, Office of Financial Review
Jeff Roskelley, Senior Examiner, Provider Solvency Unit
Michelle Yamanaka, Supervising Examiner, Provider Solvency Unit

1) Welcome - Agenda

Chairperson Ann Pumpian called the meeting to order and welcomed attendees.

2) Minutes from August 20, 2014 FSSB Meeting

Jacob Furgatch made a motion to approve the August 20th FSSB meeting minutes. Rick Shinto seconded the motion. Meeting minutes were approved with no opposition.

3) Director's Remarks and Introductions

Shelley Rouillard introduced the new consumer representative of the Financial Solvency Standards Board (FSSB). Betsy Imholz is the Special Projects Director for Consumers Union, which is a nonprofit publisher of Consumer Reports. Ms. Imholz is an attorney and a recognized expert on health policy and consumer protection. Mary Cantwell, Chief Deputy Director for Healthcare Programs at the Department of Health Care Services (DHCS), was introduced as a resource regarding Medi-Cal.

Ms. Rouillard mentioned there are a couple of topics not on the agenda that the Board discussed in the past. The Department of Managed Health Care (DMHC) is still analyzing the California Association of Physician Groups (CAPG) proposal for restricted licensees. The DMHC is also still evaluating the topic around licensure of COHS plans.

Ms. Rouillard announced the DMHC has completed its non-routine surveys of Anthem Blue Cross and Blue Shield provider networks in the individual market. Once completed, the reports will be posted to the public website.

4) Alameda Alliance for Health Update

Gil Riojas, Deputy Director of the Office of Financial Review (OFR), provided an update on Alameda Alliance for Heath (Alameda Alliance).

- The conservator has been working for about six months. The number of claims received per month has increased from 85,000 in December 2013 to 120,000 at the end of October 2014. Here is an update regarding the progress:
    - Claims Processing
        - At the end of April 2014, there were 393,000 unprocessed claims in which some were aged to around 80 calendar days.
        - Currently, the claims inventory decreased by over 50 percent to only 171,000 that are aged to around 40 calendar days. This is within regulatory guidelines for the DMHC.
    - Denial Rate of Claims
        - In 2013, the denial rate for inpatient claims was only two-tenths of one percent (0.028%) under Alameda Alliance's control.
        - Under the conservator, the denial rate for inpatient claims is approximately five and a half percent (5.5%). This is considered to be an appropriate level.
    - Member Services
        - In February 2014, the wait time to speak with a live person was 55 minutes. This resulted in an 83 percent call abandonment rate (people hanging up).
        - Call center staff have been reassigned to appropriate areas, the phone tree has been remapped and the Plan started using an overflow vendor in October 2014. The wait times have decreased significantly to approximately 14 minutes with a 43 percent call abandonment rate. The goal is to answer 80 percent of the calls within 30 seconds.
    - Financial Status
        - In August 2014, there was a net loss of $2.9 million.
        - In September 2014, there was a net income of $3 million. The tangible net equity (TNE) remains a challenge with the deficiency around $7.5 million. For the first time in over a year, the working capital is positive.
    - Information Technology (IT)
        - In early 2014, the Plan was to implement the HEALTHsuite system, but had to pull back to do additional testing.

- Plan representatives met with a plan that has successfully implemented the HEALTHsuite system. Additional testing has been done and the goal is to implement the HEALTHsuite system by April 2015. A strike team has been developed to work on any issues as they come up and resolve them in a timely manner.

Discussion:

Larry de Ghetaldi stated one of our goals was to not prevent new beneficiaries from picking one of the two plans, Alliance or Anthem. He asked what has happened to the two plans in terms of beneficiary growth. Have we preserved the four-to-one ratio between the Alliance and Anthem?

Mr. Riojas replied the percentages are similar to what they have been in the past.

Ms. Rouillard commented Alameda is now getting the default assignments from Medi-Cal. This was stopped for a while when the conservator first took over then restarted again around the beginning of October 2014.

Mr. de Ghetaldi asked if there were issues discovered that can be foreseen so other plans do not go down the same path.

Mr. Riojas replied there were warning signs with their TNE and working capital. The expansion of Medi-Cal in January and the complete failure of their claims system really accelerated things. The DMHC did not anticipate the failure of Alameda Alliance's claims system. We will be keeping track of other plans implementing new systems.

Ms. Imholz asked how the claims denial process has changed.

Mr. Riojas replied the DMHC conservator has implemented systems and processes to review claims as they come in and deny claims, if necessary.

Ms. Rouillard added there was not an effective utilization management program to process the claims, so the majority of the claims were approved.

Ms. Pumpian asked what benchmarks DMHC is using that suggest the denial rate is appropriate.

Mr. Riojas replied our benchmark is based on historical denial rates of other plans in similar areas. Not necessarily in Alameda County, but in other counties with other plans.

Ms. Kelch commented that as we move forward it would helpful to identify the types of claim denials by category to get a better understanding of what is being denied.

Ms. Pumpian asked what methodology they are using to calculate claims incurred but not reported (IBNR).

Mr. Riojas replied an actuary was contracted to calculate that information. They have taken a very conservative approach regarding IBNR.

Ms. Rouillard commented since the DMHC took over the plan the Board of Governors is no longer the authority, the DMHC is. The DMHC is in regular contact with the Board through monthly briefings. The Board has advised the DMHC and DHCS that they do not want to move ahead with CCI in Alameda County. The priority is to get the plan on solid, financial operational footing so it can be returned to the Board and to the community. The State has decided not to implement CCI in Alameda County.

5) Impact of Various Tangible Net Equity Requirements on RBOs - Presentation

Jeff Roskelley, Senior Examiner in the Provider Solvency unit (PSU) presented the impact of various TNE and Risk-Based Capital (RBC) requirements on Risk Bearing Organizations (RBOs).

- Currently, the TNE requirements for RBOs are simply positive, a positive number.
- After implementation of SB 260, a significant number of RBOs had problems maintaining compliance with TNE.
- New Proposal Assumptions
    - New TNE requirements would require a regulation change.
    - All RBOs would report financial statements to the Department.
        - Currently, RBOs with less than 10,000 lives are required to submit only financial and compliance statements.
    - RBOs would be required to submit their own enrollment report.
        - Currently, health plans report enrollment for all RBOs.
- New Proposals
    - Risk-Based Capital (RBC) – The calculation comes from the National Association of Insurance Commissioners (NAIC) and is usually used for larger insurance companies. The calculation includes a percentage of overall claims expenses, a percentage of capitation expenses and a percentage of administrative expenses. It is a very complicated calculation.
        - Requires a minimum reserve
        - Small RBOs would find it very difficult to have the support to calculate risk-based capital
        - Impact of risk-based capital calculations on health plans based on the 2013 annual financial data shows that half of the health plans would not be compliant with a risk-based capital standard.
        - Greatest impact is on RBOs under 50,000 lives.

- Specialized health plan criteria for TNE
  - Greater of $50,000 or a percentage of annualized premium (capitation) revenues - Nine RBOs would not meet this requirement
  - Percentage of revenue - 23 RBOs would not meet this requirement
  - Percentage of expenses - 46 RBOs would not meet this requirement
  - 80 percent of the RBOs reporting have less than 50,000 lives
    - 49 of 172 RBOs would be noncompliant with the specialized standard option
- TNE dollar amount per enrollee that reports at quarter end (simple calculation)
  - $10 for Medicare and commercial enrollees
  - $8 for Medi-Cal groups with over 50 percent of enrollees in Medi-Cal
  - Greatest impact on RBOs under 50,000 lives

Discussion

Ms. Pumpian asked the theory behind discounting the Medi-Cal enrollment 20 percent.

Mr. Roskelley replied they looked at what RBOs receive and what they pay. For a commercial or a Medicare enrollee, the reimbursement rate on fee-for-service is going to be higher than the reimbursement rate on Medi-Cal. That is the reason for the discount.

Mr. Furgatch commented he does not necessarily agree with the methodology used for the TNE per enrollee with the discount on Medi-Cal, but could see using TNE per enrollee with a different methodology. Also, the specialized health plan criteria sounds outdated. The RBC has been around a while and is more proven, but is designed for large organizations.

Ms. Kelch asked if RBC was chosen for RBOs, would health plans still be doing TNE. She asked if it would be helpful for both the RBOs and plans to use the same standard.

Mr. de Ghetaldi asked if these three models were retrospectively applied to RBOs that got into trouble, which of them would have had the greatest sensitivity in predicting the trouble?

Mr. Shinto recommended the calculation should be based on revenue and costs. A dollar amount per member does not really address the issue.

Mr. Meadows commented that RBC would be the best option and it would identify many kinds of issues, but it would be odd for the RBOs to have an RBC requirement and the medical plans to have a TNE requirement. His recommendation would be the specialized health plan option, but suggested reevaluating the criteria used and how it applies to RBOs. The TNE per enrollee does not have merit since it does not have much to do with risk exposure.

Mr. Cymerys commented it would be a little disconnected to have one approach for health plans and another for RBOs. It would be helpful if the DMHC would gather information regarding what the RBC calculation, TNE calculation or other alternative would be for each of the groups and track that going forward. The RBC is the standard across the country, is widely used by both regulators and rating agencies concerned about solvency, and it now takes into account capitation payments.

Mr. Barcelona commented that evaluating a change in the financial solvency standards needs to be focused on adequate capitalization of at-risk groups. Those are typically Medi-Cal Managed Care (MMC) groups that have 75 percent or more of their lives in MMC. In the last few years, most of the group failures have been MMC groups. There is lower capitation being paid to MMC groups, yet they would have greater reserve requirements tying up capital. Those are the groups that need to spend capital on infrastructure. They need to build care management. They need to focus on health IT adoption to manage the higher acute population in MMC. Mr. Barcelona requested the DMHC make presentations at the CAPG Medi-Cal Committee and the CAPG Contracts Committee. These are smaller groups, with a wealth of experience that can provide good information.

Don Comstock, an independent consultant, commented that full service HMOs, specialized plans and RBOs are very different. He agreed with trying to keep the calculations somewhat consistent across the organizations. He added that the difference between Medicare revenue and expenses is approximately five times as much as the commercial revenue. Regarding the TNE per enrollee calculations, there are significant operational differences between each type of organization. Everyone is familiar with an organization or health plan that capitates its professional services to medical groups, but some of the health plans are also capitating the hospitals. So, 80 percent of their expenses are capitated, therefore, the plans' risk exposure is very limited. There are also differences between independent IPAs and medical groups that employ their physicians. The potential risk to members of these two different organizations is substantially different.

6) Report on Trends of Declining RBOs - Presentation

Pritika Dutt, Examiner in the Provider Solvency Unit (PSU), provided an update on the impact of various TNE requirements on RBOs.

- Since 2005, 92 RBOs have gone out of business due to insolvency.
    - Of the 92, 51 RBOs had no financial concerns (10 had greater than 50 percent Medi-Cal lives)
        - 39 RBOs were purchased by other health plans or RBOs
        - 12 RBOs ceased operations
    - Of the 92, 41 RBOs had financial concerns at the point of closure (16 had greater than 50 percent Medi-Cal lives)
        - 16 RBOs ceased operations
        - 15 RBOs were merged or purchased by another entity

        - 10 RBOs were de-delegated by their contracting health plans
        - Warning Signs
            - Low reserves - borderline complaint with TNE working capital and cash-to-plan claims requirement
            - Continued net losses
            - Provider complaints to the DMHC indicating there were claims payment issues with these RBOs
            - Relied heavily on the receivables so there were low cash balances, but high receivables in these RBOs
            - Lots of affiliate transactions between certain RBOs
            - Dramatic growths in enrollment
        - 9 RBOs were filing compliance statements and were required to file financial statements only on an annual basis.
        - Currently 42 RBOs are filing compliance statements.

- How the warning signs apply to current RBOs (using second quarter financials)
    - 31 RBOs on the monitor closely list showed similar warning signs (two-thirds have greater than 50 percent Medi-Cal lives)
        - 21 RBOs showed at least one warning sign
        - Eight showed two warning signs
        - Two showed three or more warning signs
    - 10 RBOs on a Corrective Action Plan (five have greater than 50 percent Medi-Cal lives)
        - Five showed at least one warning sign
        - Five showed two or more warning signs
    - Monitoring these RBOs
        - Once the financials are received, these are reviewed first. Based on the review, additional information may be requested such as detailed financial statements, backup documentation, monthly financials and projections.

Discussion

Mr. Furgatch asked how many of the 21 RBOs that had one warning sign had dramatic growth in enrollment.

Michelle Yamanaka replied the majority of those 21 RBOs had low reserves, and very few had a dramatic growth in enrollment.

Ms. Pumpian asked if the DMHC is receiving notes in the quarterly financial statements that would suggest related party transactions exist.

Ms. Dutt replied the DMHC does not receive notes in the quarterly financial statements, but the annual audited financial statement indicates if there are affiliate transactions.

Ms. Yamanaka added that in the TNE calculation, affiliate transactions are recorded to be deducted from the calculation, so that information is in the Financial Survey Reports.

7) 2015 FSSB Meeting Dates

8) Public Comments

Ms. Pumpian asked if there any public comments on items not on the agenda. There were none.

9) Agenda Items for Future Meetings

- CAPG restricted licenses
- Licensure of the COHS plans
- RBO enrollment report by Health Plan
- Quality and access in Medi-Cal Managed Care

10) Closing Remarks/Next Steps

The next meeting is scheduled for March 18, 2015.

The Meeting was adjourned at 11:41 a.m.