Financial Solvency Standards Board Meeting
June 15, 2016
Meeting Notes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Edward Cymerys, Collective Health
Dr. Larry de Ghetaldi, Sutter Health
Betsy Imholz, Consumers Union
Dave Meadows, Liberty Dental Plan
Dr. Jeff Rideout, Integrated Healthcare Association
Shelley Rouillard, Department of Managed Health Care
Dr. Rick Shinto, InnovaCare Health, Inc.

Department of Managed Health Care (DMHC) Staff Present:
Stephen Babich, Supervising Examiner, Office of Financial Review
Pritika Dutt, Supervising Examiner, Office of Financial Review
Gil Riojas, Deputy Director, Office of Financial Review
Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations
Michelle Yamanaka, Supervising Examiner, Office of Financial Review

1) Welcome & Introductions- Agenda

Director Shelley Rouillard called the meeting to order and welcomed the attendees. Ms. Rouillard announced that she would facilitate the meeting in the absence of the Board chair, Ann Pumpian. The Board members introduced themselves to the audience.

2) Minutes from March 16, 2016 FSSB Meeting

Ed Cymerys asked that the minutes reflect that he no longer works for Blue Shield of California and is now affiliated with Collective Health. Dr. Jeff Rideout made a motion to approve the March 16, 2016 minutes. Dave Meadows seconded the motion. Meeting minutes were approved with the change noted by Mr. Cymerys.

3) Director's Remarks

Ms. Rouillard announced several organizational changes to the DMHC executive team. Carol Ventura is now the Acting Deputy Director of the newly-created Office of Plan Monitoring. The Office of Plan Monitoring combines the Division of Provider Networks and the Division of Plan Surveys, and will afford the DMHC a greater focus on its monitoring efforts. As a result of this change, Drew Brereton is now the Acting Deputy Director for the Office of Enforcement.

In addition, Cassandra (Cassie) McTaggart is the Acting Deputy Director for the Help Center until a permanent Deputy Director is recruited. As a result, Teresa Gonzales is now the Acting Deputy Director for the Office of Administrative Services.

Ms. Rouillard stated the Department is seeking to contract with a consultant who will act as the DMHC's Chief Medical Officer (CMO). She explained the CMO will assist with Help Center issues, plan monitoring functions, and network adequacy. In addition, the CMO will act as an advisor to the Director on incorporating clinical quality improvement into its oversight functions.

Ms. Rouillard provided an update on health plan mergers. The DMHC approved the acquisition of Health Net by Centene on March 22, 2016. Since Centene is an out-of-state company buying a California company, there are undertakings that require key functions of Health Net to remain in California, such as enrollee grievance and appeal functions and clinical decision-making. In addition, there are undertakings related to plan performance, including:

- Improving quality scores on the Office of the Patient Advocate (OPA) report card
- Meeting the Department of Health Care Services (DHCS) requirements for clinical quality goals and milestones
- Improving performance on the Right Care Initiative indicators

Ms. Rouillard also mentioned several other undertakings related to the acquisition, including:

- Publish and maintain accurate provider directories
- $340 million in community investments over a five year period
- $50 million over five years to strengthen the Medi-Cal Health Care Delivery System
- $200 million to construct a service center, with an expected generation of 300 hundred new jobs
- $75 million infrastructure investment fund
- Establish an advisory committee to advise on expenditures

DMHC is still reviewing the proposed acquisition of Humana by Aetna and the proposed acquisition of Cigna by Anthem.

Ms. Rouillard provided an overview of the DMHC Timely Access Report for measurement year 2014, which was published in April 2016. The health plan data has improved and become more standardized. However, further improvement is expected for measurement year 2015 as the health plans are required to use a standardized

methodology. The report, data, and a consumer education fact sheet about rights to timely access can be found on the DMHC website.

Discussion

Dr. Rick Shinto asked whether the CMO will be an M.D. or consultant. Ms. Rouillard answered the CMO will be a contracted physician consultant not a civil service position. Dr. Shinto then asked why the DMHC pursued this route rather than hiring a full-time employee. Ms. Rouillard explained that, given the experience level expected of the CMO, the DMHC will more likely find a suitable candidate if it is able to offer a competitive salary. In addition, the CMO may be needed for approximately thirty hours per week, which would be more appropriate for a consultant.

Dr. Shinto suggesting having the CMO spend time performing data analysis. Ms. Rouillard stated the DMHC is establishing a Data Analytics Division within its Office of Technology and Innovation. The DMHC will be hiring a new Chief Information Officer and anticipates there will be overlap between the CMO and the Analytics team.

4) Office of the Patient Advocate Complaint Data Report

Elizabeth Abbott, Director of the OPA, presented an overview of the OPA Complaint Data Report, which was released in May 2016. The report focuses on consumer complaints and the underlying reasons for those complaints.

Ms. Abbott explained the OPA collects complaint data from four health agencies: DMHC, DHCS, California Department of Insurance (CDI), and Covered California (Covered CA). The data collected from these agencies represents complaints that are filed with the regulator, purchaser, or program overseer. For measurement year 2014, the OPA received data on 27,028 complaints from the four agencies. In addition, the four agencies reported the following requests for assistance:

- DMHC received 109,760
- DHCS received 1,375,772
- CDI received 36,986
- Covered CA received 4,424,070

Regarding the Covered CA data, Ms. Abbott explained 2014 was the baseline year for the Affordable Care Act (ACA) and Covered CA did not track complaints specifically about health plans for that year.

Ms. Abbott stated the top five complaint reasons were claim denial, quality of care, medical necessity denial, co-payment issues, and enrollment issues. The data indicates a significant percentage of complaints are decided in favor of the consumers. Ms. Abbott reviewed the average resolution times per complaint reason for each agency, the volume of DHCS Medi-Cal complaints by county, and the complaint ratios per health

plan regulated by each agency. Further analysis, including recommendations, summaries, and methodology are posted on the OPA website.

Ms. Abbott concluded by recognizing Dianne Ehrke, lead researcher at OPA, for her work on this project.

Discussion

Dr. Shinto asked if the data is reflective of only triaged inquiries or if it includes all inquiries received by Covered CA regardless of whether or not the inquiry was forwarded to another agency. Dr. Shinto expressed concern that the data might include double-counting. Ms. Abbott responded OPA made an effort to avoid double-counting in the report, but the data is not perfect. Some agencies may not have properly referred consumers in the beginning, but the tracking mechanisms are being refined.

Dr. Rideout asked if there are any benchmarks that can be used for comparison because a rate is easier to understand and compare than just the raw numbers. Ms. Abbott said she is not sure if any benchmarks can be extrapolated from the existing data, but made note of the suggestion for improvement of the report in the future.

Dr. Shinto said the information is beneficial and recommended the DMHC should look at this information along with the other reports on financial, clinical and quality data. Each one has a tipping point to consider. He added the report, in combination with other reports tells a story. Dr. Shinto also suggested blinding the data initially to look at all of the different reports. Ms. Abbott suggested the OPA report will be increasingly informative in future years.

Betsy Imholz said Consumers Union did a survey years ago that showed Californians didn't generally complain to any State agency about anything and don't normally complain about insurance issues. Approximately 85 percent of people didn't know where to go. She added it would be beneficial to align the definitions for the complaint categories to ensure comparable data in future years.

Anthony Wright, Executive Director, Health Access California, acknowledged the significance of the report and it highlights the importance and good work of the DMHC. It is a tool that more people should utilize in dealing with their health plan. Mr. Wright also suggested the DMHC consider a protocol for addressing a health plan with issues which span across the purview of multiple regulators. Ms. Rouillard responded the DMHC does coordinate with the other three agencies when issues arise.

5) Department of Health Care Services Update

Mari Cantwell, Chief Deputy Director, Health Care Programs and State Medicaid Director, DHCS, provided an update on the DHCS 1115 waiver. She explained that DHCS is moving forward with the implementation of all four major programs, as

discussed in the previous FSSB Meeting on March 16, 2016. Updates for the four components included:

1. Applications for the Whole Person Care Pilot Program are due on July 1, 2016. DHCS and Centers for Medicare and Medicaid Services (CMS) will review the applications and make final decisions regarding the program in fall 2016.
2. DHCS approved the applications for 53 public hospital systems to move forward for the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program.
3. DHCS is finalizing the qualifications for alternative payment methodologies related to the transformation of public hospital funding for the remaining uninsured. There is a requirement that, by 2018, 50 percent of the payments are in alternative payment methodologies. This will increase to 60 percent by the end of the waiver. Applications for the Dental Transformation Initiative are due on August 2016.

Ms. Cantwell stated CMS approved the Managed Care Organization (MCO) tax in May 2016. A modification to the tax structure pertaining to plan exemptions was necessary in order to obtain approval. CMS viewed the definition for non-profit plans as a Hold Harmless Agreement, since the definition failed to include a Medicaid plan. While DHCS disagrees with this interpretation, the modification was made to satisfy CMS and ensure an expeditious approval. The modification resulted in a reduction of the overall tax amount to the State by approximately $200 million over the next three years, with the total amount now $3.8 billion rather than $4 billion.

Ms. Cantwell also discussed the Medicaid Managed Care (MMC) rule that was officially published in May 2016. The rule is essentially a re-write of all of the regulations pertaining to MMC. DHCS is developing a work plan to engage stakeholders in the elements of the regulation. The requirements will take effect over the next five years, with many of the requirements starting with the next contract cycle on July 1, 2017.

She said California is ahead of the game on some of the requirements, such as network adequacy, because they are currently required for Knox Keene licensed plans or through contract for the County Organized Health Systems (COHS). There are certain requirements under the Managed Care regulations that the Knox Keene Act does not currently require. Separate standards will need to be developed for adults and pediatrics in several service categories, including primary care, specialty care, and behavioral health. DHCS will begin working on standards with stakeholder input by July 2018.

Other components of the regulation include:

- Development of a Medicaid quality star rating system
- Requirement for MMC plans to report a minimum 85 percent medical loss ratio (MLR) and utilization of MLR data to ensure that an 85 percent MLR is achievable

- Elimination or reduction of alternative methodologies to incorporate additional rates for certain providers into health plan rates
- Documentation regarding the data allowed for use by State actuaries in setting rates
- Adjustment of the grievance and appeals process

Discussion

Dr. Larry de Ghetaldi inquired if there is an effort to allow Medicaid beneficiaries to compare plans and quality ratings, given the effort in the Medicare program. Ms. Cantwell said there are different perspectives between the states and CMS, but the regulation is an attempt at standardization across states.

Ms. Abbott asked for further explanation regarding the CMS quality metrics and whether or not the OPA rating system will need to be adjusted to align with the CMS rating system. Ms. Cantwell speculated that CMS would likely align with Medicare, but they have several years to develop regulations. It will likely be sometime in 2019 before they issue guidance.

Ms. Rouillard congratulated DHCS on the 50th anniversary of Medi-Cal this year and mentioned the reception DHCS held to celebrate the impact Medi-Cal has had on the lives of its nearly 14 million enrollees.

Dr. de Ghetaldi mentioned the work of the Integrated Healthcare Association and the Healthcare Effectiveness Data and Information Set (HEDIS) data on their website, which compares the clinical quality across the Medicare Advantage system. He added it supports the goal of increasing visibility and encouraging the rest of the industry to perform at the level of Medicare Advantage.

Dr. Shinto commented on the quality rating system and the confusion that might result for consumers when comparing ratings with different metrics or systems. Dr. Rideout reiterated the challenges of aligning the measures, and added the purpose is to help the end-user make comparisons.

6) Financial Summary of Local Initiatives and County Organized Health Systems

Pritika Dutt, Supervising Examiner, Office of Financial Review, presented the Financial Summary of Medi-Cal Managed Care Plans as of March 2016. Ms. Dutt stated the report has been expanded to include the non-governmental Medi-Cal (NGM) plans, which are non-LI and COHS plans that report greater than 50 percent Medi-Cal enrollment.

Local Initiative (LI) Health Plans:

- From March 2015 to March 2016, enrollment increased by 600,000 lives, or 14 percent. Comparatively, between 2014 and 2015, enrollment increased by 35 percent.
- The premium revenue received by LIs was sufficient to cover the medical expenses.
- Almost all LIs reported positive net income in March 2016 and for the last five quarters. While the Health Plan of San Joaquin reported a net loss for the most recent quarter, their year-to-date net income was $8.3 million.
- All LIs reported over 200 percent of the required tangible net equity (TNE), with reported TNE ranging from 279 percent to 978 percent.
- The liquid TNE, or cash on hand, ranged from negative 2,321 percent to 230 percent.
- Two LIs, L.A. Care and Contra Costa, were deficient in their claims processing timeliness. This could be attributed to increased claim volume as a result of increased enrollment.

County Organized Health Systems (COHS):

- From March 2015 to March 2016, enrollment increased by 141,000 lives, or eight percent.
- Per-member per-month (PMPM) revenue surpassed PMPM expenses for all plans.
- Similar to the LIs, all COHS reported over 200 percent of required TNE, with TNE ranging from 617 percent to 1,424 percent.
- Liquid TNE ranged from 90 percent to 701 percent.

Non-Governmental Medi-Cal Plans:

- There are five non-governmental Medi-Cal plans that serve 31counties.
- From March 2015 to March 2016, enrollment increased by 430,000 lives, or 14 percent.
- Similar to LIs and COHS, the PMPM revenue for each NGM plan surpassed the PMPM expenses. All NGM plans reported positive net income for March 2016.
- All NGM plans reported over 200 percent of required TNE, with TNE ranging from 258 percent to 587 percent.
- Liquid TNE ranged from negative 241 percent to 125 percent.

Ms. Dutt concluded by stating the LIs, COHS, and NGMs continued to experience significant growth in 2015 and the trend continued in early 2016. While the LIs and COHS continue to report positive net income and healthy TNE reserves, the NGM plans reported higher net income but lower TNE reserves. One reason for the lower TNE reserves is the NGM plans pay out dividends to their parent companies.

Discussion

Mr. Meadows stated it appears the profits for this quarter decreased in comparison to 2015. Ms. Dutt said one possible reason is the decrease in the Medicaid Coverage Expansion (MCE) rates. The MCE rates dropped on July 1, 2015, which resulted in a decrease of net income for the plans.

Dr. Rideout asked if Health Net Community Solutions is reported on separately because it is a subsidiary. Ms. Dutt responded Health Net has two full service plans that have separate lines of business – Health Net of California and Health Net Community Solutions.

Dr. Shinto referred asked why the medical expenses for COHS were significantly lower than the other two types of plans. Gil Riojas, Deputy Director, Office of Financial Review, answered the table on page 20 compares all medical expenses, and mostly depends on enrollment. He said that the lower the enrollment, the fewer medical expenses will be incurred.

Dr. de Ghetaldi said providers are struggling financially caring for the Medi-Cal populations while the plans are experiencing increased rates of excess TNE. He said the plans might experience flattening or reversal of the TNE rates in 2016. He suggested asking health plans if these savings are being reinvested into the communities to care for their members. Mr. Meadows agreed that the percentages seem fairly high and the TNE calculations are probably based upon the revenue determination. Ms. Dutt responded this is the reason why the DMHC examines the liquid TNE, and all other ratios, not just TNE.

Ms. Imholz expressed concern related to San Francisco Health Plan's much higher TNE compared to the other LIs and asked if there was a reason it was so much higher. Ms. Dutt replied while San Francisco Health Plan's TNE was higher, their liquid TNE was significantly lower than the other LIs. This could be because the plan primarily has fixed assets, which cannot be easily converted to cash to pay claims.

Bill Barcelona stated CAPG retains experienced consultants in this area, who have flagged examples of rapid expansion of reserves for some public plans during the past year. He expressed concern that the capitation rates for the dual eligibles are being cut routinely over time, yet the reserves are being amassed.

Dr. Shinto asked Mr. Barcelona if CAPG has observed instability in the medical groups for Medicaid. Mr. Barcelona said they have not seen any failures of smaller groups,

which is possibly attributed to the success of Senate Bill (SB) 260 and the DMHC's monitoring of financial solvency.

7) Tangible Net Equity Discussion

Ms. Rouillard reminded the Board that the discussion about TNE is not a new topic and improvements have been observed since the implementation of the reports on LIs and COHS. She said the DMHC is not planning any regulation changes related to TNE at this time.

Mr. Riojas stated the TNE presentation was updated in response to the Board's request at the March 16 meeting to include TNE by enrollment and to list the names of the top five plans. He reviewed the definitions and provided an overview of the plans with the highest TNE per enrollee by category.

Mr. Riojas added his office is also beginning to review the quality data associated with the plans and the findings will be presented at a future meeting.

Discussion

Dr. Shinto said the TNE was much different several years ago. He anticipates the plans will recycle their justification for holding onto the earnings.

Mr. Cymerys added theTNE requirements went into effect over twenty years ago, and caution should be taken in concluding how much TNE is too much. The benchmark used for comparison should at least include comparison to measures used in other states. He encouraged the DMHC to begin benchmarking the plans against measures used outside of California such as risk-based capital (RBC).

Dr. Shinto said that the initial report of the TNE could be confusing for some provider groups, especially if data from California is being compared with other states.

Dr. Rideout asked Mr. Riojas about the variability in liquid TNE, to which Mr. Riojas replied that, while a difference in the makeup of assets is present, there is no requirement for liquid TNE.

Presentation: Local Health Plan Community Investments

Brianna Lierman Esq., Chief Executive Officer of Local Health Plans of California (LHPC), presented an overview of the local health plans, their community investment programs, and the impact of Medi-Cal rates.

Many of the local health plans were created by their communities over twenty years ago to serve the Medi-Cal program. There are 16 local health plans, which cover 36 counties and serve 7.2 million enrollees, or 70 percent of Medi-Cal Managed Care. Fifteen of the 16 plans are quasi-public entities governed by the Brown Act, including

nine LIs that serve two-plan model counties and compete against a commercial plan, and six COHS. There is one Geographic Managed Care (GMC) plan, Community Health Group in San Diego, which remains a non-profit.

Medi-Cal enrollment and rates are primary drivers of the financial health of local plans. The plans are paid a monthly capitated rate, consisting of individual PMPM amounts based on certain aid codes. The plans' rates are based on two years' prior actual utilization, with allowances for trend and other factors as developed by the State's actuary, Mercer.

Ms. Lierman referenced Ms. Cantwell's presentation regarding the anticipated changes in upcoming years, including new network adequacy and quality requirements, new Medicaid regulations, and possible adjustments to ACA rates.

Ms. Lierman stated the local plans make significant community investments, citing the following examples:

- L.A. Care established a Community Health Investment Fund, which has produced more than $150 million of community investments in the health safety net in Los Angeles County.
- Central California Alliance for Health launched several programs designed to help grow the infrastructure of their service area. The Central California Alliance for Health has awarded $10 million since last year to bring almost 90 new providers into their service area.
- Inland Empire Health Plan (IEHP), which covers 22,000 square miles, is investing in growing clinical space where members can go for services. IEHP created a $30 million provider capital fund to renovate, expand, and construct new medical facilities in their service area. Additionally, the plan has allocated $25 million for staffing and coaching at twenty-nine sites to fully integrate physical and behavioral health.
- The Health Plan of San Mateo, which is much smaller in size compared to L.A. Care and IEHP, has designated $49 million to focus on recruiting new physicians to the network, improving member access, and creating home visiting programs. One such program is the Community Care Settings Pilot, which has a goal of connecting more than 800 members with housing and care coordination services within five years.

Ms. Lierman stated that the local plans now have adequate TNE after several challenging years. For some plans, the minimum TNE amount is equivalent only to several days or weeks of expense, depending on how the providers are paid.

Discussion

Dr. Rideout asked Ms. Lierman about the investment profiles of San Francisco Health Plan and CalOptima, both of which were cited as having excess TNE. She said they

both have similar investment programs, but could not answer specifically as to the status.

Dr. de Ghetaldi stated he serves on the board of a COHS that has a very high TNE and a very generous community investment strategy. He has to explain to his providers why it is a valuable program and that they are being paid 100 percent of Medicare. He suggested explaining to physicians that changing from the Medi-Cal fee schedule to the Medicare fee schedule, provides an upside opportunity for clinical quality, member satisfaction, and access. This will likely get physicians on board and increase network participation. He reiterated that physicians understand the Medicare fee schedule and encouraged the local plans to get as close to Medicare rates as possible.

Dr. de Ghetaldi then asked if provider incentives for quality or community incentives for recruitment or housing for Medi-Cal patients is included in the 85 percent MLR calculation. Ms. Lierman replied the optional expansion population had an 85 percent MLR and the incentives had to be linked to actual care in order to be attributed to medical expenses. Housing grants are not reimbursable by Medicaid so it is not considered a medical expense unless it is provided in a medical context, such as recuperative care as opposed to rent subsidies. Traditionally, housing is paid from reserves.

Dr. Shinto asked if the local health plan industry has established a policy around TNE requirements for the plans. Ms. Lierman responded there are no set policies on reserves or TNE, other than the policy set in the law.

Dr. Shinto asked if the majority of providers are directly contracted or if they contract with delegated provider groups. Ms. Lierman answered it depends on the service area. In the rural areas there is less delegation to groups, while in urban areas there is more delegation.

Dr. Rideout said there is sensitivity regarding the nature of contracting and sub-delegation, because in Los Angeles, for example, the contracts are not just with delegated groups, but with other plans as well. Ms. Rouillard added that the issue of sub-delegation will be discussed further in a future FSSB meeting.

8) Dental Medical Loss Ratio Discussion

Mr. Meadows presented a briefing on key differences between medical and dental plan administration and the impact of applying dental loss ratio (DLR) standards to the dental plans.

There are 3.2 million enrollees in Dental Health Maintenance Organizations (DHMOs), and 14.8 million enrollees in Dental Preferred Provider Organizations (DPPOs). The premiums for DHMOs are no more than $12 dollars per month, while DPPO premiums generally are in the $40 to $50 range. Since dental coverage is optional, it is more common for lower-income individuals to not have dental coverage.

Dental coverage is divided into three classes of services: preventive/diagnostic, basic coverage, and major coverage. DPPOs usually include deductibles and coinsurance, while DHMOs do not. Additionally, DPPO providers are usually paid on a claim or fee-for-service (FFS) basis, while capitation is common in DHMO plans.

He added that there is a wide range of products and pricing, which are all crafted to meet the needs of the consumer. Some plans cover preventive services only, while other plans cover everything. Unlike mandated health plans, there are vast differences in plan design among dental plans.

While dental plan premiums are significantly lower than health plan premiums and products and plan designs vary, they have many of the same administrative and regulatory requirements and costs. This leads to inconsistency in the MLR across plans and makes it difficult for the dental plans to provide the same administrative functions as a health plan with only a fraction of the PMPM rates.

For example, a DHMO with a $13 premium and a 58 percent Dental Loss Ratio (DLR) will spend $5.46 on administration and $7.54 on claims. In comparison, a DPPO with a $57.62 premium and 65 percent DLR will spend $19.88 on administration and $37.74 on claims. In this example, the DHMO member gets a lot of value for their $13 monthly premium with basic services covered at 100 percent. The higher DLR of the DPPO does not translate into more dental care or better oral health. Low DLR plans can be more affordable to more people, while plans with a higher DLR can be less affordable.

Regarding actuarial value, he said that there are major coverage differences among dental plans and a single actuarial value calculator is not sufficient due to the variety of covered services.

Mr. Meadows stated dental premiums are too varied across products and market segments. Fixed administrative expenses don’t scale down with lower premium products. He also said that a DLR threshold threatens the most affordable dental products, leaving in place products least likely to be selected on a voluntary basis by those least likely to have dental coverage: individual and small group.

Discussion

Mr. Cymerys asked Mr. Meadows to clarify if he considers 6.7 million uninsured consumers to be too many, or if the 80 percent of consumers that have dental coverage is an appropriate number that could be jeopardized if the MLR rules are enacted. Mr. Meadows clarified that the results are based on the National Association of Dental Plans (NADP) survey and includes Medicaid. He added he believes the number of individuals without dental coverage is probably higher and is much higher than the number without medical coverage because dental coverage is not mandated.

Mr. Cymerys observed dentists in the DHMO products are accepting lower payment for the same services provided by DPPO dentists. He added the only way to get to 85 percent actuarial value would be if the dentist is willing to provide services at a very low cost or at a discount. He also commented on Mr. Meadows' example of increasing premiums to afford administrative costs, and said that if the actuarial value was increased to 85 percent, it would force plans to double what they are paying dentists. Mr. Meadows agreed that the contracts would need to be revised to pay more for the same services that are provided now.

Ms. Imholz acknowledged that dental is a different kind of product and the MLR that applies to medical may not fit. Generally, a higher MLR is better for consumers. Mr. Meadows responded at his plan he is responsible for millions of lives around the country, primarily in Medicaid and Medicare. Most of the business is subcontracted from the health plans and the government business is very interested in MLR. Many of the clients want to impose a MLR in their subcontracting relationships. He has numerous MLR agreements with plans, but no two are alike. There is no consistency and no simple solution.

9) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Examiner, Office of Financial Review, provided an update on the financial solvency of Risk-Bearing Organizations (RBOs) for the quarter ending March 31, 2016:

- 177 RBOs were required to file reports. Of these, eight RBOs reported non-compliance. Of the plans reporting compliance, five are on corrective action plans and seven are on the monitor closely list.
- 16 RBOs were on corrective action plans, including 10 that are meeting their projections, four new RBOs and two not meeting their corrective action plans. DMHC is in discussions with those two groups.
- As of June 14, 2016, six corrective action plans were closed because the RBO obtained compliance with all solvency criteria, reducing the number of outstanding RBOs on corrective action plans to ten.

Ms. Yamanaka said the corrective action plan process is a collaborative effort between the RBO, the contracting health plans, and the DMHC. However, when enrollment is sub-delegated, or the RBO passes risk to another RBO, the health plan is not involved. The regulations do not give much guidance for these situations. Ms. Yamanaka stated more information would be presented at the next FSSB meeting for the Board's input.

10) Health Plan Quarterly Update

Stephen Babich, Supervising Examiner, Office of Financial Review, presented the highlights of the health plan quarterly update for the quarter ending March 31, 2016:

- As of June 3, 2016, there are 73 Knox-Keene licensed full-service health plans. He also mentioned that a new restricted licensee in the Medicare Advantage market was licensed in May 2016.
- Enrollment in full-service plans is 25.73 million lives.
- For the first time, enrollment in Medi-Cal exceeded 10 million lives in Managed Care, with 10.31 million lives.
- There are 20 full-service plans being closely monitored, including three Medi-Cal plans.
- There were no TNE-deficient plans.

11) Public Comment on Matters Not on the Agenda

Ms. Rouillard asked for public comment on items not on the agenda. There was none.

12) Agenda Items for Future Meetings

Ms. Rouillard noted that the topic of sub-delegation will be added to the next meeting.

Dr. Shinto suggested a discussion regarding the variables related to TNE and quality.

Mr. Cymerys requested that the board consider discussing the impact of startup companies focused on particular populations.

Dr. de Ghetaldi requested a report card dashboard to compare the MLR, TNE, quality, and member satisfaction of the LIs and COHS. Ms. Rouillard responded that the DMHC is in progress of creating a health plan dashboard.

Ms. Imholz suggested a discussion regarding analysis of trends in the California health care marketplace compared to other states.

The next meeting will be held on September 14, 2016.

12) Closing Remarks/Next Steps

The meeting was adjourned at 12:56 p.m.