DEPARTMENT OF Managed Health Care

Financial Solvency Standards Board Meeting
March 16, 2016
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Edward Cymerys, Collective Health
Jacob Furgatch, Coast Healthcare Management
Dr. Larry de Ghetaldi, Sutter Health
Dave Meadows, Liberty Dental Plan
Ann Pumpian, Chairperson, Sharp HealthCare
Dr. Jeff Rideout, Integrated Healthcare Association
Shelley Rouillard, Department of Managed Health Care
Dr. Rick Shinto, InnovaCare Health, Inc.

Department of Managed Health Care (DMHC) Staff Present:
Stephen Babich, Supervising Examiner, Office of Financial Review
Gil Riojas, Deputy Director, Office of Financial Review
Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations
Michelle Yamanaka, Supervising Examiner, Office of Financial Review

1) Welcome & Introductions- Agenda

Chairperson Ann Pumpian called the meeting to order and welcomed the attendees. The board members introduced themselves to the audience

2) Minutes from December 9, 2015 FSSB Meeting

Ms. Pumpian made a motion to approve the December 9, 2015 FSSB meeting minutes. Dr. Larry de Ghetaldi seconded the motion. Meeting minutes were approved without objection.

3) Director's Remarks

Director Shelley Rouillard welcomed Dr. Jeff Rideout, President and Chief Executive Officer (CEO) of the Integrated Healthcare Association, to the Board.

Ms. Rouillard also introduced Jenny Phillips, who was recently appointed as Deputy Director for Legislative Affairs at the DMHC.

Ms. Rouillard provided an update on the pending mergers. The DMHC is still reviewing three of the mergers and public meetings have taken place for all three mergers. The

DMHC expects to make an announcement regarding the acquisition of Health Net by Centene within two or three weeks. Decisions on the mergers will be posted on the DMHC website and sent to those on the list serve.

Ms. Rouillard provided an update on the Governor's budget, most notably that the Managed Care Organization (MCO) tax had passed. The DMHC has several budget proposals primarily related to legislation implementation, including:

- Mental health parity compliance project.
- Provider directory activities related to Senate Bill (SB) 137.
- Large group rate review related to SB 546.
- Several bills related to prescription drugs, cost sharing and tiering of specialty drugs.
- Limits on out-of-pocket maximums and deductibles for individual and family plans related to Assembly Bill (AB) 1305.
- Requirements on vision plans and the co-location of optometrists and opticians.
- Legal requirements of the plans related to the End of Life Options Act, which will take effect on June 9, 2016.

Ms. Rouillard provided an update on the DMHC Strategic Plan. The Plan was released in September 2015.

Ms. Rouillard acknowledged Marta Green, Chief Deputy Director, for her work to improve the organization's efficiency and effectiveness.

4) Department of Health Care Services Update

Mari Cantwell, Chief Deputy Director, Health Care Programs and State Medicaid Director, Department of Health Care Services (DHCS), provided additional information about the MCO tax. It is a broad tax reform policy on MCOs, which replaces the existing tax and two other taxes on health plans regulated by the DHCS, DMHC, and the California Department of Insurance (CDI).

The tax is tiered differently for Medi-Cal lives and non-Medi-Cal lives and there are some exemptions. The next step is for DHCS to submit the proposal to the Centers for Medicare and Medicaid Services (CMS) for approval by March, with an anticipated response by July 1, 2016.

Ms. Cantwell also provided an updated on the other significant event at DHCS, the approval of the Medicaid 1115 waiver. The final waiver is different from the original proposal, but maintained most of the important core elements. The waiver includes $6.2 billion in federal funds over the next five years, with the potential for additional funding.

The waiver has four major programmatic components, including:

1. The Public Hospital Redesign and Incentives in Medical (PRIME) Program, which is a continuation of the Delivery System Reform Incentive Payments (DSRIP) program from the previous waiver. The new program is expanded to include district and municipal hospitals.
2. Dental Transformation Initiative, which provides incentive payments to dentists for various programs, including the use of preventive services for children and continuity of care. The initiative also includes an opportunity for some local dental pilot programs.
3. Transformation of public hospital funding for the remaining uninsured, which takes prior hospital funding that was hospital focused and cost based and turns it into a global budget which incentivizes the use of primary preventative care rather than in-patient and emergency care.
4. Whole Person Care pilot program, which will consist of locally-based pilots. The counties or other public entities will apply as the lead entity, but there is a role for health plans too.

In addition to the four programmatic components, there are various studies and evaluations, including one specifically related to Medi-Cal Managed Care.

The waiver requires an independent access assessment of Medi-Cal Managed Care, including the Knox-Keene Act requirements which have been incorporated into the plan contracts, state fair hearings and other elements. The assessment will compare access in Medi-Cal Managed Care to the plan's other lines of business. The assessment will be completed by an External Quality Review Organization (EQRO) and the structure of the assessment will be informed by an advisory committee with broad representation of consumer groups, health plans, legislature, etc.

Discussion

Ms. Rouillard asked how many pilot programs are expected. Ms. Cantwell explained that no single pilot is allowed to collect more than 30 percent of the funding, unless too few pilots apply. The goal is to utilize all of the funds, which will be dependent on the number of applications received. The original expectations were between ten and fifteen.

Dr. Rick Shinto inquired about the aggregate dollar amount for the pilots. Ms. Cantwell said that the amount is $300 million per year in federal funds, which will be matched with $300 million from the public entities.

Dr. de Ghetaldi asked about the primary goals of the pilot. Ms. Cantwell responded the focus is on high-cost, high-risk populations. She added that the pilot programs will include activities related to infrastructure, data sharing, and health outcomes. The money will be earned based on those deliverables and is focused more on improved outcomes rather than cost.

5) Office of the Patient Advocate Report Cards

Elizabeth Abbott, Director of the Office of the Patient Advocate (OPA), presented an update on the recent activities of the OPA. The OPA has issued report cards on quality information for the past fifteen years, including its four-star rating system for rating Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and medical groups.

Ms. Abbot indicated there are more than 2,000 clinical and patient experience data points on the OPA website. An additional entry for the total cost of care for medical groups has been added to the report cards, which includes hospitalization, physician services, specialists, ancillary care, laboratory services, radiological findings, and pharmacy services.

Ms. Abbott said the OPA Report Card was recently named the best of its kind in the country and according to Google Analytics, the OPA website is receiving web traffic from 108 different countries.

In addition, the OPA recently released the Medicare Medical Group Report Card, which was previously found on the IHA website. The transition is anticipated to increase awareness of the quality ratings specific to seniors and persons with disabilities.

The OPA is also tracking the complaints filed by consumers across four State health agencies, including DMHC, CDI, Covered California, and Medi-Cal. The report will include demographic data, such as the county, language and ethnicity. It will also include the resolution, health plans, and the ratio of complaints based on enrollment by health plan. Once this information is released, California will be the first state in the nation with a complete data report.

Discussion

Dr. Shinto asked Ms. Abbott and Dr. Rideout if the OPA, IHA and Medicare star ratings have the same value. He expressed concern that the use of stars can be confusing for consumers because the same plan could have four stars on one report card and two stars on another. He asked if there was any effort to align the definition of the star ratings across report cards.

Dr. Rideout responded the stars represent more than a percentile ranking but also a relative position of one star versus two stars. Both DMHC and CMS are non-voting ex-officio members of the IHA board and provide input on the development of the measures. However, the broader challenge is the diversity and discord of measures within the industry. IHA has tracked over a hundred measures across the four major product lines - Medicare Advantage, Medi-Cal, commercial and the Exchanges – and there are only two that are the same across all five measures.

Dr. Rideout acknowledged the work of IHA, the physician organizations, health plans and other experts that have helped over the last seven years. The Report Card is a more inclusive modification of a National Quality Forum measure which has been modified to fit the capitated environment in California. He stated the benchmarking done on these measures to national standards and the integrated delivery system in California, are way ahead on quality, patient experience and utilization.

The IHA has put information on their website that compares plan performance across different product types and geography for nine measures. This level of detail has previously not been measured. IHA has also trended total cost of care for the last five years and found that the total cost of care for the physician organizations has decreased each year and went negative last year.

Dr. de Ghetaldi said the total cost of care data is geographically-adjusted based on cost inputs and population risk to give a fair comparison across different medical groups that serve different communities. His concern is that there are too many report cards and both physicians and consumers will compare the various sites. Consumers may become confused and provider groups will become disengaged. He also mentioned IHA is developing a standardized Medi-Cal quality report, which is intended to give Medi-Cal beneficiaries the same options available to the commercial HMO patients.

Ms. Pumpian asked if any correlation has been made between health plan or medical group performance and their financial solvency on a report card. Ms. Abbott answered that this has not been measured, but agreed that this is a valid consideration.

Ms. Abbott added that the OPA reports are not just a tool for consumers but also for purchasers. It may need to be more sophisticated to include correlations but purchasers can use the data to look at whether plans are improving their performance, reducing costs or improving quality. She would also like some union employer groups to look at the report cards and use the information in their contract negotiations.

Dr. Rideout stated the IHA Board has started to look at correlations between the total cost of care and performance metrics, which may be in the same realm as solvency. He said there are not strong correlations between total cost of care and overall quality of performance. However, there are strong relationships between chronic care management and overall utilization statistics. The way that a medical group manages chronic care patients is an indication of the degree of integration or behavior of the overall system.

Tam Ma with Health Access California thanked Ms. Abbott for her work in making these tools available to consumers and purchasers. She added they are eager to review both the Complaint Data Report and the DMHC Timely Access to Care data.

Ms. Ma stated Health Access California is sponsoring SB 1135 (Monning), which would give consumers a notice of their existing rights to timely access to care and to language

assistance. The bill would also require the plans to include the DMHC and CDI help line phone numbers on all medical insurance cards.

6) Excess Tangible Net Equity Discussion

Gil Riojas, Deputy Director, Office of Financial Review, reviewed the tangible net equity (TNE) levels for the top reporting full service plans as of December 2015. TNE is defined as a health plan's total assets minus its total liabilities, reduced by the value of intangible assets and unsecured obligations outside of the normal course of business. Excess TNE is anything over the required amount of TNE. The TNE requirement for full-service plans is the greater of $1 million or a percentage of premium revenues or healthcare expenses.

The Department also looks at liquid TNE, which excludes receivables and any fixed assets from the TNE calculation. Liquid TNE is an indication of whether a plan has access to liquid assets if they had to pay their liabilities quickly or if their assets are held up in buildings or something else they can't access quickly.

Mr. Riojas reviewed the TNE ranges and the average TNE for each product category:

- The TNE for for-profit plans ranged from 103 percent to 1,084 percent, with an average TNE of 298 percent.
- The TNE for not-for-profit plans ranged from 150 percent to 1,653, with an average TNE of 664 percent.
- The TNE for commercial plans ranged from 130 percent to 1,653 percent, with an average TNE of 488 percent.
- The TNE for Medi-Cal plans ranged from 176 percent to 1,349 percent, with an average TNE of 574 percent.
- The TNE for the Medicare plans ranged from 103 percent to 1,525% with an average TNE of 225 percent.

Mr. Riojas noted one significant factor to consider when reviewing the data for the Medi-Cal plans is the rates the plans receive from DHCS. The rates for the Medi-Cal Managed Care (MMC) population have been relatively high. However, going forward, the rates have been reduced, and DMHC anticipates the excess amounts for these plans to decrease in future quarters.

Mr. Riojas asked the Board which factors the DMHC should consider when analyzing these percentages. He asked if a higher TNE indicates that the health plan is healthy, whether or not there should be different expectations of not-for-profit TNE as compared to for-profit TNE, and how much TNE is too much.

Discussion

Edward Cymerys, Collective Health, asked if the top five plans shown in the charts are the five largest plans. Mr. Riojas answered the chart shows the five plans with the highest TNE percentages, but they are not necessarily the largest plans.

Mr. Cymerys commented on the definition Mr. Riojas used for excess TNE, quoting Wikipedia's definition for the word "excess" as "an amount that is more than necessary, permitted or desirable". In his opinion, the Department is comparing the plan's surplus to the TNE rules established many years ago. It is still a mystery how those rules were developed, but it is a good question to ask what the right amount is for the surplus to back up the obligation of the plan.

He suggested DMHC leverage the work occurring in the industry, such as that of the American Academy of Actuaries and the National Association of Insurance Commissioners (NAIC), and compare with the financial solvency requirements of other states. One of the concepts under discussion is setting a minimum level of surplus and restrictions on moving surplus above this threshold. Mr. Riojas agreed that it would be valuable for DMHC to compare its requirements with those of other states.

Jacob Furgatch asked for clarification about what constitutes liquid TNE. Mr. Riojas said cash, structured receivables, marketable securities, Certificates of Deposit (CDs), and long-term CDs.

Mr. Furgatch added cash is most important when it comes to paying claims for providers. Mr. Riojas agreed, and added that DMHC not only analyzes TNE, but also working capital, cash to claims, cash flow operations, and enrollment. He reminded the Board that TNE is only one measure. For example, if the TNE for a plan consists of nearly all fixed assets, it would be possible for the plan to appear healthy based on the TNE data but remain on the DMHC's watch list.

Ms. Pumpian stated she was surprised that no plan fell below the TNE requirement because some of them had been on a corrective action plan (CAP) due to TNE. Mr. Riojas responded this was the first quarter in a while where there hasn't been a plan below the TNE threshold, but any plan close to the 100 percent threshold might be put on the watch list.

Dave Meadows agreed that this shows there is a lot of excess TNE, but it is based on a 26 year-old TNE requirement instead of what amount is necessary. He cautioned drawing any conclusions that 1,000 percent, for example, is excess TNE because it may not really be excess. Mr. Riojas said that the requirement is a baseline and something to measure against, but there may be other ways to look at it.

Dr. Rideout stated he would like to see it weighted by membership to see the risk to consumers. This could be an early warning system for member protection, particularly

looking at trends from quarter to quarter and over 12 months. He also noted that it was interesting the for-profit plans are of greatest concern when looking at liquid TNE.

Dr. de Ghetaldi said the Medi-Cal plans have experienced periods of feast or famine, particularly in the 2000s. While the plans are in a better position currently, there is anxiety because of what they have experienced historically. He said he wasn't sure how much was too much, but would expect that if TNE got too high, the plans should reinvest tax payer dollars back into the patients. Mr. Riojas stated that he has been in contact with some of the Medi-Cal plans about this issue and they are working to make investments where they need to.

Dr. Rideout asked why the plans are not named in the TNE data. Ms. Rouillard replied DMHC generally does not name specific plans in the reports to the Board, but that the information is available to anyone. One of the issues the Department is looking at is the correlation between the financial standing of the health plans and the quality scores. She added if quality performance is poor for a plan but the plan has excess TNE, the excess should be utilized to improve access or the care being delivered.

Dr. Shinto observed the for-profit plans scrutinize their holdings differently than not-for-profit plans. The 85 percent Medical Loss Ratio (MLR) requirement is forcing the for-profit plans to build infrastructure they may have been delaying. He added there needs to be levers to start to change the practice of health care and ensure excess TNE is reinvested to benefit the consumers.

Mr. Cymerys asked if the Department was considering modifying the TNE requirements or if the intent was to stimulate conversation. Mr. Riojas responded the intent was to get the Board's input as the Department considers how to move forward.

Ms. Pumpian stated while rating agencies and external organizations look at for-profit and not-for-profit entities differently, the role of the Board is to protect consumers and ensure providers are adequately compensated for the care they provide. Dr. Shinto agreed that protecting consumers and providers should be the priority.

7) Dental Medical Loss Ratio Update

Mr. Riojas provided an overview of AB 1962, which requires certain dental plans to file a medical loss ratio report no later than September 30, 2015, and each year after until January 1, 2018.

The Department worked with the dental plans, CDI, and various stakeholders to develop a template and guidance which the plans used to submit their 2014 data on September 30, 2015.

Mr. Riojas reviewed the key findings from the 2014 data:

- The dental HMO (DHMO) individual market reported MLRs ranging from five percent to 97 percent, with an average of 43 percent
- The DHMO small group market reported MLRs ranging from 41 percent to 86 percent, with an average of 54 percent.
- The DHMO large group market reported MLRs ranging from seven percent to 86 percent, with an average of 61 percent.
- The dental Preferred Provider Organizations (DPPO) individual market reported MLRs ranging from 46 percent to 55 percent, with an average of 51percent.
- The DPPO small group market reported MLRs ranging from 22 percent to 70 percent, with an average of 55 percent.
- The DPPO large group MLRs ranged from 76 percent to 90 percent, with an average of 83 percent.

Mr. Riojas said there is significant variance between the plans and the products they offer. DMHC will be contacting the plans to develop a better understanding of the reported numbers. He anticipates the MLR variances for calendar year 2015 will be less than those for 2014, but cannot make any guarantees.

Mr. Riojas added the premium dollars are lower for the dental plans and the administrative cost ratios are higher compared to full service plans, but the dental plans are responsible for many of the same functions as the full service plans. This may account for some of the low MLRs for the dental plans. This is an important consideration when reviewing the numbers and as the Department looks at whether there should be standards and what they should be.

This information was presented to the California Association of Dental Plans and they have indicated the process is complicated, but they will work with the Department to better understand what the MLRs include. If the Legislature decides to enact a dental MLR and the percentage is too high, it might limit the number of dental products offered in the marketplace, ultimately reducing the options for consumers.

Discussion

Mr. Meadows reminded the Board that unlike medical, there are no required dental benefits. Dental coverage is open-ended, with a wide range of options between plans. The plans at the lower levels provide the basics, such as a cleaning and x-rays, while the higher-tier plans are usually more comprehensive.

Ms. Rouillard asked Mr. Meadows which product is more popular. Mr. Meadows replied it varies by plan, but when looking at the low-benefit plans, the MLR is going to very low. However, if you look at it from an actuarial stand point, a lot of these plans have a high

actuarial value. The member gets a lot of benefits with a low premium so the actuarial value is high on a very low MLR.

Dr. Rideout stated that the actuarial value approach might be better because the benefit designs are so different. It would be difficult to compare plans based on MLR without standardization. Mr. Riojas agreed that the lack of standard benefits makes a comparison difficult.

Dr. de Ghetaldi advised against jumping to conclusions based on the first year results. The data suggests inadequate funds have been allocated towards patient care as a function of the total premium received. The MLR may not need to be at 85 percent because of the administrative complexity, but it shouldn't be 40 percent.

Mr. Cymerys added that it would be more sensible if there were a way to compare the MLR with bands of actuarial value for the dental plans. Mr. Furgatch echoed this statement, and said that the actuarial value should be taken into account.

Ms. Abbott indicated that she is a consumer representative for NAIC, which was asked to reexamine the MLR. According to Ms. Abbott, the American Health Insurance Plans (AHIP) Trade Association contended the MLR was too restrictive and there are other factors that can be considered for patient healthcare services, such as nurse hotlines, fraud and abuse efforts, credentialing processes for physicians, and other utilization review materials. Ms. Abbott said consumer representatives disagree and believe that the data will show MLR standards have had a significant impact on the consumers, including access to care and health outcomes, and it should not be based on administrative exigency for health plans. She reminded the Board that NAIC's decision regarding MLRs was adopted by CMS and the Center for Consumer Information and Insurance Oversight (CCIIO) so any further recommendations could be influential and she suspects they may look at dental MLR.

Ann Milar from the California Dental Association (CDA) expressed appreciation for the Board's proactive stance in reviewing the reports. Ms. Milar stated CDA shares many of the concerns and the potential that patients are offered illusory benefits. She encouraged the DMHC to work with the plans to ensure greater consistency in future reporting.

8) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, presented an update on RBO financial solvency for the quarter ending on December 31, 2015:

- All 178 Risk Bearing Organizations (RBOs) are required to submit annual filings. To date, 23 have submitted their annual reports and the majority will submit their filings by May 30, 2016.
- 133 of the 178 RBOs filed quarterly survey reports, which include the balance sheet, income statement, statement of cash flows, and the calculation of

solvency criteria. The remaining 45 RBOs submitted compliance statements, attesting to their compliance with the solvency criteria.

- Three RBOs filed monthly financial statements, as required by their CAP.
- The number of RBOs decreased from 178 to 176 compared to the previous quarter. One RBO closed and three new RBOs began reporting.
- 28 RBOs are in the superior category, a decrease from 37 in this category in the previous quarter. The reason for the decrease was primarily due to paying out year-end bonuses.
- 92 RBOs reported compliance, of which one is on a Corrective Action Plan (CAP) and five are on the monitor closely list.
- Nine RBOs who were on a CAP in the prior quarter remain on a CAP and five new RBOs have CAPs. For the nine RBOs with continuing CAPs, seven are meeting their approved CAP and two are not.
- The top 20 RBOs have more than 50 percent of Medi-Cal enrollment with approximately 2.9 million Medi-Cal lives. Two of these RBOs have a CAP and one is on the monitor closely list.
- The remaining 62 RBOs have approximately 1 million Medi-Cal lives. Four of these RBOs have a CAP and one is on the monitor closely list.

Ms. Yamanaka provided a summary of RBO performance for 2015 across four aspects, including the number of RBOs reporting, the change in financial status indicators, the monitor closely list, and the CAPs.

1. Number of RBOs: At the beginning of the year, there were 176 RBOs reporting to the DMHC, four of which were inactivated because of consolidation, and one which closed altogether. There are six new RBOs reporting to the DMHC, which serve a substantial number of Medicare enrollees. In total, there were 178 RBOs at the end of the year.

2. Financial Status Indicators: There were 18 RBOs in the superior category, 61 which were compliant, and three in the non-compliant category for the entire year. Twenty-seven RBOs changed from a superior status to the compliant category, and one RBO changed from the superior category to the non-compliant category.

3. Monitor Closely List: There was an average of four RBOs per quarter on the monitor-closely list. None of the RBOs went on CAPs, which is possibly attributed to the DMHC being more diligent in its monitoring and questioning of the plans. The majority of these RBOs were on the list due to low reserves, concerns with reporting, or for heavy reliance on receivables to meet the solvency criteria.

4. Corrective Action Plans: The DMHC worked on 32 CAPs in 2015. Sixteen of those RBOs achieved compliance with their CAP in 2015. Two CAPs were closed, one because the RBO closed and the other because the RBO failed to meet its compliance date and had additional concerns, resulting in a new CAP entirely. Fourteen CAPs are current.

   The CAPs were also reviewed based on deficiency type. Fifteen RBOs were non-compliant for claims timeliness, while 14 RBOs were non-compliant for TNE. There were nine RBOs that failed to meet the working capital requirements or were found non-compliant, and there were four RBOs that were non-compliant in the cash-to-claims category.

   An RBO can enter into a CAP with between one and five deficiencies. The majority, 25 RBOs, were deficient in one criteria, five RBOs were deficient in two of the criteria, one RBO was non-compliant with three criteria, one with four, and one with five.

Additionally, the Provider Solvency Unit conducts audits of the RBOs, which involves reviewing their claims, provider dispute resolutions, and finances. For the year 2015, there were 24 audits scheduled, 23 of which have been completed. The remaining audit is in its final stages and should be completed soon. There are 24 audits scheduled for 2016, seven of which are in progress.

9) Health Plan Quarterly Update

Stephen Babich, Supervising Examiner, Division of Financial Oversight, provided the health plan quarterly update for the quarter ending December 31, 2015:

- The DMHC currently licenses 72 full services plans, a slight increase from the previous year.
- There are nine applicants in the queue, including five full service plans. The remaining four are restricted license applicants, two of which are behavioral health applicants and two are vision plan applicants.
- Enrollment is nearly evenly split between commercial and government. The greatest increase in government enrollment occurred between 2013 and 2014.
- For 2015, most of the enrollment increases were in the individual market, which includes Covered California.
- 28 plans are on the monitor closely list, including 22 full service plans with approximately 2.6 million lives and six specialized plans with approximately 500,000 lives.
- Compared to a year ago, the number of Medi-Cal plans on the monitor closely list has stayed the same. However, there has been an increase in the number of Medicare Advantage plans and commercial plans. The increase in commercial plans was largely due to reductions in cash flow.

- For the 28 plans on the monitor closely list, most have TNE between 130 percent and 250 percent. Three of the entities are at 500 percent or higher since TNE is not the only factor that is considered when placing plans on the monitor closely list.
- The number of specialized plans on the monitor closely list is the same as the prior year.
- There are no TNE-deficient plans. Fifty-seven plans have a TNE of 500 percent or more and only five plans are below 130 percent TNE.

Discussion

Mr. Furgatch asked if the Medicare Risk group is the dual eligibles or straight Medicare Advantage. Mr. Babich replied that the dual eligible enrollment data is reflected within the Medi-Cal category. The Medicare Risk category includes the 16 Medicare Advantage licensees.

Mr. Furgatch requested, given the earlier discussion on TNE and high reserves, to have a presentation at a future meeting on liquidity issues. Mr. Babich agreed that liquidity is the primary driver for ending up on the monitor closely list.

10) Public Comment on Matter not on the Agenda

Ms. Rouillard asked for public comment on items not on the agenda. There was none.

11) Agenda Items for Future Meetings

Dr. Shinto suggested having Mr. Meadows give a presentation regarding the dental infrastructure within the State. He would be interested in understanding the types of dental plans, their size, the scope of services they provide, and continuing the conversation about MLR.

The next meeting will be held on June 15, 2016.

12) Closing Remarks/Next Steps

The meeting was adjourned at 11:47 a.m.