AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

MONDAY, MARCH 23, 2014

1:30 P.M. - STATE CAPITOL ROOM 127

ITEMS TO BE HEARD

ITEMS TO BE HEARD

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

ISSUE 1: DEPARTMENT OVERVIEW & BUDGET

PANELISTS

- **Robert P. David**, Director, OSHPD
- **Guadalupe Manriquez**, Finance Budget Analyst, DOF
- **Maricris Acon**, Principal Program Budget Analyst, DOF
- **Shawn Martin**, Managing Principal Analyst, LAO

The Office of Statewide Health Planning and Development (OSHPD) develops policies, plans and programs to meet current and future health needs of the people of California. Its programs provide health care quality and cost information, ensure safe health care facility construction, improve financing opportunities for health care facilities, and promote access to a culturally competent health care workforce.

Seismic Safety Update

One of OSHPD's responsibilities is to implement the state's hospital seismic safety requirements. The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 established a seismic safety building standards program under OSHPD's jurisdiction for hospitals built on or after March 7, 1973. Numerous pieces of legislation since then have amended the Alquist Act, increasing OSHPD's responsibilities and modifying seismic safety requirements and deadlines for hospitals.

Most recently, SB 90 (Steinberg), Chapter 19, Statutes of 2011, sought to respond to the fiscal challenges facing many hospitals, the resulting difficulty for them to meet the seismic deadline of 2013, and the possibility of hospital closures. SB 90 authorized OSHPD to grant hospitals an extension of up to seven years beyond the 2013 deadline if specific milestones and public safety conditions were met.

OSHPD states that 330 acute care hospital buildings remain in "Structural Performance Category 1," (the highest risk category, at risk of collapsing in an earthquake), out of an original inventory of 1,313 buildings. Hence, there has been a 75 percent reduction in the number of buildings in this highest-risk category. Put another way, given that some of these buildings have been demolished or otherwise removed from service, and new buildings built, 89 percent of the current inventory of acute care hospital buildings meet Structural Performance Category 2 standards or higher, meaning that, at a minimum, they are not at risk of collapse, though services may not be available in these (meaning the SPC-2) buildings.

Investment in Mental Health Wellness Update

A 2013 budget trailer bill, SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, established the Investment in Mental Health Wellness Act of 2013 which invests a total of $206.2 million in mental health wellness. Of this total amount, $2 million (Mental Health Services Act Fund - State Administration) was to provide training in the areas of crisis management, suicide prevention, recovery planning, and targeted case management and to facilitate employment of peer support classifications.

In April 2014, OSHPD awarded contracts to four organizations to support peer personnel by providing training in one or more of the following: crisis management; suicide prevention; recovery planning; targeted case management; and other related peer training and support functions to facilitate the deployment of peer personnel as an effective and necessary service to clients and family members and as triage and targeted case management personnel. The organizations awarded include:

Organization Contracted	**Contract Amount**	**Contract Term**
Contra Costa Behavioral Health	$436,386.00	4/9/2014 – 6/30/2016
Mental Health Association of San Francisco	$500,000.00	4/9/2014 – 6/30/2016
National Alliance on Mental Illness San Diego	$456,755.00	4/9/2014 – 6/30/2016
Recovery Opportunity Center	$500,000.00	4/9/2014 – 6/30/2016

OSHPD Budget

OSHPD's proposed 2015-16 budget is summarized in the table below. Overall expenditures are proposed to decrease by $35.1 million (19 percent), primarily reflecting a $30 million reduction in the Mental Health Services Fund (MHSF). This reduction is occurring because the majority of the funding was appropriated in the 2-13-14 and 2014-15 budgets, though it will be expended in equal amount over several years. Specifically, the 2014-15 MHSF budget of $55.9 million is comprised of $26.2 million ongoing and $29.7 million carryover from the prior year. Funds are available until the end of FY 2017-18 and will be used for the second five-year plan (2014-2019). $37.5 million is anticipated to be spent in 2014-15 and the remainder will be rolled over into the next budget cycle and used towards the second year of the five-year plan.

OSHPD Budget (Dollars in Thousands)					
Fund Source	**2013-14 Actual**	**2014-15 Projected**	**2015-16 Proposed**	**BY to CY $ Change**	**BY to CY % Change**
General Fund	$-	$75	$1	$(74)	(98.6)%
Hospital Building Fund	$47,510	$59,361	$59,984	$623	1.0%
Health Data & Planning Fund	$26,331	$36,937	$33,160	$(3,777)	(10.0)%
Registered Nurse Education Fund	$1,917	$2,202	$2,184	$(20)	(1.0)%
Health Facility Construction Loan Insurance Fund	$7,476	$4,955	$5,009	$54	1.1%
Health Professions Education Fund	$15,466	$10,801	$8,990	$(1,811)	(16.8)%
Federal Trust Fund	$1,288	$1,449	$1,440	$(9)	(0.6)%
Reimbursements	$7,468	$7,860	$7,861	$1	0.01%
Mental Health Practitioner Education Fund	$472	$548	$392	$(156)	(28.5)%
Vocational Nurse Education Fund	$184	$229	$230	$1	0.4%
Mental Health Services Fund	$23,457	$55,921	$25,954	$(29,967)	(53.6)%
Medically Underserved Account For Physicians, Health Professions Education Fund	$3,859	$2,303	$2,315	$12	0.5%
TOTAL EXPENDITURES	**$135,428**	**$182,641**	**$147,520**	**$(35,121)**	**(19.2)%**
Positions	451.0	482.6	483.6	1	0.2%

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to provide an overview of the department and its proposed budget, and to provide updates on seismic safety of hospitals and the Investment in Mental Health Wellness funding.

Staff Recommendation: No action is recommended at this time.

ISSUE 2: ELECTIVE PERCUTANEOUS CORONARY INTERVENTION (SB 906) BCP

PANELISTS

- **Ron Spingarn**, Deputy Director, Healthcare Information Division, OSHPD
- **Guadalupe Manriquez**, Finance Budget Analyst, DOF
- **Maricris Acon**, Principal Program Budget Analyst, DOF
- **Shawn Martin**, Managing Principal Analyst, LAO

OSHPD requests two permanent positions, one Research Scientist III and one Research Program Specialist I, and increased expenditure authority of $372,000 in 2015-16 and $319,000 ongoing from the California Health Data and Planning Fund for the implementation of SB 906 (Correa), Chapter 368, Statutes 2014. This bill establishes the Elective Percutaneous Coronary Intervention (PCI) Program and requires OSHPD to produce annual risk-adjusted public performance reports on participating hospital's PCI-related mortality, stroke, and emergency Coronary Artery Bypass Graft outcomes.

BACKGROUND

SB 891 (Correa), Chapter 295, Statutes 2008, established the Elective PCI Pilot Program in the California Department of Public Health (DPH) which authorized up to six eligible acute care California hospitals with licensed cardiac catheterization laboratory services but without onsite surgical backup to perform scheduled, elective PCIs. SB 357 (Correa), Chapter 202, Statutes 2013, extended the Elective PCI Pilot Program until January 1, 2015, and required the oversight committee to conduct its final report by November 30, 2013. The bill required DPH, within 90 days of receiving the final report from the oversight committee, to prepare and submit its report to the Legislature on the initial results of the Elective PCI Pilot Program.

The Elective PCI Pilot Program established an advisory oversight committee to oversee, monitor, and make recommendations to the DPH concerning the results of the pilot program and whether elective PCI without onsite cardiac surgery should be continued in California. Six hospitals – Los Alamitos Medical Center, Sutter Roseville Medical Center, Kaiser Walnut Creek Medical Center, Doctors Medical Center-San Pablo, Clovis Community Medical Center and St. Rose Hospital-Hayward – participated in the pilot program.

The *Advisory Oversight Committee Report to the California Department of Public Health* and the subsequent report, *The Elective Percutaneous Coronary Intervention (PCI) Pilot Program: Report to the Legislature*, showed that the morbidity and mortality results of procedures from the pilot hospitals during the program's duration were consistent with the morbidity and mortality results from hospitals not enrolled in the pilot program. Thus, there was no increased risk to patients in allowing elective PCIs to be performed at hospitals without onsite cardiac surgery.

SB 906 makes permanent the Elective Percutaneous Coronary Intervention Program as of January 1, 2015. This bill requires DPH and OSHPD to obtain and use data collected by the American College of Cardiology's National Cardiovascular Data Registry, a national cardiovascular registry, to adopt and validate risk-adjustment models and annually report each certified hospital's PCI performance outcomes with regards to patient mortality, stroke, and emergency coronary artery bypass graft surgery.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 3: SONG-BROWN HEALTH CARE WORKFORCE TRAINING PROGRAM UPDATE & ADVOCATES' PROPOSAL

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Healthcare Workforce Development Division, OSHPD
- **Guadalupe Manriquez**, Finance Budget Analyst, DOF
- **Maricris Acon**, Principal Program Budget Analyst, DOF
- **Shawn Martin**, Managing Principal Analyst, LAO

The 2014 budget included the following augmentations related to the Song-Brown Program:

1. ***Song-Brown Program – New Residency Slots***. Augmented OSHPD's budget by $4 million (California Health Data and Planning Fund) to fund new residency slots in the Song-Brown Health Care Workforce Training Program over the next three years. Adopted trailer bill language to specify criteria for this funding, including that priority shall be given to support new primary care physician slots and to physicians who have graduated from a California-based medical school. The Request for Assistance for this program was released on January 22, 2015 and the deadline to apply for this funding is March 30, 2015. OSHPD anticipates 13 programs will apply and 26 residents would be funded. The decisions on funding are projected to be made at the April 28-29, 2015 California Healthcare Workforce Policy Commission.

   Physician groups are requesting the Legislature and administration appropriate $8 million in increased California Health Data Planning Fund for new residency slots permanent and ongoing. This proposal is discussed in more detail below.

2. ***Song-Brown Program Residency Program***. Approved $2.84 million (California Health Data Planning Fund) per year for three years to expand the Song-Brown program. Adopted trailer bill language to expand the eligibility for Song-Brown residency program funding to teaching health centers and increased the number of primary care residents specializing in internal medicine, pediatrics, and obstetrics and gynecology. Approved one three-year limited-term position to develop and implement the program expansion. The Request for Assistance for this program was released on January 22, 2015 and the deadline to apply for this funding is March 30, 2015. OSHPD anticipates 25 programs will apply and 53 residents would be funded. The decisions on funding are projected to be made at the April 28-29, 2015 California Healthcare Workforce Policy Commission.

BACKGROUND

Song-Brown provides grants to support health professions training institutions that provide clinical training for Primary Care residents, Family Nurse Practitioners, Primary Care Physician Assistants, and Registered Nurse students. Residents and trainees are required to complete training in medically underserved areas, underserved communities, lower socio-economic neighborhoods, and/or rural communities (Health Professional Shortage Areas, Medically Underserved Areas, Medically Underserved Populations, Primary Care Shortage Areas, and Registered Nurse Shortage Areas).

According to OSHPD, Song-Brown funded programs have led practitioners to be at the forefront of curricula development and clinical care for many contemporary challenges facing California's healthcare system such as homeless, refugee, and immigrant health. Various studies indicate that residents exposed to underserved areas during clinical training are more likely to remain in those areas after completing their training.

Funding is provided to family practice residency programs via capitation funding. Each training program funded by Song-Brown must meet the accreditation standards set forth by their specific discipline. Song-Brown funds do not replace existing resources but are used to support and augment primary care training. Family practice residency programs are funded in increments of $51,615 per capitation cycle ($17,205 per year for three years). The funding level per capitation cycle has remained the same since the program's inception in 1974 and only covers a portion of a resident's training cost which has been estimated to exceed $150,000 per year.

The California Health Data Planning Fund is supported by annual assessments on California's hospitals and skilled nursing facilities. Health and Safety Code Section 127280(h) provides for a maximum assessment rate of .035 percent of a hospital or skilled nursing facilities annual gross operating expenses. The current assessment rate for hospitals and skilled nursing facilities is .027 percent and .025 percent, respectively. In 2008, the CHDPF made a $12 million loan to the General Fund which was repaid in 2014-15. The assessment fee could be raised within the existing statutory limit to provide additional on-going support for the program.

Advocates' Proposal

Advocates for physician groups propose that the budget include an ongoing increased appropriation of $8 million from the CHDPF for the Song Brown Program in order to provide ongoing support for existing residency slots as well as to create opportunities to expand and create new, additional slots in the future. Advocates note that other sources of funding will be decreasing as follows:

1. A 5-year Teaching Health Center Graduate Medical Education Grant Program, that has provided more than $16 million to California residency programs within THCs, expires this year (2015);

2. The federal Primary Care Residency Expansion program, which has awarded more than $18 million in grants to California for primary care residency programs is ending in 2015;

3. A 3-year $21 million grant from The California Endowment in support of Song Brown expires in 2016.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to provide an update on the implementation of the increased resources that were included in the 2014 Budget Act for Song Brown and to respond to the following:

1. What does OSHPD anticipate will happen to the new residency slots being created in three years, if more state resources are not made available.

2. Please describe how the CHDP assessment levels are established and how they could be changed in order to raise sufficient resources to fund new residency slots on an on-going basis.

3. Has an evaluation of the Song Brown program ever been done? If no, how does OSHPD know if the program is meeting its goals?

Staff Recommendation: Staff recommends holding this item open to allow for more time for discussion and analysis.

4150 DEPARTMENT OF MANAGED HEALTH CARE

ISSUE 1: DEPARTMENT OVERVIEW & BUDGET

PANELISTS

- **Shelley Rouillard**, Director, and **Marta Green**, Chief Deputy Director, DMHC
- **Guadalupe Manriquez**, Finance Budget Analyst, DOF
- **Maricris Acon**, Principal Program Budget Analyst, DOF
- **Felix Su**, Senior Fiscal & Policy Analyst , LAO

The mission of the Department of Managed Health Care (DMHC) is to regulate, and provide quality-of-care and fiscal oversight for health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

The department achieves this mission by:

- Administering and enforcing the body of statutes collectively known as the Knox-Keene Health Care Service Plan Act of 1975, as amended.
- Operating the 24-hour-a-day Help Center to resolve consumer complaints and problems.
- Licensing and overseeing all HMOs and some PPOs in the state. Overall, the DMHC regulates approximately 90 percent of the commercial health care marketplace in California, including oversight of enrollees in Medi-Cal managed care health plans.
- Conducting medical surveys and financial examinations to ensure health care service plans are complying with the laws and are financially solvent to serve their enrollees.
- Convening the Financial Solvency Standards Board, comprised of people with expertise in the medical, financial, and health plan industries. The board advises DMHC on ways to keep the managed care industry financially healthy and available for the millions of Californians who are currently enrolled in these types of health plans.

DMHC Budget

The DMHC receives no General Fund and is supported primarily by an annual assessment on each HMO. The annual assessment is based on the department's budget expenditure authority plus a reserve rate of 5 percent. The assessment amount is prorated at 65 percent and 35 percent to full-service and specialized plans respectively. The amount per plan is based on its reported enrollment as of March 31st of each year. The Knox-Keene Act requires each licensed plan to reimburse the department for all its costs and expenses. As summarized in the table below, the Governor's 2015-16 Budget proposes a modest increase of $2.5 million (3.9%) in the Department's overall budget. The decrease and elimination of federal funds is due to the fact that these funds were available in the form of short-term grants under the

Affordable Care Act to set up a premium rate review program and a consumer assistance program.

DEPARTMENT OF MANAGED HEALTH CARE
(Dollars In Thousands)

Fund Source	2013-14 Actual	2014-15 Projected	2015-16 Proposed	BY to CY Change	% Change
Federal Trust Fund	$1,584	$518	$0	$(518)	100%
Managed Care Fund	$38,388	$61,984	$65,551	$3,567	5.8%
Reimbursements	$2,999	$3,157	$2,640	$(517)	(0.2)%
Total Expenditures	**$42,971**	**$65,659**	**$68,191**	**$2,532**	**3.9%**
Positions	299.8	394.8	417.0	22.2	5.6%

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to provide an overview of the department and its proposed budget and provide updates on the Alameda Alliance Conservatorship and the recent Kaiser enforcement actions.

Staff Recommendation: No action is recommended at this point in time.

ISSUE 2: FEDERAL MENTAL HEALTH PARITY BCP

PANELISTS

- **Shelley Rouillard**, Director, and **Marta Green**, Chief Deputy Director, DMHC
- **Guadalupe Manriquez**, Finance Budget Analyst, DOF
- **Maricris Acon**, Principal Program Budget Analyst, DOF
- **Shawn Martin**, Managing Principal Analyst, LAO

DMHC requests 11.0 positions (5.5 permanent and 5.5 two-year limited term) to address workload associated with conducting medical surveys of the 45 health plans affected by the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). In addition, two positions are requested starting in 2016-17, providing 7.5 permanent positions ongoing.

The requested positions and proposed activities are as follows:

1. **Help Center – Division of Plan Surveys -** 11.0 positions (5.5 permanent, 5.5 two-year limited term), effective July 1, 2015.
   - Attorney III (1.5 permanent, 1.5 two-year limited term)
   - Staff Health Care Service Plan Analyst (permanent)
   - 6.0 Assistant Health Care Service Plan Analyst (2.0 permanent, 4.0 two-year limited term)
   - Office Technician (permanent)

Beginning January 1, 2016, the Help Center's Division of Plan Surveys (DPS) will conduct focused medical surveys of the 45 health plans required to comply with the MHPAEA, scheduled to be completed by December 31, 2016. According to DMHC, due to the complexity of the MHPAEA and its requirements and the large number of focused surveys to be conducted in twelve months, it is imperative that DPS has sufficient resources to efficiently plan and prepare to ensure that all 45 focused surveys are conducted and completed in 2016. Beginning July 1, 2015, DPS will begin the pre-survey planning necessary, including training new staff; drafting focused survey procedures and required documentation; researching outstanding legal, compliance, and regulatory issues; and, reviewing and analyzing health plan filings regarding their methodologies for complying with the MHPAEA.

Once the focused MHPAEA surveys are completed by December 31, 2016, the DPS will be responsible for completing the post-survey workload, including reviewing all final reports and identifying uncorrected deficiencies that warrant referral to the Office of Enforcement (Enforcement); comparing and analyzing all final reports to identify trends or systemic issues that may exist across multiple health plans; and, conducting analysis to identify serious deficiencies for potential non-routine or expedited follow up surveys. All post-survey workload will be completed by June 30, 2017. In addition to the focused surveys and in support of the sustained compliance oversight of the 45 health plans, beginning in 2017-18, the DPS will perform a special and specific review of mental

health benefits during each health plan's existing schedule of triennial routine medical surveys, which equates to 15 surveys per fiscal year. These surveys will continue to require the use of highly specialized medical, psychological, medical risk management and other clinical experts that will require the use of consulting services. Results will be reported in the final report for each routine survey.

2. **Office of Enforcement -** Two positions (permanent), effective July 1, 2016.
- Attorney III (permanent)
- Senior Legal Analyst (permanent)

Enforcement expects a total of six MHPAEA compliance case referrals annually beginning in 2016-17 and ongoing, three from DPS and three from the Help Center's Division of Legal Affairs, with the DPS referrals being the most time consuming. According to DMHC, the MHPAEA compliance cases will be more complex than typical case referrals and the DMHC anticipates that enforcement of MHPAEA compliance cases will be more aggressive. MHPAEA legal issues are new and unique to the DMHC and the managed care industry and are expected to involve challenging legal matters including federal pre-emption issues.

3. **Clinical Consulting** - This request also includes $1.86 million for 2015-16; $2.22 million for 2016-17; and $166,000 for 2017-18 and ongoing for clinical consulting services for the medical health plan surveys and for expert witness and deposition costs for enforcement trials.

DMHC currently contracts for the specialized medical and mental health expertise that is required and not available through the civil service system. These consultants support the DPS in evaluating the specific elements related to the requirements of the MHPAEA. Conducting effective MHPAEA focused medical surveys will require the use of highly specialized medical, psychological, medical risk management and other clinical experts that are not available through the civil service system.

BACKGROUND

In 2008, Congress enacted the MHPAEA, requiring only large group health plans that offer mental health benefits do so in a manner comparable to medical and surgical (medical) benefits. After the enactment of the Affordable Care Act (ACA) in 2010, federal regulations and state statute implementing Essential Health Benefits (EHB) made the MHPAEA also applicable to individual and small group health care and health insurance products. As of July 1, 2014, the rules apply for all group products as employers renew or purchase coverage. For individual products, the rules apply to the new policy years beginning January 1, 2015.

Assessing compliance of health plans with the rules requires an analysis that is significantly different from the analysis the DMHC currently conducts to enforce state mental health parity requirements. The DMHC presently reviews health plans' Evidences of Coverage (EOC) for compliance with state law, generally focusing on whether analogous benefits for specific severe mental illnesses and serious emotional

disturbances in children are subject to the same cost-sharing and utilization-management requirements as medical conditions.

In contrast, these rules require analysis of broader benefit classifications. Rather than a comparison of the applicable terms and conditions, the rules require extensive review of the health plans' processes and justifications for classifying benefits into six permissible classifications:

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network
4. Outpatient, Out-of-Network
5. Emergency Care
6. Prescription Drugs

After classifying all benefits into the six categories, health plans must then determine parity for financial requirements (e.g., deductibles, copays, co-insurance); quantitative treatment limitations (QTL) (e.g., number of visits, days of treatment) and non-quantitative treatment limitations. According to DMHC, the analyses of the health plans' methodology for determining compliance requires extensive reviews that are beyond the DMHC's existing capacity and expertise. Moreover, the analyses required under the rules are data-intensive and require information the health plans do not routinely file with DMHC (e.g., methodologies to determine benefit classifications, projected plan payments, and rationale for application of NQTL). As such, implementation and enforcement of health plan compliance with the MHPAEA require the DMHC to undertake both an initial focused analysis and continuing evaluation of a new depth and breadth due to the complexities of this law and the inter-relationship with existing California mental health parity laws and EHB requirements.

2014 Budget Resources for Federal Mental Health Parity

The 2014 budget included a one-time augmentation of $369,000 (Managed Care Fund) in 2014-15 for clinical consulting services to conduct initial front-end compliance reviews to ensure oversight of California's implementation of the MHPAEA and five positions to enforce these requirements. (The Legislature augmented DMHC's budget by $4.2 million to add ten positions and consulting services to ensure enforcement of these requirements and the Governor vetoed five of the positions added by the Legislature, resulting in a net augmentation of five positions.)

Findings from DMHC's Initial Front-End Reviews

According to DMHC, it is still early in DMHC's review of the federal mental health parity compliance filings. Each plan is in a different point in the process, so it is not yet possible to make industry-wide assessments of compliance. DMHC has encountered a variety of compliance issues during all stages of the review process, some minor, some significant and/or complex. As an example, there are plans that need to adjust cost-sharing for specific services or refine language in their evidences of coverage to ensure consistency with the law. Further, some plans are still working to submit a complete compliance filing due to the complexity of the requirements. As the review team

encounters compliance issues, DMHC's licensing counsel works with the plans to develop corrective actions to bring them into compliance.

As DMHC began developing the specific reporting criteria for the compliance project, DMHC determined that 26 full-service health plans would be required to submit filings. Specialized behavioral health plans under contract with full service health plans are required to include their filing information with the full service plans. While the total number of plans submitting filings is lower than DMHC originally anticipated, the complexity and length of each plan's filings is significantly higher. Each plan was required to submit complete information for 15 separate products (to the extent they offer products in each market segment).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 3: INDIVIDUAL MARKET REFORMS BCP

PANELISTS

- **Shelley Rouillard**, Director, and **Marta Green**, Chief Deputy Director, DMHC
- **Guadalupe Manriquez**, Finance Budget Analyst, DOF
- **Maricris Acon**, Principal Program Budget Analyst, DOF
- **Felix Su**, Senior Fiscal & Policy Analyst , LAO

DMHC requests seven permanent positions and $1,134,000 for 2015-16 and $1,070,000 for 2016-17 and ongoing to address the increased workload resulting from the revised projected increase in enrollment in the individual market pursuant to SB 2 X1 (Hernandez), Chapter 2, Statutes of 2013-14 of the First Extraordinary Session. This request includes $208,000 for 2015-16 and ongoing for expert witness and deposition costs for enforcement trials.

The requested positions are:	**Number of Positions**
Program/Classification	
Help Center	
Attorney I	1.0
Nurse Evaluator II	0.5
Associate Governmental Program Analyst	1.0
Consumer Assistance Technician	1.0
Office of Enforcement	
Attorney III	1.0
Legal Secretary	0.5
Office of Administrative Services	
Associate Governmental Program Analyst	1.0
Office of Technology and Innovation	
Associate Information Systems Analyst	1.0
Total Positions	**7.0**

BACKGROUND

DMHC is a health care consumer protection organization that helps California consumers resolve problems with their health plans and works to provide a stable and financially solvent managed care system. DMHC regulates health care service plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended.

Existing federal law, the Affordable Care Act (ACA), enacts major health care coverage market reforms that took effect January 1, 2014. With the passage of SB 2 X1, California law now conforms to the ACA requirement that beginning January 1, 2014

health plans that offer health coverage in the individual market accept every individual that applies for that coverage.

As a result, DMHC is now responsible for providing consumer assistance and regulatory oversight to millions of enrollees and new health plans and products offered through Covered California.

In the 2014 budget, DMHC received 13.5 positions effective July 1, 2014, with an additional 5.5 positions effective July 1, 2015, for a total of 19.0 permanent positions for the workload associated with SB 2 X1. As part of the 2014 budget request, DMHC estimated that 90 percent of all new enrollees in individual market plans would be under the jurisdiction of the DMHC with the other ten percent under the jurisdiction of the California Department of Insurance (CDI). However, in the past year it has been realized that the DMHC has jurisdiction over approximately 98 percent of the enrollees in Covered California individual market plans, with only two percent under the jurisdiction of the CDI. Because of this percentage increase, along with the revised enrollment projections of 1.9 million individuals enrolled in health plans—licensed by DMHC—in the individual market (compared to 1.7 million estimated in May), DMHC requests additional resources.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 4: LARGE GROUP CLAIMS DATA BCP

PANELISTS

- **Shelley Rouillard**, Director, and **Marta Green**, Chief Deputy Director, DMHC
- **Guadalupe Manriquez**, Finance Budget Analyst, DOF
- **Maricris Acon**, Principal Program Budget Analyst, DOF
- **Felix Su**, Senior Fiscal & Policy Analyst , LAO

DMHC requests one permanent position (a senior legal analyst), effective January 1, 2016, and $85,000 for 2015-16 and $148,000 for 2016-17 and ongoing to address the increased workload resulting from the implementation of SB 1182 (Leno), Chapter 577, Statutes of 2014, regarding large group claims data exposure. This request also includes $23,000 for 2015-16 and $45,000 for 2016-17 and ongoing for clinical consulting services to provide methodology and statistical sampling of the claims data provided.

BACKGROUND

SB 1182 requires a health care services plan or health insurer to annually provide de-identified claims data at no charge to a large group purchaser that requests the information and meets specified conditions. Most health plans already provide some large group purchasers with some level of de-identified claims data about their employee populations. Ensuring that all health plans and insurers are subject to the same disclosure standards promotes a level playing field, enables purchasers to better negotiate rates, and also assist efforts to improve the health of employees in large groups through disease management programs and other mechanisms aimed at improving the health of a large group membership.

The Office of Enforcement expects to see complaints from large group employers regarding a health plan's failure to provide de-identified claims data or failure to provide complete data. As purchasers receive and analyze this information it is expected that disagreements between large group plans and large group purchasers will arise over whether the health plan has satisfactorily provided required information. It is also expected that disagreements will arise between consumer advocacy groups and health plans as to whether the information is sufficiently de-identified so that an employer group cannot identify an employee based off of the claims data provided.

The requested positions would sort, organize, review, and summarize the documents submitted by a health plan and large group purchaser, as well as the documents provided in response to the DMHC's discovery requests. This position would also identify the issues presented and provide a written evaluation to an attorney as to whether a health plan met statutory and regulatory standards regarding provision of de-identified claims data. This evaluation will be necessary for each referral and will require a comparison between established standards and submitted documents as well as identification of deficiencies.

In addition, the requested funding for clinical consulting services would be used to provide methodology and statistical sampling of the claims data provided. The consultant will also be responsible for advising the Office of Enforcement on the sufficiency of the claims data provided and for establishing baselines of what constitutes a sufficient submission of information by a large group plan.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 5: DENTAL PLANS MEDICAL LOSS RATIO BCP

PANELISTS

- **Shelley Rouillard**, Director, and **Marta Green**, Chief Deputy Director, DMHC
- **Guadalupe Manriquez**, Finance Budget Analyst, DOF
- **Maricris Acon**, Principal Program Budget Analyst, DOF
- **Felix Su**, Senior Fiscal & Policy Analyst , LAO

DMHC requests 1.5 permanent positions and $189,000 for 2015-16 and $173,000 for 2016-17 and ongoing to address the increased workload resulting from the implementation of AB 1962 (Skinner), Chapter 567, Statutes of 2014, regarding dental plan medical loss ratios (MLR).

BACKGROUND

AB 1962 requires health plans that issue, sell, renew, or offer specialized dental plan contracts to file a report with DMHC that contains the same information required in the federal MLR Annual Reporting Form. This report is due to DMHC on an annual basis beginning no later than September 30, 2015. The bill declares the intent of the Legislature that the data reported pursuant to these provisions be considered in adopting an MLR standard that would take effect no later than January 1, 2018. AB 1962 requires DMHC to make available to the public the MLR data received, and allows DMHC to issue guidance outside the Administrative Procedures Act. Identical provisions apply to health insurers regulated by the California Department of Insurance.

DMHC reviews all health plan filings related to health coverage, including health plan subscriber contracts and evidence of coverage documents, resolves inquiries and complaints from enrollees with health coverage, conducts financial oversight, and takes enforcement action when health plans fail to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended. In addition, the DMHC oversees dental care products both inside and outside California's Health Benefit Exchange (Exchange), Covered California.

DMHC regulates health plans, including specialized health plans such as dental plans, under the KKA. While the KKA historically did not include an MLR requirement for any health plans, Public Health Service Act (PHSA) Section 2718, added by the Affordable Care Act (ACA), requires that individual and small group plans provide an annual rebate to each enrollee if the percent of premium spent on claims and quality improvement activities is less than 80 percent (unless a state determines a higher percentage) of the plan's MLR. AB 51 (Chapter 644, Statutes of 2011) incorporated this requirement into the KKA. However, the ACA's MLR provision does not apply to stand-alone dental plans, which are "excepted benefits" under PHSA Section 2791 (c)(2)(A), and the KKA similarly exempts dental plans from the ACA's MLR requirement.

Existing state law requires a health care service plan or health insurer to comply with specified MLR requirements and requires a plan or insurer to provide an annual rebate to enrollees and insureds if the ratio of the amount of premium revenue expended by the plan or insurer on specified costs to the total amount of premium revenue is less than a certain percentage. Existing law specifies that these requirements do not apply to specialized health care service plan contracts or specialized health insurance policies, such as dental plans.

For 2014, inside the Exchange, five dental plans offered stand-alone dental products in the individual market: Anthem Blue Cross, Blue Shield of California, Delta Dental, Liberty Dental, and Premier Access. Nine plans offered stand-alone dental products in the small group market: Access Dental, Blue Shield of California, Delta Dental, Guardian, Liberty Dental, Managed Dental, MetLife, Premier Access, and SafeGuard. For 2015, Covered California anticipates offering a wider range of dental care products that are overseen by the DMHC: (1) stand-alone dental plans covering pediatric oral care and family dental plans (covering both pediatric and adult oral care), and Qualified Health Plans (QHPs) that offer 10 Essential Health Benefits (EHBs) inside the Exchange, (2) stand-alone dental plans covering pediatric oral care and family dental plans (covering both pediatric and adult oral care) that are bundled with a QHP that offers ten EHBs, and (3) QHPs with pediatric dental benefits embedded.

The Department of Health Care Services (DHCS) requires a 70 percent MLR for all Medi-Cal Dental Managed Care plans. DHCS currently contracts with three Dental Managed Care plans (Access Dental Plan, Health Net of California, Inc., and Liberty Dental Plan of California, Inc.) and DMHC conducts MLR reviews of these plans on behalf of DHCS. DMHC also conducts MLR reviews of all full-service medical plans, pursuant to Health and Safety Code section 1367.003 and its attendant regulation, California Code of Regulations, Title 28, Rule 1300.67.003.

The requested positions would be used to (1) acquire permission to use the federal MLR reporting form and then implement an MLR reporting form, (2) determine whether the DMHC should adopt federal MLR standards and definitions, or use the KKA's MLR standards and definitions for the new dental MLR annual reports, (3) develop a new examination program and training procedures for dental plan MLR examinations, (4) perform three additional examinations each year to assure the accuracy of the financial reporting, (5) review of 18 additional MLR reports on an annual basis, and (6) potentially assess MLR for dental products embedded in full service plans. DMHC indicates that it is unable to absorb this new workload.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DMHC to present this proposal.

Staff Recommendation: Staff recommends holding this item open.