Financial Solvency Standards Board Meeting
December 9, 2015
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Jacob Furgatch, Coast Healthcare Management
Dr. Larry de Ghetaldi, Sutter Health
Betsy Imholz, Consumers Union
Dave Meadows, Liberty Dental Plan
Ann Pumpian, Chairperson, Sharp HealthCare
Shelley Rouillard, Department of Managed Health Care
Dr. Keith Wilson, Molina Healthcare

Department of Managed Health Care (DMHC) Staff Present:
Stephen Babich, Supervising Examiner, Office of Financial Review
Pritika Dutt, Supervising Examiner, Office of Financial Review
Kristine Mapile, Assistant Chief Counsel, Office of Plan Licensing
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 attendees. The board members introduced themselves to the audience

2) Minutes from September 9, 2015 FSSB Meeting

Jacob Furgatch made a motion to approve the September 9th FSSB meeting minutes. Betsy Imholz seconded the motion. Meeting minutes were approved without objection.

3) Director's Remarks

Director Shelley Rouillard announced Dr. Jeff Rideout, President and Chief Executive Officer (CEO) of the Integrated Healthcare Association (IHA), as the new alternate member on the Board taking the place of Tom Williams. Ms. Rouillard expressed her gratitude for Mr. William's service to the Board.

Ms. Rouillard provided an update on the status of the acquisition of Care1st by Blue Shield. The transaction was approved on October 15, 2015. As part of the approval process, the DMHC negotiated several undertakings related to improving quality and

access, including a $200 million investment to increase transparency and accessibility in health care and support consumer assistance programs, including:

- $2 million per year for five years ($10 million total) to support consumer assistance programs throughout California.
- $50 million to strengthen the health care delivery system, particularly for Medi-Cal, through programs intended to improve infrastructure at the plan and provider level. This includes a provider database project and an IHA-sponsored encounter data project.
- A minimum of $14 million per year for ten years ($140 million total) allocated to the Blue Shield Foundation.

Other significant undertakings include:

- Converting Care1st to nonprofit status, which has been completed.
- Improving Blue Shield's scores on both the Right Care Initiative measures and the Office of the Patient Advocate (OPA) Report Card.
- Improving Care1st's scores on the Medi-Cal Managed Care Quality Report Card.
- Ensuring Care1st files timely and accurate encounter data with the Department of Health Care Services (DHCS).
- Requiring Blue Shield to demonstrate a plan to become proficient in the Medi-Cal program.
- Requiring Blue Shield to meet and confer with the DMHC if a rate is determined to be unreasonable.
- Requiring Blue Shield to surrender its tax exemption status, regardless of the outcome of its pending appeal with the Franchise Tax Board.

Ms. Rouillard commended the work of the DMHC staff involved with the review, analysis, and negotiation of the transaction.

Ms. Rouillard stated the DMHC held a public meeting regarding the acquisition of Health Net by Centene on December 7, 2015 and will hold the next public meeting on the acquisition of Humana by Aetna on January 4, 2016. The Anthem-Cigna public meeting has not been scheduled.

Ms. Rouillard provided an update on SB 964 (Hernandez), which requires the DMHC to annually release information to the public regarding the reporting of timely access data. The first report was due on December 1. The report is currently under review and the Department expects to post the report for Measurement Year 2014 sometime after the beginning of 2016.

Ms. Rouillard stated 2015 marked several milestones for the Department, including the fifteenth anniversary of the DMHC, the fifth anniversary of the signing of the Affordable

Care Act (ACA), and the fortieth anniversary of the Knox-Keene Act (KKA). To highlight these milestones, the Department released the Anniversary Report, which also serves as the 2014 annual report. Highlights of the Anniversary Report include:

- The DMHC now protects the health care rights of over 25 million Californians.
- The DMHC has assisted 1.6 million consumers through the Help Center.
- In 2014, more than 100,000 consumers were aided in resolving issues with their health plans.
- The DMHC has recovered more than $20 million from health plans on behalf of Californians for services that should have been covered by the plans.
- The DMHC has saved Californians more than $101 million in health care premium increases, with 2014 accounting for $41 million.

Discussion

Ms. Imholz expressed concern regarding Blue Shield's decrease in charitable contributions to the company's Foundation from $35 million annual average to $14 million. She also expressed concern about Blue Shield's excessive surplus and stated they are way over their Tangible Net Equity (TNE) requirements.

Dr. Larry de Ghetaldi, commented on the recent trends of expansion in coverage within the past year, and voiced concern for declining access to care. He encouraged the Department to look for trends to see if expanded coverage has resulted in reduced access.

4) Alameda Alliance for Health Update

Gil Riojas, Deputy Director, Office of Financial Review, announced that the conservatorship of Alameda Alliance had ended. The Department will continue to monitor the plan by reviewing monthly financial statements, meeting with the executive leadership of Alameda Alliance on a bi-weekly basis to discuss any operational or claims-processing issues, and attending the plan's Board of Governors meetings on a monthly basis.

For the September quarter, Alameda Alliance reported 491 percent of its required TNE, a healthy working capital ratio of 1.21, and net income of $20 million.

Discussion

Ms. Imholz asked about the experience of enrollees. Mr. Riojas explained that phone surveys have been conducted, and the results are positive. Ms. Rouillard added call wait times and member services metrics were factors in returning the plan to local control.

Ms. Pumpian asked if the plan's Board meetings are interactive and whether the Board includes both consumers and plan representatives. Mr. Riojas responded there has been increased engagement in the meetings and there is one remaining vacancy on the Board for a consumer to fill.

5) Mergers and Acquisitions

Kristine Mapile, Assistant Chief Counsel, Office of Plan Licensing, provided an overview of the three mergers the Department is currently reviewing.

1. Centene Corporation Acquisition of Health Net, Inc.
   - Parties:
     - Health Net, Inc.: Health Net of California, Inc.; Health Net Community Solutions, Inc.; Managed Health Network
     - Centene Corporation: California Health and Wellness Plan
   - Purchase Price: $6.8 billion
   - Public Meeting: December 7, 2015
2. Aetna Inc. Acquisition of Humana, Inc.
   - Parties:
     - Aetna, Inc.: Aetna Health of California; Aetna Dental of California; Health and Human Resource Center
     - Humana, Inc.: Humana Health of California; Arcadian Health Plan
   - Purchase Price: $37 billion
   - Public Meeting Date: January 4, 2016
3. Anthem Inc. Acquisition of Cigna Corporation
   - Parties:
     - Anthem, Inc.: Blue Cross of California; Blue Cross of California Partnership Plan; Golden West Health Plan, Inc.
     - Cigna Corporation: Cigna HealthCare of CA., Inc.; Cigna Behavioral Health of CA., Inc.; Cigna Dental Health of CA., Inc.; HealthSpring Life & Health Insurance Company, Inc.
   - Purchase Price: $54.2 billion
   - Public Meeting Date: To Be Determined

Ms. Mapile stated the Department also recently completed review of a change in control filing for a specialized vision plan, For Eyes, Inc. Reviews are still pending for changes in control at the grandparent level for March Vision Care and UDC Dental.

Discussion

Ms. Imholz asked Ms. Rouillard if there was a role for the Board in advising the Department on these significant transactions.

Ms. Rouillard responded the Department would appreciate input from the Board on possible undertakings. In addition, if any of the members have experience with mergers and acquisitions, she would welcome input on things the Department should be looking at, particularly regarding solvency or the financial status of the plans.

Mr. Furgatch expressed concern over the potential disruption to service areas and narrowing of options as a result of these mergers, which Ms. Rouillard acknowledged.

Dr. de Ghetaldi referenced the uniqueness of the Blue Shield acquisition, given the transition from nonprofit status to for-profit. He felt that the largest concern is the long term impact on the cost of care, but in the short term expects no alterations to patient/physician relationships or networks to occur.

Ms. Pumpian questioned the Department's confidence in how Blue Shield's balance sheets compare in California versus the rest of the nation. Furthermore, Ms. Pumpian questioned how the potential DMHC undertakings could be affected by the California composition of these plans as opposed to all others.

Mr. Riojas indicated that his office is analyzing the financial impact of all of the transactions and the percentage of the transaction that is in California. This has been the baseline for the undertakings.

Dave Meadows asked if there is a Knox-Keene-licensed entity in California, each with its own balance sheet, for all of the proposed mergers. Mr. Riojas confirmed there is and part of the discussion with the plans is related to their balance sheets, pre-transaction and post-transaction.

Ms. Pumpian inquired about the projected timeline for resolution of the mergers. Ms. Mapile responded that resolution would come after the public meetings are held. Ms. Rouillard added the health plans would like a resolution sooner rather than later.

Mr. Furgatch asked if the DMHC questions the plan's intent when determining approval of the merger. Ms. Mapile responded that some of the filings address those questions.

Dr. Keith Wilson asked whether or not the anti-trust issues are outside of the DMHC's purview. Ms. Rouillard confirmed that anti-trust issues are reviewed by the Attorney General.

Ms. Imholz asked if the DMHC would consider potential operational issues, such as necessary adjustments to the plan's Information Technology (IT) systems, in the

undertakings. Ms. Mapile mentioned there were similar undertakings in previous filings, such as the Blue Shield acquisition of Care1st.

Tam Ma with Health Access California questioned if these transactions ultimately benefit the consumers and the health system. Ms. Ma questioned Centene's method of entry into the California market, indicating that Centene could provide consumers with a new choice and increased competition as opposed to merging with an existing insurer. She added she has found no evidence that mergers lead to improved quality or lower prices. Other concerns include how the mergers affect government purchasers and the lack of experience of out-of-state companies in the California commercial market. She encouraged the Department to include clear undertakings that ensure no harm to patients, consumers, and government purchasers.

Don Crane, CEO of the California Association of Physician Groups (CAPG), expressed that, initially, CAPG viewed the mergers with opposition and added it is best to view these consolidations with caution. Mr. Crane and CAPG believe the mergers present a unique opportunity to develop a new infrastructure in the health care system to connect providers, plans, and hospitals alike. Mr. Crane raised three suggestions to achieve this goal:

1. Establish a common clearinghouse for the transmission of encounter data.
2. Develop an accumulator to track financial data, particularly deductibles.
3. Fund the development of a centralized utility to support accurate provider directories.

Mr. Crane encouraged the Department to monitor improvement of the delivery system in California and use the mergers as an opportunity to build an infrastructure for shared data.

In response to Mr. Crane's comments, Dr. Wilson asked Mr. Crane's opinion regarding the progress of a Health Information Exchange (HIE) in California as compared to other states. Mr. Crane suggested that a data warehouse might be a possibility, but acknowledged potential concerns, such as issues related to propriety, confidentiality, or competition.

Dr. Wilson asked Mr. Crane if he would suggest the establishment of a data warehouse as a recommended undertaking. Mr. Crane indicated that this is closely related to his previous suggestions.

Dr. de Ghetaldi asked Mr. Crane how the mergers will affect the Medicare Advantage options for seniors in California. Mr. Crane stated the market will most likely have a strong response due to the growing popularity of the program. However, it is appropriate to require undertakings that hold plans accountable for their performance in the pay-for-performance program and negative consequences if they fall short.

Ms. Imholz stated history suggests mergers lead to higher costs for consumers, and expressed reservations towards the mergers. Ms. Imholz stated she appreciated Mr. Crane's creative thinking and interesting ideas, but expressed reservations with the word "utility". She added a centralized provider directory database is a brilliant concept that requires public oversight, and public and consumer involvement. Mr. Crane responded that he used the word "utility" because it implies a sort of common good.

Dr. Wilson asked for clarification about the nature of Mr. Crane's suggested undertakings and its application to physician groups. Mr. Crane confirmed that one of the three, the accumulator, is relevant to physician groups. Dr. Wilson requested that Mr. Crane elaborate on his suggestions, particularly regarding the implementation of safeguards for physician groups from a financial solvency perspective.

Mr. Crane further explained the accumulator system, and how it would provide transparency into the status of financial accounts. Mr. Crane explained that it would benefit providers and patients alike by helping to determine payment status and track deductible balances.

6) Financial Summary of Local Initiative Health Plans and County Organized Health Systems

Mr. Riojas provided an update on the Financial Summary Report of Local Initiative (LI) Health Plans and County Organized Health Systems (COHS) for September 2015.

Local Initiative Health Plans:

- From September 2014 to September 2015, enrollment continued to increase with individual plan enrollment increases ranging from 14 percent to 25 percent. This may put a slight strain on the system, particularly pertaining to processing claims.
- Per Member per Month (PMPM) medical expenses and premium revenue range from $8 to $46. Each of the LI's reported positive net income for the September quarter. However, the reported net income has decreased for most plans since June.
- One notable plan is the Local Initiative Health Authority for L.A. County (L.A. Care). DMHC has questioned the plan's irregularly high income, and will report back when further information is available.
- All of the plans reported a positive TNE. In particular, Alameda Alliance was at a negative TNE in March of 2015, but the plan is now at 491 percent of required TNE.

County Organized Health Systems

- Similar to the LIs, the COHS enrollment steadily increased, with the exception of Health Plan of San Mateo. For the quarter ending September 2015, the plan reported a decrease in Medicare enrollment.

- The PMPM figures for the COHS have also grown, with increases ranging from $13 to $98. All plans reported a positive net income for the quarter. However, the net income for four plans has decreased since June 2015.
- All of the COHS report healthy reserves, ranging from 400 percent to 1,300 percent.

Mr. Riojas thanked Stephen Babich, Supervising Examiner, Office of Financial Review, and Pritika Dutt, Supervising Examiner, Office of Financial Review, for their work on the report.

Discussion

Dr. de Ghetaldi expressed concern over the superior performance of the COHS compared to the LI's, and asked if TNE can ever be too high. In response, Mr. Riojas stated that neither the regulations nor the Knox-Keene Act set a maximum level of TNE.

Dr. de Ghetaldi stated that the plans may be overspending or over committing, rather than acting with prudence. He also questioned whether plans with a high TNE are investing in their members.

Ms. Imholz expressed concern regarding the spending practices of the plans and asked if there was an explanation for the high TNE of some plans. Mr. Riojas responded that there is correlation with the medical loss ratio and the funds will eventually return to DHCS if unused.

Mr. Furgatch asked whether or not the funding, if available, will be distributed to the provider communities, particularly physicians. Mr. Furgatch also mentioned that the State potentially overfunded the Medi-Cal program, so now corrections have been made.

Dr. de Ghetaldi stated this is only part of the story. He would like to see a comparison of the LIs and COHS that goes beyond the financial picture. He would like to see their ratings on clinical quality, member and provider satisfaction, and access to care. He added that it is difficult to make a determination that their TNE is too high without knowing how they are performing their mission to care for patients. It would be good to see a star rating system that compares the plans on member services. He also expressed interest in homogenizing the Medi-Cal fee schedule with the Medicare fee schedule to allow for easier comparisons.

Ms. Pumpian suggested that there might be value in comparing the results of the LIs and COHS with those of the health plans monitored by the DMHC, particularly those that are Medi-Cal. Mr. Riojas agreed that these suggestions should be considered, but acknowledged that the report would be complex. She suggested overlaying the quality data with the financial data to create the report.

Beth Abbott, Director of the OPA, encouraged Ms. Rouillard to act as a second representative for California in The National Association of Insurance Commissioners (NAIC), which has been petitioned by the American Association of Health Insurance Plans (AHIP) to revisit the definitions of the medical loss ratio, with the intent of relaxing what expenses can be considered legitimate medical expenses.

Brianna Lerman, CEO of Local Health Plans of California (LHPC), stated there is concern about the perception that local plans are accumulating excessive funds. A good portion of these funds have been encumbered and will be returned to the State under the Medical Loss Ratio (MLR) rules for Medi-Cal Expansion (MCE). Ms. Lerman was unclear if the MCE monies had been accounted for in the DMHC report.

Mr. Riojas responded the Department will be asking the LIs and COHS about where they are reporting this amount. Mr. Riojas added that standardization would be beneficial to the reporting process.

Ms. Rouillard asked Mari Cantwell, Chief Deputy Director, Health Care Programs, from DHCS when they would collect back the MLR differences. Ms. Cantwell responded the final data will not be available until the end of the fiscal year for the first eighteen-month period. Ms. Cantwell added this only applies to the first two and a half years and DHCS will have to revisit this issue as they move forward.

Bill Barcelona, from CAPG, expressed concern that smaller Medi-Cal groups do not wield much leverage when negotiating with plans. Mr. Barcelona also discussed growing concerns about plan MLR over the past year, and mentioned that the differentiating factor between Medicare Advantage plans and Medi-Cal Managed Care plans as of late has been the variation in rates. It is not a stable environment for providers to go through 30 to 40 percent fluctuations in capitation rates in 12 to 16 months. He added that California needs a greater degree of stabilization in the rate cycle at the provider level.

Mr. Barcelona added that CAPG is also concerned that after cuts in capitation have occurred, the groups have seen an increase in utilization. If rates are cut and utilization increases, there will be a problem with the solvency of the groups. This is particularly puzzling when drastic rate cuts are happening at the same time as the reserves are doubling and tripling for some of the LIs and COHS.

Mr. Meadows stated the Department should be cautious in assuming that a plan at 100 percent of TNE is satisfactory, and stated that it is necessary to determine what exactly is defined as excessive.

Dr. de Ghetaldi stated the plans appear to have safety net providers with adequate access and capacity, yet the patients are unable to receive timely care. To demonstrate the point, Dr. de Ghetaldi stated that the clinical picture of a patient enrolled in 2014 would not be complete until 2015.

7) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, provided an update on the financial solvency of Risk-Bearing Organizations (RBOs) for the quarter ending September 30, 2015:

- 43 of the 176 RBOs submitted compliance statements attesting to their compliance with all solvency requirements; 131 RBOs filed financial statements; and there were two non-filers during this reporting period.
- 37 RBOs are in the superior category.
- 86 RBOs are reporting compliance.
- Four RBOs are on the Monitor Closely list.
- Eight RBOs are non-compliant.
- There are 17 active corrective action plans, six of which were new for the quarter and 11 which carried over from the previous quarter. Nine of the 11 RBOs from the previous quarter are meeting their milestones and two are not meeting their targeted projections.
- Six RBOs have complied with their corrective action plan and all solvency requirements and should be closed by the end of December.
- There are 3.8 million Medi-Cal lives accounted for in the 176 RBOs, an increase of 140,000 enrollees, or 4 percent, over the previous quarter.
- The top 20 RBOs have approximately 2.9 million Medi-Cal lives; one of the top 20 RBOs is on the Monitor Closely list.
- The remaining 62 RBOs hold approximately 970,000 Medi-Cal lives; one of these RBOs is on the Monitor Closely list and five RBOs have a corrective action plan.

Ms. Yamanaka added the Attorney General granted conditional approval of the transaction between Blue Mountain and the Daughters of Charity Health System Medical Foundation on December 3, 2015.

Discussion

Dr. de Ghetaldi asked how many lives are with the Daughters of Charity and if greater than 50 percent of those are Medi-Cal. Ms. Yamanaka responded they have between 20-30,000 lives with more than 50 percent in Medi-Cal.

Ms. Pumpian asked about the financial status of Daughters of Charity. Ms. Yamanaka replied that the RBO is on a corrective action plan and is meeting the established milestones.

Ms. Pumpian asked why the two RBOs did not file. Ms. Yamanaka explained that the two non-filing RBOs filed at the quarter ending June 30, 2015. One has fewer than 10,000 lives, while the other has over 20,000 lives. The DMHC has been in discussion

with the RBOs, who are working with their accountants to submit the financial reports. Ms. Yamanaka answered that neither of the RBOs was under corrective action in June.

Mr. Furgatch sought clarification regarding the RBOs that fell off of the list, in particular, if they corrected the long-term issues. Ms. Yamanaka explained how RBOs join and exit the list. The regulations provide timeframes for the RBOs to come into compliance. One year is allowed for TNE, working capital, and cash to claims. Six months is allowed for claims timeliness. Three months is allowed for the incurred but not reported (IBNR) methodology.

Ms. Imholz asked if the number of corrective action plans has increased and requested further details regarding how the increased number of corrective action plans compares amongst the three aforementioned timeframes.

Ms. Yamanaka answered that over the past four quarters there has been an increase in corrective action plans and the majority of corrective action plans this quarter were related to claims timeliness due to backlogs. She stated the factors are dependent on the RBO and current financial trends for each RBO. However, claims timeliness is the primary cause, followed by TNE and working capital.

Ms. Pumpian commented that the implementation of the latest International Classification of Diseases (ICD-10) coding may worsen claims timeliness. Ms. Yamanaka agreed and stated that a system upgrade for ICD-10 was a cause of some of the timeliness issues this quarter.

8) Health Plan Quarterly Update

Stephen Babich, Supervising Examiner, Office of Financial Review, provided an overview of the responsibilities of the Division of Financial Oversight, including:

- Review Health Plan Filings
- Review Financial Statements
- Financial Examinations
- Claims Initiative Exams
- Medical Loss Ratio Exams

In addition, as a result of AB 1962 (Skinner), the Office will now be responsible for reviewing some dental MLR examinations as well.

Mr. Babich provided the following update on the financial status of the health plans for the quarter ending September 30, 2015:

- As of November 30, 2015, there were 122 Knox-Keene licensed plans, including a record high 72 full service health plans.

- There are four full service applicants in the queue, including one behavioral health applicant and two vision plan applicants.
- Enrollment increased to 28.29 million, with a near equal distribution of 12.57 million lives from commercial enrollment, and 12.38 million lives from government enrollment.
- The greatest growth in commercial enrollment has come from the individual market. Medi-Cal enrollment contributed to the greatest growth in government enrollment, increasing over 11 percent from the previous year.
- A total of 25 full service plans are on the Monitor Closely list, including:
    - Two Medi-Cal plans
    - Eleven Medicare Advantage plans
    - Seven Commercial Plans
- There was one TNE deficient plan, which was a specialized plan.
- Four plans had TNE between 100 percent and 130 percent. Three of the four plans are on the Monitor Closely list.
- Two plans had TNE above 150 percent.

Mr. Furgatch asked if comparison data was available for the Medicare Advantage plans. Mr. Babich indicated that in 2011, there were ten Medicare Advantage plans on the Monitor Closely list and 12 in 2012.

Ms. Imholz asked what qualifies a plan to be placed on the Monitor Closely list. Mr. Babich explained that a variety of criteria applies, such as declining financial trends, overall ratios, TNE, working capital, and operating cash flow. He added that something as simple as a newspaper article, depending on its gravity, could place an entity on the list if there was substance to the content of the article.

Mr. Furgatch noted that it is helpful to see the information for the closely monitored plans.

9) Public Comment on Matters not on the Agenda

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

10) Agenda Items for Future Meetings

The next meeting will be held on March 16, 2016.

There were no suggestions for future agenda items.

11) Closing Remarks/Next Steps

Ms. Imholz sought to ensure that the records reflected the discussion regarding overlaying data from both DMHC and DHCS to include TNE, quality data, and consumer satisfaction. Ms. Pumpian assured Ms. Imholz that the minutes would reflect the discussion.

The meeting was adjourned at 12:08 p.m.