DEPARTMENT OF Managed Health Care

Financial Solvency Standards Board Meeting
February 11, 2013
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Chairperson Keith Wilson, President and CEO, Talbert Medical Group
Brent Barnhart, Director, Department of Managed Health Care
Grant Cattaneo, CEO and Founder, Cattaneo & Stroud
Edward Cymerys, Senior Vice President and Chief Actuary, Blue Shield of CA
Larry deGhetaldi, M.D., Palo Alto Medical Foundation
Deborah Kelch, Independent Consultant
David Meadows, Senior Vice President of Government Programs, LIBERTY Dental Plan
Tom Williams, Executive Director, Integrated Healthcare Association

DMHC Staff Presenters:
Dennis Balmer, Deputy Director, Office of Financial Review
Michelle Yamanaka, Manager, Provider Solvency Unit
Suzanne Goodwin-Stenberg, Chief, Division of Financial Oversight

Presenters:
Dr. Douglas Brosnan, Director of Provider Relations, CEP America
Brett Johnson, Associate Director, Center for Medical and Regulatory Policy, CA Medical Association
Dr. Bing Pao, Director of Provider Relations, CEP America
Dave Meadows, Senior Vice President of Government Programs, LIBERTY Dental Plan
Leann Gassaway, Regional Vice President, State Advocacy, America's Health Insurance Plan
Tom Williams, Executive Director, Integrated Healthcare Association
Bill Barcellona, Senior Vice President Government Affairs at CA Association of Physician Groups

1) Welcome
Keith Wilson, FSSB Chairperson, called the meeting to order and welcomed the attendees.

2) Opening Remarks
Brent Barnhart stated there are critical developments in health care that will be discussed today.

Mr. Barnhart began by saying that at the last meeting, that the Chief Deputy Director Shelley Rouillard distributed a letter from Our SALUD requesting that Dr. Wilson be removed as Chair of the Board because Our SALUD felt he had an impermissible conflict of interest due to his affiliation with HealthCare Partners (HCP). Director Barnhart stated the FSSB has no authority regarding the appointment or removal of Board members. He also told the Board that the Department of Managed Health Care (DMHC) has determined there is no conflict of interest.

Mr. Barnhart asked for public comment.

Nestor Valencia commented that Dr. Wilson has a conflict of interest and should be removed from the FSSB. Mr. Valencia said HCP is operating as a plan without a license.

3) Minutes from November 8, 2012 FSSB Meeting
The board approved the minutes from the November 8, 2012 meeting.

4) Director's Update Regarding Allegations of Board Member Conflict of Interest
Mr. Barnhart stated there is no conflict of interest.

5) Presentations and Discussion: Solvency Requirements and Licensure

Presentation: California Medical Association - Presentation
Brett Johnson, Associate Director, Center for Medical and Regulatory Policy, CA Medical Association (CMA) and Dr. Douglas Brosnan, Director of Provider Relations, College of Emergency Physicians (CEP) America discussed how the Medi-Cal Managed Care expansion, Health Benefit Exchange (Exchange), and Bridge Plans would expand the number of insured.

California has 7.1 million uninsured. Using parallels to the Massachusetts experience. California could experience an expansion in enrollment of over 4 million into the Exchange, Bridge Plans, and Medi Cal, potentially adding 100 patients for every primary care doctor in California. Many of the newly eligible enrollees in the Exchange will be high utilizers of health care services. Currently, less than 60 percent of physicians in

California are accepting new Medi-Cal patients primarily due to low reimbursement rates. This, combined with the 90 day grace period, for non-payment of premiums, could strain provider group solvency.

Discussion:

Mr. Wilson asked to define Physician Dispute Report (PDR).

Mr. Brosnan stated a PDR is a denied claim on an Explanation of Benefits.

Mr. Wilson asked if the 90-day unpaid premium grace period is different than what exists in the commercial market. Is there something different in the Exchange?

Mr. Johnson replied currently the grace period lasts for 30 days after giving notice to an enrollee who has not paid premium. The Affordable Care act (ACA), provides a 90-day grace period for individuals in the Exchange who receive subsidies. It is estimated that about half of the Exchange population will be eligible for a subsidies. The final federal Health and Human Services regulation states the plans may send claims to providers for the last 60 days of the 90-day grace period. Plans may pend or deny claims when coverage terminates if the enrollee does not pay the premiums owed.

Mr. Williams asked if enrollees through Medicaid would be affected because they're not paying a premium. Does this apply only to enrollees in commercial plans?

Mr. Johnson replied the 90-day grace period applies to those individuals receiving Federal subsidies to purchase commercial Exchange coverage. This might include individuals in the Bridge Plan which would be a Medi-Cal Managed Care Plan.

Mr. Williams commented that to the extent the subsidy for an individual is 100 percent this wouldn't necessarily be a problem because the premium is paid in full.
How big is the population that might be affected? Would it be a subset of the folks enrolled on the commercial side?

Mr. Johnson said some estimates go as high as 4.4 million enrollees in the Exchange by the end of 2016. Of those, approximately 2.1 million would be subsidized. This would be that population to which the 90-day grace period would apply.

Mr. Williams commented that Emergency Room (ER) usage will increase for the newly insured in geographic areas where there is low primary care physician coverage.

Larry deGhetaldi asked if the Emergency Medical Treatment and Active Labor Act (EMTALA) require that a specialist, such as an orthopedist, see a closed ankle fracture within 72 hours.

Mr. Brosnan replied the EMTALA does not require that a private physician see every patient who is referred to them from the ER unless the on-call contract with the hospital includes such a requirement.

Mr. Barnhart asked the panelists about network adequacy and the need for there to be sufficient participation of providers within a service region.

Mr. Brosnan replied the EMTALA providers are mandated providers regardless of whether the Risk Bearing Organizations (RBO) decides to contract with the EMTALA provider. To even the playing field, regulations should require RBOs to contract with a certain threshold percentage of mandated providers.

Deborah Kelch asked how the plan could be held accountable if the providers do not have an obligation to contract and if providers continue to believe it's in their best interest not to have a contract.

Mr. Brosnan replied the state of the market is that the RBO can pay the EMTALA providers whatever the RBO wants. EMTALA providers are reluctant to contract with RBOs because the RBOs aren't willing to negotiate. DMHC has not determined a "reasonable rate" for services.

Mr. Wilson asked so what Mr. Brosnan meant by the statement that the RBOs are responsible for capitalizing themselves.

Mr. Brosnan replied RBOs have a 45-day lag time in which to process and pay claims. RBOs need to have financial reserves to cover the costs of unpaid claims. Health plans should build this into how the RBOs are paid. Holding plans accountable for unpaid claims would incentivize them to adequately compensate RBOs.

Mr. Wilson stated there is legislation addressing the physician shortage by expanding mid-level providers and/or scope of service for new provider levels. He asked whether CMA has a position on whether that would be in the best interest of the State or not.

Mr. Brosnan replied mid-levels play an essential role in the health care landscape but they cannot replace a physician.

Mr. Wilson asked if there were any questions or comments. There were none.

Presentation: CA Chapter of the American College of Emergency Physicians - Presentation

Dr. Bing Pao, Director of Provider Relations and the CA Chapter of the American College of Emergency Physicians (CEP) discussed the impact of payer financial insolvency on the emergency care network and provided some suggestions and potential solutions for the some of the provider payment issues they face. The new enrollment population from the Exchange should improve the payment situation for ER doctors. It is difficult to predict the payment impacts.

Discussion

Mr. Cymerys asked if Mr. Pao's organization has done any analysis around uninsured patients ending up in the ER?

Dr. Pao commented a number of these uninsured patients will end up going to Managed Care Organizations.

Mr. deGhetaldi asked about undocumented Californians. Are there areas of the State that are doing a better job of avoiding unnecessary Emergency Room use by the Medi-Cal population?

Dr. Pao commented that the undocumented population is going to continue to exist but is mainly a geographic concern. His organization works with the DMHC regarding problem RBOs so DMHC can identify the problem early and to implement a Corrective Action Plan (CAP).

Ms. Abbott asked if the RBOs that were referred to the DMHC are ones that DMHC already knew about and had an open investigation or are they new ones.

Dr. Pao commented these are payers that his organization had previously brought to the attention of the DMHC. It is up to the DMHC to determine who should be investigated and placed on a CAP.

Mr. Wilson asked if there were any questions or comments. There were none.

Presentation: Dave Meadows, Liberty Dental Plan

Dave Meadows, Senior Vice President of Government Programs, LIBERTY Dental Plan made recommendations to the FSSB regarding solvency requirements and licensure.

Discussion:

Mr. Meadows presented his concern for Medi-Cal and the impact on the financial soundness, the stability of the plans, their delivery systems, and provider networks given a lot of the recent and upcoming activities. Mr. Meadows stated that the transition of Medi-Cal populations into managed care is creating a dramatic increase in financial exposure for plans and providers. Plans continue to pass risk onto their providers.

Mr. Meadows requested that the Board discuss ways to address the solvency issues, standards, and requirements.

Director Barnhart asked Mr. Meadows to describe what was happening in the market 15 years ago.

Mr. Meadows said insolvencies were rampant, financial standards were not adequate, and many medical groups were having financial problems. There was little oversight of how much of the delegated dollars from health plans were going to actual care delivery.

Mr. Cymerys commented that it is appropriate to look at the requirements at this time given the uncertain environment in 2014.

Mr. Wilson invited public questions and comments.

Ms. Romo commented regarding the history and how only 14 out of 48 RBOs were put on a CAP by the DMHC. She emphasized the Board should have a Patient Advocate to speak on the patients' behalf.

Mr. Comstock, independent consultant, commented that health plans go through a three-tier calculation of tangible net equity (TNE). One is the base of a million dollars, the second is two percent of revenue, and the third is a calculation based upon fee-for-service expenses; that is, what percentage of expenses are paid on a fee-for-service basis and who they are paid to. The Department should consider a tiered approach similar to how plans are capitalized.

Mr. Johnson commented or JP Morgan's analysis of California's Exchange market. JP Morgan is estimating rates of about 10 to 15 percent below current commercial rates for similar products. The CMA has seen essential community provider contracts in the range of about 125 percent of Medi-Cal for Exchange products.

Presentation: The Health Insurance Tax - Presentation

Leanne Gassaway, Regional Vice President of America's Health Insurance Plans discussed the $102 billion in health insurance tax over the next ten years, Medicare Advantage Plans (MAPs), and Medicaid Managed Care plans.

Discussion:

Ms. Kelch asked if the health insurance tax would lead to decreased benefits.

Ms. Gassaway responded most MAPs offer enhanced benefits above and beyond Medicare Fee-for-Service or traditional Medicare. She said this is the area where there will be reductions in benefits. If those MAPs have to incorporate the new taxes into their bids to CMS, the MAPs will have to start scaling back on additional benefits they have been able to offer enrollees.

Mr. Wilson invited public questions and comments.

Ms. Abbott commented that plans should look at what counts towards the Medical Loss Ratio (MLR) such as marketing and CEO salaries for savings. There are several exemptions from these taxes. The taxes aren't affecting Employee Retirement Income Security Act (ERISA) plans and plans that are specifically marketing stop-loss provisions to small employers. Ms. Abbott noted that by self-insuring, this is a way for small employees not to comply with the ACA.

Ms. Abbott asked that a representative from CA Department of Insurance and Department of Health Care Services provide their expertise at FSSB meetings.

Presentation: Tom Williams, Integrated Healthcare Association -

Tom Williams, Executive Director, Integrated Healthcare Association discussed regulatory issues related to bundled payments.

Discussion:

Mr. deGhetaldi acknowledged the Medicare Fee-for-Service program transition to a value-based program for physicians will be incentivized to drive down total cost of care and improve quality and access.

Ms. Kelch commented that the Board should determine if the existing regulatory structure is still workable, viable for ACO arraignments.

Mr. Wilson invited public questions and comments. There were none.

Presentation: Bill Barcelona, CA Association of Physician Groups -

Bill Barcellona, Senior V.P. Government Affairs at CA Association of Physician Groups (CAPG) discussed RBOs, the federal concurrent model, Medi-Cal expansion, and subsidization issues.

Discussion:

Mr. deGhetaldi stated that Federally Qualified Health Centers (FQHCs) and the rural health centers are going to play an increasingly important role in the Medi-Cal expansion. There could be tension created by solvency issues with the safety net providers and their relationship to downstream providers. Are there any concerns about what it will look like in two to three years when FQHCs are double in size and are caring for more Medi-Cal Managed Care patients?

Mr. Barcellona stated he was not versed enough in the FQHC world to be able to answer that question. The CA Primary Care Association (CPCA) represents that segment of the provider community. CAPG is talking to other players in the delivery

system and providing some education and lessons learned around taking capitated payments.

Mr. Williams asked if CAPG is suggesting provider payment rate regulation. If so, is there any precedent he could point out in CA?

Mr. Barcellona commented he was not suggesting rate regulation but transparency and accountability. If provider data is collected and transparently reported, it would be possible to see where things balance out, where there are outlier situations, and where there are problems.

Mr. Wilson asked what areas in the expansion of SB 260 would be most appropriate. Mr. Barcellona suggested looking at the nature of risk under SB 260 and deciding whether the alternative payment mechanisms that are being employed, particularly with Accountable Care Organizations around bundled payments, constitutes risk and how that relates to the traditional concept of risk under the Knox-Keene Act.

Mr. Williams asked if the current solvency standards point only towards capitated medical groups or do they include hospitals that take capitation.

Mr. Barcellona commented the solvency standards do not include hospitals.

Mr. Balmer commented the solvency standards apply just to medical group/RBOs.

Mr. Wilson invited public questions or comments. There were none.

6) Provider Solvency Updates

Presentation: Provider Solvency Update - Provider Solvency Unit

Michelle Yamanaka, Manager of the DMHC Provider Solvency Unit, provided an update as of September 30, 2012. The DMHC received 132 quarterly survey reports, 52 compliance statements, and four monthly financial statements from groups that were on corrective action plans. Some of the common audit findings include incorrect interest and penalty payments, checks that are not cleared within best practice guidelines, claims that are not paid in accordance with section 1371 (45 working days), claims that are not date-stamped correctly, claims that are not forwarded within 10 working days, or failure to acknowledge Provider Dispute Resolutions in a timely manner.

Discussion:

Mr. Wilson invited public questions and comments.

Elizabeth Abbott of Health Access asked if the DMHC expands the audit when problems are uncovered.

Ms Yamanaka responded the DMHC doesn't expand the sample. The only circumstance where the DMHC would expand is if the RBO disagreed with the findings.

Elba Romo, of Our SALUD, commented that Health Care Partners should be licensed.

7) Health Plan Solvency Updates

Presentation: Division of Financial Oversight Update –
Health Plan Solvency Updates

Suzanne Goodwin-Stenberg, Division of Financial Oversight, provided a brief update regarding the DMHC's oversight of health plans. The DMHC regulates 107 managed HCPs with 22.6 million enrollees.

Discussion:

Grant Cattaneo asked for a definition of grandfathered enrollees.

Ms. Goodwin-Stenberg commented to look for the definition at PPACA 1083.

Mr. Cymerys responded that there is a provision in the ACA that, for people who kept their existing policy when the ACA was enacted ("grandfathered plan"), those plans are not subject to the changes of the ACA.

Mr. Wilson invited public questions and comments.

Ms. Romo commented that the DMHC should remove Dr. Keith Wilson from the FSSB because he holds an impermissible conflict of interest and that HCP is operating as a plan without a license.

8) Public Comment on Matters not on the Agenda

Mr. Wilson invited public comments. There were none.

9) Agenda Items for Future Meetings

The following topics were suggested for future meetings:

- Update on SB260
    - Who is covered and should it be expanded
    - Risk needs
    - Relationship with Medicare Advantage plans
- Access
- Suggested the Department of Insurance and/or the Department of Health Services attend the meeting(s)s

10) Closing Remarks/Next Steps

Meeting was adjourned at 12:58 pm