Note: Due to technical difficulties with the recording of this meeting, the meeting minutes may not reflect all remarks and comments that were made during the meeting.

Financial Solvency Standards Board Meeting
July 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
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 April 18, 2018 FSSB Meeting

Ms. Imholz asked if there were any changes to the April 18, 2018, FSSB meeting minutes. Meeting minutes were approved without objection.

3) Director's Remarks

Director Shelley Rouillard announced Ms. Imholz would be retiring and this would be her last Board meeting. She thanked Ms. Imholz for her service to the Board since November 2015 and presented her with a certificate of appreciation. She said John Grgurina had agreed to be the new Board Chairperson starting with the October Board meeting.

Ms. Rouillard stated the Governor signed the 2018-2019 State budget. The State has gone from a billion-dollar deficit in 2007 to fully funding the "rainy day" reserve at $13.8 billion. Although there were a number of proposals from consumer advocates to extend

coverage to the remaining seven percent of those who are uninsured, the budget did not directly address those proposals.

The budget does consider a number of findings from a report commissioned by the California Assembly Select Committee on Health Care Delivery Systems and Universal Coverage, referred to as the Select Committee. The Select Committee convened a series of meetings in the fall of last year to hear from experts about the current state of health coverage and options for the future. The proposals in the budget will provide the Legislature with practical steps to continue California's efforts to expand coverage and improve the health care delivery system.

The budget contains funding to establish a "Council on Health Care Delivery Systems", an independent body within the California Health and Human Services Agency. The Council is tasked with developing a plan with options on how to advance progress toward a healthcare delivery system that provides universal coverage. The Council will consist of five members appointed by the Governor, Senate Rules Committee and the Speaker. The Council will consider key design options, including benefits, service delivery, provider payments, quality improvement, and opportunities to control health care costs. The Council must submit a recommendation and plan to the Governor and Legislature by October 1, 2021.

The budget includes funding for the establishment of a "Health Care Cost Transparency Database" within the Office of Statewide Health Planning and Development (OSHPD). The database will collect data from health plans, health insurers, and other payers regarding the cost of services. OSHPD will convene a review committee of health care stakeholders and experts to provide input on the creation, implementation, and ongoing administration of the database. The goal is to provide greater transparency on health care costs to inform policymaking. In addition, OSHPD will submit a report to the Legislature by July 1, 2020.

In addition, the budget includes a requirement for Covered California to present options to the Governor, Legislature and the Council for providing financial assistance to help low and middle income Californians access health coverage. That report is due by February 2, 2019.

In regards to the Department's budget, Ms. Rouillard said the budget for Fiscal Year 2018-19 is $81.1 million and 451 authorized positions. The DMHC submitted two Budget Change Proposals (BCPs):

- The first proposal extends funding for clinical consultants to review health plans' compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA).
- The second proposal adds one actuarial consultant to the Office of Financial Review (OFR) to analyze the impact of SB 17, the prescription drug cost transparency bill signed by the Governor in 2017.

The budget also authorizes an augmentation of $1.94 million for the DMHC to increase the mandated funding for the consumer assistance programs from $260,000 to $2.6 million. The Western Center on Law and Poverty submitted the budget proposal.

The Legislature continues to consider bills introduced in response to the Select Committee recommendations. It remains to be seen which, if any, of those will be enacted. The Legislature wraps up its session on August 31, 2018 and the Governor has until September 30, 2018 to act on those bills that make it to his desk.

Ms. Rouillard said she had planned on discussing the 2019 proposed premium rates for the health plans participating in the Exchange. However, due to the federal administration's action on the Risk Adjustment Transfers (RAT), Covered California has delayed the announcement of their negotiated rates to July 19, 2018. This is also when the DMHC's rate review process will begin.

She provided an update on the federal regulation regarding Association Health Plans (AHPs). The final regulation did not include any significant changes to the proposed rule published in January. The Department of Labor did not address concerns raised by many health care industry observers, including DMHC. These included concerns regarding the history of fraudulent or insolvent AHPs that left substantial unpaid medical claims, market segmentation leading to higher premiums in the Affordable Care Act (ACA)-compliant market, and more consumers purchasing less-comprehensive coverage.

The impact to the California market will depend on pending legislation and the interaction between the new regulation and state law. Senate Bill (SB) 1375, currently pending in the Legislature, would prohibit certain sole proprietors and small businesses from purchasing large group coverage. Since 1995, the California Insurance Code has prevented new self-insured AHPs from forming or offering coverage in California.

Ms. Rouillard mentioned one recent study, which estimated up to 4.3 million consumers nationwide would shift from ACA-compliant individual or small group products to an AHP, causing premium increases of 4 percent in the small group market and 2 percent in the individual market. Existing California law and pending legislation may mitigate these effects in California.

Ms. Rouillard provided an update on mergers. The Optum/DaVita and CVS/Aetna mergers are currently under review. The DMHC is planning to hold a public meeting on the Cigna/Express Scripts merger in September. The Department of Justice (DOJ) is reviewing the CVS and Cigna transactions.

In regards to Blue Shield and the undertakings for the Provider Directory Utility, the Integrated Healthcare Association (IHA) is engaged in a soft launch of the Utility, which is going well. Anthem Blue Cross, Blue Shield, Health Net, and a number of medical groups and provider organizations are participating. Blue Shield and IHA are negotiating a contract for Phase III of the project, which would start in September through the end of

2022. She is optimistic IHA will achieve critical mass, with at least half of the health plans and provider organizations participating.

Health Net is working on a $50 million encounter data initiative. Health Net recently met with their Community Advisory Committee and recommended funding for 20 provider organizations to hire a consultant to assess their capabilities regarding encounter data. The assessments will be conducted over a 12 week period, and results should be available by the end of the year. Health Net has also contracted with a company that will do an evaluation of the encounter data initiative.

In addition, Health Net provided funding to IHA to conduct market research regarding the issues and challenges with encounter data. IHA recently completed a white paper with their findings, which included several recommendations for improving encounter data submissions, including:

- Providing outreach and training to physicians, billers, and other relevant staff to help establish a common and more workable knowledge base of encounter data.
- Establishing a single, statewide clearinghouse could greatly streamline and simplify the process by eliminating the barriers associated with the multiple handoffs. This would also be less administratively burdensome for providers, provider organizations and health plans.
- Streamlining and simplifying Electronic Health Record (EHR) systems and standardizing coding schemes to ease many of the burdens in generating encounter data.
- Providing incentives might help to motivate completeness and accuracy in submissions.

Ms. Rouillard stated poor quality and missing encounter data remain major challenges for the health care industry across all lines of business. She believes an industry-wide solution is needed to improve the quality and timeliness of encounter data, and to reduce the administrative burden associated with data exchange.

Health Net also has an Infrastructure Investment Committee, which advises Health Net on how to invest $75 million in projects that provide health services to underserved communities. To date, Health Net has invested approximately $10 million for two projects. One was in conjunction with the Anthem and United investment funds to support the expansion of a Federally Qualified Health Center (FQHC) in the Central Valley. The second investment will support the development of a new independent living and memory care center in Sacramento to serve individuals with complex health care needs.

Ms. Rouillard provided the following update regarding regulations:

- Assembly Bill (AB) 72, Average Contracted Rate (ACR) Methodology. AB 72 required the Department to develop a standard methodology for calculating the ACR for the purpose of reimbursing out-of-network providers who provide services at in-network facilities. The DMHC held two public comment periods and

is preparing the final regulation package for submission to the Office of Administrative Law (OAL). The regulation must be in effect by January 1, 2019.

- Risk and Restricted Licenses. This regulation codifies the DMHC's practice regarding the types and levels of risk that require Knox-Keene Act (KKA) licensure. The DMHC held three public comment periods, and the regulation is in final internal review. The regulation package will be submitted to OAL in the next few weeks.
- Risk Bearing Organization (RBO) Financial Filing Requirements. This regulation updates the financial and other requirements for RBOs to better address the changing nature of the relationships between RBOs and health plans, including sub-delegated RBOs. The first 45-day comment period closed on July 9, 2018, and the DMHC is currently reviewing the public comments.
- Cancellations, Terminations and Non-renewals of Coverage. AB 2470 amended Health and Safety Code Section 1365 to comply with provisions of the ACA and regulations were adopted in 2014. This regulation updates and clarifies the requirements for cancellations for nonpayment of premiums. The first comment period began on June 22, 2018 and ends on August 6, 2018.
- SB 1052, Standard Template Drug Formulary. SB 1052 required the DMHC and the California Department of Insurance (CDI) to develop a standard template formulary for plans and insurers to use. The DMHC is in the final stages of drafting the regulations, and plans to publish this regulation for comment in late summer or early fall.

Ms. Rouillard announced the DMHC annual report is on the Department's website. The report highlights some of the Department's accomplishments and updates the infographic that summarizes the work since the Department's inception.

Discussion

Dr. Jeff Rideout said IHA's next contract for the Provider Directory Utility is milestone based. He reiterated the need for an industry-wide solution to encounter data and there may be an opportunity with the Health Net undertakings to develop a statewide database.

Dr. Larry deGhetaldi noted, in regards to encounter data, there is an overall market migration from paying for volume to paying for quality. However, providers think Current Procedural Terminology (CPT) codes are more important than diagnosis codes. Moving to a risk-adjusted world means diagnosis codes become more important.

John Grgurina stated while there has been a lot of focus on protecting the gains we've made in California over the years and the frustrating decisions out of Washington D.C. It is exciting to see activity to try to solve system wide issues, such as provider directories and encounter data, while still focusing on protecting what we've got.

4) America's Physician Groups Presentation

Don Crane, President and CEO of America's Physician Groups (APG), provided an update on the organization and their recent rebranding. He stated APG became a national organization four years ago and now has over 300 groups in 45 states, plus Puerto Rico and the District of Columbia. About half of the groups remain in California and are very sophisticated in terms of capitated integrated care. The groups outside of California represent a wide spectrum of risk-based care. The general trend is to move to higher levels of risk and the goal across the groups is to get to fully capitated integrated care.

In January, the association changed its name from CAPG to APG to make it clear they no longer just represent California. They are an association of physician groups, not health plans or hospitals. Their tag line is "Taking Responsibility for America's Health". Mr. Crane explained this is an audacious statement that comes from the payment and delivery model. The payment model is when a group receives a capitated sum for a group or an assigned population of patients and becomes responsible for the cost of that care. If the group is not able to deliver care at an amount less than the capitation, they lose money. This creates a budget mindset and accountability for quality, particularly when it is coupled with a pay-for-performance model, like in California. The fiscal and quality accountability is why APG believes they can take responsibility for improving America's health.

Mr. Crane said the move to a national organization has provided a perspective on health care around the country and an appreciation for the delivery system in California, which is the envy of the rest of the country. He noted they have members joining from across the country because they want to learn the California model. Part of what they admire is that California has the FSSB, the DMHC, the KKA, and all of the regulations that have been promulgated under it. This body of law provides clarity in terms of what they can do, which is lacking outside of California.

One of the things those in other states envy the most is what was presented by Dr. Rideout at the last meeting regarding the IHA Regional Health Care Cost and Quality Atlas. The capitated integrated model is superior over the fragmented fee-for-service model in terms of quality and total cost of care. In Medicare where the population is even more acute, the deltas were even greater. These findings are important for maintaining affordability during a time when the average wage earner in California can't pay their premium on the Exchange without a subsidy.

A recent report from Milliman looked at what the spend would be in California without capitated integrated care based on a review of the IHA Quality Atlas II. They determined spending in California would increase by $3 billion for commercial health care if capitated delegated care was eliminated. Mr. Crane stated the same data wasn't available to do the analysis for Medi-Cal, but that analysis should be completed as part of the single payer health care discussion and going back to a fee-for-service model.

Mr. Crane expressed concern that while the rest of the country is moving ahead and faster, California appears to be moving backwards in how providers are paid. At the federal level, there is Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which includes Alternative Payment Models (APMs) and Merit Based Incentive Payment Systems (MIPS) and completely revamped the way physicians are paid in Medicare. Physicians get a flat rate update if they stay in MIPS, but the profit and pay raises are on the APM side, which creates a strong motivation for physicians to move into APMs. However, there is no companion statute in California and there is not a similar motivation, at least on the legislative side. Mr. Crane also mentioned the recent Request for Information (RFI) released by the Centers for Medicare and Medicaid Services (CMS) Innovation Center to solicit input on Original Fee-for-Service (FFS) Medicare entering into direct contracts with physician groups. This is similar to the APG's proposal a few years ago to bring coordinated care to fee-for-service Medicare.

Mr. Crane gave several examples of innovative business models in other states:

- Stewart Health Systems, headquartered in Boston, has business in approximately 10 states and 33 communities. In each community, they have a physician group and a hospital and some have a wraparound Independent Practice Association (IPA). They view all components of the integrated system as cost centers and try to remove redundancy and waste from every component of the system. They are achieving amazing results in terms of high quality and low cost without risk pools or risk sharing because everything is a cost center.
- ChenMed, headquartered in Florida, just has Medicare Advantage. They have a strong mission to treat the weak, poor, and needy, and use data to stratify the population and identifying the sickest 5 percent. They are now using artificial intelligence and mechanical learning to help develop treatment protocols and diagnoses at the point of care.
- New West, headquartered in Denver, Colorado, realized they delivered better care in Medicare Advantage than original Medicare so they moved completely into Medicare Advantage.

Mr. Crane said he does not believe his California members are seeing that kind of innovation because the legislative and regulatory platform is not helping the model as much as it should. He does not think the California government, except DMHC, recognizes the superiority of the model that exists in California.

Mr. Crane presented three requests regarding areas in which APG can work more closely with the DMHC. The first request is to shift to a focus on value and population health by expanding the capitated integrated model to places where it doesn't exist in order to deliver greater affordability and value to Californians. He noted the mission of the DMHC is to ensure a stable health care delivery system, which the Department has done, and now it is time to shift and evolve to focus on value as the rest of the industry has done.

Mr. Crane commented that Employee Health Systems (EHS) and SynerMed were excellent in pay-for-performance and part of APG's Standards of Excellence program. They were perennially high scorers and elite winners on quality. He said they were "summarily executed" without a hearing, which he does not believe has been done to any health plan. He cautioned against coming down harder on the groups than the health plans. He noted there may be a deadly fact that he is not aware of because there was not a hearing. His concern is that it was too precipitous an action.

The second request is to allow direct contracting. APG has promoted a regulation that would have allowed direct contracting between groups and employers in California. The Department took the view that it was not permissible under the current statutory framework and legislation was needed. He believes this should be revisited. Non-Kaiser commercial enrollment has dropped below 3 million compared to 10 million ten years ago. It is beginning to feel like Employee Retirement Income Security Act of 1974 (ERISA) and self-insured products are largely unregulated in California and actions need to be taken to address that. His recommendation is the adoption of regulations to allow sophisticated groups to contract directly with employers. If the Department does not believe it can allow that, at a minimum it should not stymie the growth of Accountable Care Organizations (ACOs) in California. His understanding is the pending Risk and Restricted License regulation would require risk-sharing ACOs to get a restricted Knox-Keene license. He believes this goes beyond the Department's jurisdiction.

The final request is to continue to partner with the Department and to work more closely to develop a better delivery system in California.

Discussion

Amy Yao said there is a large movement to value-based care with many different models. She noted it appears APG favors capitation and asked if he is a fan of other models. Mr. Crane responded he is in favor of experimentation and they are watching this, particularly through the Innovation Center. However, as he looks at the various payment models out there, none of them are succeeding anywhere near the extent to which the capitated, delegated, and integrated model in California is succeeding. He would encourage continued experimentation, but would urge the rest of the country to imitate California because it has proven to be successful.

Dr. Rideout thanked Mr. Crane for mentioning IHA's Atlas 2. He said as the Atlas information becomes more refined and people start to use the results for research, it is important to understand the level of insurance is driving a lot of quality control. What is less clear is how the level of risk sharing financially relates to the level of integration. Anecdotally, they believe there is a strong connection. The distribution of performance at every level of risk sharing generally shows more financial risk taking leads to higher quality. The difference between HMO and PPO was convenient historically, but it is less relevant now because you can have integrated care in any product. This is true both within and outside of Kaiser. Mr. Crane added it is the nature of the model, not so much the label, that counts.

Dr. deGhetaldi stated In the Medicare Compare Reports, hospitals report as single and separate entities, however physicians report at the level of the taxpayer ID number. In one circumstance, a mega group of physicians in Sutter from Healdsburg to Watsonville appear as if they are one physician with identical report cards. However, there's a hierarchy of quality with Medicare Advantage at the top, followed by commercial, fee-for-service Medicare, Medi-Cal Managed Care, then PPO. He said we can no longer rationalize the quality differentials. It is an ethical imperative that the primary care physician owns the patient's entire experience and the patient's total quality. In Medicare Advantage, Stars is an additive payment. Providers risk adjust their patients and own their clinical outcomes. The question is how do we spread the Medicare Advantage experience across the state. Mr. Crane responded, his pipe dream is something like a legislative mandate or carrots and sticks that create a climate where there's a strong incentive to move towards Medicare Advantage and away from fragmented PPOs.

Ms. Imholz asked how medical groups ensure people get to the specialist they need when there is no specialist in the group. Mr. Crane responded the health plans have an obligation when it submits a product to the Department to ensure it has a sufficient number of primary care providers and specialists. The parties primarily responsible for an adequate network are the plans and the DMHC.

Ms. Imholz asked how medical groups oversee their Management Services Organizations (MSOs). Mr. Crane stated there are MSOs that are APG members and participate in the Standards of Excellence program. If they have sufficient competencies across six domains, they are given elite status. They have a way to identify characteristics that correlate with excellence in care, which the MSOs are subject to. Mr. Crane said the MSOs contract with plans who are regulated by the DMHC so that is the regulatory path. The MSOs are a slightly different animal but they still follow the same contractual path. The health plan is responsible for the care and contracts with the MSO or directly with the group for the delivery of care. A lot of focus has to be on the plan and whether they are doing their job correctly.

He added when you've seen one MSO, you've seen one MSO. Historically, they were less capable compared to some of the staff model groups that had spent a lot of time and money developing their competencies. To a certain extent, they were there to help develop networks for physicians for the plans to contract with. Mr. Crane commented that SynerMed, "may it rest in peace", was at the forefront of quality, getting high marks on the Standards of Excellence program and were used as a case study in excellence for many of their programs. They also had a poverty program in downtown Los Angeles that was a model of outreach in terms of social determinants. Mr. Crane believes they were a very good MSO.

Ms. Imholz asked if the MSOs contract with medical groups as well as the health plans. Mr. Crane said generally the MSO provides centralized support that historically, some of the smaller IPAs didn't have the capital or means to do these services themselves. The MSO develops the care managers, owns and operates the data warehouse, and

conducts the outreach all for eight percent of premium or some negotiated amount. It is an expedient way to equip smaller IPAs with the services they need. MSOs have grown a lot and are popping up all over the country. Many think they are the future of American health care because you can form an IPA rapidly and a single sophisticated MSO might be able to rapidly deliver competencies in multiple areas. They are an important component of health care but they do need to be monitored.

Ms. Imholz expressed concern about the oversight of MSOs. Mr. Crane said DMHC is looking at whether plans have sufficient monitoring of their subcontracted MSOs and groups. The laws and regulations are clear that the plan has primary responsibility for ensuring compliance.

Ms. Imholz asked Mr. Crane to explain economic profiling and whether economic profiling is at the core of the delegated model. Mr. Crane said it starts with the development of the network, which is filed with the DMHC. The plan selects the network because it will provide access and also high levels of quality. Next, a physician group in a delegated model is monitoring referrals within a very narrow network. The goal is high quality and low cost so there is appropriate steerage to more convenient providers, higher quality providers, or providers with special expertise to take care of the patient's special needs.

Mr. Crane noted he does not believe there is much of a problem or a widespread effort to send consumers to the lowest cost provider. The current statute requires health plans to submit a plan that speaks to how referrals are done and that may not have been done sufficiently and should be. He said he does not believe the problem is physician groups trying to always use the lowest cost provider in order to generate higher profits. The profit motivation these days is through risk adjustment and getting the patients with higher acuity. If they can keep these people out of hospitals and keep them healthy through prevention and early intervention, that is where the profit is.

Now that we have risk adjustment, pay-for-performance and quality monitoring, the nature of practices has changed to find out who is sick and keep them healthy, even if that means sending them to the most expensive medical center because it produces the best outcome. Mr. Crane said it really is a matter of human economics. If you get more money by keeping people well, behavior will change and you will see more outreach and services, not less.

Mr. Grgurina thanked Mr. Crane for his participation in the meeting and for the work they are doing to spread the delegated model beyond California. He said San Francisco Health Plan has worked with capitated groups for years. While there are a lot less insolvencies, he cautioned against shifting the focus because maintaining a focus on the basics is important. Mr. Grgurina added the plans contract with the groups who contract with the MSOs. The plans are improving their monitoring of MSOs through audits and compliance reviews.

Ms. Yao said there has been a movement to more self-insured. As Mr. Crane noted, non-Kaiser enrollment has decreased from 10 million to 3 million. Consumers react to

cost and Kaiser is still better in terms of quality and cost compared to fully capitated arrangements. She asked what APG is doing to catch Kaiser? Mr. Crane responded Kaiser is the gold standard and most groups envy Kaiser in terms of quality. However, there are some APG members that score higher than Kaiser. He said we should have a high bar and should be aiming to move the entire bell curve up and over every year.

APG wants to bring capitation and higher levels of value to the self-insured market. The 8 million Californians that are in the self-insured model don't get the consumer protections delivered by DMHC or the kind of quality from pay-for-performance. They do get very high deductibles and pay a big share of premiums for lesser value. If someone wants to buy lower value, they can, but policy makers should at least give them the opportunity to have a capitated model. He recommends bringing them under DMHC's jurisdiction and allowing for capitation that produces value.

Paul Durr commented on the value provided to patients. He said the groups are looking for the right alternative for patients not the cheapest alternative. They need to do a better job of educating consumers about value because the average consumer doesn't understand that.

Dr. deGhetaldi said there is a halo effect in California where the clinical quality and efficiencies of the delegated model carries over into the fragmented PPO world. Groups are translating what they learn on the HMO side to other lines of business.

Ms. Rouillard said the IHA Atlas has two different types of risk. The first is global risk, which means the group is taking on professional and institutional risk in one capitated contract. The second is dual risk, where the payment for hospital services is made directly from the plan to the hospital and there are parallel capitation payments. She asked Mr. Crane if this was his understanding of the different risk arrangements. Mr. Crane said he believes there is every possibility under the sun. One CEO recently said they have all types of arrangements including global capitation, per diem, dual risk arrangements and shared risk pools. Dr. Rideout noted the risk categories in the Atlas are self-reported.

Ms. Rouillard said the Department has heard from plans that they are having trouble understanding the financial standing of the groups. The RBOs provide financial information to the Department. She asked why the RBO's financials would not be available to the plans. Mr. Crane said he was surprised to hear this. Most group contracts require financial information to be sent to the plans and it is usual and customary for the plans to have access to even more robust information.

Ms. Rouillard noted there are some examples the Department is investigating where the plans did not know about the financial issues. Mr. Crane responded the plans should require this in their contracts if they don't already.

Ms. Rouillard stated when a plan delegates to a group, all expenses are considered medical in the Medical Loss Ratio (MLR) calculation yet a significant amount goes to the administrative expenses of the medical groups. She noted there were groups with

administrative costs of 25 percent or higher. She asked why all capitated funds should go towards medical expenses at the group level. Mr. Crane said the Center for Consumer Information and Insurance Oversight (CCIIO) and the feds have looked into this issue.

Mr. Durr added it has to do with the definition for each category. For example, should chronic care managers or MSOs be considered administrative or medical? He said most of the delegated amount goes to support quality or the provision of care. Ms. Rouillard said that is true for some but not all.

Dr. Rideout said there does not appear to be an immediate connection between financial risk and the amount spent on care management infrastructure.

Mr. Grgurina stated the plans have not focused a lot on MLR. After an audit, his plan started to focus on it and noticed a large third party administrator (TPA) had an MLR with 100 percent administration. Since the audit, they changed their focus and started to look at what goes into each bucket and what counts and what doesn't. He said many of the provider groups need to do the same.

Ms. Rouillard asked Mr. Crane if he had any recommendations for plans on how to incentivize quality. Mr. Crane recommended putting more funding into pay-for-performance. In the early days of pay-for-performance, $50 million across the plans really drove profitability. He added if you want good results, you need carrots and sticks and the carrot is more funding for pay-for-performance. He said the total spend has been hovering around one to two percent, but should probably be closer to ten percent.

Ms. Rouillard thanked Mr. Crane for coming to the meeting and for answering all of the Board's questions.

5) Financial Summary of Medicare Advantage Plans

Pritika Dutt, Deputy Director, Office of Financial Review, provided an update on the Financial Summary of the Medicare Advantage (MA) plans and Medicare Advantage Restricted License (MA-RL) plans for the quarter ending March 31, 2018. She noted the MA plans receive their enrollment directly from CMS while the MA-RL plans provide and administer health care services to MA enrollees as a subcontractor to the MA plans. The DMHC licenses and oversees MA and MA-RL plans for administrative capacity and financial solvency compliance. All other compliance oversight is performed by CMS.

Ms. Dutt explained the report highlights enrollment, financial metrics, and tangible net equity (TNE) for plans with Medicare enrollment that is greater than 50 percent of their total enrollment. She summarized the key findings from the report for each.

MA Plans:

- There are 15 plans that have a MA license with the DMHC. However, the report includes only 11 of the plans. Humana Health Plan of California, Inc. did not have

any MA enrollment as of March 2018 and three newly licensed plans – Vitality Health Plan of California, Inc., Health Net Health Plan of Oregon, Inc. and Providence Health Assurance – will not be reporting data until August 15, 2018.

- MA plans provided services to over 500,000 enrollees, of which 96 percent were MA enrollees as of March 2018.
- Enrollment increased by 8 percent from March 2017 to March 2018.
- Seven of eleven MA plans reported net losses for the quarter, which totaled $15.9 million.
- All MA plans met the Department's reserve requirement and had TNE ranging from 103 percent to 1,370 percent of required TNE.

MA-RL Plans:

- There are eight MA-RL plans currently serving 18 counties.
- MA-RL plans provide services to over 49,000 enrollees, of which 99 percent are Medicare enrollees.
- Six of eight MA-RL plans reported positive net income for the quarter. The total net profit was $2.3 million.
- The reported TNE ranged from 33 percent to 286 percent of required TNE. The TNE for all MA-RL plans exceeded the regulatory requirements, except for Choice Physicians Network, Inc. which reported 33 percent of required TNE. The DMHC is currently working with the plan to cure the deficiency.

Ms. Dutt noted enrollment in MA and MA-RL plans continues to increase overall. There were three MA plans licensed in 2018 and two MA-RL plans licensed in 2017. The DMHC is currently reviewing one MA and two MA-RL applications for Knox-Keene licensure.

Ms. Dutt commented, with two exceptions, MA and MA-RL plans reported stable TNE for the last five quarters. Nearly, two-thirds of the MA plans reported a net loss for March 2018, compared to one-quarter of the MA-RL plans that reported a net loss.

In conclusion, Ms. Dutt said the DMHC checks for financial solvency similar to other non-Medicare plans, and if a health plan's reserves fall below 130 percent or there are other concerns with the health plan, the Department may place the plan on monthly reporting, ask for financial projections, or perform a non-routine examination. Currently, there are seven MA and seven MA-RL plans on monthly reporting due to low reserve levels or because they are newly licensed.

Discussion

Ms. Imholz stated it was concerning that two-thirds of the plans have losses. Ms. Dutt responded the MA plans have higher medical expenses because of higher utilization. They also tend to serve a high risk population.

Dr. Rideout asked for clarification regarding which plans are included in the report because IHA is tracking 2.4 million enrollees in Medicare Advantage, significantly higher than what is noted in the report. Ms. Dutt clarified only MA plans with Medicare enrollment that is greater than 50 percent of their total enrollment are included in the report.

Dr. Rideout noted the results may be skewed due to the small population numbers because it does not include all MA plans. It doesn't take away the concern but it is skewed towards plans with greater MA enrollment.

Mr. Grgurina said it is important to make sure that plans below the required TNE continue to be viable and he appreciates the Department's work to continue to monitor financial solvency.

Dr. deGhetaldi said hospitals and physicians still lose money caring for Medicare patients, but they lose less with MA and are able to deliver higher quality.

Bill Barcellona representing APG said there are 8 million lives in restricted license plans at DMHC. There's a significantly higher percentage of lives in MA Restricted Knox-Keene plans than what is represented in the report.

Mr. Grgurina agreed and said for the plans in the report, Medicare is the majority of their business. However, the information shouldn't be used to compare to their whole line of business or to make inferences about what is happening in Medicare in California. It might be helpful to understand what other information the Board would like to see in the report to see the whole picture. It might be helpful to see what portion Medicare represents of their whole business. Ms. Dutt said enrollment is reported separately, but the revenue stream is all lumped together so it can't be isolated.

Ms. Rouillard asked the Board if the report was helpful given the limitations. Mr. Grgurina said it is helpful to understand how these specific plans are performing but it would be good to point out the report represents only a small portion of the market.

Dr. Rideout said this may reinforce the idea that a high concentration of MA lives may be a problem and diversification across products may bring better stability and performance.

Mr. Durr noted most of the plans losing money are supported by another organization or parent. It would be helpful to understand their relationship to the parent.

Dr. deGhetaldi said he would like to understand how many are dually insured and how that impacts profitability because as many as one-quarter of Californians are dually insured.

6) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, provided an update on the financial solvency of RBOs for the quarter ending March 31, 2018:

- 189 RBOs are required to file reports. For the fiscal year ending in 2017, one RBO was a non-filer, and was referred to the Office of Enforcement for administrative action.
- Five RBOs filed monthly financial survey reports as required by their corrective action plan (CAP).
- 178 of the reporting RBOs reported compliance with the solvency criteria, including:
    - 36 RBOs were in the Superior category.
    - 91 RBOs were in the Compliant category, of which 4 RBOs were on a CAP and 5 RBOs were on the monitor-closely list.
    - 51 RBOs filed compliance statements
- 11 RBOs reported non-compliance and were on a CAP.
- There were 15 RBOs on a CAP. Of these, 4 of the CAPs continued from the previous quarter and are meeting their approved projections. One RBO was not meeting their approved projections and the health plan has moved all the members from this RBO. There were 10 new corrective action plans in this quarter, of which 3 were for failure to meet the 95 percent base finance criteria and 7 were non-compliant with the TNE requirements. In addition, 6 of the 7 RBOs were also non-compliant with additional solvency criteria, which includes working capital or cash to claims ration.
- There were 88 RBOs with Medi-Cal enrollment covering approximately 4.1 million enrollees.
    - The top 20 RBOs served approximately 3.1 million Medi-Cal lives. Of these, 18 have no financial concerns and 2 were on a CAP.
    - The remaining 68 RBOs served approximately 1 million Medi-Cal lives. Of these, 57 have no financial concerns, 8 were on a CAP, and 3 were on the monitor-closely list.
- For the fiscal year ending in 2017, 8.1 million lives were assigned to RBOs, including 2.9 million commercial lives, 4.3 million Medi-Cal enrollees, and 900,000 Medicare lives.
- There has been a downward trend in the number of commercial lives assigned to RBOs over the past few years. While Medi-Cal enrollment increased over the

past several years due to the Affordable Care Act, there was a decrease of approximately 100,000 Medi-Cal lives assigned to RBOs in 2017. There has been a gradual increase in Medicare enrollment from 2011 to 2014, and enrollment has held steady for the past few years.

Ms. Yamanaka stated the Office of Financial Review has 24 audits planned for 2018, of which 11 have been completed and 13 are in progress. The financial field work has been completed for 6 of them and audits are scheduled for the remaining 7.

Discussion

Ms. Imholz asked if there are any trends in provider solvency. Ms. Yamanaka said in the year end financials, there is a distribution to providers. Sometimes the RBOs distribute more and they will make up for it in the first quarter of the year. This is a common issue they see year-over-year.

7) Health Plan Quarterly Update

Stephen Babich, Supervising Examiner, Office of Financial Review, presented the health plan quarterly update.

- There were 125 Knox-Keene licensed plans, including four new full-service plans and two new behavioral plans.
- Enrollment growth in full-service plans has slowed down, with full-service lives growing just 1 percent from last year. Commercial enrollment went up a little over 1 percent and Medicare enrollment went up almost 6.5 percent.
- There were 23 full-service plans with 1.25 million lives on the closely-monitored list compared to 16 plans in 2017. 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 3 specialty plans with 200,000 lives on the closely-monitored list.
- There were 3 TNE deficient plans, including 2 full-service plans and 1 specialty plan.
- Fifty-five percent of the plans had over 500 percent of required TNE. Eight plans are below 130 percent of TNE, of which 5 plans are involved in Medicare.
- There were 26 plans on the closely-monitored list, of which 73 percent of the plans have less than 50,000 lives.
- There were 21 plans on corrective action plans, including 9 in progress and 12 pending approval. Most of these are a result of routine financial examinations.

Mr. Babich said there were 3 completed examinations, 13 in progress, and 32 planned for fiscal year 2018-19.

Discussion

Mr. Grgurina asked if there were reasons other than financial concerns that would lead to a plan being placed on the closely-monitored list. Mr. Babich said there could be other factors, such as something in the news or other evidence that the Department should take a closer look. There have been instances where a plan performs well financially, but is known to have issues with their claims shop and will be on the closely-monitored list.

Dr. Rideout asked if TNE was the only metric. Mr. Babich responded TNE is only one factor and they also look at cash, the plan's burn rate, how much they are losing every day and how many days they can go without any revenue.

Dr. Rideout noted 2 of the 12 Medicare plans on the closely-monitored list have liquidity issues. He is aware of one MA plan, Alignment which was formerly Honored Citizens, that has been losing money for years and is owned by a private equity fund. Their Star rating is up to 4.5 so perhaps the investment will bear some fruit and they will be able to turn the entity around.

Ms. Imholz asked if it is challenging to get financial information when a private equity fund is the backer. Mr. Babich responded many of them operate globally and have plenty of cash, but they need to be educated about the Knox-Keene Act and TNE. They often don't understand that they need to maintain the minimum TNE at all times and if they are not paying attention may end up TNE deficient. Sometimes they are resistant to putting more money in.

Mr. Durr noted the number of plans has increased along with the number of plans on the closely-monitored list. However, the number of examinations hasn't changed. He asked if the Department has adequate staffing. Mr. Babich said before a newly licensed entity receives its first routine examination, it receives an orientation examination. By statute, DMHC is required to perform a routine financial examination every 5 years, but tries to visit the full-service plans every 3 years. The Department monitors staffing needs and if the growth rate continues, it can submit a BCP to request additional positions.

Ms. Imholz questioned the growth in large group enrollment from 7.69 million in 2017 to 7.96 million in 2018. Mr. Babich said two-thirds of that growth was due to an accounting error by one plan that was reporting some lives in their Administrative Services Only (ASO) category rather than the large group category. Otherwise, the growth in large group would be flat.

8) Public Comment on Matters not on the Agenda

Ms. Imholz asked for public comment on items not on the agenda. Don Comstock, with Comstock and Associates, suggested a presentation on the relationship between a health plan, an IPA and a MSO.

9) Agenda Items for Future Meetings

Ms. Imholz asked for agenda items for future meetings. There were none.

10) Closing Remarks/Next Steps

The meeting was adjourned at 12:13pm.