STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

DEPARTMENT OF MANAGED HEALTH CARE

980 9th STREET, 5th FLOOR

SACRAMENTO, CALIFORNIA, 95814

WEDNESDAY, MAY 28, 2025

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Barbara Dewey (participated virtually)

*Paul Durr (participated virtually)

Andie Martinez Patterson

Jarrod McNaughton (participated virtually)

David Seidenwurm, MD (participated virtually)

*Jessica Sellner (participated virtually)

Katrina Walters-White (participated virtually)

Mary Watanabe

* = Joined after Roll Call

DMHC STAFF

Pritika Dutt, Deputy Director, Office of Financial Review

Sarah Ream, Chief Counsel

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Supervising Examiner, Office of Financial Review

ALSO PRESENTING/COMMENTING

William "Bill" Barcellona
America's Physician Groups

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PROCEEDINGS

10:01 a.m.

MEMBER WATANABE: Good morning, everybody. I hope you don't get tired of hearing my voice because I will be facilitating this meeting today.

This meeting is being conducted in a hybrid format, with the opportunity for public participation in person or virtually through video conference or teleconference.

For those in the room, the restrooms on this floor are locked. The bathroom badges are on the table near the entrance of the room so please remember to return those.

For our Board Members, please remember to unmute yourselves when making a comment and mute yourself when you not speaking.

For the Board Members and the public, you can join the Zoom meeting on your phone should you experience a connection issue.

Questions and comments will be taken after each agenda item.

For the attendees on the phone, if you would like to ask a question or make a comment please dial *9 and state your name and the organization you are representing for the record.

For attendees participating online with microphone capabilities, you may use the Raise Hand feature and you will be unmuted to ask your question or comment.

To raise your hand, click on the icon labeled Participants on the bottom of your screen, then click the button labeled Raise Hand. Once you have asked your question or provided a comment please click Lower Hand.

All questions and comments will be taken in the order of raised hands.

As a reminder, the FSSB is subject to the Bagley-Keene Open Meeting Act which preserves the public's right to governmental transparency and accountability.

As part of our presentation today we are going to do an overview of the Bagley-Keene Act. Sarah Ream our Chief Counsel, will be doing that later so I am not going to go into a lot of detail on the Bagley-Keene Act right now. But I will ask the Board Members to refrain from emailing or communicating with each other about FSSB matters outside of this meeting.

With that, I am excited to announce that we have two new Board Members. Andie Patterson is the CEO of the Alameda Health Consortium and Community Health Care Network. She just stepped out but when she gets back, I will have her do a more detailed introduction of herself.

And then Barbara Dewey is a principal and consulting actuary at Milliman. Barb, can I ask you maybe just to give a quick overview of yourself and your background?

MEMBER DEWEY: Sure, yes. So, I'm an actuary with Milliman. I've been with Milliman since 2008. I do a fair bit of work in different parts of the California market. So, active purchaser, government, employer health plan built around a county-owned hospital, and then mandate work in California. So definitely interested to see this piece of it too.

MEMBER WATANABE: Great. Thank you, Barb. We're excited to have you join the Board.

And maybe I will quickly have the Board Members introduce

themselves. If you can give your name and the organization you represent. I will start with those I see here on the screen. Jarrod, do you want to go first?

MEMBER MCNAUGHTON: Hi, Mary, and hi, team. I'm Jarrod McNaughton, the CEO of Inland Empire Health Plan, the public entity plan covering San Bernardino and Riverside Counties. Thanks so much, Mary.

MEMBER WATANABE: Thanks, Jarrod.

Katrina?

MEMBER WALTERS-WHITE: Katrina Walters-White. I am a Regulatory Advocate with Health Access. It is a consumer -- not a consumer. An advocacy organization. And I am also new to the Board.

MEMBER WATANABE: Glad to have you back, Katrina.

David?

MEMBER SEIDENWURM: Hi. David Seidenwurm here. I'm a Medical Director of Sutter Health and a neuroradiologist by training. And welcome to our Board. I think you will find the content very interesting, and we hope to have positive impact on the constituents in California.

MEMBER WATANABE: Great, thank you. And I think that's the only Board Members I see right now. Maybe if I can -- Andie, can I ask you to introduce yourself? Thank you.

MEMBER MARTINEZ PATTERSON: Yes, hi. Thanks, Mary. Andie Martinez Patterson. I'm the CEO of the Community Health Center Network and we are an IPA risk-bearing organization of eight FQHCs in Alameda, contracting solely at this point with just Medicaid.

MEMBER WATANABE: Excited to have you join the Board, Andie. And we'll see. We may have a few more Board Members join us momentarily.

So just quickly, you will see the agenda here. I will note that there is a lot happening in the state. I will give a very brief overview of the May Revise under my remarks. But you will notice we do not have any departments presenting today. As you can imagine, there's a lot they're busy with with the budget as well as all the federal activities. I am hoping to have one of our departments present at our next meeting.

I am actually really excited today to do a quick overview of just the DMHC and the FSSB in general. I think this was a recommendation from the Board. So excited to spend some time today talking about that.

Let's see here. I am just going to quickly introduce our DMHC team. So Pritika Dutt is our Deputy Director for the Office of Financial Review. You will hear more from her in a minute.

Sarah Ream is our Chief Counsel.

Michelle Yamanaka is a Supervising Examiner in our Office of Financial Review.

And then I think for our Board Members, most of you know Jordan Stout, a Manager in our Office of Financial Review who helps us with all things related to the Board.

With that, we will move on to Agenda Item 2, which is the meeting summary from our last meeting. Did any of the Board Members have changes to the meeting summary or any questions or comments on the meeting summary?

If not, can I get a motion to approve?

MEMBER SEIDENWURM: Move to approve.

MEMBER MCNAUGHTON: Second.

MEMBER WATANABE: Thank you, David and Jarrod. With that

we will move those forward. All right.

Moving on to the Director's Remarks. So, I will start just quickly with Essential Health Benefits. As I've noted at our prior meeting, California initiated a process last year to add new Essential Health Benefits or what we call EHBs to our Benchmark Plan. These are the benefits that all plans that participate in the individual and small group market must cover. We had a series of public meetings and legislative hearings to solicit input on the benefits to add, and I am pleased to share with you that earlier this month we filed the application with CMS to add hearing aids, durable medical equipment and fertility services to California's Benchmark Plan. If CMS approves the new Benchmark Plan these will take effect in 2027. So, exciting news there to update some of the benefits in our Benchmark Plan.

Moving on to May Revise. The Governor's January budget forecasted a $363 million surplus; however, the May revision to the budget is projecting a $12 billion deficit. The state's budget is projected to be approximately 322 billion, of which 226 billion is from the General Fund. The Governor noted in his press conference the significant increases in the cost of the Medi-Cal program are impacting the budget. The primary drivers are higher overall enrollment, pharmacy costs and higher managed care costs. Over the last 10 years the General Fund costs for Medi-Cal has increased from about 17 billion to 37.6 billion and enrollment has increased from 12.7 to 15 million.

I am not going to go into detail on all of the projected or the recommended budget solutions, but there's a lot related to the Medi-Cal program, particularly related to those with unsatisfactory immigration status.

The proposal is to freeze enrollment for full scope Medi-Cal

expansion for those adults with unsatisfactory immigration status, implementation of a $100 premium, elimination of long-term care benefits and dental coverage. There is also a proposal to eliminate the coverage of GLP-1 one drugs in Medi-Cal, reinstate the Medi-Cal asset test limits for seniors and disabled adults, eliminate prospective payments for FQHCs and clinics, eliminate Prop 56 supplemental payments for dental, family planning and women's health providers. There is also a proposal to increase the MLR for managed care plans to 90% and implement UM step therapy and prior authorization for some drugs.

There are a number of workforce investments that are proposed to continue, including investments in reproductive health and the behavioral health workforce programs that are under the Department of Health Care Access and Information.

Related to the DMHC, I will note the May Revision included a proposal for the DMHC to license Pharmacy Benefit Managers, and this would include Pharmacy Benefit Managers or PBMs that contract with DMHC licensed plans and California Department of Insurance licensed insurers. The current PBM registration requirement would sunset in 2026 and PBMs would be required to obtain a license in 2027 or whenever we establish the licensure process.

PBMs would be required to submit quarterly financial statements and other information to the DMHC, and we would have the authority to do audits. We would be -- PBMs would be required to report information to HCAI's health care payments database regarding pricing and payments for prescription drugs, including drug pricing fees paid for PBM services, rebates and affiliations between PBMs and pharmacies. And the DMHC would have the authority to enforce those requirements.

One final note is just that the May Revise does not take into account some of the anticipated federal reductions. I know many of you are probably tracking that very closely. And again, this is the Governor's proposal, and the Legislature will have the opportunity to review and make decisions about the cuts and hopefully we will have a final budget in June.

So that concludes my updates on the budget. Again, there's a lot that I am far from the expert on and I know there's a lot of conversations happening in other spaces. But I will just open it up to the Board and to the public. If there's things in particular maybe that you are tracking for your organization. I am particularly interested in things that we should be tracking as the FSSB that may impact the financial stability of both our RBOs and the health plans. So, if there's anything either the Board wants to share or the public. I am also happy to answer any questions about any of my updates. Any questions? Andie, I will ask you first. Anything from you?

MEMBER MARTINEZ PATTERSON: No.

MEMBER WATANABE: No, okay. We will let you get settled, yes.

All right, David, I see your hand, go ahead.

MEMBER SEIDENWURM: Yeah, thank you for that excellent review. And I know these are, you know, challenging times and I know there's a lot of uncertainty. But it seems like we are being pulled in a couple of different directions at the same time. For example, the new mandated benefits and then the fewer resources to implement them. Is there anything that we can do to help improve that balance or influence that in a manner that helps the solvency of the groups in the state?

MEMBER WATANABE: Yeah, no, I appreciate your comment.

David. I think this comes up a lot too when we talk about the Office of Health Care Affordability and the spending target. I will just note that I think for EHBs and adding new benefits there was an estimate that the impact to premiums would be about $8-9. And again, that's only in the individual and small group market so that's not for Medi-Cal.

I think as has been noted in a lot of different forums, whenever we have a budget deficit, particularly one of this size, there's tough choices that need to be made. And I think even through the EHB process and the public meetings we had a lot of discussion of just, you know, the choices and the challenges of increasing costs, particularly with the unknown of what will happen at the federal level and balancing that with things like hearing aids. Particularly a lot of focus on hearing aids for kids, on wheelchairs, and obviously for fertility services.

So again, I think it's that balance. And again, I think in these meetings it's very helpful just to understand how some of these changes might impact the financial solvency of both providers and plans and things that we should be tracking and monitoring.

MEMBER SEIDENWURM: Thank you for clarifying that.

MEMBER WATANABE: Jarrod.

MEMBER MCNAUGHTON: Yes, thanks so much, Mary, and really appreciate that overview too that you shared. That was very, very helpful, thank you for that.

You know, from our perspective, we are anticipating based on what we see happening at the state and the federal level, and depending of course, what it looks like with what the Senate might do on the federal side with the House bill, that in about 18 months or so because everything kind of is timed out

about 18 months when you look at some of the federal pieces. We are anticipating about a 200,000 or so membership loss in the plan based on things on the unsatisfactory immigration status side, the UIS side, as well as the work requirements side, on how the bill is written today.

Our caution that we have been trying to just share and provide some education on is that the worry is that you could start to see a little bit of what we are calling -- I know this is a technical term -- but Whack a Mole. Where you could start to see folks that may have been covered under the Medicaid or Medi-Cal program previously, without coverage now, now utilizing ER services at a much higher rate and then that's putting an additional strain on the entire system.

And we have had to even remind folks that there is a federal law called EMTALA that folks have to be seen regardless of their ability to pay or their status. And so there has just been a lot of education that we're having to do on the congressional front just to make sure that they know that whatever law is passed it will impact the system as a whole because folks are still going to be here in the country and they will still need to have services provided and you will just see that in a different, provided in a different way.

That being said, on the Medi-Cal front the part that we are a little bit worried about is that for those that are going to be paying the premium on the Medi-Cal side, that choose to stay in the Medi-Cal program. It is pretty reasonable to assume that that means the risk pool is going to start changing because folks that are going to pay the premium are only people that are going to really need it. So, the healthy folks are not going to pay the premium because they are going to feel like they don't need the coverage, and so that means that

the risk pool will dynamically change for the plans and that you could see elevated utilization from that group that is paying the premium.

So, all of those things are just important to point out because I think both on the utilization front as well as the risk front you could see some significant shifts coming in addition to just the sheer membership loss.

MEMBER WATANABE: Yeah, no, I appreciate that, Jarrod. And as you know, I think we're expecting I think Covered California individual rates coming in any time. And that's something I think Covered California has highlighted as well is the potential impact to the risk mix depending on what happens at the federal level. So, definitely something we will be tracking and sharing information as those rates come in for next year as well. Thank you.

(Board Member Paul Durr joined the meeting.)

MEMBER WATANABE: Any other questions or comments?

MEMBER MARTINEZ PATTERSON: More of a comment on Jarrod's point on just the fluctuations that we will see. I assume that health centers, FQHCs, serve a preponderance of the undocumented population. And the proposal that they not receive a wraparound payment, which I would venture to say is 80% of the reimbursement, and that you wouldn't find out that you didn't receive that for six months, seven months, you just don't know when that would happen, on reconciliation is, in my estimation, just an untenable position to put FQHCs in. There are some FQHCs I've heard that serve 40% undocumented. It's just -- you cannot ask them to continue to deliver that level of care.

And so, and it puts FQHCs in a really uncomfortable position because you do not ask immigration status and you don't want to flag this population. But in some ways you have to provide transparency to the provider

that you are -- this patient has a different type of coverage. So just to put that on the table. I find that to be really destabilizing. I am not sure where they're going to land, but an important thing to keep mindful of if you have FQHCs your network.

MEMBER WATANABE: Thank you, Andie.

Barb, go ahead.

MEMBER DEWEY: Thanks. Sorry, I'm going to switch gears a little bit and talk about pharmacy. So, I think it's good that the PBMs are going to report their data to HCAI. And I just wanted to bring up that pharmacy is tricky in that claims data doesn't capture a lot of the -- a lot of the spend or the rebates or the admin fees. So, I think making sure you've got a thoughtful way to capture that other information that's not just the typical claims data will be important for that.

MEMBER WATANABE: Super helpful. We would like to get HCAI back here too. I think maybe once we get the budget done that would be a good topic of discussion with HCAI as well in addition to updates maybe on what they are doing around the hospital spending targets as well. Thank you.

Other questions from the Board Members before we go to in the room here?

All right, I will open up. Anybody in the room have a comment that you would like to make. You can come up to the podium.

Okay, seeing none. Any questions or comments from those that are virtual? Jordan, do you see anything?

All right. Well, I think with that, we will go ahead and move on to our next agenda item here, which is an overview of the DMHC and the Board.

So again, really excited since we have a number of new Board Members. I don't know that we have done kind of our high-level overview of the DMHC in quite some time so excited to share this with you; and feel free to stop me and ask questions if you have any as we go along. Let's go to the next slide here.

So, I think, as most of you know, our mission is protect consumers' health care rights and ensure a stable health care delivery system. I will warn you that we have started a strategic plan process and may be updating our mission statement so more to come on that. Next slide here.

This is actually our infographic from 2023. We will have an updated version probably before our next Board meeting. But you can see here, we license 140 health plans. That's 98 full-service plans, 42 specialized plans. We have, as you will see in Pritika's presentation, over 30 million Californians that are under the DMHC's jurisdiction. We will have an updated slide that shows 97% of state regulated commercial and public health plan enrollment is under the DMHC. And again, you can see here $296.1 million saved in our Premium Rate Review Program since the inception. Next slide.

So, I think most of you know we regulate all HMO and some PPO and EPO products.

This includes large group, most small group and individual products.

We also have most of the Medi-Cal Managed Care plans under our jurisdiction.

We do not have most of the County Organized Health Systems under our jurisdiction.

Another one that comes up is County Behavioral Health Plans are

also not under the DMHC.

But then our specialized plans would be dental, vision, behavioral health, chiropractic and prescription drugs.

And then for Medicare Advantage we license Medicare Advantage plans, but we only review financial solvency. So, for enrollees that have Medicare Advantage they are not able to come to the Help Center, they do go to CMS for any issues. Next slide.

MEMBER MARTINEZ PATTERSON: Mary, can I ask?

MEMBER WATANABE: Go ahead.

MEMBER MARTINEZ PATTERSON: Why on the -- why not on the COHS? So like, so just as selfishly Alameda. So, Alameda used to be a two-plan county. Did you used to? No. So never Alliance. The County Organized Health Plan was never --

MEMBER WATANABE: Never.

MEMBER MARTINEZ PATTERSON: Never.

MEMBER WATANABE: Correct.

MEMBER MARTINEZ PATTERSON: And they, what rules do they?

MEMBER WATANABE: So, they, they have a contract with DHCS.

MEMBER MARTINEZ PATTERSON: They're just D-H -- they're only DHCS.

MEMBER WATANABE: Yes. So, we have some COHS, and this has evolved over the years. So, we have COHS that have other lines of business that are under the DMHC's jurisdiction. IHSS is a good one, they have some county employees that might fall under I think large group. So, to the

extent that they have other lines of business they would report to us for financial solvency so we do have some visibility.

There are -- and Pritika when she does her Medi-Cal managed care financial summary report will have more of a breakdown of where we have oversight there. But this goes back many, many years, predates my time. I don't know, I don't think we've ever licensed COHS. No, Sarah is saying no. There have been some legislative proposals over the years to license COHS but none of those have gone forward.

MEMBER MARTINEZ PATTERSON: Is it fair to say that they operate basically the same way? That there's some conversation -- they don't operate in their own universe with different rules?

MEMBER WATANABE: I mean, they have their -- so they have their contract with DHCS. I think the biggest gap, from my perspective, is they can't come to our Help Center. So, if a consumer has an issue they would go through the Ombudsman Office at DHCS, but not through, through our Help Center.

MEMBER MARTINEZ PATTERSON: Got it. Thank you.

MEMBER WATANABE: You're welcome. Okay, next slide.

So, I think we talk a little bit about this when I think Dan Souther will come and do a presentation next time on our budget. But the DMHC does not receive any General Fund. We also don't receive any federal funding. We are funded by assessments on health plans. So we really just look at what our budget is going forward, what our balance is, what are -- we have a what we call prudent cash reserves, so some reserve in case we need it. And we basically take that amount and it is assessed against health plans. Next slide.

And you can see that split. It's prorated 65% for full service, 35% for specialized plans. For full-service plans that was 300 -- excuse me, $3.25 per enrollee in ’24-25 and $1.44 per enrollee for specialized plans. We are still working on our assessment for ’25-26.

And then here you can just see our enrollment over time. And again, I think in Pritika’s presentation she will get into much more detail about our enrollment by market segment as well. But we have approximately 14 million in commercial enrollment and then government enrollment is about 16 million. This has shifted. We for years were kind of evenly split and now we have more government enrollment.

And then on the specialized enrollment it's kind of the opposite. The bulk of it is commercial, about 14.5 million commercials in specialized plans, and less, I think it's about 600,000 in government. And the next slide.

(Board Member Jessica Sellner joined the meeting.)

MEMBER WATANABE: Just a reminder, there are two state regulators in California. In most states there's only one. We do have the California Department of Insurance. As you all probably know, the Commissioner is elected by voters, where I am part of the administration and appointed by the Governor, report up to our California Health and Human Services Office. CDI has about a million health care consumers, and they also regulate other types of insurance. I think as you probably read in the news, they have homeowners’ insurance as well as auto insurance and other types of insurance. Next slide.

This is very much a repeat but just a reminder, 96% of state-regulated commercial and public enrollment. I actually presented this slide to

Covered California and someone noted that there is a tiny amount of dental plan enrollment. I think in the employer market, that is actually under CDI. So about 99.9% of Covered California's enrollment is under the DMHC. The next slide.

I always want to remind folks that we have our Help Center. These are our statistics again from 2023. But any consumer that is in a health plan we regulate can come to our Help Center. We assist with kind of what we call the complaint side, which can be just issues accessing an appointment, help understanding the plan or other issues. Maybe let's go to the next side.

I will just note we have a Provider Complaint Center as well branch where providers can complain if they have issues with claims payment or any other issues.

This slide just shows generally what consumers come to the Help Center about. When I am talking about this with other stakeholders everybody assumes access to care is the big one. It's actually not. We have seen that increase over the years. But claims and financial is the top reason that people come to our Help Center, followed followed by benefits and coverage issues, then provider customer service. So, this just gives you a sense of what people are coming to our Help Center about. Next slide.

And we do have an Independent Medical Review process. And so, this is when a health plan denies a service as either not medically necessary or experimental or investigational. Consumers can come to our Help Center and there is an independent review by a provider with expertise in their condition. And 72% of health plan members that appeal the denial by the health plan have the service approved through our Independent Medical Review process. So that number has fluctuated over the years from somewhere around maybe 60 to 65%

up to 72%.

So just a reminder for maybe anybody that is listening to this, I really encourage you to use our Help Center. You can find more information on our website at dmhc.ca.gov. All right, next slide.

All right. So why are we here? What is the Board charged with? So, Bill Barcellona is here in the room with us and probably could give us quite the history lesson on the FSSB.

But the FSSB was established by SB 260 in 1999 in response to concerns about the financial solvency of RBOs, many of which were going bankrupt in the late ‘90s.

The purpose of the FSSB was really to advise the Director on matters of financial solvency affecting the health care delivery system.

To develop and recommend financial solvency requirements and standards related to plan operations, plan affiliate operations and transactions, plan provider contractual relations, provider affiliate operations and transactions, and to periodically monitor and report on the implementation and results of the financial solvency standards requirement and standards.

Additionally, the SB 260 directed the FSSB to provide or study or report to the Director on several specified criteria related to risk bearing organizations, or RBOs. It also required the DMHC to adopt regulations related to solvency standards and monitoring of RBOs.

And starting in about, 2000 -- I think -- and ‘5, the Board really shifted to more of what you see today, which is ongoing financial solvency monitoring, and really an opportunity for us to report out generally on the activities of the Department. But in those first four to five years, it really was

focused on regulations around financial solvency, specifically around RBOs.

So that's kind of the history of the Board and the purpose.

I will just, particularly for our new Board Members -- let's go to the next slide.

Just to give you some orientation to how these meetings generally work. We try to have an update from one of our other state departments, including the Department of Health Care Services, Covered California, HCAI, at least annually. I think that has been a challenge this year with everything happening federally and in the state.

Sarah Ream usually will do a regulation and federal update.

Pritika does the health plan quarterly update, which is all about the financial solvency of the health plans.

Michelle or someone on her team will do an update on the RBO financial solvency, which is our Provider Solvency Quarterly Update.

And then at least usually we have been doing this every other meeting, an update on the financial summary of Medi-Cal managed care plans.

So those are kind of our standing agenda items. Let's go to the next slide.

MEMBER MARTINEZ PATTERSON: Mary?

MEMBER WATANABE: Yes, go ahead.

MEMBER MARTINEZ PATTERSON: May I ask? Was there a crisis that inspired the legislation? Because I would imagine that there were some standards already in place, but that there was a need for a statewide board to oversee it. So, I am just curious what the impetus was.

MEMBER WATANABE: I know. Bill, you want to answer that, or

Pritika? We had quite the crisis with RBOs. So RBOs weren't licensed, correct?

MS. DUTT: Correct.

MEMBER WATANABE: Go ahead.

MS. DUTT: Back in late '90s, a few medical groups went down so this Board was created under SB 260. What year was that Bill, 1999? So, SB 260 created our oversight of RBOs where RBOs that met a certain definition. They were required to register with the Department and report. It also established the Board. And then Bill, I see you there, so maybe you (overlapping).

MR. BARCELLONA: Yeah, Andie. So, between '98 and 2001 about 110 risk-bearing medical groups went out of business in the state for a variety of reasons, poor management, bad IT, inability to really gauge the risk that was being assumed. And we also lost about six health plans during that time period.

When DMHC was formed and took over from Department of Corporations to address this they created a Special Compliance Branch in the Licensing Division, which I ran. And we monitored the closures and created the Continuity of Care Act to deal with terminations and block transfers. We moved about four and a half million lives out of insolvent organizations into solvent organizations.

The interesting lesson in all of this has been that what really started it, was the failure of KPC Med Partners in Southern California. It was a huge, publicly-traded provider organization that took global risk and when it went under it created an initial wave of disruption. But then there was a second wave of disruption where physicians who took over these medical groups from KPC Med

Partners couldn't really make a go of it and then they all started collapsing as well.

So, then DMHC stepped in and we got things going with financial solvency. There was a lot of resistance by providers to reporting their quarterly financials, but the system worked.

And by June of 2002 the insolvencies stopped very abruptly. There was one month in late 2001 where we had 20 groups close in one month. But the dust settled in 2002 and ever since then the DMHC financial solvency staff has been monitoring the system. We've had a handful, one or two notable closures that were surprises. But for the most part it has been a very stable market. About 10% of the RBOs in California are on corrective action plans from year to year, which is unfortunate, but that just seems to be the, the statistic. But they haven't closed, they have been monitored very well. So.

MEMBER MARTINEZ PATTERSON: So, the magic is transparency?

MR. BARCELLONA: Transparency and oversight.

MEMBER MARTINEZ PATTERSON: And with the oversight, what comes with the oversight that brings someone back from the brink?

MEMBER WATANABE: That's a very good question that we're going to cover in a few slides.

MEMBER MARTINEZ PATTERSON: Great, thank you.

MEMBER WATANABE: Michelle is going to talk about that. Yeah, no, that's -- I will say that's a lot of focus of these meetings. It actually was quite the -- it was interesting for me to go back. I have been at the Department now 10 years. This is actually our 25 year anniversary of the movement to creating the

Department from the Department of Corporations.

And our reporting has actually evolved quite a bit based on the Board feedback. We actually want to see more about this. Can you tell us about the RBOs that are on corrective action plan and why. Now we report with their plan affiliation and summaries too. But Michelle is going to talk in a minute more about just kind of the oversight. The standards that were set up and recommended by the Board, how we monitor that, how corrective action plans work. So, she will tackle that in just a minute.

All right, I'm going to keep going. You can see here, let's go -- okay. So, annual presentations. Again, we usually have a budget update, which, again, will happen at our next meeting.

We present a Federal Medical Loss Ratio, our MLR summary, annually.

Large group aggregate rates and prescription drug cost report.

We will have a legislative update at the end of the legislative session. Amanda Levy, our Deputy Director for Health Policy and Stakeholder Relations, will come and talk about the bills that were signed and that have implementation activities for the Department.

Again, rates in the individual market. We will present those once those are finalized.

We talk about risk adjustment transfers.

I will note that this goes back quite a few years. I'm going to say maybe eight or nine years. There was a requirement for us to collect dental medical loss ratio information. The intent was to bring transparency to dental MLR. There are no requirements like there are in the individual, small and large

group market. With the intent that the legislature may set a standard. That has not happened. So, every year we had presented that report. I think there was some frustration maybe from the Board of they weren't quite sure what to do with the information since there is no standard. So, we still -- we still send out that report but we don't do a presentation. I think that usually goes out at the beginning of the year. Did we do that last time maybe?

MS. DUTT: We did, in February.

MEMBER WATANABE: In February. So, it's on our website if you're interested in checking that out.

And again, part of our intent with sharing all of this information with the Board today is if there are things you want to hear more or less about or anything that's missing, please let us know. I'm excited about the Board growing and having new members. But again, just reference this going forward too. At the end we always ask for agenda items for future meetings and would love to get your input on other things that you would like to see. All right.

And I think I'm going to turn it over to Pritika to talk about health plan financial requirements.

MS. DUTT: Okay, I will go over some of the financial reporting and financial compliance requirements for health plans. Obviously, there's a lot more requirements a health plan has to meet, but I will only cover the financial ones. And then Michelle will go over our oversight of RBOs, including the definition. And then after that we will turn it over to Sarah for a Bagley-Keene update.

So, all licensed plans are required to submit quarterly and annual financial statements.

Additionally, for brand new licensed health plans, they have to

report monthly financial statements to the DMHC. We also require plans whose TNE falls below 150% to submit monthly financial reports to the DMHC.

And some of you have been attending these meetings for years. We do require plans that have a downward trend, like if we see they're reporting losses, if we see their enrollments changing, so we may place a plan on monthly reporting even prior to them hitting the 150% of required TNE mark.

We have financial reporting templates that health plans are required to complete. And then additionally health plans are required to submit an annual independent auditor's report with their annual submission. So, they have to go through an audit by a CPA firm every year and submit that with their annual financial reports.

So, all health plans must meet the tangible net equity reserve requirement so you will hear TNE a lot in these meetings. So TNE is the financial reserve requirement that all health plans must meet. So, the requirement, as you will hear, is higher for health plans than for RBOs depending on the level of risk. And there are different TNE requirements even within the health plans for full-service plans versus the specialized plans. So, I will cover, maybe I will hit on the full-service plans.

The full-service plans have to maintain a TNE of greater than $1 million or a percentage of their revenues or a percentage of their medical expenses, so the higher of that. Again, it depends on the risk that the plans are taking. They need to maintain enough reserves to cover their costs.

And TNE is defined as a health plan's total assets minus total liabilities, reduced by the value of intangibles and unsecured obligations of officers. So, these are receivables that a plan is owed by their affiliates and

which are not in the normal course of business. And any debt that is properly subordinated may be added to the TNE calculation, which serves to increase a plan's TNE. So, this is coming directly from 1300.76 of California Code of Regulations. Next.

In addition to TNE we also evaluate a health plan's financial solvency through analyzing various key performance indicators and financial matrix. You will see some on this slide, but it doesn't cover everything we look at. So, working capital is one of the things we look at under financial solvency, which is current assets minus current liabilities, and it measures the health plan's ability to pay its liabilities that become due within the year. Ideally, we want a health plan to maintain a working capital or greater than $0. So, they need to have a positive value.

And then current ratio. So, this is like working capital but in a ratio format. So again, here we want the plan to have a ratio of one. That means they have enough assets to cover their current liabilities.

And then positive cash flow from operations. That measures the cash a plan generates, so it's health plan revenues. And basically, we want them to have enough revenues to cover their medical expenses. So that's one of the measures we look at.

And then cash-to-claims ratio. The cash-to-claims ratio helps assess a health plan's ability to pay its medical claims obligations using available cash, short-term investment, and receivables due within 60 days. So again, on the claims side, we also look to make sure that they are booking their claims liability correctly and then also they have a reserve set aside. You will hear Incurred But Not Reported, the IBNR, a lot here. So, we want to make sure that

the plans are booking their IBNR correctly as well.

And then administrative expenses. We do have a number in 1300.78. So, health plans have to maintain an admin cost of no more than 15% of total revenues. So, if that number goes higher our team reaches out to the plan, we ask for justification on that. So again, this standard reinforces that health plans are spending a majority of the money they receive through revenues -- through premium, on health care delivery rather than their overhead.

And then health plans are also required to maintain a restricted deposit, maintain insurance.

And then we also look at other financial ratios or measures. Again, the goal again is to make sure the plans are financially stable. We look at net income trend. We look at enrollment changes, enrollment mix, and then we look at the various investments they have, and we also look at days of cash on hand.

MEMBER WALTERS-WHITE: I just had a quick question. For the reserve -- and you may have mentioned this. Are the reserves not included on their financial statements that they are providing?

MS. DUTT: They are but we have other calculations. So, the financial statements is we get the balance sheet, cash flows, revenue statement. So, we have -- these are tabbed in the financial statements for TNE calculations. But using the financial statements we get we also look at their previous financials that were submitted. So, we calculate some analyses based on the, you know, based on historical information, current information. So, we do some trend analysis to come up with these, you know, different KPIs or Key Performance Indicators. Jarrod. Katrina, do you have a follow-up?

MEMBER WALTERS-WHITE: Yes. Are they required to report

their reserves?

MS. DUTT: Yes.

MEMBER WALTERS-WHITE: In the regulation? Okay.

MS. DUTT: Yes. So if you -- so we have the financial reporting template. It is required in our regulations that each health plan completes that financial reporting, a template that the Department has out there. And it requires like -- it's consistent with GAAP, Generally Accepted Accounting Principles. So, all financials have to be consistent with GAAP. There's tabs in there that require them to complete their TNE calculation. So, these various tabs in there. We ask for enrollment data. So, there's a lot of information that we collect from health plans on a regular basis.

MEMBER WALTERS-WHITE: Thank you.

MS. DUTT: Of course. Jarrod.

MEMBER MCNAUGHTON: Thanks Pritika. Sure appreciate your presentation. And I just was curious how the Department may be thinking about responding to some of the current legislation on that MLR piece and how that could change the ratio that you just shared with us here on the slide for the administrative cost, if it would.

MS. DUTT: So that's a good question. We do work closely with DHCS on our review analysis of health plans, the Medi-Cal Managed Care Plan, so we will be coordinating with them. One of the things we see is, okay, we have the 15% benchmark that we can look for. However, for the Medi-Cal plans I think they tend to have a lower admin cost ratio. But again, Jarrod, that will take some coordination between the DMHC and DHCS to ensure that the plans are meeting the DHCS requirement and the DMHC requirements and not going insolvent.

Barb.

MEMBER DEWEY: Thanks. Yes. So, this all makes sense for kind of normal insurance setups. I wonder, what are you looking at for risk adjustment? You know, like, if you think about the individual market risk adjustment for some of the plans, especially some of the lower cost Medi-Cal plans, can be a substantial portion of their liabilities but isn't really captured in the claims or the reserves.

MS. DUTT: So, we do have plans that are booking things in other current liabilities. So, if you look at a balance sheet, the plans have to estimate their, like I said, the financials have to be prepared in accordance with GAAP. So, if they have like a, you know, risk adjustment payment that they owe to CMS, they have to make a reasonable estimation and book that liability in their balance sheet.

So, it will be factored in. Like when we're calculating TNE they should have made a reserve booking in their balance sheet for that. Because it's on accrual basis so the financial statements are on accrual basis, it's not cash basis. Meaning that they have to book things that, you know, are happening, like not only when they receive cash. They have to book, you know, an estimate of their expenses as they come due.

MEMBER DEWEY: Yes. Is there also a standard way to pressure test the reasonableness of those assumptions?

MS. DUTT: Yes, and then -- that's a good question. Our actuaries -- I have a couple of slides here that talk about premium rate review. So, our rates review team does look at the TNE levels for a health plan when we are doing our rate review analysis, even for the individual plans and small group

and large group. So, for the commercial plans that are subject to the premium rate review requirement of the DMHC. So, in addition to looking at the rate filing our team -- the actuaries also coordinate with our financial review team that is working on health plan financial analysis. They look at medical loss ratio reporting that comes in annually and then -- so there is a lot of coordination that happens between our financial analysts, our examiners and our actuaries in, you know, the rate review analysis and the financial analysis as well. Because it all kind of ties together like when you look at the grand scheme of things.

MEMBER DEWEY: Mm-hmm. Thanks.

MS. DUTT: And we talk to Covered California a lot as well.

Okay, next slide. All right.

So, claims processing requirements. So, health plans are required to reimburse complete claims within 30 working days, this is the current requirement, after receipt of the claim, or if a health plan is an HMO, a Health Maintenance Organization, then they have 45 working days after receipt of the claim unless the claim is contested by the plan.

So, AB 3275, it's a 2024 bill that updates the claims processing requirements. So effective --

MEMBER WALTERS-WHITE: I have some questions, thank you. So, if the insurance company isn't -- or if the plan or provider hasn't received the claim and it falls back on the consumer, is there like any recourse for that? Like, if the address is wrong that the -- or there's like some type of delay within them receiving the claim. How does that fall back on the consumer?

MS. DUTT: So, the providers typically submit the claim over to the plan. So, are you asking whether -- if the plan doesn't receive it? Is that what

your question is?

MEMBER WALTERS-WHITE: Yeah, if the health plan hasn't received the claim and the bill falls back on the consumer. Is there, is there like a requirement or will it just be further delayed?

MS. DUTT: If the plan doesn't receive the claim from the provider, then they wouldn't know they have to pay for this particular service. So typically, Mary maybe you can jump in as well. Typically, the enrollee would reach out to the plan if they receive a bill. You know, if the plan doesn't help them out, they come to our Help Center. And then we get involved and we reach out to the plan to ensure that the providers get paid and get the enrollee out of the middle.

But I would think that's how the process like would work. Like, you know, if providers are chasing the enrollees down for payment if they didn't bill them correctly. So, I would think that if the plan didn't get the claim, you know, they may reach out to the provider, or the enrollee would provide them the copy of the invoice so the plan can get involved. But if the plan doesn't resolve the issues and then the enrollee ends up coming to us then we will get involved, make sure to get the enrollee out of the middle. Do you have anything?

MEMBER WATANABE: Yeah, no, Katrina, I will just add. I mean, I think that was probably when I showed that Help Center slide. It is always, I think, a little surprising to me, that that's the top reason that people come to our Help Center, claims and financial. And again, all of this can impact cost sharing. So, enrollees that have a cost share and have to meet their deductible depending on what the request for reimbursement is, that can impact how much the enrollee is asked to pay. In some instances where there's an issue of the provider getting paid, they will try to bill the enrollee and then they come to us. So again, a lot of

those are issues that we resolve at our Help Center. Again, enrollees can -- we always encourage enrollees to go to their health plan first, file a grievance. These hopefully are resolved quickly when they are related to a payment issue. But if not, they can always come to our Help Center as well.

MEMBER WALTERS-WHITE: Thank you.

MS. DUTT: All right. So, like I said, effective -- so AB 3275 updated the claims processing requirement and effective January 2026 all plans must reimburse a claim within 30 calendar days after receipt of the claim. If the claim, additionally the claim is contested or denied, the plans must notify the claimant within 30 days of receiving the claim and they must like tell them why they are contesting or denying this claim so the provider can provide the additional information for health plan consideration. So again, these -- the requirement will go into effect for claims received on or after January 1, 2026.

So, health plans are required to resolve 95% of all completed provider disputes within 45 days.

And then we also issue an Annual Provider Dispute Resolution Report.

So, some of the things we are doing for AB 3275 implementation. Obviously, we are busy. We are working. We issued an All Plan Letter, I think it was APL 25-07. So, we issued the APL and then provided plans guidance on the documents they need to submit to the Department to demonstrate they are getting ready for this new requirement.

We are also working internally to update the regulation that would be -- that we will share with stakeholders when they are ready to make sure that the regulations reflect the updated claims processing requirement.

So how we monitor claims processing requirements? So, health plans submit quarterly and annual claims processing reports to the DMHC. And then like when I mentioned the Annual Provider Dispute Resolution Report. So, the data from these annual reporting is used to -- is compiled into this Annual Provider Dispute Resolution Report, which is a legislative report and available on the DMHC website.

We also verify compliance with claims and provider dispute requirements during health plan routine examinations. So that's a common reason that my shop, the Office of Financial Review, will place a plan on a corrective action plan is because they fail to demonstrate compliance with the claims processing requirement in one of our examinations. So, we do routine examinations of health plans every three years and if we find any, you know, major issues, we tend to conduct a non-routine examination. Jarrod, go ahead.

MEMBER MCNAUGHTON: Yes, thanks Pritika, for sharing this. And I should know this. I'm sorry that I don't know this, but I just would love to have your help on this. Can you remind me, in that APL as well as in the statute, what are the appropriate -- oh, I don't know what you want to call them, but avenues for a delegate entity or a plan to actually not abide by this if there is fraud, waste and abuse either suspected, or if you're working with law enforcement on an issue or whatnot. I can't recall what was in there regarding that. Can you remind me of that?

MS. DUTT: So, first of all, for noncompliance, the health plan is required to collect information from their delegate and report it to the Department. So, the RBOs, medical groups, don't report to us directly on the claims settlement reporting, those go to the health plan. So, you will collect -- for Inland Empire

you will collect your delegates reports and then you will include that in your reporting, whether it's quarterly or annual. And if the RBO medical group is not meeting the claims processing requirement, it will require a CAP. So, if they are not meeting the 95% compliance requirement we require a CAP in the reporting, the corrective action plan. And if there's like issues with fraud, waste and abuse, we will get our Enforcement Team involved. So, we would make a referral to our Enforcement Team so they can work with the plan or, you know, the contact person, to investigate into it further.

MEMBER MCNAUGHTON: Okay, gotcha. I just wanted to make sure there was an avenue that if, if an RBO or the plan itself detected or was concerned about a situation where a provider had an FWA issue, that we still have the ability to slow down claim payments as appropriate, or if there's a law enforcement agency asking us to do that, either asking us or our RBO, our delegate partner, to partner with them. And it sounds like it's probably just an effort to make sure to communicate with you folks that this is happening, FYI, and just to make sure you're in the know, if I'm, if I'm hearing what you're saying.

MS. DUTT: Yes. So, you have to demonstrate that you are really like looking at this provider, that you have some, you know, why you're looking at unfair billing practice from this provider. Because again, we want to make sure that claims are processed within the required time frames. So, if there's delay you need to, like, demonstrate to us, like, why there's a delay, right? So, if you have a legitimate reason then we'd like to know that. So, giving us a heads-up early would be helpful instead of us finding something during our exam.

MEMBER MCNAUGHTON: Gotcha. Okay. Thanks so much.

MS. DUTT: Thank you. Okay. So, now health plan corrective

action plans. We do have many of those. So, a health plan is placed on a corrective action plan for deficiency with financial and compliance requirements based on financial statement review or exam, examination findings. Again, this is limited to what we do in the Office of Financial Review, because we have our Office of Plan Monitoring that may place a plan on a CAP based on their surveys finding, which is like looking at their UM and other compliance areas.

So, what do we do when a plan is on a corrective action plan or if we have concerns?

We have frequent meetings with the plan, so we may have weekly meetings, we could have bi-weekly meetings, monthly meetings, to get a status of what's going on.

And then we require financial projections and detailed assumptions. So, if a plan is showing noncompliance with TNE, if we have financial concerns, we will require financial -- a set of financial projections and assumptions to demonstrate how they would come out of their negative situation. We may require them to provide actuarial analysis if we have issues with their claims liability IBNR. So, we may require actuarial report if we have concerns there.

We require monthly financial reporting, as I had mentioned earlier.

We require progress reports.

And then lastly, we may refer a plan to Enforcement if, you know, there’s non-compliance issues. Okay, next I will go over the medical loss ratio requirements.

So, under both federal and California regulations, health plan must adhere to the following MLR standards. So individual and small group markets, health plans have to spend 80% of their premium revenues on medical care and

quality improvement activities.

And for large group plans, they must spend at least 85% of premium revenues on medical care and quality improvement activities.

So, there's a specific form the health plan has to complete to do the MLR calculation, it's not just like looking at standard medical, you know, revenues and then looking at medical costs. So, there's some calculation involved in coming up with a medical loss ratio number.

And if a health plan does not meet the MLR requirement. So, if the individual and small group are not meeting 80% and a large group plan is not meeting their 85% they must issue rebates to the individual or by the employer.

And the health plans are required to submit annual MLR reports to the DMHC and CMS. And the DMHC may conduct MLR audits of the health plans. David.

MEMBER SEIDENWURM: Yeah. Can you discuss the quality improvement as part of the MLR and how we distinguish quality improvement activities from those which might overlap with administrative overhead?

MS. DUTT: Sure. So, there's specific requirements in the guidance that CMS has issued and we have adopted here in the state that certain activities qualify for quality improvement. And like I said, we do audits to ensure that those are reported correctly because there's a lot of things that could be subject to -- you know, could be construed as quality improvement. But the guidance is specific on what a health plan can report under quality improvement. So, like, you know, doing some different measures, like making sure that enrollees are getting -- getting their vaccines timely and all that. So, like I said, these specific requirements, I can share that if that would be helpful.

MEMBER SEIDENWURM: Thank you, that would be a great idea.

MS. DUTT: Okay.

MEMBER MARTINEZ PATTERSON: How does the MLR, the 80 and the 85% relate to -- Jarrod mentioned this earlier. There's a proposal in the budget for -- does it -- I don't know if it impacts the DMHC plans, the 90%. If everybody would be at 90%?

MEMBER WATANABE (OFF MIC): (Shook head).

MEMBER MARTINEZ PATTERSON: No, just Medi-Cal plans. So DHCS oversight plans, COHS.

MS. DUTT: So those plans, the Medi-Cal managed care plans are licensed with us. But that 90%, the reporting would go to DHCS. So, one thing we have to coordinate with is on the financial oversight because we get financial reports. Those plans are subject to our TNE requirement, the tangible net equity financial reserves. We want to make sure that those plans are financially healthy. So, like I had mentioned earlier, we would be coordinating with DHCS to ensure, like, you know, the plans are not going insolvent.

MEMBER MARTINEZ PATTERSON: Yeah.

MS. DUTT: But those reporting will go to DHCS for that Medi-Cal managed care. So, what we look at for the commercial plans.

MEMBER MARTINEZ PATTERSON: Yeah, yeah. No, it's -- I had no idea that anyone would be allowed to be at 80%. So, I'm curious. Which feels when you look at what is actually allowed in terms of quality and things that are disallowed and that smaller, smaller entities can have lower thresholds. Running an RBO I can tell you it feels really hard to like -- in Bill's comment that tech brought some folks down. Tech is really expensive. Cyber is really

expensive. Compliance is really expensive. Things I would -- I would love to not have to do the plumbing, that would be so much fun. But so, I'm just I'm curious, that is such a big difference, 80% to 90%. I'm just curious if they consulted with you and the risks that we run on Medi-Cal when we're also doing a number of other changes to Medi-Cal on solvency.

Just that alone feels really risky, the MLR reporting, and especially with other RBOs that fall underneath when you have multiple -- there's some RBOs with multiple plans and there's still lack of clarity on how to -- how it's actually reported and audited in a manner that feels fair and keeps those entities alive. And then a 90% just feels like you're stripping away most of the things that are actually required through regulation. Just pretty tight, thin margins.

MEMBER WATANABE: Yeah, and then maybe I will just add, I mean. I think we will want to coordinate very closely with DHCS as well to understand just how this will all work and be calculated as well. And then again, Pritika and her team work closely with the team at DHCS just so they understand the metrics that we're monitoring as well on financial solvency.

So, it's part of the reason why we wanted to have the discussion today of just, you know, what is everybody thinking about this and what should we be tracking as, you know, the Department and the Board as it relates to the overall financial solvency and TNE requirements. So more to come, I'm sure, yeah.

MS. DUTT: All right. And then one more point on this slide is we do collect MLR reporting from dental plans, but they are not subject to any of this minimum threshold. We review them, present it to the Board or share the information with the Board in our February FSSB Board meeting.

So, the DMHC reviews proposed rate changes and methodologies for commercial health plans, including dental plans, which just started this year. So, we look at the proposed rate changes and methodologies for commercial plans and dental plans in the individual, small group and large group market.

So, the DMHC 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. So basically, we make sure that the rate increases are reasonable and the plans are not doing any unjustified increases. Jarrod, go ahead.

MEMBER MCNAUGHTON: Yes. And I am so sorry that I can't tell who was asking the previous question that was in the room.

MS. DUTT: It was Andie.

MEMBER MCNAUGHTON: Andie. Okay, sorry. So, Andie though got me thinking just something to share. I do think that over the next coming months, and certainly with some of the proposed legislation that's out there, we are just going to have to really watch the health of some of the plans as well as some of the risk-bearing entities and delegate partners. I mean, we are already, as you guys know, we are under monthly reporting to you now just because of our significant issues that we had last year coming out of COVID and some of the risk pool changes and utilization changes.

And we are now starting to see more of that now even with our delegate entities where they are coming to us and saying, you know, we are now seeing our financial shifts taking place and what can we do to discuss capitation changes and whatnot. And rightfully so. When you look at their information and their data, at least in our market, you know, we have, we have some of our

delegate partners that have been incredible partners with high quality that they're really struggling right now on the financial front. And that's typical, I guess to Andie's question, that we always see a little bit of a delay, a little bit of a lag on the delegate front versus the health plan front and so we kind of were expecting that and we're working through that with them.

But I just -- when she had mentioned that question it just got me thinking that I do think that we just need to make sure we are doing everything we can to really strengthen some of the underlying underpinnings of the system itself when it comes to our delegate financials to make sure that they are strong and that they can continue to support the communities that we serve. Again, pushing on quality, always pushing on quality, which, of course, we do. At the same time making sure that some of these new pieces of legislation that are coming out aren't going to have unintended consequences potentially.

MEMBER WATANABE: Yes, thank you, Jarrod.

And Paul. I just, I will just say I think we had two members; Jessica Sellner also joined from Health Net. But Paul, would you introduce yourself and then ask your question?

MEMBER DURR: Sure. Paul Durr with Sharp Community Medical Group, an IPA in San Diego. Sorry I was late, and great discussion.

My question had to do, Pritika, on the slide where you talk about the actuarial review processes. How much feedback do you get with the various health plans and your comfort level with their explanations? I think tying into what Jarrod and Andie were talking about it's like, you know, as they have to delegate down to medical groups and, you know, we struggle with the plumbing and the infrastructure and then being able to pay our doctors. You know, I don't

know how well that is built into the answers that the health plans provide. So just maybe if you have a comment or an overview of how that process works and your comfort level with that, that would be helpful. Thank you.

MS. DUTT: Maybe I'll start and then, Barb, if you have anything to add you can jump in as well since we have an actuary on the Board. So, once we get the data, the health plan's reports, the premium rate filing, we make that financial -- we make that filing public. So, there's chances -- I mean, there's opportunity for the public to review, share their feedback, comment with us. And then our actuaries have 60 days to review the rate filing. So, these are a lot of back and forth that happens in our analysis. We ask for a lot of data to justify the rate increase, right. Even up to -- even if there's no rate change, we still get a filing annually from the health plans to like support their -- support what they're presenting in front of us. So, if they --

We get the actuarial report, which is signed by an independent actuary. So before even we get it an independent actuary looks at it, signs off on it. And then so if there's things that we see doesn't make sense, if there's any outliers, we coordinate with our consultants. There's a lot of, like I said, back and forth that happens within that 60-day time frame. Sometimes we're at the end of the wire, right? We're like, ready to post but we're saying, hey, we still have outstanding issues with certain plans. So, like I said, there's a lot of back and forth. There's a lot of data requests that happens even outside of what we get in the regular filing. We may ask for more, more information to support those rate increases. Barb, do you have anything to add?

MEMBER DEWEY: Yeah. Well, I think part of, part of your question was, how much of the downstream provider impact is discussed as part

of that rate review? And that's tricky because so much of this process is public so it does seem like there's not a lot of, hey, there's a specific provider we're struggling with and that's why our trend is so high or,, you know, we've got a lot of FQHCs and that's why we're trying to put more supplemental payments with this uncertainty in the market. There's just not really that level of detail because of the confidentiality of that piece of it.

MEMBER DURR: Yes, that makes sense. You know, the follow up to that is, as I was thinking about it is, how that really all ties back into OHCA and sort of what they're doing from a health care cost trend. Given the wonderful review that DMHC does on the rate setting seems to maybe affirm or attest to what is the rate needed for those increases in order to keep the whole infrastructure moving. So, I wonder how that interfaces with OHCA to some degree on a broader level? So, thanks for the comment.

MS. DUTT: And then Paul, just to kind of add to what Barb said. So, if there's plans that are struggling with certain providers on like rates, we may get some information confidentially so they -- the statute does allow for us to collect information on a confidential basis if it's to do with specific provider contracts. So, we may ask for more detail on those areas. But then we may not post those on the DMHC website, because again, we don't want to interfere with the contractual -- again, the contractual process between a health plan and providers. Katrina?

MEMBER WALTERS-WHITE: I guess I'm just wondering if for some of these outliers or for the -- that we're discussing, is there like a, like a common reason as to why they're having increases?

MS. DUTT: The main one is medical trends. Right now, what

we're hearing is like, you know. What we're hearing from some of the plans for the 2026 rate year. We don't have the rate filing yet, but we're hearing that pharmacy is like a big driver of this rate increase for the 2026 year. So, like I said, we don't have the filing yet, they're coming in mid-July, and then we will be posting them on the website and then we will be sharing more insight onto the 2026 rates.

But we will hear in the near -- you know, in the next few weeks we will be meeting with Covered California to, like, discuss from what they're seeing. Again, some of these conversations are confidential because, again, we don't want to interfere in their negotiating process with the plans.

So again, like I said, sometimes, like you will see pharmacy, medical cost trends, the claims cost, you know, the more sicker enrollees in a plan which drives up the plan's claims cost. So, there's like different reasons. But again, anytime a reason is provided we need to make sure it's backed up by data.

MEMBER WALTERS-WHITE: Thank you.

MEMBER DEWEY: Another thing to jump in on that. So, rates are usually set with a summary of historical data and then trends and adjustments. And usually the adjustment piece is small, so, so the biggest pieces of a rate development tend to be the historical data and the trend. What Pritika said, pharmacy trends especially high now. That's one that everybody's seeing across the board. But going back to the summary data that it's based on, I feel like that's not super well understood but is an important part of the rate increase each year. Especially, and I hate to, I hate to blame COVID, but the stability of that base period has definitely been less stable since COVID; 2022 was more

expensive than everybody thought. There has just been a lot more what we call restatement of the base period in rate setting in the past few years too. DMHC is gathering a lot of information about that though so it's not just the forward-looking rates, it's also like a look back at the data.

MS. DUTT: All right. Next slide.

So, the DMHC does not have the authority, you will be surprised, to deny rate increases. But through our Rate Review Program we hold health plans accountable. It gives transparency to the plans' rate development process. So, like again, we post those rates on our public website so I think the transparency does help, our line of questioning does help. Because if we do find a health plan's rate is not supported, so if we -- the DMHC determines that a rate increase is not, is not, is not reasonable or justified, we -- the health plan has certain notice requirements. We will publish that on our website. The health plans will have to give notices to their employer groups or enrollees. So, these different requirements that trigger-in if we find the health plans rates are unreasonable.

And through the DMHC's rate review program we have saved enrollees $300 million by negotiating lower premium increases. So basically, what happens is if we find a plan rates are not justified we engage in conversations with the plan. And then based on our back and forth the plan may agree to drop their rates down before we deem the rate unreasonable because the health plan will have to have additional reporting requirements if they are found unreasonable with their rates.

And the public can --

MEMBER MARTINEZ PATTERSON: Question.

MS. DUTT: Go ahead.

MEMBER MARTINEZ PATTERSON: I know you can't deny a rate increase, but do you have the ability to like flag a plan's rate increase on the website that says, like --

MS. DUTT: Oh yes.

MEMBER MARTINEZ PATTERSON: -- way over the top.

MS. DUTT: So, like I was saying, we have 60 days to review that rate, the rate filings, and after the 60 days we will go close it. And then if a rate is unreasonable, we will mark them unreasonable, and then we will put some comments in there why. And then the health plans will have to -- there's notice requirements for the health plan to send out. And then we have more reporting requirements. We have to do an Unreasonable Rate Report and so there's different reporting requirements.

MEMBER MARTINEZ PATTERSON: So, employer groups will get a letter that says we're raising our rates, just so you know. The state of --

MS. DUTT: Unreasonable.

MEMBER MARTINEZ PATTERSON: -- California finds that's unreasonable.

MS. DUTT: Exactly. So how does that look?

MEMBER MARTINEZ PATTERSON: Yeah, shaming, yeah, yeah, yeah. And do they ever come back just because the market denies them and then they turn around and reset rates?

MS. DUTT: We haven't, we haven't. had that in the recent years. I think in the beginning of the rate review program, and that was before I was in my role, we had some plans in the beginning of the rate review process when ACA first came about. So, we had some plans that were -- their rates were found

unreasonable. You can find that on our website. But in the recent years we have had like, you know, the health plans worked with us to drop those rates down if we found them unreasonable.

So, then it will show modified rate. Like on our review notes it will say, you know. Sometimes there is no change so it will say no change. And then if we negotiate a rate down then we will say modified. And then if it's unreasonable, then we will say unreasonable.

And then the public can review and submit comments on rate filings that all are available on the DMHC's website.

So, with that I will turn it over to Michelle to talk about RBOs.

MS. YAMANAKA: Thank you, Pritika.

All right, today I'm going to go over what an RBO is, the financial reporting for RBOs, the grading criteria, required grading criteria, and the corrective action plan or CAP process.

So, let's start with what is an RBO. An RBO needs to meet four -- if an entity or organization meets four requirements then they are classified as an RBO.

So, the first one is the structure of the entity. It 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.

They contract with a health care service plan or arranges for health care services for the health plan enrollees.

They receive compensation on a fixed capitated or a fixed periodic payment basis.

And they're responsible for processing and paying claims.

So, an entity, if they meet all four of these requirements, they will need to register with the DMHC and file financial reports with us.

To obtain an RBO number the RBO completes an RBO questionnaire, which is located on our website. The link is the on the last bullet of the slide. And the questionnaire can be downloaded, and there are instructions on how to file with the DMHC. The RBO number is needed in order to file the reports with the Department.

Okay, moving on to financial reporting. Next slide, please.

RBOs are required to report on a quarterly and annual basis with the Department. For quarterly reporting the slide shows the list of items that are in the Quarterly Survey Report which include the Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Net Worth, grading criteria calculations and additional information on areas such as Cash, Receivables, Incurred But Not Reported methodology or IBNR, Revenue, Expenses, Claims and Enrollment. The Quarterly Survey Reports are due 45 days after the close of the quarter.

For annual reporting we have the Annual Survey Report as well as the Annual audited financial statements of the RBO. The Survey Report is based on those annual audited financial statements and include the same statements as well as additional information as the Quarterly Survey Reports. In addition, the Annual Survey Report includes the Statement of Organization, which includes information about the RBO such as the number of lives, the counties served, MSO information, contracting health plans and the total number of contracted physicians. The Annual Survey Reports are due 150 days after the

close of the RBO's fiscal year end.

We also post information on the DMHC website regarding the Quarterly and Annual Survey Reports submitted to the Department. The link is the last bullet of the slide.

And the last piece of information is the corrective action plans that are required if an RBO reports non-compliant with one or more grading criteria. Additional information regarding the CAP process will be in a couple of slides.

Okay, moving on to the grading criteria. There are five grading criteria that RBOs need to meet at all times. Pritika mentioned the tangible net equity requirement, same calculation, different requirement for the minimum. For RBOs the minimum requirement of TNE is the greater of 1% of annualized health care revenues or 4% of annualized health care expenses.

The working capital calculation is the difference between the current assets and current liabilities, and it must be positive.

The cash-to-claims ratio shows that if the RBO has sufficient cash and health plan capitation receivables to cover their total current claims liability; and the minimum must be .75.

Claims timeliness. It's a minimum of 95% of complete claims that are required to be reimbursed, contested or denied within 45 working days after the date of receipt.

And the last is the IBNR methodology and the RBO needs to have a mechanism to estimate and document the claims liability on a monthly basis.

So those are the five grading criteria that RBOs are required to meet at all times. In the event that an RBO does not meet one or more of the grading criteria we have a corrective action plan process. Next slide please.

The CAP is required to be submitted along with the Quarterly Survey Report when the RBOs non-compliant with one or more grading criteria.

The CAP includes financial projections and assumptions on how the RBO will attain and maintain compliance with the grading criteria.

Our CAP process is a collaborative effort between the RBO, all of its contracting health plans and the DMHC. And the DMHC requests health plan feedback on the CAP submitted.

As part of the requirements of a CAP, an RBO may be required to submit monthly financial statements and/or monthly claims timeliness reports.

The provider solvency unit examiners review and trend each quarterly and annual survey report to verify compliance with the grading criteria. They work with RBOs and their contracting health plans to obtain an approvable CAP and they monitor the CAP. They monitor the CAP until the RBO demonstrates compliance with all grading criteria.

The Provider Solvency Quarterly Update to the FSSB provides information regarding the latest RBO survey reports and CAPs filed with the Department. Today we will provide you with an update regarding the quarter ended December 31, 2024, in Agenda Item number 7.

Do I see any questions?

MEMBER WATANABE: Michelle, can I ask you a question because I know this comes up quite frequently. We have new Board Members, and we present that chart with data on the RBOs that are on a corrective action plan, and there are some that continue or go on and off.

MS. YAMANAKA: Yes.

MEMBER WATANABE: I think you have talked in the past, our

goal is to really help the RBO, turn them around, and we work closely with the health plan. Many of these small RBOs in particular serve a very important need in their community providing culturally and linguistically appropriate care. So we go to great lengths to try to help them. But what happens if we can't get them to turn around? Can you maybe just talk about the steps of the extremes?

MS. YAMANAKA: Sure, sure. We're going to the extremes now, yes. As Mary mentioned, we do work with the RBOs. We do get approved corrective action plans. We do monitor them on a monthly basis. In the event that the examiners when they're trending the financials, if they see that the RBO is not meeting their approved projections, they will work with the RBO to find out, okay, what needs to be done in order to get back on track with the approved CAP, or if an extended date is needed because the RBO needs more time to obtain compliance with the grading criteria.

In the event that none of those two actions work, we do have administrative action that we may take, which is then there's really only two options. It's to freeze the enrollment so the RBO can no longer get new enrollment, or to de-delegate where the entity needs to no longer take that risk. So those are our two options. Those are the extreme but in some cases it's necessary, and so does that, does that help?

MEMBER WATANABE: Does that get to your question too, Andie?

MEMBER MARTINEZ PATTERSON: Yes, yes.

MEMBER WATANABE: I know this comes up quite a lot. And again, I will say as the Director, it's not a decision we take lightly to either freeze enrollment, or in the most extreme, to require the plans to de-delegate, but it is an option we've had to use in some extreme circumstances. But I want to make

sure that answered your question from earlier as well.

MEMBER MARTINEZ PATTERSON: Yes, yeah. I mean, I think I'm curious when -- I must-- a lot of it is just public. It's pressure and shame and moving in the right direction. Do the plans -- perhaps the plans appreciate having a partner in the state where they don't have to do the hard thing. But I would imagine, wouldn't it be the in the plan's best interest to do these things before the state gets involved? Is it -- what's the dynamic there that is --

MS. YAMANAKA: You know, it's different for each plan. Some plans do take, do take that -- they don't wait for us. They go ahead and take that step on their own to freeze the enrollment or to do one of those two options. But some do wait. They want to give the RBO time, as much time as they can. But at some point, if things just -- they are not able to turn, turn it around, then they will do what needs to be done if they don't do it on their own, yeah.

MEMBER MARTINEZ PATTERSON: And how long, how long do you give an RBO to turn it around?

MS. YAMANAKA: You know, the regulations for claims timeliness, they have six months. For the solvency requirements, TNE, working capital, cash-to-claims, they have up to a year.

MEMBER MARTINEZ PATTERSON: A year.

MS. YAMANAKA: But there again, there's just some that just need a little bit more time. Some need a lot more time. One case I think it took two years, but they were able to turn the operations around and they -- and since then they have been compliant, yeah. So, it really depends, yeah.

MEMBER WATANABE: All right. Seeing no more questions we're going to talk about the fun Bagley-Keene Act, Sarah.

MS. REAM: Said no one ever, fun Bagley-Keene Act.

So, this will take just a moment and this is really -- the main thing I need the Board Members to take away from what I'm going to be talking about is no serial meetings. No talking with each other, either via email, texting, phone call, chat, about the business of the Board when you're not at a Board meeting and it's out in the open verbal.

So as background, the Bagley-Keene Open Meeting Act is a California law that requires all meetings of public bodies, of which the FSSB is a public body, to be open to the public, out in the open. So, they may not be behind closed doors. Very limited circumstances when you can have a closed-door meeting, which those circumstances do not apply here.

There's two types of meetings. So, there's a physical meeting, a teleconference, what we're doing right now.

Then as I mentioned there's what's called serial meetings, and those are strictly prohibited by the Bagley-Keene Act. So next slide, please.

So, a serial meeting is, you can think of it as a game of Telephone where one Board Member talks to another Board Member and then another Board Member talks to another, and they're talking about substance within the purview of the FSSB. So, you cannot, you cannot do that.

I know we are all very used to having sidebar conversations with colleagues, where you -- through messaging or things and you might say -- even during a public meeting you might say, hey, should I ask this, or what do you think of that? Cannot do that. Everything needs to be out in the open. Next slide, please.

So again, bottom line is do not communicate with each other in any

way about matters relating to the FSSB outside of a public FSSB meeting.

One question that does come up and I appreciate it because people do want to follow the rules, we will get questions of, well, can I -- I'm not going to be able to make it to the Board meeting? Can I, can I tell somebody? Yes, that is not substance, that's more procedural, so you can certainly email admin staff at DMHC. Or if there's an item you would like to see on the agenda you can certainly let Mary know, or Pritika, or whomever. That is not a serial meeting. But it's when you are communicating with each other outside of the view of the public. Cannot, cannot do that.

And the consequence is that any action you might take would be void. You cannot -- that action would be void. It is also an embarrassment and there can be other consequences too. But we haven't had a problem with that to date so I'm sure that we will continue to be in good standing.

MEMBER WATANABE: Just a couple notes. I think for prior Board meetings we had, I think, the ability for Board Members to use the Chat feature. We have quickly, I believe, disabled that. Jordan is nodding his head yes. Because that is another thing. Chat was -- like the Board Members could see but the public could not see and so then we were in a position of having to, like, say what was in Chat. So just so you all know, we've, I believe, disabled that.

The other question that sometimes will come up is some of us run into each other at conferences. That's perfectly fine for you all to chat at a conference, just please don't talk about matters related to the FSSB.

All right, you all are officially certified in DMHC 101 financial review and probably some of the most technical things we do at the Department. I hope this was really helpful. I will just go again to the Board to see if there's any other

questions you have now that we've kind of gone through this overview, any questions or comments, and then we will go to public comment as well.

All right. Seeing no questions from the Board, any questions or comments from anybody in the room?

Bill Barcellona, thank you again for helping us with our history lesson. Appreciate the background. Don't know where I was 25 years ago but I was not here.

All right, let's see if there's any questions from members of the public online.

I don't see any. Okay, all right. We are going to move on to our next presentation. Sarah, you're up for a regulation update.

MS. REAM: Great. Thank you, Mary. Next slide please.

So, I'm going to be providing just a quick update on two regulations that the DMHC has been working on. As I say every time, we have a lot of regulations in the queue that we are actively working on, these are the two that are the most, the farthest along.

So, the first is the Fertility Preservation Regulation, which implements SB or Senate Bill 600 from 2019. And this bill stated that fertility preservation services are basic health care services that plans must cover.

Just as background, fertility preservation services are services that are designed to treat iatrogenic infertility. Iatrogenic infertility is infertility that is caused or may be caused directly or indirectly from some other covered treatment. I think the easiest example to lay out is if someone is going to be undergoing chemotherapy and the chemotherapy may impact their ability to have children in the future, it may impact their sperm or their eggs, their organs. In

that instance the health plan must cover services to protect that person's future fertility.

Services can be relatively non-invasive, such as organ shielding during radiation, or they can be removal of sperm or eggs, removal of gonadal tissue, a creation of embryos and storage of those embryos. So, it runs the gamut from very non-invasive to quite extensive.

The DMHC, like I said, this bill passed several years ago. We have been working very hard on adopting these regulations. We worked with the health plans. We worked with stakeholders. We worked with experts in the field of fertility and fertility preservation. I am thrilled to say that in April the Office of Administrative Law approved our reg package and that reg package takes effect in July, on July 1st, and I have the codification where it will be codified in our, in Title 28 of the California Code of Regulations. So that's an exciting one that we have got that one over the finish line. Next slide please.

We are also in process on the provider directory. The long, long-coming Provider Directory Regulation that will largely codify the current practices and requirements that are imposed on plans with respect to provider directories. We have had two comment periods so far. The second one actually closes today. I'm happy about that. I don't know that we will need a third. If we do we -- obviously there's a public notice and right to comment there. Hopefully we won't. You can find more information on the DMHC’s website about this regulation. Once --

Assuming we don't need a third comment period we will finalize the package and submit it to the Office of Administrative Law, I would say in the next -- in less than a month, hopefully. Office of Administrative Law then has 30

calendar days to review and approve or deny that package. We assume it will be approved. So hopefully by midsummer this regulation will have been approved by the Office of Administrative Law, and it would take effect then the following quarter, so probably in the fall.

I want -- I don't have a slide for this, but I want to mention one more reg that we're working on, it's the General Licensure Regulation. I know that we've had a lot of people interested in that. Bill is sitting here laughing. I know, Bill, we're top of mind for you. We are working on that.

In the meantime, entities that have applied for an exemption from licensure, those exemptions continue on until such time as a regulation takes effect and, you know, their exemption may or may not be impacted by the regulation. But look for that one to come out hopefully to stakeholders in the next -- probably this summer we will be getting that one out. And that's it for me.

MEMBER WATANABE: Thank you, Sarah.

Questions from the Board Members on any of the reg updates?

MEMBER WALTERS-WHITE: No questions on the reg updates but just wanted to say that we, Health Access appreciates the ability to be able to provide comments on the Provider Directory Reg changes and we will submit another comment today.

MEMBER WATANABE: Thank you, Katrina. Long time in the work. I think it was my first project I worked on when I came to DMHC back in 2015. So, we've been at this for 10 years.

All right, any other questions from the Board?

No, all right. Questions from anybody in the room?

Okay, questions from any members of the public online?

Okay, seeing none, we are going to move on to our Health Care Premium Rate and Prescription Drug Cost Report. Pritika, you're back up.

MS. DUTT: Thank you, Mary. So I will summarize the findings from the 2024 individual, small group and large group annual rate filings, and also highlight some of the key findings from our prescription drug transparency reporting for Measurement Year 2023. So, the DMHC issued two reports, the Health Plan Aggregate Premium Rate Report for Measurement Year 2024 and the Prescription Drug Cost Transparency Report for Measurement Year 2023. Both reports are available on the DMHC website and provide more detailed information on the filings. So, if you're interested you can go on our website and download these reports.

So, the majority of the enrollees in the commercial market are covered by employer sponsored plans in the large group market. And hence that's why the MLR requirement for the large group plans are higher.

Approximately 7.6 million enrollees were in the large group market licensed by the DMHC, and then compared to 2.4 - 4 million enrollees in the individual market and 2.29 million enrollees in the small group market. So, as you can see, the large group market covers like the lion's share of the commercial book of business.

And then average premium per member per month increased by $100 from 2021 to 2024.

The average premium per member per month was $638 in the individual market, $655 in the small group market, and then $650 in the large group market.

And the weighted average rate increase was 9.5% for the individual

market, 8.5 for the small group market, and 10.7 for the large group market. In comparison, Covered California had an average rate increase of 9.6% and CalPERS had an average rate increase of 10.9% in 2024.

This chart shows the average monthly premium per enrollee in the individual, small group and large group market. So, you can see the trend line, it is going up. So, what does the large group, small group and individual market types mean? So large group coverage includes employer-sponsored coverage where the employer has more than 100 employees. Small group market coverage includes employer-sponsored coverage where employer has between 1 and 100 employees. And the individual coverage is where the health plan covers -- provides coverage to individual consumers rather than purchased -- rather than the consumer purchasing through employer-sponsored coverage. And the majority of the individuals purchase coverage through Covered California's Health Benefit Exchange.

The average premium in the small group and large group market are almost the same, while the individual market premium is slightly lower for 2024. The majority of the enrollees, about 62% of commercial enrollees, as I mentioned earlier, are covered in the large group market.

And from 2021 to 2024 the average premium in the individual market increased by 16%, for the small group increased by 23%, and for the large group within the three years premiums have increased by 22%.

Okay, go ahead, David.

MEMBER SEIDENWURM: Yeah. With respect to the change in the relative premium in the individual versus the group markets, what accounts for the lower premium in the individual market over time? I mean, one would

think that there would be potential for adverse selection and so forth in that market that might result in a higher actuarial risk. Do we have an explanation for that?

MS. DUTT: So, there's more enrollees covered in the large group market. And then I think one of the things is the benefit design across the three markets may be different. So, further slides down you will see the actuarial value for the large group plans is higher, so about 92% on average. So, meaning 92% of the cost of the care when enrollees go seek care is paid by health plans, while 8% is paid by the enrollee for employer sponsored coverage. So that's a big difference right there in the benefit design. And then it's, you know, I think it's the benefit design and then, you know, looking at out-of-pocket costs and things like that. So, I don't know, Barb, if you have anything to add on that variation?

MEMBER DEWEY: I think benefit design is a big one because you'd expect the individual and small group to be a little bit leaner.

Another thing that's going on in here, like if you think about the individual market, what's gone on since 2020 is that the federal subsidies expanded and so people were able to buy richer plan designs. The state had enhanced benefits. So, there's a few things that have made it so that the average premium went up there, I want to say with the richer plan design. So, talking about like the mix of Bronze versus Silver, that will affect the average premium that gets factored in here even though it's a very big difference in coverage.

MEMBER SEIDENWURM: Thank you. So, benefit design and subsidies. Thank you.

MS. DUTT: This chart shows the weighted average rate increase

for health plans in the individual, small group and the large group markets. One thing I want to point out is the 2021 individual market average rate increase should be 0.4 not negative 0.4, so we will be making that change in the slide and posting updated slides after. And as you can see from this chart here, the average rate increase in all three markets increased in 2024. And based on the health plans' 2025 projected rate submission, we are expecting a larger increase in all three markets in 2025; and then I think we are hearing similar trends for 2026. Next slide.

In 2020 California enacted Assembly Bill 2118 for the purpose of increasing transparency of rates in the individual and small group markets. And this is specific to annual reporting. So, health plans that offer commercial products in the individual and small group markets are required to report specified information, including premiums, cost-sharing, benefits, enrollment and trend factors to the DMHC annually by October 1. The DMHC is required to annually present the reported information at various meetings as specified, and post the reports on the DMHC's website no later than December 15 of each year. So, in this next section I will summarize the aggregate rate information and weighted average rate increase on health plan premiums for the individual market for Measurement Year 2024; then I will cover the small group market right after.

For Measurement Year 2024, 13 individual plans submitted data to the DMHC. Oscar exited the Exchange or the individual market. And then Inland Empire Health Plan joined the Exchange for the 2024 benefit year.

The 13 individual plans covered approximately 2.4 million enrollees and then enrollment increased by almost 100,000 lives compared to 2023.

The weighted average rate increase, as mentioned in an earlier slide, was 9.5% on average.

And the average premium per enrollee was $638 compared to $590 in 2023.

And the average actuarial value for the individual market products under DMHC was about 77%. So, I mean, that's one of the things you can see. Like 77% of the cost for health care was covered by the health plan while 23% was the out-of-pocket costs covered by the, by the enrollees. Next slide.

For Measurement Year 2024, the DMHC received individual market aggregate rate filings from 13 plans, including five statewide health plans and eight regional health plans. The 13 individual health plans covered almost 2.4 million enrollees. Overall, the weighted average increase was 9.5%, with the average premium per member per month across all plans was $638. So, 12 health plans offered individual products On-Exchange and covered approximately 1.98 million. So almost 2 million enrollees were covered by the Covered California Exchange Program and the average premium for those products was $633 per member per month.

And then we had 12 health plans that offered Off-Exchange products and covered 431,000 enrollees. And the average premium -- average premium for the Off-Exchange products was $653.

And then only two health plans, Anthem and Kaiser, offered grandfathered plans that covered 45,000 enrollees with an average premium of $763. So, with respect to the grandfathered plans, these are pre-ACA, pre-Affordable Care plans that may not include all the Essential Health Benefits.

Okay. So, in this section I will summarize the aggregate rate

information and weighted average rate changes on health plan premiums for small group coverage for the 2024 reporting year.

So, the DMHC received small group aggregate rate filings from 13 plans for Measurement Year 2024 including 7 statewide plans and 6 regional health plans.

In 2024 approximately 2.3 million enrollees had small group coverage.

And the weighted average increase was 8.5%.

And the monthly premium was $655 per member per month.

And the average actuarial value was 79% in the small group market. Next slide.

Overall, the weighted average rate change, as mentioned earlier, was 8.5% for, for the small group market plans. So approximately 2.3 million enrollees were covered in the small, small group health care plans.

And then the Off-Exchange covers most of the enrollees in the small group market. So, there were about 2.1 million enrollees in the Off-Exchange product, so about 90%. And the average weighted rate increase for these Off-Exchange products were 8.4% and the average premium was $658.

And then the small group market On-Exchange products covered 84,000 lives, and the average rate increase was 8.7% and the average premium was $639.

And then for the grandfathered plans, they covered 141,000 lives with average rate increase of 8.9%. And the average, the average premium was like slightly under $620. Next slide.

So large group health plans must file aggregate rate information

and specified information regarding health plan spending and year-over-year cost increases for covered prescription drugs annually. So, we started collecting this information back in 2017 under SB 546 so sometimes you will see templates and our reports mentioning that bill number. We get pretty tied to the bill number. So, you will see the templates reports, they may still reference SB 546.

So, the DMHC conducts a public meeting every even-numbered year to permit public discussion regarding changes in the rates, benefits and cost sharing in the large group market.

Health plans include information in their Notice of Premium Rate Change indicating whether their rate change is greater than the average rate increase for CalPERS and Covered California or the average rate increase in the large group market. So, what that means is, when a health plan sends a renewal notice to the employer group, they have to show the comparison between the rates that they are offering and then show what Covered California's rate increase was and also CalPERS' rate increase, because CalPERS is a large group purchaser.

So, 23 health plans were required to file their large group reporting.

Approximately 7.7 million enrollees were covered by large group plans licensed by the DMHC.

The large group rate increase -- rate increased by 10.7% on average.

And the average premium was $650.

And here's something I wanted to highlight, the average actuarial value for the large group products was 92%, which means that 92% of the medical costs was paid by health plans while 8% was paid by the enrollee. So

that's a big difference you will see between the actuarial value in the large group market versus individual and small group. Next slide.

So, as I mentioned earlier, health plans are required to include information in their renewal notices to employers that compares the rate change to those in Covered California and CalPERS. So Covered California and CalPERS negotiate rates with the plans similar to large group employers, so it gives some comparison to the large group employers. And you can see here information going back to 2019, although we do have information going back, you know. In the previous reports you will see like we have data going back to 2017.

So, increases had -- increases had remained low through 2022 but we have seen an uptick in rates consistent with general inflationary trend. Next slide.

This table shows the average rate increase, number of enrollees and average premium per member per month for all group -- all large group plans and Kaiser, and all plans excluding Kaiser. Because Kaiser has approximately 67% of the large group market share, they are shown separately in the large group report.

So, Kaiser reported an average increase of 12.2% with an average monthly premium of $642.

Excluding Kaiser, the remaining large group plans covered 2.5 million members and reported an average premium of 7.8%, an average premium of $665.

The average increase across all plans in the large group market was 10.7% and then the average premium was $650.

Okay. So, Assembly Bill 731 expanded the rate review practice

that the state already has in place. Upon receiving notice of a rate change, a large group contract holder that has coverage in experience rated in whole or blended can request the DMHC to review a rate change if the contract holder makes a request within 60 days of receipt of their notice. A large group contract holder may only request a review of the rate change from the plan licensed by the DMHC. To apply for review of a rate change for a particular group at least the following should be followed:

So, the plan has to have -- the contract holder has a combined total of more than 2,000 enrollees. And there are certain -- so if a health plan does not provide requested claims data to the large group employer, then they can also request a rate review from the Department.

So, if you have questions you can visit the DMHC site, this link provided on this slide. If there's a question you can reach out to me, and I can help navigate on that process.

All right, now I'm going to go over the Prescription Drug Cost Transparency Report for Measurement Year 2023. So, health plans are required to file specific data related to prescription drugs annually by October 1. And then we are required to post -- take this data. We get a lot of confidential data from health plans. We aggregate the data across all the reporting plans and then we create this report, which is required to be posted by January 1 of each year.

So, health plans must report to the DMHC information on their top 25 most frequently prescribed drugs, 25 most costly drugs by total annual spending, and 25 drugs with the largest year-over -- with the highest year-over-year increase in total annual spending. So again, for each of these categories we asked for data on generic, brand name, and specialty drug information.

Thank you, Mary. And then like I said, the DMHC issues an annual report that summarizes how premium drug costs impact health plan -- health plan premiums. And this information is also considered in our premium rate review analysis when we do that upon receiving a health plan's premium rate change.

And then plan reporting is limited to prescription drug costs associated with pharmacy benefit.

And health plans -- health plans do not include prescription drug costs for inpatient or hospital or costs borne by delegated medical groups in their reporting.

And then prescription drug costs for self-funded arrangements, Medi-Cal Managed Care Plan, Medicare Advantage and insurers not regulated by DMHC are not included in the report issued by the DMHC.

And then the 25 commercial health plans covered 12.6 million enrollees.

All right. So, some of the key findings here for 2023 include -- so health plans paid approximately $13.6 billion for prescription drugs in 2023, which was an increase of $1.3 billion from 2022 and almost a $5 billion increase from 2017 when we first started collecting information.

Prescription drugs accounted for 15.1% of total health plan premiums in 2023, an increase of 14.3% from 2022.

On a per member per month basis, health plans' prescription drug costs increased by 12.3% in 2023, whereas medical expenses increased by 4%. Overall total health plan premiums increased by 6.2% from 2022 to 2023, so as you can see the prescription drug costs are increasing at a larger rate compared to medical costs and premiums.

So, specialty drugs accounted for only 2% of all prescription drugs dispensed but accounted for 65.8% of total annual spending on prescription drugs.

And then generic drugs accounted for 89.2% of all prescribed drugs, but only 12.7% of total annual spending on prescription drugs.

The primary drugs that are driving up the increase in total drug cost spending for 2023 are in the specialty and brand name drugs. They are mainly like the GLP-1 drugs or drugs used to -- used in the management of diabetes or weight loss. So, we have Jardiance, Ozempic, Victoza, Farxiga and Wegovy, to name some of the drugs here.

This chart shows the total health plan premium, medical expenses, prescription drug expenses and profits on a per member per month basis from 2017 to 2023, on a per member per month basis or PMPM basis. So, all categories except profit increased consistently from 2017 to 2023. On average, enrollees paid nearly $600 per member per month in premiums in 2023 compared to $560 in 2022 and $455 in 2017. So, this means the average premium has gone up about 30% since 2017. And then prescription drug expenses increased by 53.6% over the last seven years while medical expenses increased by 31.7%.

This chart shows the year-over-year increase in prescription drug costs on a per member per month basis, as shown in the blue bars. So, you can see the cumulative increase over the last 7 years on the green -- so the green line shows the cumulative increase while, you know, the year-over-year increase in shown in blue bars. So, prescription drug costs have increased by 53.6% over the last 7 years. And then, on average, prescription drug costs have increased

by 7% each year.

This chart shows the year-over-year increase in medical expenses on a per member per month basis, as shown in the blue bars. And then again, similar to the previous slide, the cumulative increases captured by the line graph in green. So medical increased -- medical expenses increased by 31.7% over the last 7 years. About the spike in medical expenses between 2020 and 2022, for 2020 medical expenses were lower than usual due to COVID; and since elective surgeries were dropped so we saw lower medical expenses in 2020. But then later higher medical expenses were reported due to price inflation and pent-up demand. So again, like these are some things that are considered during our rate review process.

All right. So, on this slide we are sharing the links to the detailed reports so if you are interested you can go check out these reports. Have a lot of useful data. Our actuaries spent a lot of time analyzing data preparing these reports so a big shout-out to our actuaries. So, there's a lot of like nice information shared in these reports - and then these other reports going back to 2017 since we started collecting this information.

All right. With that, that brings me to the end of my presentation. I will take questions. Barb.

MEMBER DEWEY: Thanks, yeah. If we look at the pharmacy trend tab, I think it's two or three tabs ago, I have two questions. One, do those trends, are those -- do those consider rebates? Or is it a gross drug cost before a rebate trend?

MS. DUTT: I'd have to get back to you on that one. I think it does, but I need to check on that.

MEMBER DEWEY: Okay. I also know that California has, has benefit mandates. But in the more recent years it seems like there has been more of a focus on pharmacy benefit mandates. Does DMHC look at all at any of the specific categories that get mandated to track if they're in line with the expectations or if that's a bigger source of trend?

MEMBER WATANABE: I know I'm trying to think of a pharmacy benefit mandate that's happened recently. I will just say, I mean, one of the things that we do sometimes ask about is certain, certain new requirements, whether there has been an impact, where the plans will tell us there has been an impact related to a new benefit. I know behavioral health is something we have been looking into. Is there a specific pharmacy mandate that you can think of? I'm trying to think of one.

MEMBER DEWEY: Well, yeah. So, I think there's two that come to mind, the more recent one being the GLP-1s. But one that is a few years old is coverage for PrEP without step therapy or (overlapping).

MEMBER WATANABE: Okay, PEP and PrEP, yeah. I don't know. Let us take that back. I don't know, Pritika, unless you know something specific we're asking about that. I mean, the plans certainly could explain that in their filing if they're seeing an uptick in utilization related to a new mandate.

I will say with the new EHB requirements that's something I think we will be looking at is what's the actual impact of that on rates versus what I think at least some of the preliminary analysis showed. But yeah, those are good examples. Anything to add?

MS. DUTT: No, we will have to take that back. But sometimes we do get asked questions when we're working with OHCA on like the data we're

capturing, what we're receiving from health plans in SB 17. So sometimes we get asked, asked for information, like, you know, specific, certain drugs. But we will have to take that one back and look into it a little bit more.

MEMBER WATANABE: And then I will just say on your question about whether rebates were included. If you go to the full report, I believe we have a number of different charts related to prescription drugs. And some, I think there's a footnote related to whether rebates were included. Pritika will probably try to look it up. But if you look at the full report, I think there's some more information there as well.

MEMBER DEWEY: Okay, thanks.

MEMBER WATANABE: Thank you. Paul.

MEMBER DURR: Yeah, my question or comment is related to the fact of all of the medical expenses that are -- includes also like the oncologic drugs and self-injectables. So, there's another category of medicine, if you will, that, you know, that are drugs related that are the delegated risk of the provider groups that have risen as well and kind of get lost in this. And outside of the delegated groups providing that information to you, you would have no way of getting that. But I think it gets lost in the medical expense side of it and thinking that that's really going to the physicians when it's really not necessarily, because it's going to pay for oncologic drugs, which obviously have gone up as well as self-injectable medications that also are the risk.

So, it's unfortunate we don't have an easy way to capture all that information because then we can really clearly see what’s sort of non-physician cost versus whether it's DME or ancillary, those types of costs that have risen and overall driving the cost.

So, love this report. I think it's great insight. I've liked how this has evolved. Pritika, you have done a great job of showing the cumulative effect. And so, my compliments to you and your team for this insight and information, it is very helpful. Thank you.

MEMBER WATANABE: Thank you, Paul. I will echo those kudos. I think we used to have these in three separate reports, and I really appreciate having all of the data in one report too to really look at the trends across markets. It will be interesting to continue to watch these trends as well as we get more years worth of data.

Any other questions or comments from the Board before we go to the public?

Okay, seeing none, any comments or questions from those in the audience here in the room?

Okay, seeing none. How about online, any comments or questions?

MS. DUTT: Mary, I do have a response.

MEMBER WATANABE: Oh yeah, okay, go ahead.

MS. DUTT: So, Barb, it does not, it's not netted. Those percentages are not adjusted for rebates.

MEMBER DEWEY: Okay, thanks.

MS. DUTT: Of course.

MEMBER WATANABE: All right, Michelle, Provider Solvency Quarterly Update.

MS. YAMANAKA: Okay, here we go. Today I'm going to provide an update regarding the December 31, 2024, quarterly financial submissions.

Next slide, please.

We have 203 RBOs reporting to the Department as of Quarter 4 2024. There is one new RBO that began reporting this quarter. Five RBO account -- five RBO accounts were deactivated. Three of those accounts deactivated. Those RBOs were no longer -- are no longer in business. And then two of the accounts were deactivated because the RBOs were consolidated with another RBO for financial reporting. The three RBOs that were deactivated no longer in business had less than 10,000 lives -- 10,000 lives assigned to them, and two of the three had mainly Medi-Cal enrollment. All were compliant with the grading criteria when the accounts were deactivated.

And then we have 183 of those 203; 90% of the RBOs are reported in our Compliant category. Of those 183, 5 are on our Monitor Closely List to give you an idea of what is monitored closely. Those include low financial reserves, financial reporting issues, downward trends, consecutive net periods of net losses.

And we have an increase in our CAP count. For the quarter ended December 31 there were 19 RBOs or 9% of the RBOs on CAPs.

And when we produced the slides there was one non-filer. We subsequently received that report, but that RBO is not captured in the data.

The RBOs are also required to submit Annual Survey Reports for the fiscal year end. A majority of our RBOs have a fiscal year end of December 31 and those filings are due at the end of this month. I checked yesterday, we received a total of 60 so there are several coming in.

And we have eight RBOs that are required to file monthly financial statements with the Department.

To provide some additional information regarding the RBOs we have a handout titled RBO Enrollment and Grading Criteria. We compiled the relative TNE, relative working capital, cash-to-claims and claims timeliness percentage for each of the RBOs for the past five quarters to provide some additional information. Next slide please.

Regarding the Corrective Action Plan. Again, 19 RBOs or 9% of the RBOs are on CAPs. Ten of the 19 are continuing from the previous quarter. We had 9 new CAPs based on the quarter end December 31, 2024. Of the 10 continuing, 6 are improving, meeting their approved projections. Four RBOs did not meet their RBO projections, and we are working with those RBOs to determine how they are going to get back on track with their approved projections or additional time is needed.

And of the 9 RBOs on CAP, the new -- of the 9 RBOs that had CAPs, new CAPs as of December 31 2024, 4 resulted in non-compliance with claims timeliness, 5 resulted from not meeting financial metrics, TNE, working capital and/or cash-to-claims.

And of the 19 approved CAPs -- or of the 19 CAPs, 9 are approved, 10 are in review.

We have another handout regarding all of our corrective action plans and those are sorted by the management services organization or MSO, and it includes additional information on the CAPs, the contracted health plans enrollment in ranges, the quarter the CAP was initiated, if the RBO is meeting its approved projections, and the grading criteria deficiencies.

After our December 31 review, 4 of those CAPs that were in progress have been approved.

Moving to the next slide, talking about the grading criteria. The first is TNE. We use the TNE to required TNE to calculate this ratio. At quarter end December 31, 2024, 137 or 67% of the RBOs had over -- more than 500% of TNE. Four RBOs reported non-compliance with this requirement, and two out of the four had less than 10,000 lives.

Moving on to relative working capital, also known as the current ratio. This metric measures the RBO's resources available to finance its day-to-day operations. The December 31 financial shows that over 96% of the RBOs were able to cover their current liabilities, and 6 RBOs reported non-compliance with this requirement.

Cash-to-claims ratio, next slide please, shows that seven RBOs had less than .75, which is the minimum requirement to be compliant with this, this requirement. And a majority of the RBOs were meeting cash-to-claims. Cash-to-claims is calculated using the cash available, health plan capitation receivables collectible within 30 days, and divided that by the total claims liability.

And last slide is the claims timeliness requirement; 195 RBOs are reporting compliance. Seven RBOs are reporting non-compliance with this grading criteria. And then you can see where the RBOs lie with the number of enrollees that they have.

Okay, next slide please regarding the enrollment. Enrollment for quarter end -- the quarter ended December 31, '24 is in the righthand column showing 8.8 million lives assigned to the 202 RBOs reporting. You can see from comparing it to the previous year at this time there was a significant decrease, mainly in the Medi-Cal enrollment. Comparing, not on this slide but comparing Quarter 4 to Quarter 3, looking at the change. There were about 162,000 lives

reduction, mainly in commercial and Medi-Cal. If we took in a factor that RBO that was -- that was not included in the data, the change would be about 65,000 reduction from Quarter 4 to Quarter 3, 2024.

Then we also compile information on RBOs that have Medi-Cal enrollment. Next slide please.

There's approximately 4.7 million lives assigned to 72 RBOs. This represents 53% of the RBOs total lives assigned to the 202 RBOs. Of those -- of those RBOs, 61 RBOs had no financial concerns, 2 are on our monitor closely list and 9 of those RBOs were on Corrective Action Plans.

Then we took the top 20 RBOs that had mainly Medi-Cal lives assigned to them. Those 20 RBOs had approximately 3.7 million lives assigned to them, which is approximately 42% of all enrollment; 17 of those RBOs had no financial concerns and 3 of those RBOs were on Corrective Action Plans.

And that concludes my presentation. Opening it up more questions.

MEMBER WATANABE: Go ahead, Paul.

MEMBER DURR: Michelle, I always love your report, thank you. Just noting on the ones that are non-compliant. There's so many that -- I think almost 47% of the ones that are on a Corrective Action Plan. One disturbing that there was a big increase in that this time so that's unfortunate. But I was noticing that more of them have zero to 5000 members and some of them have been on the report for a while. They may not be new. But it just made me think about the fact that it does take time for them to probably ramp up to get to a sizable number. And you're watching them but a couple of them are non-compliant with their CAP. Any comments that you have with how long do you let that go?

MS. YAMANAKA: Yeah. Well, the first, the first is to see if the RBO has a viable plan. Right now we are working with them to see -- they're not meeting their milestones. So, the next thing is, you need to produce the CAP to show when you can obtain compliance and your financial assumptions to support those. That also gets reviewed by the contracting health plans. If it is viable, we will look to extend the time period. If it doesn't seem reasonable, we may ask them to revisit it to see if there's something else that they can do as well. Yeah. It's hard to give a timetable, Paul, because each RBO has its own set of circumstances on how they can obtain compliance. Some will do cash infusions. Some will try to earn their way out of it, which definitely takes longer.

MEMBER DURR: And thank you for that, Michelle, I respect that. I think also, given that many of them only have up to 5,000 lives, the exposure isn't as great compared to a couple of the others. Obviously, any patient or any enrollee that is harmed is put in the middle.

MS. YAMANAKA: Right.

MEMBER DURR: But to your point, it does minimize it. So, thank you.

MEMBER WATANABE: All right, any other questions from the Board?

Any questions from those in the audience here? You want to get up, Bill? (Laughter.) Okay, all right.

Any questions from those joining virtually?

All right, seeing none we are going to move on to our Health Plan Quarterly Update. We're almost done, hang on.

MS. DUTT: The purpose of this presentation is to provide, provide

you an update of the financial status of health plans at quarter ended December 31, 2024. So, as I had mentioned earlier in the overview of the DMHC presentation, all health plans are required to submit quarterly and annual financial statements to the Department. Additionally, monthly financial statements are required from newly licensed plans with a lower than 150% of required TNE or plans with financial issues.

So, we included a handout that shows the enrollment of health plans at December 31, 2024, by line of business, and it also includes TNE for five consecutive quarters from December 31, 2023, to December 31, 2024.

As of May 1, 2025, we had 139 licensed health plans. So, we had a few surrenders, and then we had like a few new plans licensed. So, we had three health plans that surrendered recently. So CCA Health Plans of California surrendered license on April 7, 2025, California Health and Wellness surrendered its license on April 24, 2025, and then Universal Care surrendered its license on April 24, 2025. And then we licensed Ventura County Medi-Cal Managed Care Commission DBA Gold Coast Health Plans. That's what everybody knows Gold Coast as. So, we licensed the plan back in February 7, 2025.

And I think Andie had a question on the COHS plans and our oversight of it. Although their Medi-Cal line of business is exempt, those plans had to get a license from the -- from the DMHC for their D-SNP line so they can get a contract with CMS. So that was one of the requirements, they needed a license from DMHC.

And then we have 14 applications for licensure in progress. A majority of them are restricted. And we are working with these -- with these applicants, and reviewing the applications.

Okay. So, we did pass the 30 million mark. So, as Mary said, we are going to issue an annual report that will show we have over 30 million enrollees covered under DMHC oversight.

So, at December 31, 2024 there were 30.16 million enrollees in full service plans licensed with the DMHC.

Total commercial enrollment includes HMO, PPO, EPO and Medicare Supplement enrollment. And as you can see on the table, compared to previous quarter, total full-service enrollment increased slightly.

This slide shows the makeup of HMO enrollment by market type. So, HMO enrollment in all markets remained relatively stable compared to previous quarters. And then large group HMO product experienced a light increase from the previous quarter.

And this slide here shows the makeup of PPO/EPO enrollment. And as you can see here, PPO/EPO enrollment slightly decreased in the large group and individual market.

And just one thing I want to flag here, we did make changes to the DMHC financial reporting template that included like substantial changes to our enrollment, how we collect enrollment data. And we are going to start showing PPO and EPO separately because we are capturing that data starting with quarter ended 12/31/2024. So we will be -- right now since the data was still in review we will start showing this information separately by PPO/EPO. Next slide.

This table shows government enrollment, which is Medi-Cal Managed Care and Medicare Advantage. So, enrollment for both Medi-Cal and MA plans have experienced consistent growth until -- so at 12/31/2024 Medi-Cal, enrollment increased by 86,000 lives and Medicare Advantage enrollment

decreased slightly. We had a 62,000 decrease compared to previous quarter.

We have 31 plans that we are monitoring closely, which includes 25 full-service plans and six specialized plans. And there's various reasons why we monitor health plans closely, which could include the plan is newly licensed, just trying to, you know, we monitor them until they break even, low enrollment, financial solvency issues, concerns with parent entity, claims processing issues, enforcement action, staff turnover. Things we may find in the media like there's an article that makes us like look, look at the plan closely. And then we also look at SEC filings for plans with a publicly-traded parent to ensure that there's nothing going on there with a publicly-traded parent of the plan. Next slide.

Okay, so this slide here shows the plans that were TNE deficient. So, four health plans did not meet the Department's minimum financial reserve or tangible net equity requirement.

Access Dental Plan reported TNE deficiency of about a million dollars for year-ending December 31, 2024. So, the health plan was able to -- and the audit -- I mean, the deficiency was as a result of yearend adjustments, so we are working with the plan to ensure that they meet compliance with the requirement.

Then we had Align Senior, it's a Medicare Advantage plan. They've reported a small TNE deficiency. And the plan was able to get a capital infusion of half a million dollars in January of 2025 and that cured their TNE deficiency. So, they're compliant for the first quarter.

And then we had Astiva Health. They reported almost a $5 million TNE deficiency for quarter ended December 31, 2024. The plan received capital contribution of $3 million from their parent entity to cure their TNE deficiency in

the first quarter.

And then we had Meritage Health Plan. You've probably seen them here on this slide previously. So, Meritage reported TNE deficiencies starting August of 2024 and is currently still deficient. The plan did file a change in control filing which is under the Department's review. So, the plan projects to get capital infusion upon the Department approving the change in control. So, due to their ongoing TNE deficiency the plan was referred to our Office of Enforcement and Enforcement issued a C&D, a Cease and Desist Order on January 27 to freeze the plan's enrollment.

So, the plan is a restricted Knox-Keene Plan so they get their enrollment through contracts, so they're a subcontractor to plans that directly contract with CMS. So basically, what the freeze did is those plans, for example, you can think of Humana, it's a plan that contracts with CMS. So, like what the C&D did, Humana can no longer delegate enrollment to this restricted plan, Meritage Health Plan.

This chart shows the TNE of health plans by line of business. A majority of health plans with over 500% of required TNE are specialized health plans. Again, I had mentioned previously with the specialized plans the TNE requirement is lower because the full-service plans take up, you know, take on more risk so they need to maintain higher reserves with the Department.

And then this chart shows the TNE of full-service plans by enrollment category. So, 63 health plans, or half the plans licensed -- half the total licensed full-service plans reported TNE of over 250% of required TNE. The plans below 150% of TNE are required to file monthly financial statements with the DMHC.

And this chart shows a breakdown of 26 full-service plans in the 150% to 250% range. Again, if a health plan's TNE falls below 150% the plan is placed on monthly reporting. But we start monitoring health plans early on. Like so we -- every time we receive -- every quarter we receive financial statements from all licensed health plans. Our examiners do detailed trend analysis so we may start watching them closely. We have the Watch List. We monitor, start monitoring plans closely when we see a decline in TNE, we see net losses, we see enrollment change, we see anything like in their rates, MLR, that give us concerns. So, there's frequent reporting we may require early on. Next slide.

This chart shows the TNE of full-service plans by quarter. And this slide pretty much summarizes the detailed, you know, the handout that was provided with the meeting materials. And you can see the health plans, their various TNE levels, the enrollment mix. So, you can review, review that and see where each plan stands.

This slide shows the working capital for full-service health plans by enrollment as of December 31, 2024; 14 health plans were below that 1.0 ratio that we are looking at. So again, these are the things we look at, the plan's TNE level, you know, what kind of line of business they're in. If there's any source of, there's other sources of, you know, funding available to these plans. We also look at to make sure that, you know, if the plan has long-term investment what is the composition of those long-term investments. So, there's, like I said, a lot of detailed review that we go into in our financial analysis. Next slide.

Okay. So, this slide shows the cash-to-claims ratio for full service plans, full-service health plans by enrollment. And we had 28 plans with less than one 1.0 or 100%, right. So that means that they don't have enough, they

don't have enough cash to cover their claims liability, which is claims liability plus the incurred but not reported. Again, like I said, we look at other factors in there during an analysis.

All right. And then this, this slide here breaks down further the cash-to-claims ratio for full-service plans with less than 1.0 ratio for cash-to-claims or 100%. So, you can see that the enrollment categories, most of them are like smaller plans. So again, like I said, we watch them closely. We look at the Quarterly and Annual Claim Settlement Reports to see if there's any non-compliance with claims, any backlog issues. We coordinate with our provider solvency team -- our provider complaint team, which is located at the Help Center, to see if we are receiving any provider complaints for claims payments. So, like I said, there's a lot of detailed analysis happening when we see plans with lower ratios, lower financial metrics.

All right, that wraps up my presentation. I will take any questions. Paul.

MEMBER DURR: Yes. So, Pritika, thank you, nice overview. My question had to do with Astiva Health because they drop pretty precipitously when I look at your additional information. You know, their TNE that they had just prior to this quarter was 158% of what was required, and then 234%, and then all of a sudden, they dropped to 2%. I know they got the cash infusion, but are you concerned at all as to how long that cash will last? Would be my thought.

MS. DUTT: Well, I think there were some year-end adjustments that were made. So, we continue to work with Astiva. They are on monthly reporting, so they have undertakings as part of their license. This is a fairly new

plan, so they do have undertakings that they are required to meet to demonstrate that they are meeting certain levels of TNE. So again, we've had conversations with Astiva. Our team met with Astiva and highlighted, you know, the TNE requirement, reminded them of the undertakings. Again, we do have the monthly reporting that we are looking at. Like again, we are working with the plan closely.

MEMBER DURR: I appreciate that. I think 15,000 members does make them a little bit not big but, you know, good enough of substance to be a little bit more precarious from my perspective. So, thanks for your diligent review of them.

MEMBER WATANABE: Give us one minute, Bill, I'm going to take Jarrod's question really quick here. Go ahead, Jarrod.

MEMBER MCNAUGHTON: Yeah, Pritika, I was just curious if, in the analysis that you folks are doing on the -- on the membership, kind of what the membership is looking like over the next several months. Has there been any forecasting that the Department's looking at with that last PHE enrollment and eligibility piece that's ending on July 1, where we're seeing about an auto enrollment of about 60% right now on the Medi-Cal side, that that's going to drop down to about 30% so they're going to have to be manually worked on all of the Medi-Cal front. Any forecasts on what membership drop could look like in the state of California? Have you or do you know if DHCS, if you and DHCS have talked about that at all?

MEMBER WATANABE: Yeah, no, good question, Jarrod. I mean, I think because we don't, we're not a purchaser. We're not running programs. We aren't doing our own analysis. It's something I think I will be very curious to see. I will just say we're working closely with both Covered California and DHCS

to try to understand the potential impacts of a wide range of things, as you can imagine. So, while I think we are excited that we're over 30 million, anticipating that that likely will drop. I appreciate you raising the PHE, the last kind of wave of that, because I wasn't, I had forgotten about that piece as well. But thank you for flagging.

MEMBER MCNAUGHTON: You bet.

MEMBER WATANABE: Yeah. All right, Bill, go ahead.

MR. BARCELLONA: Just a quick question, Pritika, on that one restricted license in Medicare Advantage. Who are the parent plans, the subcontracting plans for that RKK?

MS. DUTT: Which particular plan?

MR. BARCELLONA: Meritage, sorry.

MS. DUTT: Meritage.

MR. BARCELLONA: Yeah.

MS. DUTT: There's several. I can provide -- the detailed information is available on our website. I can provide you the link.

MR. BARCELLONA: Okay.

MS. DUTT: But yeah, there's a few. So, they are only taking Medicare Advantage generally so they're restricted for Medicare Advantage. So, I think they're -- There's United, there may be Humana, Alignment, Health Net. So, they some like -- they don't have large enrollment, but they have several contracts.

MR. BARCELLONA: Is it -- I mean, 10,000 lives for a restricted is pretty low enrollment? Are they -- long-term does that really bode for financial solvency and sustainability for that?

MS. DUTT: You can say that for a majority of our restricted plans, like there's a lot of small ones that try to, they try to stay afloat, right? Because most of them are connected to an RBO where if they take global risk they need to come in and get a license. So again, we try to have undertakings in place to make sure -- and then we do detailed review of their back of funding. We ask a lot of questions. Chris could probably attest to that. We do ask a lot of questions. Require audited financials of the funders to make sure that, I mean, that is a risk, right? Smaller plans. These Medicare Advantage book of business is expensive to take care of, so these like things we look at to ensure that they are financially solvent just coming in.

MR. BARCELLONA: All right, thank you.

MEMBER WATANABE: All right, any more questions from our Board Members on this agenda item?

Okay, questions from anybody else in the room?

Seeing none, questions from anybody online?

All right, that wraps up our formal presentation. Now we have an opportunity for public comment on matters not on the agenda. Any comments from anybody in the room?

How about online? Anything that we didn't cover you want to raise?

Okay, seeing none. So, moving on to agenda items for future meetings, I will just say we plan on having a budget update. I will do my best to see if either DHCS or HCAI can come and do an update. We will have our financial summary of Medi-Cal Managed Care Plans Report, and Pritika and her team are going to see if we can get the MLR Report done. If we can't get it in time for the August 20 meeting, we will have it for the next one. Are there any

other agenda items or anything we didn't cover today that you'd like to have covered at the August meeting? Anything our Board Members would like to add?

We covered a lot of information today so hopefully this was helpful.

Okay. Well, I'm not seeing any pressing items you want for August so thank you again to everybody that joined today. Look forward to seeing you in August and have a great summer. Thank you all. Bye.

(The meeting was adjourned at 12:42 p.m.)

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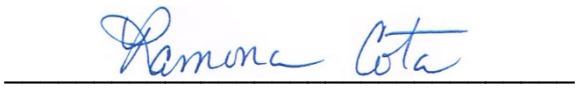
CERTIFICATE OF REPORTER

I, RAMONA COTA, an Electronic Reporter and Transcriber, do hereby certify:

That I am a disinterested person herein; that the foregoing Department of Managed Health Care, Financial Solvency Standards Board meeting was electronically reported by me, and I thereafter transcribed it.

I further certify that I am not counsel or attorney to any of the parties in this matter, or in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 17th day of June, 2025.



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