Overview of the DMHC and Role of the FSSB

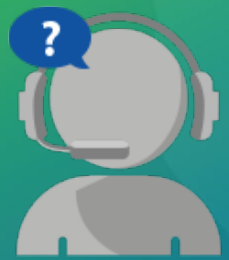
May 28, 2025

Mary Watanabe, Director

DMHC Mission Statement

The California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

2023 Accomplishments



2.9 MILLION
HEALTH PLAN MEMBERS ASSISTED

The DMHC Help Center protects health plan member rights, resolves member complaints, and helps members navigate and understand their coverage ensuring access to health care services.

$179.5 MILLION
dollars assessed against health plans that violated the law

140
LICENSED HEALTH PLANS

- **98** FULL SERVICE
- **42** SPECIALIZED

$296.1 MILLION
dollars saved on Health Plan Premiums through the Rate Review Program since 2011

29.8 MILLION
CALIFORNIANS' HEALTH CARE RIGHTS ARE PROTECTED BY THE DMHC

96% of state-regulated commercial and public health plan enrollment is regulated by the DMHC

Approximately **72%** of health plan member appeals (IMRs) to the DMHC resulted in the health plan member receiving the requested service or treatment from their health plan

$207.7 MILLION
dollars in payments recovered to physicians and hospitals

$53 MILLION
dollars recovered from health plans on behalf of health plan members

December 31, 2023

What is the DMHC?

Regulator of full service and specialized health plans

- All HMO and some PPO/EPO products
- Some large group and most small group & individual products
- Most Medi-Cal Managed Care plans
- Dental, vision, behavioral health, chiropractic and prescription drug plans
- Medicare Advantage (for financial solvency only)

DMHC Assessments

- **DMHC is funded by the assessment on health plans**
- **Assessment calculations based on:**
  - Projected fund balance
  - Prudent cash reserve
  - Expenditure authority for the upcoming FY
  - Projected revenue for the upcoming FY
  - Office of the Patient Advocate and California Health Benefit Review Program appropriations

* Plans as of December 31, 2023

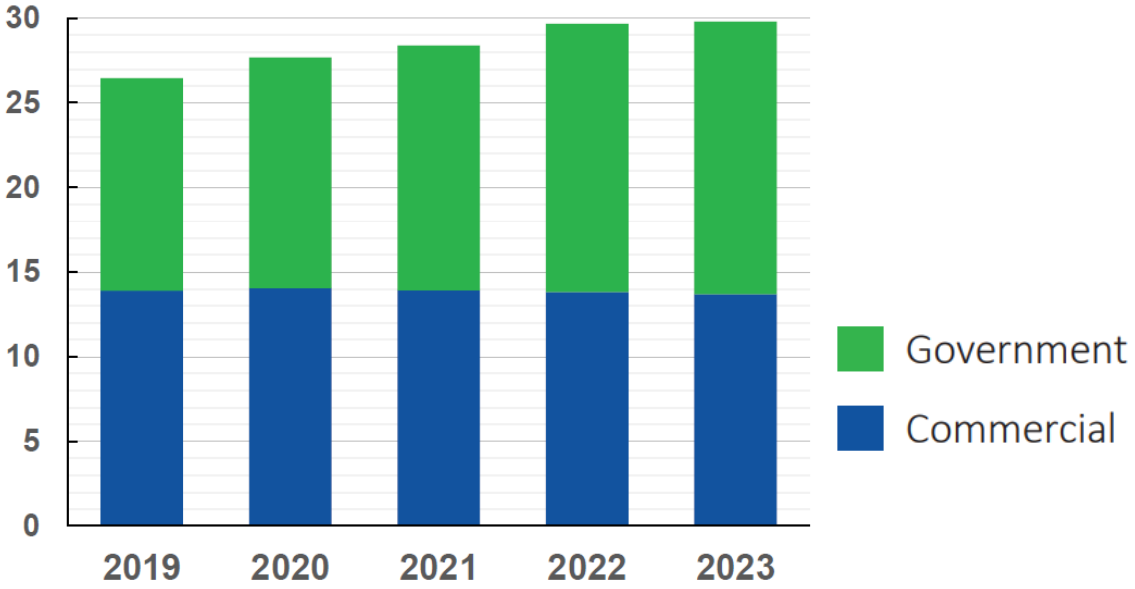
DMHC Assessments

Health plan assessments are calculated by distributing the total assessment amount to each plan based on enrollment

- Enrollment as of March 31 of each year
- Prorated 65% and 35% to full service and specialized plans, respectively
  - DMHC Full Service assessment for FY 2024-25 is $3.25/enrollee
  - DMHC Specialized assessment for FY 2024-25 is $1.44/enrollee

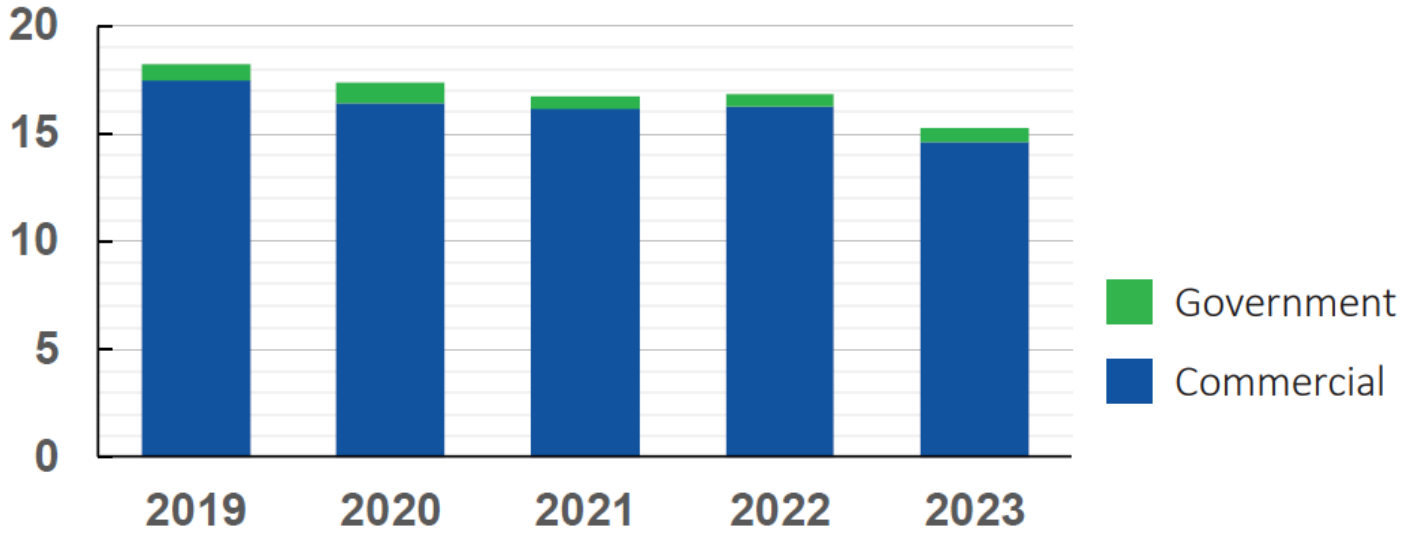
DMHC Enrollment Over Time

Full Service Enrollment (In Millions)



DMHC Enrollment Over Time

Specialized Enrollment (In Millions)



California Has Two State Regulators

DMHC

- Director appointed by the Governor
- Part of CalHHS and the Executive Branch
- Regulates health coverage only
- Health and Safety Code
- **29.8 million** health care consumers

CDI

- Commissioner elected by voters
- Separate constitutional entity from Executive Branch
- Regulates many forms of non-health insurance
- Insurance Code
- **1 million*** health care consumers

DMHC Regulates

- All HMO products
- PPO & EPO products
- Specialized plans (vision, dental, behavioral, chiropractic)
- Prescription drug plans
- Some large group and most small group & individual products
- **96%** of state-regulated commercial & public health plan enrollment
- **100%** of the state's health benefit exchange enrollment

Help Center

Assists consumers with health care issues and ensures that managed care patients receive the medical care and services to which they are entitled.

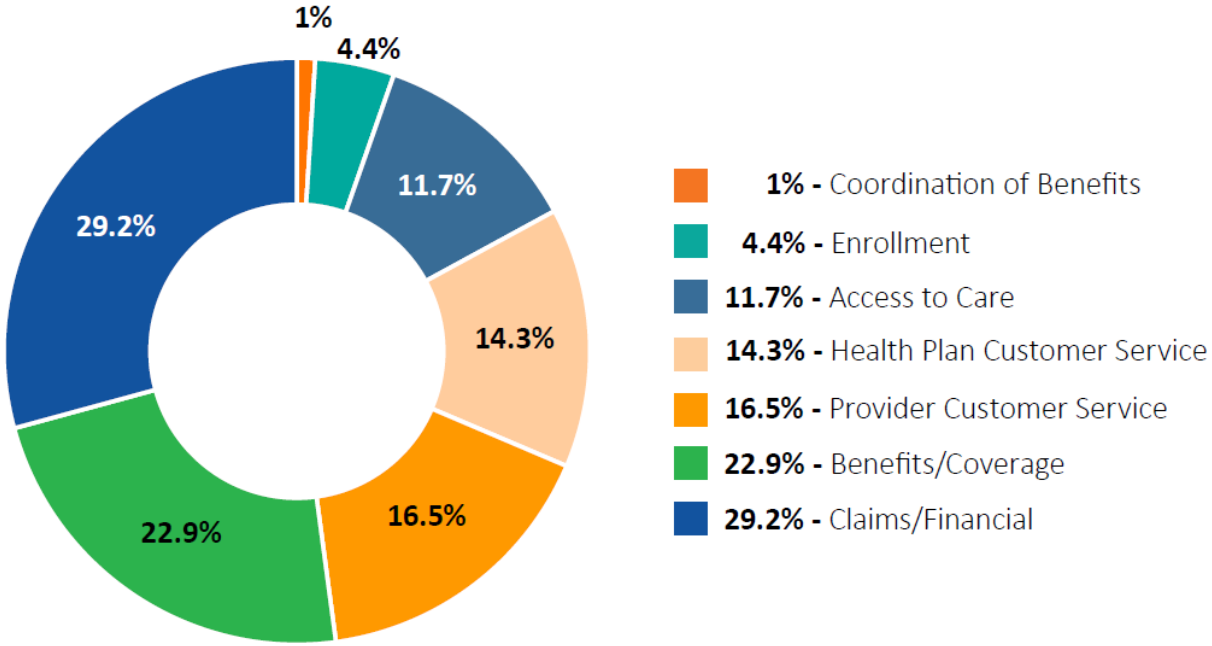
- Contact Center
- Division of Legal Affairs and Policy
- Independent Medical Review/Complaint Branch
- Provider Complaint Unit

2023 BY THE NUMBERS

HELP CENTER

140,952	CALIFORNIANS ASSISTED[4]
121,854	TELEPHONE INQUIRIES
13,245	HEALTH PLAN MEMBER COMPLAINTS[5]
3,940	IMRs CLOSED[6]
$9.1 M	RECOVERED FOR HEALTH PLAN MEMBERS
1,913	NON-JURISDICTIONAL REFERRALS
9,564	PROVIDER COMPLAINTS
$11.2 M	RECOVERED PROVIDER PAYMENTS
19	NON-EMERGENCY SERVICES IDRP CASES COMPLETED

Health Plan Member Complaints Resolved in 2023



Independent Medical Reviews (IMRs)

History of the FSSB

- Established by SB 260 (Speier, 1999)
- Purpose:
  - Advise the Director on matters of financial solvency affecting the delivery of health care services;
  - Develop and recommend to the Director financial solvency requirements and standards; and
  - Periodically monitor and report on the implementation and results of the financial solvency requirements and standards.

History of the FSSB

Additional requirements of SB 260:

- Directed the FSSB to provide a study or report to the DMHC director on several specified criteria related to risk-sharing arrangements and Risk Bearing Organizations (RBOs).
- Required the DMHC to adopt regulations related to the solvency standards and monitoring of RBOs, as recommended by the Board.

Standing FSSB Presentations

- Updates from other state departments, including the Department of Health Care Services (DHCS), Covered California, and the Department of Health Care Access and Information (HCAI) – at least annually.
- Regulation and Federal Updates – quarterly
- Health Plan Quarterly Update – quarterly
- Provider Solvency Quarterly Update – quarterly
- Financial Summary of Medi-Cal Managed Care Plans – bi-annually

Annual FSSB Presentations

- DMHC Budget Update
- Federal Medical Loss Ratio (MLR) Summary
- Large Group Aggregate Rates and Prescription Drug Cost Report
- Legislative Update
- Rates in the Individual Market
- Risk Adjustment Transfers
- Dental MLR Report (information only)

Health Plan Financial Reporting Requirements

- Health plans are required to submit quarterly and annual financial statements.
- Newly licensed health plans and plans whose Tangible Net Equity (TNE) falls below 150% of required TNE are required to submit monthly financial statements.
- We may also require monthly reporting from other plans if we have other concerns related to a health plan's financial solvency.

Tangible Net Equity Requirements

- All Health Plans must meet the TNE reserve requirement described in California Code of Regulations, title 28, section 1300.76.
- TNE is defined as a health plan's total assets minus total liabilities reduced by the value of intangible assets (i.e., goodwill, organizational or start-up costs, etc.) and unsecured obligations of officers, directors, owners, or affiliates outside the normal course of business. Any debt that is properly subordinated may be added to the TNE calculation, which serves to increase the plan's TNE.

Financial Solvency Requirements

- Working Capital = Current Assets – Current Liabilities
- Current Ratio = Current Assets/Current Liabilities
- Positive Cash Flow from Operations
- Cash to Claims Ratio
- Administrative expenses ~ 15%
- Maintain restricted deposits and adequate insurance
- Other financial ratios/measures

Claims Processing Requirements

- Health plans are required to reimburse complete claims within 30 working days after receipt of the claim, or if the health plan is a health maintenance organization (HMO), 45 working days after receipt of the claim, unless the claim is contested by the plan.
- AB 3275 (2024) updated the claims processing requirements.

Claims Processing Requirements

- Effective January 1, 2026, all plans must reimburse a claim within 30 calendar days after receipt of the claim. If the claim is contested or denied, plans must notify the claimant within 30 calendar days.
- Health plans are required to resolve 95% of all completed provider disputes within 45 working days
- Annual Provider Dispute Resolution Report

Health Plan Corrective Action Plans

- A health plan is placed on a CAP for deficiency with the financial and compliance requirements based on financial statement reviews or examination findings
- Frequent meetings with the health plans
- Financial Projections and Assumptions
- Monthly Financial Reporting
- Progress Reports
- Enforcement Referral

Medical Loss Ratio (MLR) Requirements

- The MLR requirement in the individual and small group market is 80%.
- The MLR requirement in the large group market is 85%.
- If a health plan does not meet the MLR requirement, they must issue rebates to the individual or the employer.
- The DMHC may conduct MLR audits of health plans.

Premium Rate Review

- The DMHC reviews proposed rate changes and methodologies for commercial health plans, including dental plans, in the individual, small group and large group market.
- The DMHC's actuaries review the rate filing, supporting data including underlying medical costs and trends, and ask plans questions to determine if the proposed rate change is supported.

Premium Rate Review

- While the Department does not have the authority to deny rate increases, its rate review efforts hold health plans accountable, ensure consumers get value for their premium dollar, and saves Californians money.
- The Department's premium rate review program has saved Californians almost $300 million by negotiating lower premium increases or no premium increases when increased rates aren't supported.
- The public can review and submit comments on rate filings.

Risk Bearing Organization Definition

- Structure of entity – Includes a professional medical corporation, medical partnership, medical foundation, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.
- Contracts with a health plan or arranges for health care services for the health plan enrollees.
- Receives compensation for those services on a capitated or fixed periodic payment basis.
- Responsible for the processing and payment of claims.
- RBO Questionnaire

RBO Financial Reporting Requirements

Quarterly Survey Reports are due 45 days after the close of the quarter and include:

- Balance Sheet
- Income Statement
- Statement of Cash Flows
- Statement of Net Worth
- Grading Criteria Calculations
- Additional Information on Cash, Receivables, IBNR Methodology, Revenues, Expenses, Claims, and Enrollment

RBO Financial Reporting Requirements

- Annual Survey Reports are due 150 days after the close of the RBO's fiscal year and include the Statement of Organization.
- Corrective Action Plans (CAP) – if an RBO reports non-compliance with the grading criteria, a CAP is required.
- DMHC Website: RBO - Financial Reporting Results

RBO Grading Criteria Requirements

- Tangible Net Equity (TNE) – minimum is the greater of 1% of annualized health care revenues or 4% of annualized health care expenses.
- Working Capital – positive
- Cash-to-Claims – .75 or higher
- Claims Timeliness – 95% of claims processed must be completed within 45 working days.
- IBNR Methodology – an approvable methodology to estimate and document IBNR on a monthly basis.

RBO Corrective Action Plans

- Required when an RBO is not compliant with one or more grading criteria.
- CAP includes financial projections and assumptions on how the RBO will attain and maintain compliance with the grading criteria.
- The CAP process is a collaborative process between the RBO, its contracting health plans, and the DMHC.
- As part of the requirements of the CAP, the RBOs may submit monthly financial statements and/or monthly claims timeliness reports.

Bagley-Keene Act

- **General Rule**—The public is allowed to monitor and participate in all meetings of state bodies, including the FSSB meetings
- **Two types of meetings**:
  1. Physical meetings (including teleconference)
     - Must comply with Bagley-Keene requirements
  2. Serial meetings
     - Prohibited by the Bagley-Keene Act

Bagley-Keene Act

- **Serial meeting** = A series of communications regarding any item within the body's subject matter, each of which involves less than a majority of the body, but when taken together involve a majority of the members
- Applies to communications regarding any item of business within the subject matter of the work group
- Includes communications through intermediaries or representatives

Bagley-Keene Act

Question: What all does this mean????

Answer: What the FSSB cannot do as a group outside public view cannot be done via individual communications.

Bottom line: No communications (emails, texts, calls) between any board members regarding matters within the purview of the FSSB outside of a public FSSB meeting.

Questions