Financial Solvency Standards Board Meeting
April 18, 2018
Meeting Minutes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Jeffrey Conklin, Adventist Health Plan
Dr. Larry deGhetaldi, Palo Alto Medical Foundation
Paul Durr, Sharp HealthCare
John Grgurina, Jr., San Francisco Health Plan
Betsy Imholz, Consumers Union
Dr. Jeff Rideout, Integrated Healthcare Association
Shelley Rouillard, Department of Managed Health Care
Amy Yao, Blue Shield of California

Department of Managed Health Care (DMHC) Staff Present:
Steven Babich, Supervising Examiner, Office of Financial Review
Pritika Dutt, Deputy Director, Office of Financial Review
Gabriel Ravel, General Counsel
Wayne Thomas, Chief Life Actuary, 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 Betsy Imholz called the meeting to order and asked the Board members to introduce themselves.

2) Minutes from January 23, 2018 FSSB Meeting

Ms. Imholz asked if there were any changes to the January 23, 2018, FSSB meeting minutes. Meeting minutes were approved without objection.

3) Director's Remarks

Director Shelley Rouillard provided an update on recent mergers filed with the Department. She stated the healthcare system is in a state of flux with new partnerships being developed seemingly every day and rapid consolidation by hospitals, provider organizations, and health plans over the last few years. The DMHC is seeing an increase in applications for licensure, many of them from provider organizations moving to take on institutional risk.

Ms. Rouillard stated, in 2015 and 2016, the Department saw a wave of consolidation involving health plans buying other health plans in order to enter a market segment they

weren't already in, which she called "merger mania". The current wave of consolidations, or "merger mania 2.0", involve entities like pharmacy benefit managers and medical groups. The DMHC is currently reviewing two proposed acquisitions involving DMHC-licensed health plans and other health care entities. The first is Optum's acquisition of DaVita Medical Holdings, which is the medical group not the dialysis clinics. The second is the acquisition of Aetna, Inc. by CVS. The DMHC is anticipating a third filing this year related to Cigna's acquisition of Express Scripts.

The Department's primary focus in reviewing these mergers is to ensure compliance with the strong consumer protections and financial solvency requirements of the Knox-Keene Act. The proposed mergers are examined to ensure enrollees involved in the transaction have continued access to appropriate health care services. Some of the things considered during the review is how this proposed transaction could improve access, quality of care, and affordability for California enrollees.

The DMHC held a public meeting on the Optum-DaVita acquisition on Monday, April 9, 2018, and public comments are due April 23, 2018. The DMHC will hold a meeting on the CVS-Aetna acquisition on May 2, 2018 at the DHCS Auditorium. Ms. Rouillard said, historically, the DMHC hasn't held public meetings on transactions involving the purchase of a restricted licensee. However, given the significant consolidation in the current environment, she believes it is important to be transparent and provide an opportunity for the public to provide input on what the Department should consider as it reviews the transactions.

Ms. Rouillard provided an update on the Provider Directory Utility project. The Integrated Healthcare Association (IHA) is close to finalizing a contract with a vendor to develop and maintain the database. Anthem Blue Cross, Blue Shield, and Health Net have agreed to participate in Phase I.

Ms. Rouillard provided an update on several regulation packages. The second comment period on a regulation defining risk and codifying the DMHC's practice for issuing restricted licenses closed on April 5, 2018 and the DMHC is in the process of reviewing the comments. The other regulation package is related to Assembly Bill (AB) 72, which will standardize the average contracted rate methodology. This regulation was published by the Office of Administrative Law (OAL) on February 2, 2018, and the first public comment period closed on March 19, 2018. The DMHC is in the process of analyzing the comments received and anticipates opening a second comment period in the next couple of weeks.

Discussion

Dr. Larry deGhetaldi stated a few years ago the Board looked at risk arrangements in the Medicare Shared Savings Program, including Pioneer Accountable Care Organizations (ACOs) and what constituted risk in the Medicare fee-for-service world. Alternative Payment Models (APMs) are the new thing and many groups are going into Medicare ACOs, rather than the Merit Based Incentive Payments System (MIPS). He asked if the DMHC has regulatory oversight over those arrangements where groups

have significant downside risk in fee-for-service. Gabriel Ravel, General Counsel, responded the Department's jurisdiction over Medicare is restricted to financial solvency. However, under the definition of a health care service plan in the Knox-Keene Act, the Department has authority to require licensure of any entity that accepts fee-for-service payments with downside risk.

Dr. Jeff Rideout noted the huge range of non-standardized information regarding risk sharing, attribution models, and level of risk sharing in the data IHA looked at. There may be a need to codify what levels of risk mean and how it is categorized because it seems to have a material impact on performance.

4) Federal Update

Gabriel Ravel, General Counsel, discussed three regulation packages issued by the federal government beginning with an update on the proposed regulation that would expand access to Association Health Plans (AHPs). On January 5, 2018, the Department of Labor published proposed rules for a 60-day public comment period. The DMHC submitted public comments outlining four major points, including:

1. The problematic history in California of Multiple Employer Welfare Arrangements (MEWAs), a type of AHP. MEWAs were vehicles for fraud or became insolvent, leaving consumers and providers with substantial unpaid claims.
2. Expanding access to AHPs could encourage market segmentation, weaken the Affordable Care Act (ACA)-compliant market, and raise premiums for enrollees who remain. If young, healthy individuals enroll in AHPs, then those who are left in the ACA-compliant market would be comparatively higher risk and more expensive.
3. The text of the regulations, rather than the preamble, should explicitly specify that states are permitted to regulate AHPs as they do currently.
4. The rule should explicitly allow states to apply their nondiscrimination provisions to AHPs, since the nondiscrimination provisions in the proposed rules are insufficient.

Mr. Ravel noted the Department of Labor is considering all the public comments received and a final rule is expected in the coming months.

Mr. Ravel provided an overview of the second regulation package related to short-term limited duration insurance (STLDI). It is a multi-agency proposed rule issued in late February 2018, in response to an Executive Order from the White House to examine ways in which access to non-ACA compliant products might be expanded. Public comments are due April 21, 2018. STLDI is a type of coverage that is intended to fill coverage gaps and the proposed rule would increase the duration of these types of policies from three months to one year, with possible renewals. The federal government estimates 100,000 to 200,000 consumers might switch from an ACA-compliant policy to STLDI, while others, such as the Urban Institute, estimate the figures could be much

higher. If this happens, like with the AHPs, it would raise premiums for those who remain in ACA-compliant products and also increase the federal government's premium tax credit payments to the extent premiums rise. Some of this effect is already accounted for because the penalty for the individual mandate has been reduced to zero, but the increased availability of STLDI could amplify that trend.

Mr. Ravel noted under the Knox-Keene Act, STLDI is not permissible. However, these products are sold in California as they are allowed under the Insurance Code. These policies are extremely bare bones and even before the ACA, they would not have been permitted under the Knox-Keene Act. A typical policy is not subject to guaranteed issue or community rating, contains pre-existing condition exclusions, and excludes coverage for services such as preventive care and transplants. For anyone who has more than very basic health care needs, these types of policies could leave enrollees with a substantial liability. Mr. Ravel added there is pending legislation, Senate Bill (SB) 910, which would prohibit STLDI from being offered in California.

The DMHC will be issuing a comment letter requesting the withdrawal of the rule entirely and outlining four areas of concern, including:

1. Increased availability of STLDI could increase adverse selection and destabilize the ACA-compliant market.
2. STLDI lacks very important consumer protections.
3. There is a substantial possibility of deceptive marketing of STLDI as full-service coverage.
4. If the rule is finalized in any form, the regulatory text should explicitly say that states retain the ability to regulate insurance, including STLDI, and state laws regulating STLDI are not preempted.

Mr. Ravel provided an overview of a third proposed regulation issued by the U.S. Department of Health and Human Services Office for Civil Rights (OCR), related to enforcement of federal statutory conscience protections. The proposed rule was released in late January 2018, with public comments due in late March 2018. Most significant to the DMHC is that it includes the Weldon Amendment, a rider to budget acts and continuing resolutions since 2004. The Weldon Amendment prohibits all Department of Labor, Health and Human Services (HHS), and Education funding to entities, including state governments, if that entity discriminates against a health care entity on the basis that it refuses to provide, pay for, or refer for abortions.

Mr. Ravel provided additional background information on the DMHC's history with the Weldon Amendment. In 2014, the DMHC reminded seven health plans that had unlawful restrictions in their policies with respect to abortion coverage that they had obligations under state law to cover abortions. The DMHC was then subject to an investigation under this provision. However, the OCR closed the complaints in June 2016 for a variety of reasons, and found that there had been no violation of the Weldon Amendment. Mr. Ravel noted the significance of the provision as the State receives over $100 billion annually. The proposed rule would significantly enhance the

enforcement posture with respect to this provision and the preamble specifically mentions the DMHC and the state law regarding abortion several times.

Mr. Ravel highlighted four provisions of the proposed rule that are of particular interest:

1. The OCR notes the concern that the Weldon Amendment might violate the spending clause of the Constitution, but this concern is not a reason not to enforce it to the full extent permissible.
2. The term “health care entity” should be read very broadly, to at least include plan sponsors (i.e. employers) so that health plans and their customers are protected.
3. The complainant is not required to have a religious or moral objection to abortion in order to raise a complaint. They can complain for any reason whatsoever. Under this interpretation, the health plan can object on any basis, including that their customer wants a product that does not cover the lawfully required services.
4. Complaints can come from any party and do not have to be from the party that is the subject of the entities’ jurisdiction. The OCR could also self-initiate an investigation based on news reports or other sources.

The DMHC did not comment on these proposed rules. However, the Department of Justice (DOJ) and the California Department of Insurance (CDI) commented on the legal deficiencies and ways in which the rules exceeded OCR’s statutory authority. Mr. Ravel stated if the rules are finalized in their current form, they will likely be challenged.

Discussion

In regards to the STLDI regulatory package, Ms. Imholz said she has heard that agent commissions for these short-term policies are greater than for ACA-compliant policies. This will likely lead to increased marketing for these products, including to people who currently have ACA-compliant coverage. She hopes there will be extra emphasis on the special enrollment period for those who lose their job. Ms. Imholz asked how many STLDI policies are in effect in California. Mr. Ravel responded the CDI does not have firm figures on the number of products or enrollment. Ms. Imholz noted she has heard tens of thousands, but that others thought more. She shared that Consumers Union will be commenting on this regulation package.

Dr. Rideout asked if the data from the Urban Institute estimate included the renewal option or if it was for a one-year policy. Mr. Ravel responded it was for a one-year policy and that the renewal option is concerning because if someone has a claim during their period of coverage, they could be rejected.

John Grgurina thanked Mr. Ravel for the update and noted it feels like we are going back to the 90’s and not in a good way. He added that the concerns raised in the response to the federal government were very succinct and appropriate to try to prevent this from happening in California.

Amy Yao stated her plan is in the process of developing rates to submit to Covered California and both the AHP and STLDI rules will have a material impact on the rates. Preliminary estimates are that if they go into effect, the impact to rates will be about two percent.

Dr. Rideout asked if there is an expectation that the DOJ and the CDI will continue to support the DMHC's position. Mr. Ravel responded the Department will wait for the final rule, but based on the strong position taken by both the DOJ and the CDI, it is likely they will support the DMHC.

Ms. Imholz asked if the Department reviewed the 500-page Notice of Benefit and Payment Parameters (NBPP) and if there were any implications for the DMHC. Mr. Ravel responded the Department has reviewed it. Since most of the changes are to increase options for states, he didn't see much impact to the DMHC except possibly in the area of special enrollment.

Dr. deGhetaldi stated all three of proposed rules could harm California's delivery system.

Ms. Yao asked who has final authority around the risk adjustment level since the federal government gave California some flexibility to change the premium transfer formula. Mr. Ravel responded he wasn't sure but would look into it.

5) Large Group Aggregate Rates

Pritika Dutt, Deputy Director, Office of Financial Review, provided an update on the large group rate information submitted by the health plans on October 1, 2017, as required by SB 546. SB 546 requires health plans with large group products to file aggregate rate information with the DMHC annually. The DMHC is required to annually conduct a public meeting to permit public discussion regarding changes in rates, benefits, and cost sharing in the large group market. The public meeting was held on February 7, 2018, in San Francisco. Health plans also are required to include information in their 60-day renewal notices to employers comparing the rate change to rate changes in Covered California and the California Public Employees' Retirement System (CalPERS).

Ms. Dutt reviewed the key findings for the January 1, 2017 through December 31, 2017, reporting period, including:

- The Covered California 2018 average rate increase of 21.1 percent was a significant increase from 2016 (4%) and 2017 (13.2%) due to the federal government not funding cost sharing reduction (CSR) subsidies and the surcharge included in the 2018 Silver Plan rates.

- Twenty-four health plans filed large group rate information, including seven statewide plans, ten regional plans, two cross-border plans, and five In-Home Supportive Services (IHSS) plans.
- There were nearly 7.8 million enrollees in over 13,400 renewing groups impacted by a rate change in 2017. There were over 6,400 different plans sold.
- IHSS rates are set by the county and did not change in 2017. Therefore, they were excluded from the report. Also, cross-border plans provide emergency services only and so were excluded.
- The unadjusted average rate increase for all plans was 3.9 percent and the average monthly premium was $453.71.
- The adjusted average premium increase, which adjusts for changes in benefits, cost sharing, provider network, geographic rating area, and average age, was 4.5 percent.
- Kaiser had approximately 64 percent of the large group enrollment and the lowest rate increase of 3.1 percent. By excluding Kaiser, the average rate increase for all other plans is 5.2 percent.
- The majority of employer groups, 71.5 percent, and the majority of covered lives, 87.6 percent, were enrolled in a Health Maintenance Organization (HMO) and had an average premium of $450.40.
- Two plans, Anthem Blue Cross and Blue Shield, each offered a PPO product, which had the highest average premium of over $500.
- Anthem Blue Cross was the only plan to offer an EPO product and it had the lowest monthly premium. The High Deductible Health Plans (HDHPs) had the second lowest premium.
- Five plans, Anthem Blue Cross, Blue Shield, Health Net, Kaiser and Sharp, offer Point-of-Service (POS) products. However, total enrollment was only 105,000.
- Approximately 93 percent of covered lives were in a plan with an actuarial value of at least 80 percent.
- The majority of plans are expecting an increase in medical trends in 2018. The statewide plans, excluding Kaiser, estimated an increase of 6.6 percent, which is slightly lower than last year. The regional plans estimated an increase of 5.7 percent, slightly higher than last year.
- Pharmacy allowed costs represent about 15 to 20 percent of the overall medical allowed costs, and this percentage is steadily rising as prescription drug trends have outpaced medical services in recent years. The increase in pharmacy trend is likely due to the continual impact of new specialty drugs.
- Regional plans expected pharmacy trends to increase from an average of 6.9 percent in 2017 to 8.5 percent in 2018, which is lower than the statewide plans.
- In 2016, regional plans had higher claims costs, administration expenses, and quality improvement expenses compared to statewide plans.

Ms. Dutt noted the large group rate filings are available on the DMHC's website. Additionally, SB 17 requires health plans to report information on the 25 most frequently prescribed drugs, 25 most costly drugs by total annual plan spending, and 25 drugs with highest year over year increase in total annual spending. This information will be presented at the large group public meeting in 2019.

Discussion

Paul Durr expressed concern that specialty drugs that are the responsibility of the medical groups may not be considered as part of the pharmacy costs and instead get accounted for as medical costs. He questioned whether plans are transparent about where the expected cost increase for specialty drugs is accounted for. From the medical group perspective, the cost of a number of specialty drugs is going to increase. This is something the Board should be aware of because it impacts the financial viability of the medical groups. With new technology and availability of specialty drugs for certain disease categories, the impact on the medical groups could be significant. Wayne Thomas, Chief Actuary, responded currently it is not transparent within the rate filings or the information received for specialty drugs, but that more information may be gathered with the implementation of SB 17.

Ms. Imholz asked if drugs that are considered medical expenditures are required to be reported separately or inclusively by health plans under SB 17. Mr. Thomas responded SB 17 requires pharmacy costs related to administration in the doctor's office to be separated, but not specialty drugs that are the medical group's responsibility. Mr. Durr noted that because health plans often cover specialty drugs, such as an injectable, through the medical group, it is deemed a medical expense rather than a pharmacy expense.

Dr. deGhetaldi said his infusion centers have seen an explosion of new drugs, which are a great benefit to patients. However, it is difficult to tell what component of healthcare inflation is truly pharmacy versus everything else. From his perspective, pharmacy remains the primary inflationary driver to healthcare costs.

Ms. Rouillard asked if the DMHC could ask the plans to break out specialty drugs from all other drugs as part of the rate review process. Mr. Thomas said the Department could ask.

Ms. Yao stated her plan separates out specialty drugs for trend development and the specialty pharmacy trend increase is higher, at 20 or 30 percent.

Ms. Yao also noted the higher premium for Preferred Provider Organization (PPO) plans and explained that since PPO plans have a broader network they tend to attract sicker patients. Ms. Yao asked if there is an adjustment for the risk of the population or just the age when adjusting the average rate increase. Mr. Thomas responded the only adjustments are for benefits, cost sharing, provider network, rating area, and average age. Ms. Yao asked how the provider network adjustment is determined. Mr. Thomas responded that is a question for the health plans since they submit the data, but the

Department expects the plans to make an adjustment between their full network and narrow network.

Dr. Rideout stated the Schaeffer and Price Centers at the University of Southern California (USC) are looking at the contribution of specialty drugs to the overall cost of care and could be a good resource for the DMHC.

Dr. deGhetaldi commented the risk-adjusted transfers in the individual and group market is about seven percent. Most of the innovation and expense inflation is on the sicker population and the bell-shaped curve of complexity and dollars spent is widening. There may be trouble if inflation is disproportionately on the side of the sicker population without managing the total population in an actuarially sound way. This is particularly concerning given the earlier discussion about AHPs and the potential for healthier individuals to leave the risk pool.

Ms. Yao noted the significant difference between the rate increase for Covered California and CalPERS. While the adjustment for CSRs was around 12 percent, within that percentage, the individual mandate impact was approximately 3 percent and the house insurance tax, approximately 2 percent. If we don't stabilize the market, the individual mandate impact could increase to 9 percent, which could disrupt the market and be damaging for Covered California.

Ms. Rouillard asked if the CalPERS data is an average of all plans, including the self-insured PPOs. Ms. Dutt affirmed the increase is across all plans.

Mr. Grgurina stated that although health care is expensive, 5.6 million out of 7.8 million people have a rich benefit packages with an actuarial value of 90 to 100 percent.

Ms. Imholz said Kaiser is an outlier on pharmacy trend with a zero percent change. Ms. Imholz asked if this was due to health status, negotiating or some other reason. Mr. Thomas stated it may be a result of how they manage their patient population, but he does not know for sure. Ms. Yao stated they recently hired somebody from Kaiser to run their pharmacy shop. She has learned that because Kaiser is an integrated system, they can require all doctors to use a low-cost drug. This is very difficult for other plans to do.

6) Dental Medical Loss Ratio

Ms. Dutt provided an overview of the dental medical loss ratio (MLR) data for calendar year 2016. Assembly Bill (AB) 1962 requires plans offering commercial dental coverage to file an annual medical loss ratio (MLR) report with the DMHC.

Ms. Dutt reviewed the key findings for the reporting year ending December 31, 2016:

- Nineteen dental plans offered dental HMO (DHMO) products in the individual market. The MLR ranged from 4 percent to 76 percent, with an average MLR of 43 percent. In 2015, the average MLR was 46 percent.

- The MLR for the DHMO small group market ranged from 8 percent to 96 percent, with an average of 55 percent. In 2015, the average MLR was also 55 percent.
- The MLR for the DHMO large group market ranged from 51 percent to 76 percent, with an average of 63 percent. This was a slight decrease from 2015 when the average MLR was 65 percent.
- Two plans offered a DPPO product in the individual market and reported MLRs of 65 percent and 68 percent, with an average MLR of 66 percent. In reporting year 2015, the average MLR was 77 percent.
- The MLR for the DPPO small group market ranged from 27 percent to 82 percent, with an average MLR of 61 percent. In reporting year 2015, the average MLR was 64 percent.
- The MLR for the DPPO large group market ranged from 85 percent to 90 percent, with an average MLR of 87 percent. In reporting year 2015, the average MLR was 86 percent.
- The average MLR on a consolidated basis was 58 percent. Ninety-one percent of enrollees were enrolled in a plan with a consolidated MLR of at least 60 percent and 99.5 percent of enrollees were enrolled in a plan with a consolidated MLR greater than 50 percent.

Ms. Dutt stated there is significant variation between the plans and the products they offer. For example, one plan reported a 4 percent MLR for a product with a $4 premium. The average administrative cost ratio for dental plans was 41 percent, which indicates dental plans have a higher administrative cost to premium ratio compared to full service health plans. Dental plans have the same administrative functions as the health plans but with lower premium dollars. This may account for some of the low MLRs. Ms. Dutt also noted the average net profit on a consolidated basis was six percent and five plans reported net losses in 2016, so low MLR may not be associated with high profits. Ms. Dutt concluded by noting the availability of the dental MLR reports and previous presentations on the Department’s website.

Discussion

Dr. Rideout asked who is responsible for interpreting what the data means and what should be done. Ms. Rouillard stated the intent of AB 1962 was for the Department to collect the information to inform the Legislature's decision to set a dental MLR. The Department has collected data for three years and there is currently legislation, SB 1008, to address this.

Ms. Yao asked if the DMHC information was reviewed when proposing a 70 or 75 percent MLR in SB 1008. Ms. Rouillard responded she presumed it was, but did not know for sure.

Mr. Grgurina stated dental is very different than medical, and even the large group plans wouldn’t be able to meet a 70 or 75 percent MLR. This could be a problem for

employers trying to offer a cheaper alternative for employees. He said it is important to be careful before any decisions are made and policies are set because a plan may choose not to participate or have to return funds.

Ms. Yao said the intent of MLR is to make a premium affordable. A MLR of 70 or 75 percent loss ratio could have the opposite effect and increase premiums because plans will raise the premium to cover the fixed costs.

Ms. Imholz noted the vast majority of the covered lives are in plans with a consolidated MLR of 61 percent or greater. While she understands dental plans are very different from medical plans, she still has concerns about the variation and negative profit margins.

Jeff Album, Vice President of Public Government Affairs for Delta Dental, stated MLR provides the percentage of premium spent on administration, but the presumption that administrative spending is bad and spending more on patients is good, is a myth, particularly in dental. Mr. Album used the metaphor of a tape measure and drinks on the table to illustrate that you can measure something and arrive at a scientific, proven number, but it does not indicate quality. He noted having the call center spend more time with callers would swing the plan 5 or 10 points on the MLR. When the average premium for an individual HMO is $10, $0.50 can swing a dental plan 5 percentage points.

Mr. Album suggested that instead of MLR, the Department could use the tools it already has to look at whether a product is a good value. Where there are concerns, it can take corrective actions. With a MLR of 70 or 75 percent, costs will go up 30 to 50 percent for 40 percent of the marketplace, which may result in people dropping coverage since it is not a mandatory benefit.

Ms. Yao noted you would expect to see a correlation between administration and profit margin, but she doesn't see any correlation so regulating MLR may not help.

Ann Milar with the California Dental Association (CDA) stated CDA sponsored AB 1962 in 2014, and is the current sponsor of SB 1008. The point of the legislation is to improve transparency. Consumers and purchasers have the right to understand where their dental premium dollars are going just like they do for medical. Ms. Milar said the CDA has been shocked by the wide range of loss ratios reported the last three years, and believes $0.50 on the dollar going towards actual dental care is egregious. The 70 or 75 percent loss ratio in SB 1008 is just one piece of the legislation. There are other elements in the bill to level the playing field among medical and dental plans to help consumers understand what they are purchasing with their premium dollars.

Dr. Rideout asked if there is a compromise between the CDA and Delta Dental's positions and suggested a combination of MLR with other things the DMHC is able to do. Ms. Milar stated there are four other elements included in SB 1008 and that it goes beyond just a number.

Mary June Flores with Health Access California stated they have been supportive of establishing a dental MLR. The lack of an existing standard has led to significant variation among dental plans and raised concerns that consumers are paying too much for a dental plan that does not cover what they need.

Wendy Soe with the California Association of Health Plans acknowledged that the concept of a loss ratio for dental plans does not translate in the same way MLR does for health plans because of the variation in benefit designs and lower premiums. She stated if there are outliers, there are tools available to the Department to look into those issues.

Crystal McElroy with MetLife and SafeGuard Health Plans of California stated the dental industry does not disagree with the goal of greater transparency for consumers. However, MLR may not be the right indicator to determine the value of these products. While SB 1008 includes provisions that will increase transparency, such as disclosure of benefits for members and out-of-network provider claim information, it will also increase administrative costs, which is counter to the goal of establishing a MLR. Ms. McElroy stated there is a lot of customization since dental benefits are voluntary. MLR threatens the cost and plan's ability to offer these products.

Ms. Imholz stated Consumers Union does not have a position on the bill and recognizes the products are different, but cautioned infinite choice is not always beneficial to consumers and to be aware of solvency concerns. Ms. Imholz stated in the medical world there is one MLR, and then tiers of actuarial value which may be applied.

Ms. Rouillard said the item was on the agenda to hear from the public, educate the Board, and help the Department decide how to deal with this issue. The Department is interested in transparency and will be providing technical assistance on the legislation.

7) Financial Summary of Medi-Cal Managed Care Health Plans

Ms. Dutt provided an update on the Financial Summary of Medi-Cal Managed Care Plans for the quarter ending December 31, 2017. The report highlights enrollment, financial metrics, and claims payment deficiency information for Local Initiatives (LIs), County Organized Health Systems (COHS), and Non-Governmental Medi-Cal Plans (NGMs) with greater than 50 percent Medi-Cal lives.

Local Initiative Health Plans:

- The nine LIs serve 5.2 million Medi-Cal beneficiaries in 13 counties.
- From October 2017 to December 2017, LIs reported total net income of $101 million.
- The tangible net equity (TNE) to required TNE ranged from 356 percent to 1,036 percent.
- Liquid TNE, or cash on hand, ranged from negative 2,386 percent to 336 percent of required TNE.

County Organized Health Systems:

- The five COHS that report information to the Department, serve approximately 2 million Medi-Cal beneficiaries.
- From October 2017 to December 2017, COHS reported total net income of $27 million.
- The TNE to required TNE ranged from 828 percent to 1,383 percent.
- Liquid TNE ranged from 285 percent to 622 percent of required TNE.

Non-Governmental Medi-Cal Plans:

- The five NGM plans serve 3.4 million Medi-Cal beneficiaries in 31 counties.
- From October 2017 to December 2017, NGMs reported total net income of $139 million.
- The TNE to required TNE ranged from 177 percent to 1,377 percent.
- Liquid TNE ranged from negative 149 percent to 1,039 percent of required TNE.

Ms. Dutt stated the initial surge in Medi-Cal Managed Care enrollment brought on by the ACA in 2014 slowed in 2016 and 2017. Overall, expenses and premium revenue continue to rise as enrollment increases and Medi-Cal Managed Care plans continue to meet or significantly exceed the minimum TNE requirement.

Discussion

Dr. deGhetaldi asked if the Department has seen any concerning trends such as plans raising payment rates in a way that would consume their TNE over time or if the plans have reached a stable point.

Mr. Grgurina stated his plan is at a breakeven point because when they saw the Medicaid expansion rates going down over the next three years, they decided to tell providers in advance that when the rates come down, their rate will also be lowered. Right now, their reserves are high enough that they will leave the rates higher. However, relying on high reserves to keep the rates higher could result in a discrepancy. The plans are expecting the Medicaid expansion rates for July 2018 to include another smaller cut.

Mr. Grgurina added the Department of Health Care Services (DHCS) is looking at MLR for prior years, specifically for Medicaid expansion, and anything under 85 percent has to go back to the federal government. In 2014, 2015, and 2016, there was a rise in membership, but that has come to an end. Some plans are seeing a slight decrease as the economy gets better and less people are eligible. The end of the individual mandate will not only impact Covered California, but could also lead to decreased enrollment in Medi-Cal.

Ms. Rouillard stated several LIs have decreased enrollment, including Santa Clara with a 4.3 percent decrease, and the COHS had even more significant decreases.

Mr. Durr stated the data shows one COHS plan is going in the wrong direction in the fourth quarter of 2017, which raises long-term viability concerns. Ms. Dutt responded Partnership HealthPlan has been reporting consistent losses. However, the plan still has TNE slightly below 1,000 percent. The Department reached out to the plan and was informed they have been making investments in the community.

Mr. Grgurina stated plans have policies related to maintaining TNE of more than 100 percent. However, there is a point that is too much, which his plan as set at two times capitation premium. His plan is returning funds to providers and hospitals to increase access and quality. Similar to other plans who are reinvesting back into the community, this shows as a loss in the financials. The oversight starts with the boards of these plans and their finance committees determining the appropriate place for the plans' reserves to be. Dr. deGhetaldi asked if two times capitation is a better indicator of financial stability than TNE. Mr. Grgurina responded that is the upper end of where his plan feels comfortable. Some states say it should be three or four months so it depends on a state's Medicaid program and the plan's local situation.

Dr. deGhetaldi congratulated those COHS and LIs who have increased reserves and are reinvesting in their communities to improve access, long-term performance, and utilization. Mr. Grgurina stated it is important to look at the small budgets for Medi-Cal providers and the extra dollars that are reinvested to improve services for their members.

Ms. Yao asked how two times capitation translates into TNE. Mr. Grgurina responded it depends on the plan, but for his heavily capitated plan, the TNE is less than one week's worth of expenses. Two times capitation equates to approximately 800 to 950 percent of TNE. However, every plan is different. For a fully fee-for-service plan, TNE will be higher because everything comes in cycles and it is important that reserves are high during good years to prepare for the bad years.

Mr. Durr commented on how excess TNE and medical expense compare for LIs and COHS. Mr. Durr stated that for some non-governmental plans, the excess above one year's medical expense is significant compared to other plans. Mr. Durr noted there are different models and the investment in the community may be different, but the data was surprising. Ms. Dutt responded the dividend payments to shareholders and parent companies impact the TNE or reserves for NGMs.

Tom Smith, CEO of AmericasHealth Plan, stated reinvesting in the community is good, and asked the Board for thoughts on tying reinvestment in the community to Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores and Healthcare Effectiveness Data and Information Set (HEDIS) measures and whether there should be transparency, such as publication of scores, for those participating in Medi-Cal. Mr. Grgurina responded the plans' HEDIS scores in Medi-Cal, and possibly the CAHPS scores, are available on the DHCS website. Mr. Grgurina reported that for his plan, the

reinvestment goes back into a Practice Improvement Program, which does tap HEDIS scores for provider improvements. Ms. Rouillard added the Office of the Patient Advocate Report Card also contains Medi-Cal plans' quality scores.

8) Integrated Healthcare Association Regional Health Care and Quality Atlas

Dr. Rideout provided an overview of the Health Care Cost and Quality Atlas, which is funded by the California Health Care Foundation (CHCF). The Atlas is a voluntary program in which 10 health plans, DHCS, and the Centers for Medicare and Medicaid Services (CMS) participate. Dr. Rideout noted the information he was presenting was from 2015 and they are currently collecting 2017 data and are working to speed up the reporting cycle.

The Atlas includes over two dozen standardized metrics of clinical quality, total cost of care, patient cost sharing, and utilization for approximately 29 million Californians, which is about 75 percent of the population in the state. Some of the changes coming for Atlas 2 includes looking at the performance of ACOs and different product lines. Dr. Rideout noted the Atlas is intended to be a self-service tool for the public and encouraged everyone to use the tool themselves.

Dr. Rideout highlighted some of the key results from the Atlas, including:

- There is a wide range of variation between regions. There are some very low and, in some cases, higher averages across the state depending on the measure.
- HMO products outperform PPO products.
- PPO products tend to underperform on quality and are generally higher cost, including patient cost sharing. HMO products are generally higher in quality, but not always lower in cost.
- Medicare Advantage tends to outperform on quality across the state, not surprising given the star ratings and financial impetus in this area.
- Provider groups that perform well in the commercial market do well in Medicare Advantage. Conversely, poor performers don't perform well in any product, which indicates performance is tied to commitment to certain types of infrastructure and activities and not different applications for different products.
- Medicare Advantage consistently outperforms regions with fee-for-service on both quality and total cost of care. This translates to about $3 billion in out-of-pocket costs avoided or about $5,000 per member.
- There is a correlation between the level of risk and the overall quality score. When there is no risk sharing, there is an average clinical quality rating. Performance improved significantly for those taking global risk, which is when a plan provides a single payment for all services to a physician organization. Those accepting dual risk also had higher quality ratings. Dual risk is when there is a

capitated contract between the plan for hospital services and another contract for professional services.

- There is a correlation between risk sharing and risk-adjusted total cost of care. No risk sharing is costly and sharing financial risk results in lower overall cost of care.
- There was a significant increase in enrollment from 2013 to 2015, primarily in Southern California, and there was also an increase in emergency department visits during this time period. However, there was not a correlation between the increase in enrollment by region and the magnitude of the increase in emergency department visits for that region.

Dr. Rideout noted IHA receives Medi-Cal information from DHCS rather than from the plans. DHCS provides the rates for the measures rather than using patient level data. In addition, there has been an increase in the number of measures for Medi-Cal from 2013 to 2015, so they are now able to do some trend analysis and compare data to the commercial market. However, DHCS made the decision not to share the total cost of care information, so there are limitations on their ability to make comparisons across different model types in Medi-Cal.

Dr. Rideout concluded by stating IHA is interested in exploring the degree of integrated care available in different regions and whether different regions may be able to absorb enrollment increases easier than networks based on non-integrated providers. He also noted some of the other ways to look at the data in the Atlas and encouraged the Board to look at it.

Discussion

Mr. Durr complimented Dr. Rideout and the IHA team for providing information that is useful for managing patients in a way that is meaningful and understandable. He acknowledged it is a tremendous effort to put the information together, but it makes a big impact and is used to educate providers and the community.

Mr. Grgurina said plans know in their gut that when you do more care coordination and share risk you see better outcomes and lower cost. This is the first study he has seen that compares plans, such as HMOs to fee-for service, for both commercial and Medicare. It is eye-opening to see the results by different risk levels and the impact to quality and cost. Dr. Rideout noted this is one of several programs IHA administers and they also have a valued-based pay-for-performance (P4P) program which shows a range of performance based on risk sharing, geography and Independent Practice Associations (IPAs) versus medical groups.

Mr. Grgurina stated in his plan’s Practice Improvement Program, no one wants to be at the bottom. In San Francisco, the community works collaboratively to share best practices to help each other improve. This collaborative approach is what is needed to improve quality measures.

Ms. Yao asked who has access to the data. Dr. Rideout responded the ten health plans have access to their data compared to aggregate data for the other plans. He noted plan level data is not available to the public.

Ms. Yao asked which region performed better on quality and if there was an explanation for the regional variation. Dr. Rideout confirmed Northern California generally performs better on quality but is also higher cost. When looking for the value sweet spot, the simple ratio of total cost of care and quality indicate there are some areas in Southern California, such as San Diego, that are closer to the sweet spot.

Ms. Yao asked if the data on HMO ACOs can be separated out. Dr. Rideout responded the data could be separated out. However, few plans were offering ACOs in 2015 so displaying this information would likely reveal the health plan.

Ms. Yao said she was very curious about the results for the Medicare Advantage plans, which shows low cost and high quality. It makes her wonder what can be done to move more members into a Medicare Advantage plan. Dr. Rideout responded the first step would be to get everybody that is dual eligible into a Medicare Advantage plan. Mr. Durr noted one problem is there are legal requirements regarding what a physician can and cannot do when educating members on their health plan options.

Ms. Imholz asked how consumers can use this information since they won't have information about a specific plan. Dr. Rideout responded the type of information and transparency has improved since Atlas 1. IHA's goal is not to decide what people should take away from the data but to provide the tools for people to look at the data for themselves. One interpretation is you get what you pay for and higher costs equals higher quality. However, in some regions, you can receive high quality at a low cost. Ms. Imholz acknowledged the messaging to consumers about how to get the best value and quality is confusing and complicated.

Ms. Imholz asked if there are health plans that aren't participating or are excluded. Dr. Rideout responded the Atlas website shows who is participating, which includes all the major plans, covering 75 percent of enrollment.

Dr. deGhetaldi stated he serves on the IHA P4P Committee and this information is the bread and butter and heart and soul of value. He has known for a long time that Medicare Advantage is the premier place to get the best quality in California. The Medi-Cal performance is becoming transparent and the PPO ACO world needs standardization. However, it is embarrassing that the 90th percentile varies so widely for measures like breast cancer screening, cervical cancer screening and asthma control. It is deplorable that it is based on whether you're a Medi-Cal or Medicare Advantage beneficiary. What IHA is working towards is a standard 90th percentile for all Californians. He added the dual eligibles are disproportionally enrolled in fee-for-service and disproportionately laden with social determinants of health. If we moved every Californian into Medicare Advantage, it would improve the health status of California. He stated the key is to make the information visible because providers are very competitive and when everyone is submitting data and ranked, everyone will get better.

9) 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 December 31, 2017:

- Annual financial statement or survey reports are due 150 days after the fiscal year end of the RBOs. To date, the DMHC has received 27 annual filings, and the remaining 158 filings are due on May 30, 2018.
- 136 RBOs filed quarterly survey reports and 49 RBOs filed compliance statements.
- Five RBOs filed monthly financial survey reports as required by their corrective action plan (CAP).
- 136 of the reporting RBOs reported compliance with the solvency criteria, including:
    - 31 RBOs were in the Superior category, of which 1 RBO was on a CAP and reported compliance.
    - 99 RBOs were in the Compliant category, of which 1 RBO had two CAPs.
    - 11 RBOs were on the monitor-closely list.
    - 6 RBOs reported non-compliance.
- There were 9 RBOs on a CAP. Of these, 6 of the CAPs continued from the previous quarter and 4 were meeting their approved projections and 2 were not. There were 3 new corrective action plans in this quarter. Three corrective action plans have been completed since December 31, 2017, which were Jade Health Care Medical Group (2 corrective action plans) and Merit IPA.
- There were 87 RBOs with Medi-Cal enrollment covering approximately 4.2 million enrollees.
- The top 20 RBOs served approximately 3.2 million Medi-Cal lives. Of these, 15 have no financial concerns, 1 was on a corrective action plan, and 4 are on the monitor-closely list.
- The remaining 67 RBOs served approximately 1 million Medi-Cal lives. Of these, 61 have no financial concerns, 3 were on a corrective action plan, and 3 were on the monitor-closely list.

Ms. Yamanaka stated the Office of Financial Review has 24 audits planned for 2018, of which 1 has been completed, 6 are in progress, and 17 will be completed or started in 2018.

Discussion

Dr. deGhetaldi stated there is concern among physicians about the correlation between high Medi-Cal participation and elevated risk. He noted a bill before the Legislature, AB

3087, which is described as a Medicare price for all physician payments. Dr. deGhetaldi noted if Medicare payments are assigned on the PPO and HMO side, half of his providers would move to another state.

Dr. Rideout asked how difficult it would be to look at subgroups under an RBO. In IHAs dataset, they are looking at over 300 physician organizations that have a unique geographic footprint but may be part of a single RBO. As they expand their analysis of Medi-Cal performance, it will be important to get to that level of geographic distinction to look at performance as opposed to groups that cover a lot of geographies and have many subgroups underneath them. Ms. Yamanaka responded the information received is very high level and it would be difficult to get to that level of detail.

Catrina Reyes with the California Medical Association (CMA) echoed Dr. deGhetaldi's concern about the price controls in AB 3087 and asked the Board or Department to consider the impact this could have on the financial solvency of RBOs, especially those with high Medi-Cal enrollment because the rates do not cover the cost of care.

10) Health Plan Quarterly Report

Stephen Babich, Supervising Examiner, Office of Financial Review, presented the health plan quarterly update for the fourth quarter of 2017:

- There were 76 full-service health plans and a total of 124 Knox-Keene licensed plans. Also, 2 new behavioral entities were added, bringing the total up to 13.
- The 2 most recent full service licensees were both restricted licensees in the Medicare Advantage market.
- Enrollment in commercial and government plans was a little over 13 million lives. This was a slight increase over last year.
- There were 20 full-service plans with 900,000 lives on the closely-monitored list compared to 16 plans in 2016. Most of the increase is in the Medicare Advantage market, which has a lot of new entities with inherent risk and typically low enrollment. There were 4 specialty plans with 300,000 lives on the closely-monitored list.
- There were 2 TNE deficient plans, both small specialty plans. Both TNE deficiencies have since been resolved.
- About half of the plans have over 500 percent of required TNE. Seven plans are below 130 percent of TNE. Entities below 130 percent of minimum TNE are automatically placed on monthly reporting.
- There were 24 plans on the closely monitored list, of which 20 percent have TNE of less than 130 percent and 75 percent have TNE less than 250 percent.
- There were 24 plans on corrective action plans, including 13 in progress and 11 pending approval. Most of these are a result of routine financial examinations or non-routine financial examinations.

- There were 34 completed examinations, 21 in progress, and 7 planned for fiscal year 2017-18.

11) Public Comment on Matters not on the Agenda

Ms. Imholz asked for public comment on items not on the agenda. There was no public comment.

12) Agenda Items for Future Meetings

Ms. Imholz asked for agenda items for future meetings. Ms. Yao requested more data from IHA.

13) Closing Remarks/Next Steps

The meeting was adjourned at 12:07pm.