Financial Summary of Medi-Cal Managed Care Health Plans

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I. Overview

Medi-Cal, California's Medicaid program, has experienced significantly increased enrollment in the last three years due to the transition of children from the Healthy Families Program (HFP) to Medi-Cal and the expansion of Medi-Cal eligibility to low-income individuals under the Patient Protection and Affordable Care Act (ACA).

There are two main Medi-Cal systems administered by the Department of Health Care Services (DHCS) for the delivery of medical services to Medi-Cal beneficiaries: fee-for-service Medi-Cal and Medi-Cal managed care (MCMC). Over two-thirds of Medi-Cal beneficiaries are enrolled in a MCMC plan. Approximately 10.3 million Medi-Cal beneficiaries in all 58 California counties receive their health care through six main models of managed care: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model, Imperial, and San Benito. Locally-sponsored plans known as Local Initiatives (LIs) participate as MCMC plans under the Two-Plan Model, while County Organized Health Systems plans serve Medi-Cal enrollees under the COHS Model.[1] Both LI and COHS plans are local agencies established by county boards of supervisors to contract with the Medi-Cal program. Approximately 6.7 million Medi-Cal beneficiaries are enrolled in LI and COHS plans under the Two-Plan and COHS Models. In GMC counties, Sacramento and San Diego, DHCS contracts with several commercial plans to serve approximately 1.1 million Medi-Cal beneficiaries. There are about 400,000 Medi-Cal beneficiaries served under the Regional, Imperial and San Benito model.

This report details the significant increases in the fiscal year 2015/2016 enrollment for LIs and COHS and demonstrates how Medi-Cal revenue and expenses are affecting these plans' profitability and tangible net equity (TNE). The report includes enrollment and financial information reported by LI and COHS plans as of the quarter ending March 31, 2016. Because LI and COHS plans serve primarily Medi-Cal enrollees, Medi-Cal enrollment increases and the rates provided by DHCS are driving factors for the financial performance of these plans.[2] This quarters report also includes enrollment and financial results for Non-Governmental Medi-Cal (NGM) plans. The NGM plans are categorized as any non LI or COHS plan that reports greater than 50 percent Medi-Cal enrollment. For March 2016, NGM plans reported 3.3 Medi-Cal enrollees.

[1] Counties with the two-plan model offer both a LI and a commercial Medi-Cal managed care plan. In counties using the COHS model, the COHS is the only Medi-Cal managed care plan available.

[2] Additionally, medical expenses for these plans increased due to legislation that expanded outpatient mental health benefits available to beneficiaries with mild to moderate impairment of mental, emotional or behavioral functioning resulting from any mental health condition defined by the DSM-IV, and clarified that the Early and Periodic Screening, Diagnostic and Treatment benefit includes the provision of Behavioral Health Treatment to all Medi-Cal children and adolescent beneficiaries 0 to 21 years of age that are diagnosed with Autism Spectrum Disorder.

II. Summary of Findings

Key findings from this report include:

- The financial information for LI and COHS plans were compared to Non-Governmental Medi-Cal (NGM) plans. For the purposes of this report, NGM plans include for-profit and not-for-profit plans with greater than 50% Medi-Cal enrollment. Enrollment information for Blue Cross of California and Kaiser Foundation Health Plan was also included even though they didn't meet the definition of an NGM because of the large number of Medi-Cal enrollees they reported.

- LI and COHS plans continued to experience significant growth in 2015. However, the rate of increase for fiscal year 2015/2016 is lower compared to fiscal year 2014/2015, in large part because most of the transition from fee-for-service to managed care occurred in 2014/2015. NGM plans experienced similar trends.

- All LI and COHS plans reported enrollment increases of at least 7% from March 2015 to March 2016. This is a moderate increase compared to 2014 when enrollment increased by at least 35%. NGM plans reported enrollment increases of at least 8% or more from March 2015 to March 2016.

- Increased enrollment contributed to increased medical expenses for LI, COHS and NGM plans.

- Per Member Per Month (PMPM) premium revenue exceeded PMPM medical expense for every LI, COHS and NGM plan for March 2016.

- The LI plans reported higher net income than COHS, and COHS reported higher TNE reserves than LIs. However, both the LI and COHS plans continue to report positive net income and healthy TNE reserves. In comparison, NGM plans reported higher net income with lower TNE reserves. This is in part due to a majority of the NGM plans paying dividends to parent companies/shareholders thereby reducing the reserve levels. In comparison, LI and COHS plans may need to hold on to higher reserves to alleviate any potential capital expenditure needs or future economic downturn.

III. Local Initiative Health Plans (LI)

A. Highlights

- At present, 14 counties participate in the Two-Plan model of Medi-Cal managed care. In 13 of these counties, the DHCS contracts with both an LI plan and a commercial plan; in Tulare County, the DHCS contracts with two commercial plans: Anthem Blue Cross and Health Net. The LIs must be licensed under the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act) for their Medi-Cal lines of business.

- Beneficiaries in the Two-Plan Model have a choice between the two plans, and those beneficiaries who do not make a selection are automatically assigned to a plan. The DHCS uses an algorithm based on quality and use of safety net providers to make the assignments. Overall, there are nearly three times as many Medi-Cal beneficiaries enrolled in LI plans as in commercial plans in Two-Plan Model counties.[3]

- Medi-Cal providers who wish to provide services to managed care enrollees must participate in the managed care plan's provider network.

- The LIs and the counties in which they provide services are as follows:
  - Alameda Alliance For Health ("Alameda Alliance") – Alameda
  - Contra Costa County Medical Services ("Contra Costa") – Contra Costa
  - Fresno-Kings-Madera Regional Health Authority ("Fresno-Kings-Madera") – Fresno, Kings, and Madera
  - Health Plan of San Joaquin ("San Joaquin") – San Joaquin and Stanislaus
  - Inland Empire Health Plan ("Inland Empire") – Riverside and San Bernardino
  - Kern Health Systems ("Kern") - Kern
  - Local Initiative Health Authority for L.A County ("L.A. Care") – Los Angeles
  - San Francisco Community Health Authority ("San Francisco") – San Francisco
  - Santa Clara County Health Authority ("Santa Clara County") – Santa Clara

[3] http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MonitoringPerformanceLocalVersusCommericalMediCalPlans.pdf

- LI plans reported combined enrollment of 4.92 million individuals as of March 31, 2016. Over 4.77 million (97%) of the total LI enrollment were Medi-Cal beneficiaries. The remaining 3% of non-Medi-Cal LI enrollment included other lines of business such as In-Home Supportive Services (IHSS), Healthy Kids or the Access for Infants and Mothers Program (AIM).

- Total LI plan enrollment increased by 14% from March 2015 to March 2016.

- Per member per month medical expenses and premium revenue stabilized at March 2016 as a result of Medi-Cal Coverage Expansion (MCE) rate adjustments for the 2014/2015 fiscal year. LI plans PMPM premium revenue outpaced expenses for March 2016.

- LI plans reported $91 million in net income in March 2016, which was significantly lower than the $211 million net income reported in March 2015, a decrease of 57%.

- The LIs reported TNE that ranged from 279% to 978% of required TNE.

- The LIs reported $1.3 billion in cash flow from operations, which was about 30% higher than the $1 billion reported in March 2015.

B. Enrollment Trends - LI

The LI plans serve 4.9 million enrollees in 13 counties in California. The table below lists LI total enrollment and the percentage of total LI enrollment accounted for by Medi-Cal lives. The table also shows the increase in enrollment from March 2015 to March 2016. All LIs reported an increase in total enrollment of 8% or more. L.A. Care reported the largest increase in enrollment with the addition of over 300,000 members.

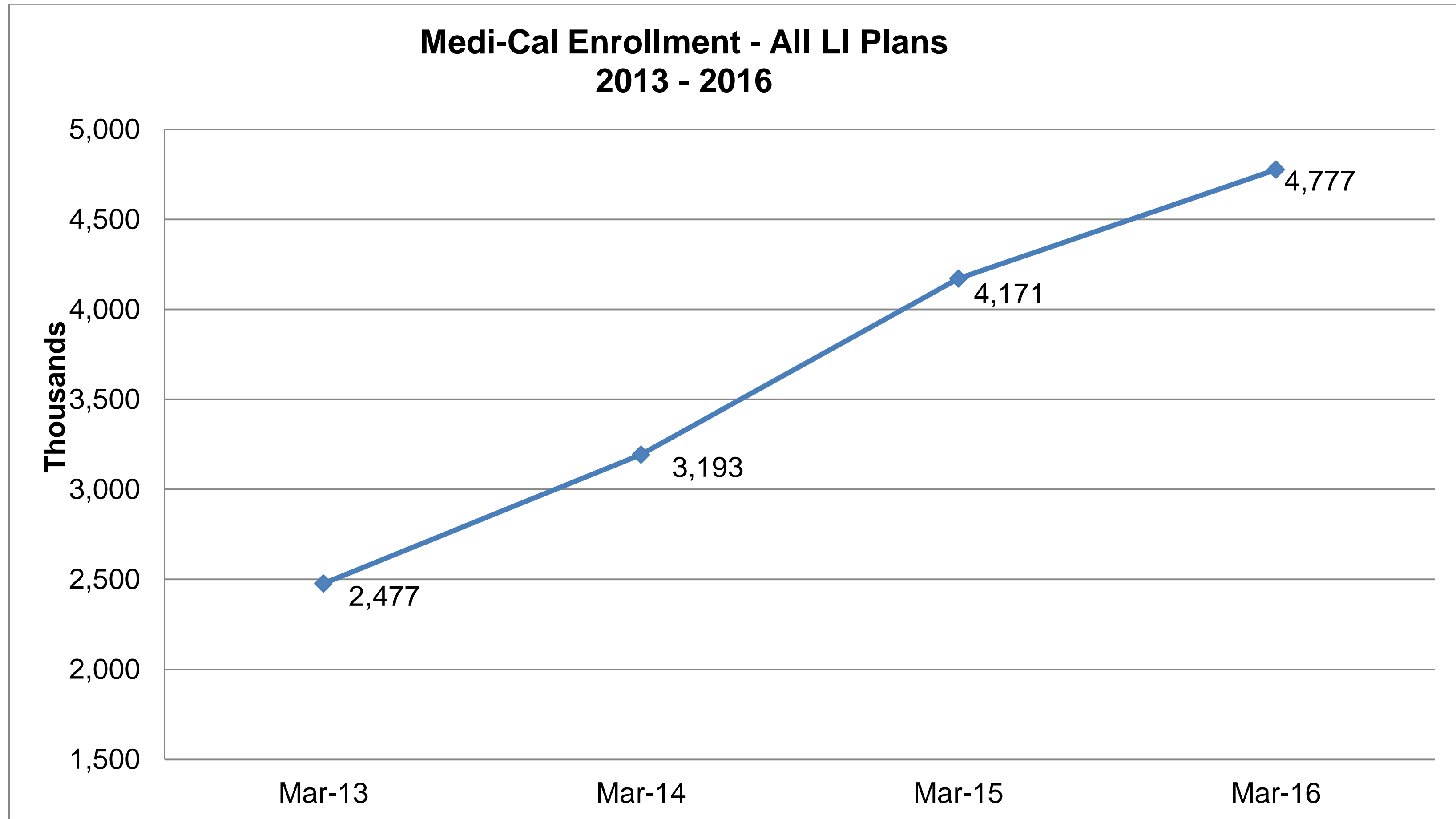
Table 1
Enrollment in Local Initiatives
March 2015 – March 2016

Local Initiative	Total Medi-Cal Enrollment March 2016	Percentage of Medi-Cal Enrollment March 2016	Total Enrollment March 2016[4]	Total Enrollment March 2015	Enrollment Increase	Percentage Enrollment Increase
Alameda Alliance For Health	262,513	98%	268,113	241,421	26,692	11%
Contra Costa County Medical Services	178,600	94%	190,067	170,095	19,972	12%
Fresno-Kings-Madera Regional Health Authority	344,776	100%	344,776	306,869	37,907	12%
Inland Empire Health Plan	1,121,299	98%	1,144,500	1,054,415	90,085	9%
Kern Health Systems	222,155	100%	222,155	192,241	29,914	16%
Local Initiative Health Authority for L.A County	1,930,374	96%	2,001,283	1,689,099	312,184	18%
San Francisco Community Health Authority	129,099	91%	142,515	132,274	10,241	8%
Health Plan of San Joaquin	327,863	99%	331,914	300,317	31,597	11%
Santa Clara County Health Authority	259,921	95%	272,916	233,492	39,424	17%
Total	**4,776,600**	**97%**	**4,918,239**	**4,320,223**	**598,016**	**14%**

[4] The total enrollment consists of Large Group Commercial, Medicare Risk, Medicare Supplement, Medi-Cal Risk, ASO, Healthy Kids, IHSS, and contracted from other plans. Note that Healthy Kids is a separate program from the Healthy Families Program.

Chart 1 illustrates the MCMC enrollment trend in LIs over the last four years by comparing March year-over-year data.

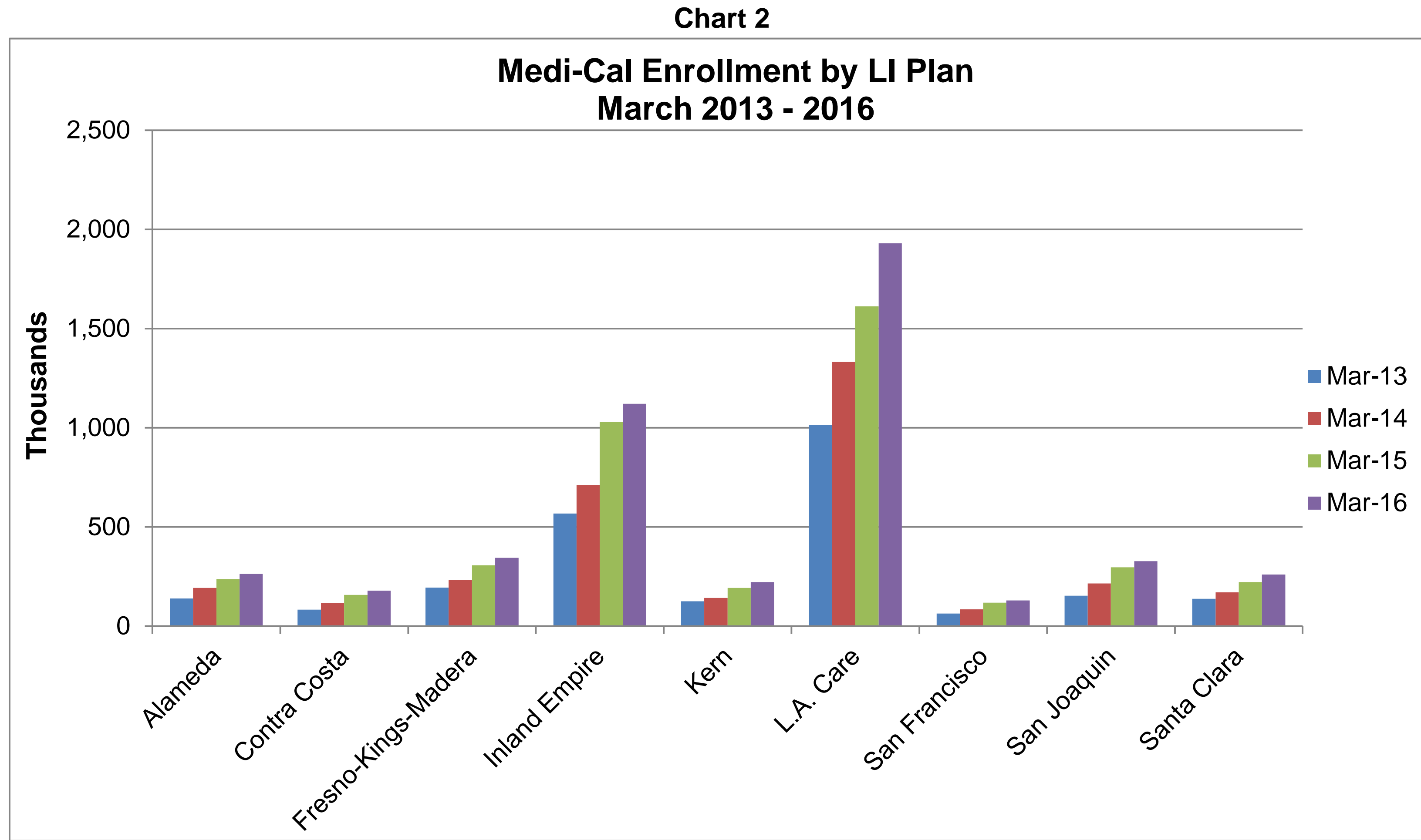
Chart 1



Medi-Cal enrollment in LIs continues to increase. Two Southern California LI plans, L.A. Care and Inland Empire Health Plan, reported the highest number of enrollees and make up the majority of the enrollment increase. L.A. Care and Inland Empire reported Medi-Cal enrollment of 1.9 million and 1.1 million, respectively.

Chart 2 shows the LI growth in Medi-Cal enrollment by plan over the past four years.

Chart 2



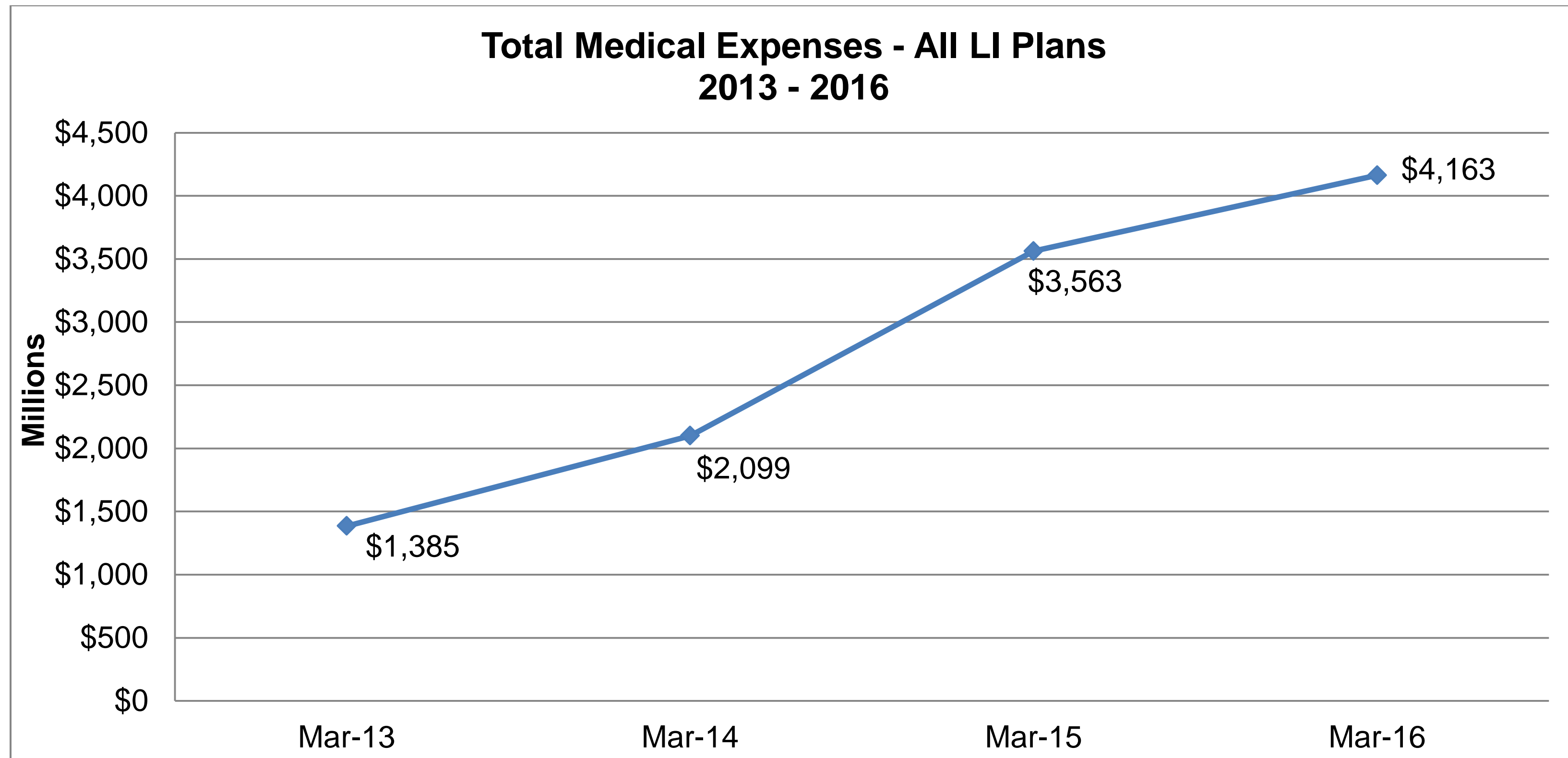
All nine LIs have experienced increases in enrollment. The majority of the increases were from their Medi-Cal lines of business. From March 2015 to March 2016, L.A. Care and Santa Clara County experienced 18% and 17% increases in enrollment, respectively.

C. Financial Trends - LI

Medical Expenses

Chart 3 illustrates total medical expenses for the LIs compared to the same quarter over the last three years. While total medical expenses continued to increase in the quarter ending March 2016 compared to the quarter ending in March 2015, the increase was not as significant as in prior years. The change in medical expenses is correlated to the increase in the LIs' enrollment and expanded Medi-Cal benefits. Generally, total medical expenses change as enrollment, enrollee mix (healthy or unhealthy, high or low utilizers) and Medi-Cal benefits change.

Chart 3



Per Member Per Month Medical Expense and Premium Revenue - LI

Table 2 shows the PMPM medical expense and premium revenue of the LIs for the quarter ending in March for the past four years, as well as the difference in PMPM medical expense and premium revenue for March 2016. L.A. Care and San Francisco reported the highest PMPM medical expense and premium revenue. All LIs had higher PMPM premium revenue than medical expenses at March 2016.

Table 2
Per Member Per Month Medical Expenses and Premium Revenue – LI
2013-2016

	Mar-13		Mar-14		Mar-15		Mar-16[5]		
Local Initiative	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	Net[6] Revenue
Alameda Alliance For Health	$241	$267	$286	$307	$260	$301	$238	$263	$25
Contra Costa County Medical Services	228	206	229	242	277	301	296	305	$9
Fresno-Kings-Madera Regional Health Authority	162	176	230	257	269	281	211	222	$11
Inland Empire Health Plan	172	186	190	206	267	322	277	302	$25
Kern Health Systems	150	154	164	177	204	215	213	236	$23
Local Initiative Health Authority for L.A County	170	177	220	234	293	306	311	326	$15
San Francisco Community Health Authority	237	309	270	290	307	345	299	328	$29
Health Plan of San Joaquin	155	163	184	184	214	246	228	234	$5
Santa Clara County Health Authority	154	170	192	299	283	297	283	298	$16

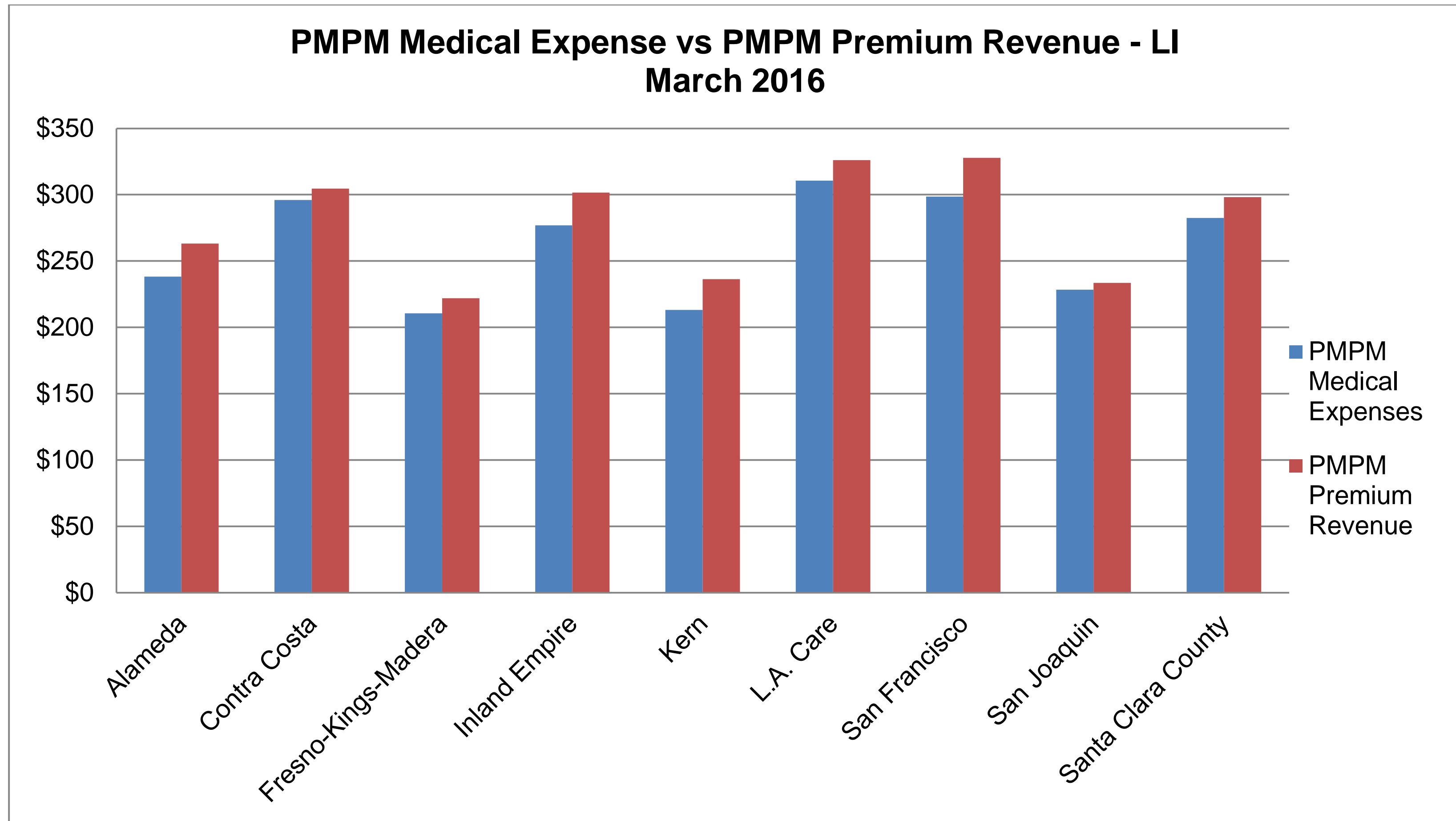
[5] March 2015 and March 2016 PMPM Medical Expense and Premium Revenue information excludes pass through income and expense items.
[6] Difference between March 2016 PMPM Medical Expense and PMPM Premium Revenue.

PMPM medical expense is calculated by dividing the total medical expenses by cumulative member months. PMPM premium revenue is calculated by dividing the premium revenues by cumulative member months. Fluctuations in PMPM medical expense and premium revenue can be due to a number of factors including utilization of medical services by enrollees, and premium rate adjustments.

PMPM Medical Expense vs. PMPM Premium Revenue - LI

Chart 4 illustrates the LI plans' PMPM medical expense vs PMPM premium revenue for March 2016. The PMPM premium revenue received exceeded the PMPM medical expense for each LI.

Chart 4



Net Income - LI

Table 3 shows the Net Income for LI plans over the past six quarters. For the quarter ending (QE) March 2016, all except one LI plan reported positive net income. Net income or loss is directly related to premium revenue and medical expenses.

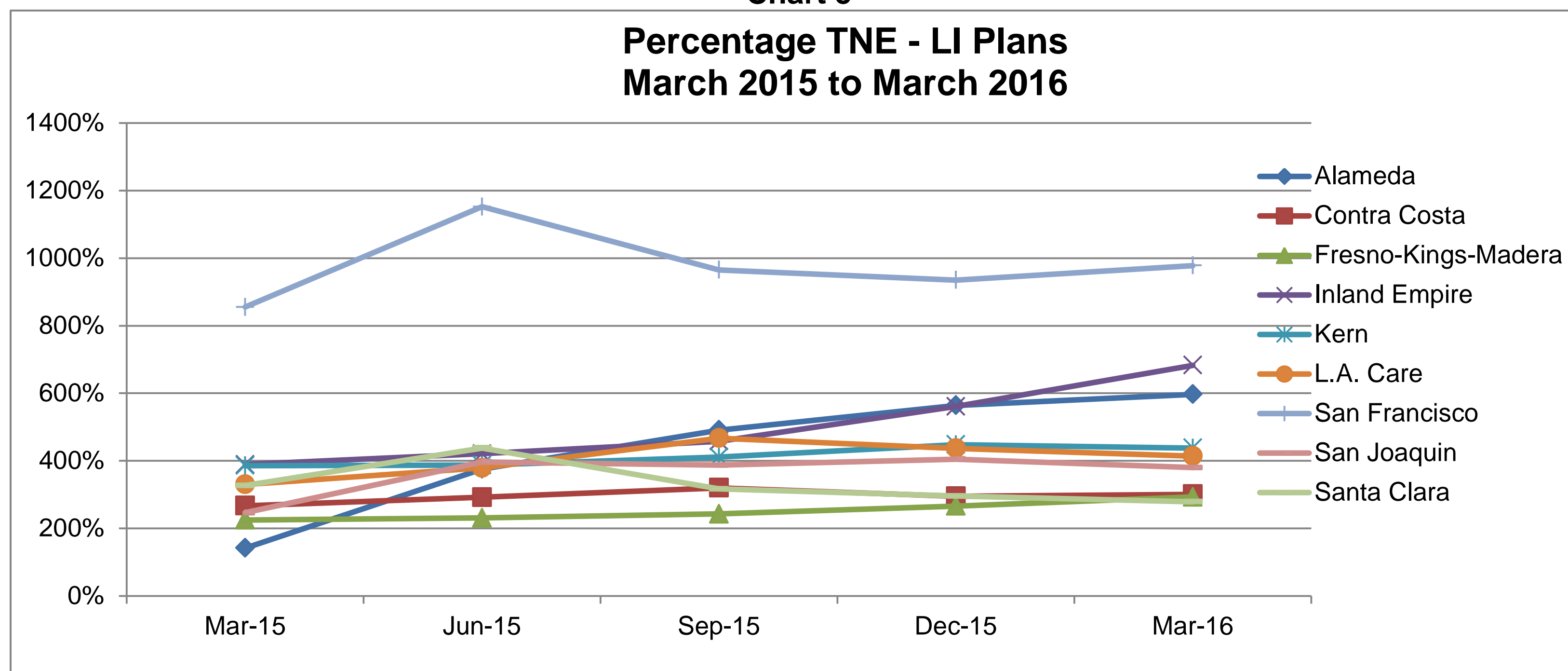
Table 3
LI Net Income by Quarter (in thousands)

Local Initiative	QE Dec-14	QE Mar-15	QE Jun-15	QE Sep-15	QE Dec-15	QE Mar-16
Alameda Alliance For Health	$7,677	$16,936	$44,715	$20,581	$7,833	$6,152
Contra Costa County Medical Services	4,842	7,726	5,950	4,526	4,528	2,166
Fresno-Kings-Madera Regional Health Authority	2,496	2,933	5,812	3,057	2,942	2,443
Inland Empire Health Plan	46,787	140,915	91,446	63,093	77,857	47,696
Kern Health Systems	7,148	3,915	6,875	10,300	12,882	6,297
Local Initiative Health Authority for L.A County	52,923	11,418	80,447	129,777	12,532	21,180
San Francisco Community Health Authority	7,489	6,867	18,176	10,344	8,661	4,833
Health Plan of San Joaquin	13,116	18,932	40,209	2,346	8,911	(2,911)
Santa Clara County Health Authority	3,105	1,550	28,693	3,319	4,428	3,259
Total LI Net Income	**$145,583**	**$211,193**	**$322,323**	**$247,343**	**$140,574**	**$91,115**

Tangible Net Equity - LI

TNE is a reserve requirement described in section 1300.76 of the Knox-Keene regulations[7] and a measure of the financial health of plans. TNE is defined as a health plan's total assets minus total liabilities reduced by the value of intangible assets (i.e., goodwill[8], organizational or start-up costs, etc.) and unsecured obligations of officers, directors, owners, or affiliates outside the normal course of business. Any debt that is properly subordinated[9] may be added to the TNE calculation, which serves to increase the plan's TNE.

Chart 5



[7] "Knox-Keene regulations" refer to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, as amended, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

[8] Goodwill is an intangible asset that arises as a result of the acquisition of one company by another for a premium value.

[9] Subordinated debt - A loan that ranks below other loans with regard to claims on assets or earnings. In the case of default, creditors with subordinated debt would not get paid out until after the other creditors were paid in full.

The Department's minimum requirement for TNE reserves is 100% of required TNE. If the health plan's TNE falls below 130%, the health plan must file monthly financial statements with the Department. If a health plan reports a TNE deficiency (TNE below 100%), the Department may take enforcement action against the plan.

The average TNE for the LIs overall was stable in 2015 and the trend continued in the first quarter of 2016. For March 2016, the reported TNE ranged from 279% to 978% of required TNE.

Cash Flow from Operations

Cash flow from operations measures the amount of cash generated by a plan's normal business operations. This is important because it indicates whether a company is able to generate sufficient positive cash flow to maintain and grow operations.

Most LI plans reported positive cash flow from operations in March 2016. The cash flow from operations totaled $1.3 billion in March 2016 compared to $1 billion in March 2015. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and the MCE rate adjustments for the 2015/2016 fiscal year.

Claims

Pursuant to the Knox-Keene Act, full service health plans are required to process 95% of their claims within 45 working days. Health plans are required to submit to the Department, on a quarterly basis, a claims settlement practice report if the Plan fails to process 95% of its claims timely and/or the plan identifies any emerging patterns of claims payment deficiencies. For the quarter ending March 31, 2016, Contra Costa and L.A. Care failed to process 95% of their claims within 45 working days and submitted a corrective action plan with the Department outlining measures they are taking to comply with the regulations.

IV. County Organized Health Systems (COHS)

A. Highlights

- Six COHS plans currently serve 22 counties. The COHS plans and the counties in which they provide services are:
    - CalOptima (Orange County Health Authority) - Orange
    - CenCal Health (Santa Barbara San Luis Obispo Regional Health Authority) – Santa Barbara and San Luis Obispo
    - Central California Alliance for Health (Santa Cruz-Monterey-Merced Managed Medical Care Commission) – Merced, Monterey, and Santa Cruz
    - Health Plan of San Mateo (San Mateo Health Commission) – San Mateo
    - Partnership HealthPlan (Partnership HealthPlan of California) – Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo
    - Gold Coast Health Plan – Ventura

- Medi-Cal beneficiaries in COHS counties have only one MCMC option.

- While California law exempts COHS plans from Knox-Keene licensure for Medi-Cal, COHS plans must have a Knox-Keene license for other lines of business. Only San Mateo has voluntarily included its Medi-Cal enrollment under its Knox-Keene license, but CalOptima, CenCal Health, Central California Alliance for Health and Partnership HealthPlan have Knox-Keene licenses for other lines of business such as Healthy Kids, IHSS, AIM and Medicare Advantage. Gold Coast Health Plan has no Knox-Keene license since it has only a Medi-Cal line of business; therefore, this report does not include information for Gold Coast.

- Enrolled beneficiaries choose their health care provider from among the COHS plan contracted providers.

- COHS plans' enrollment increased 8% from March 2015 to March 2016. Per member per month expenses and premium revenue rose for COHS plans in conjunction with increased enrollment and expanded Medi-Cal benefits. COHS plans' PMPM premium revenue outpaced expenses for March 2016.
- COHS plans reported $116 million in net income in March 2016 compared to $184 million in March 2015.
- Tangible net equity for COHS plans ranged from 617% to 1,424% of required TNE. Four of the five reporting COHS plans reported progressively higher TNE from March 2015 to March 2016.
- COHS plans reported negative $176 million in cash flow from operations in March 2016 compared to $773 million at March 2015. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and the MCE rate adjustments for the 2015/2016 fiscal year.

B. Enrollment Trends - COHS

Like LI plans, COHS plans have reported consistent increases in enrollment since 2013. CalOptima and Partnership HealthPlan reported the highest enrollment numbers. All COHS plans reported increases in total enrollment.

Table 4
Enrollment in County Organized Health Systems
Mar 2015 – Mar 2016

COHS	March 2016 Total Medi-Cal Enrollment	March 2016 Percentage of Medi-Cal Enrollment	March 2016 Total Enrollment	March 2015 Total Enrollment	Enrollment Change from March 2015 to March 2016	Percentage Enrollment Change from March 2015 to March 2016
CalOptima	775,965	98%	793,328	743,691	49,637	7%
CenCal Health	175,909	100%	176,734	158,720	18,014	11%
Central California Alliance for Health	345,059	99.6%	346,466	320,654	25,812	8%
Partnership HealthPlan	565,307	99.9%	565,753	527,171	38,582	7%
Health Plan of San Mateo	122,966	89%	137,461	128,451	9,010	7%
Total	**1,985,206**	**98%**	**2,019,742**	**1,878,687**	**141,055**	**8%**

Chart 6 illustrates the Medi-Cal managed care enrollment trend in COHS plans. Medi-Cal enrollment in COHS plans has more than doubled over the last four years.

Chart 6

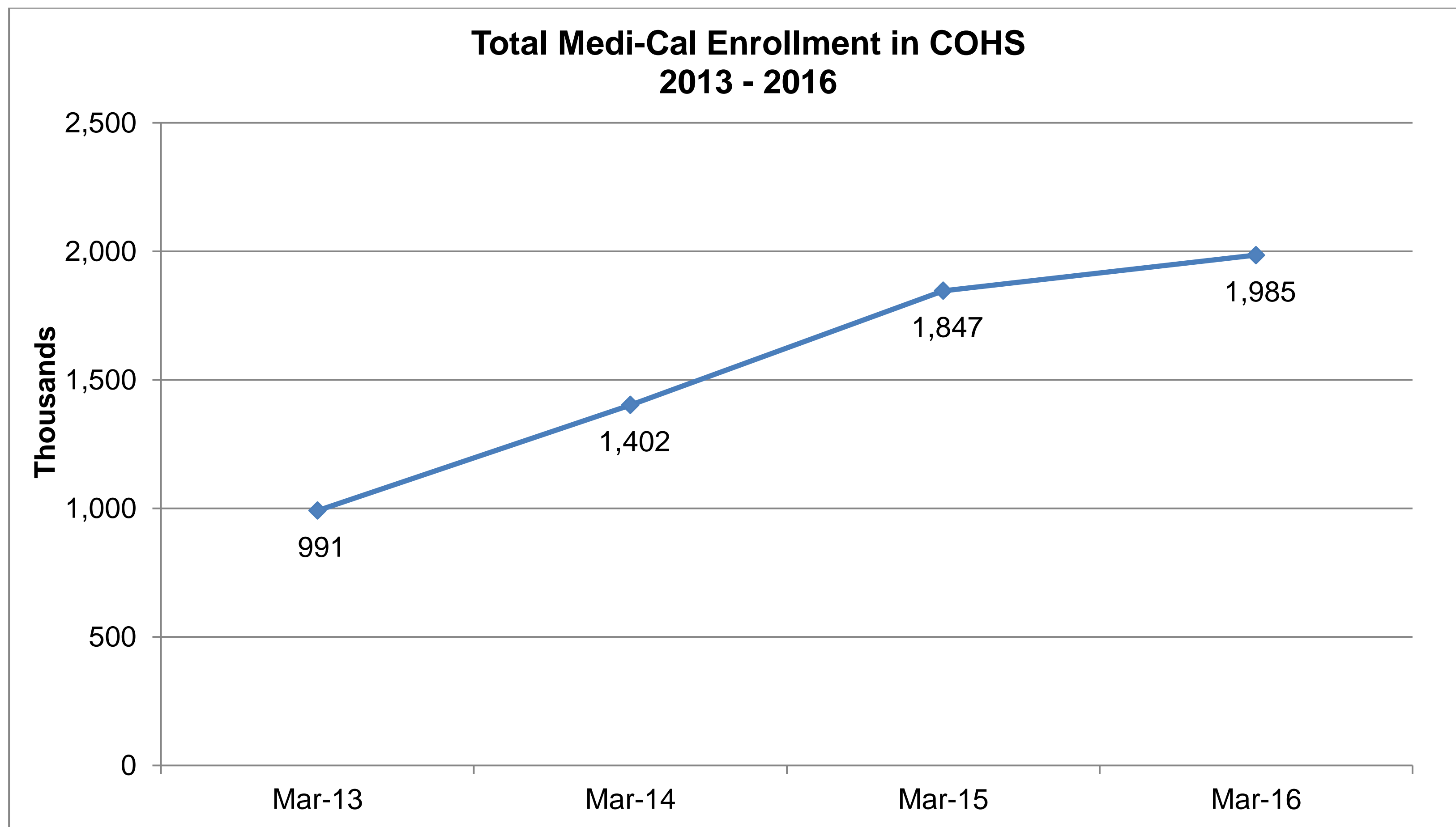
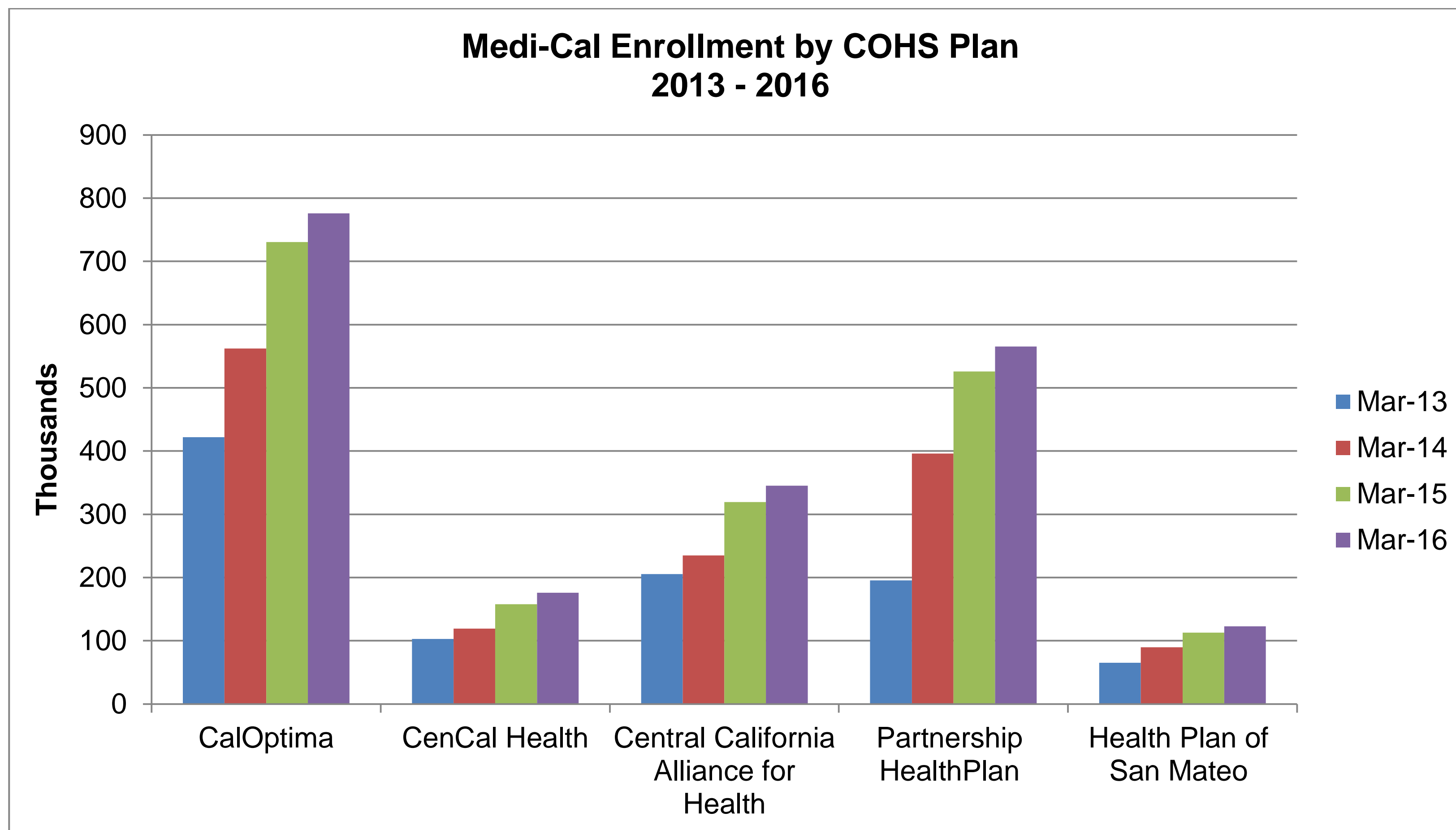


Chart 7 shows the enrollment growth for each COHS plan over the past four years.

Chart 7

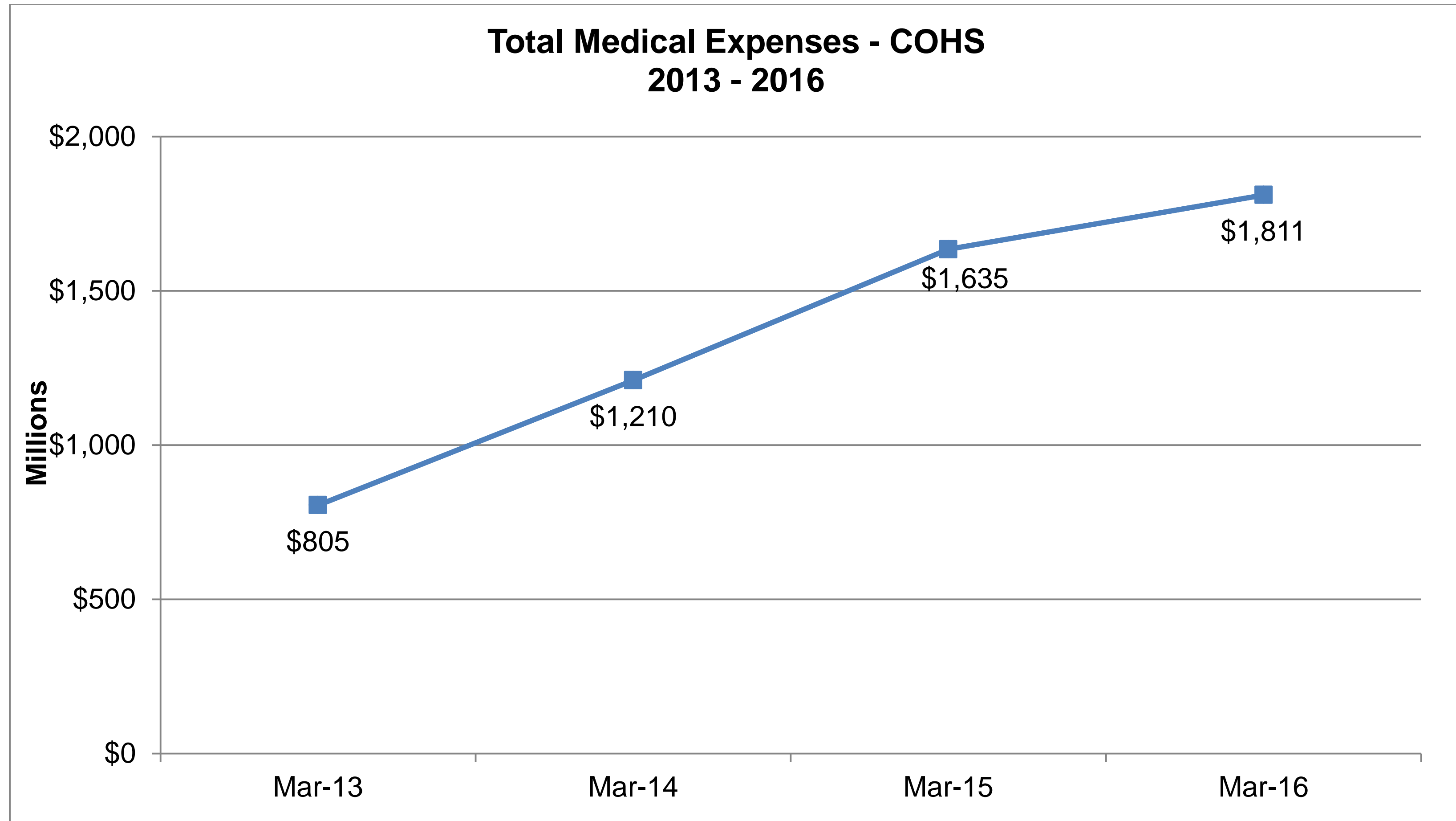


All COHS plans reported enrollment increases of 7% or more from March 2015 to March 2016. Medi-Cal enrollment for all COHS Plans increased from 2013 to 2016.

Financial Trends - COHS

Similar to LI plans, Chart 8 shows a continued increase in medical expenses for COHS plans.

Chart 8



Per Member Per Month Medical Expense and Premium Revenue - COHS

Table 5 shows the PMPM medical expense and premium revenue of the COHS plans for the quarter ending in March for the past four years, as well as the difference in the PMPM medical expense and premium revenue for March 2016.

All COHS plans had higher PMPM premium revenue than medical expenses at March 2016. Health Plan of San Mateo reported the highest PMPM medical expense and premium revenue.

Table 5
Per Member Per Month Medical Expense and Premium Revenue – COHS
2012-2015

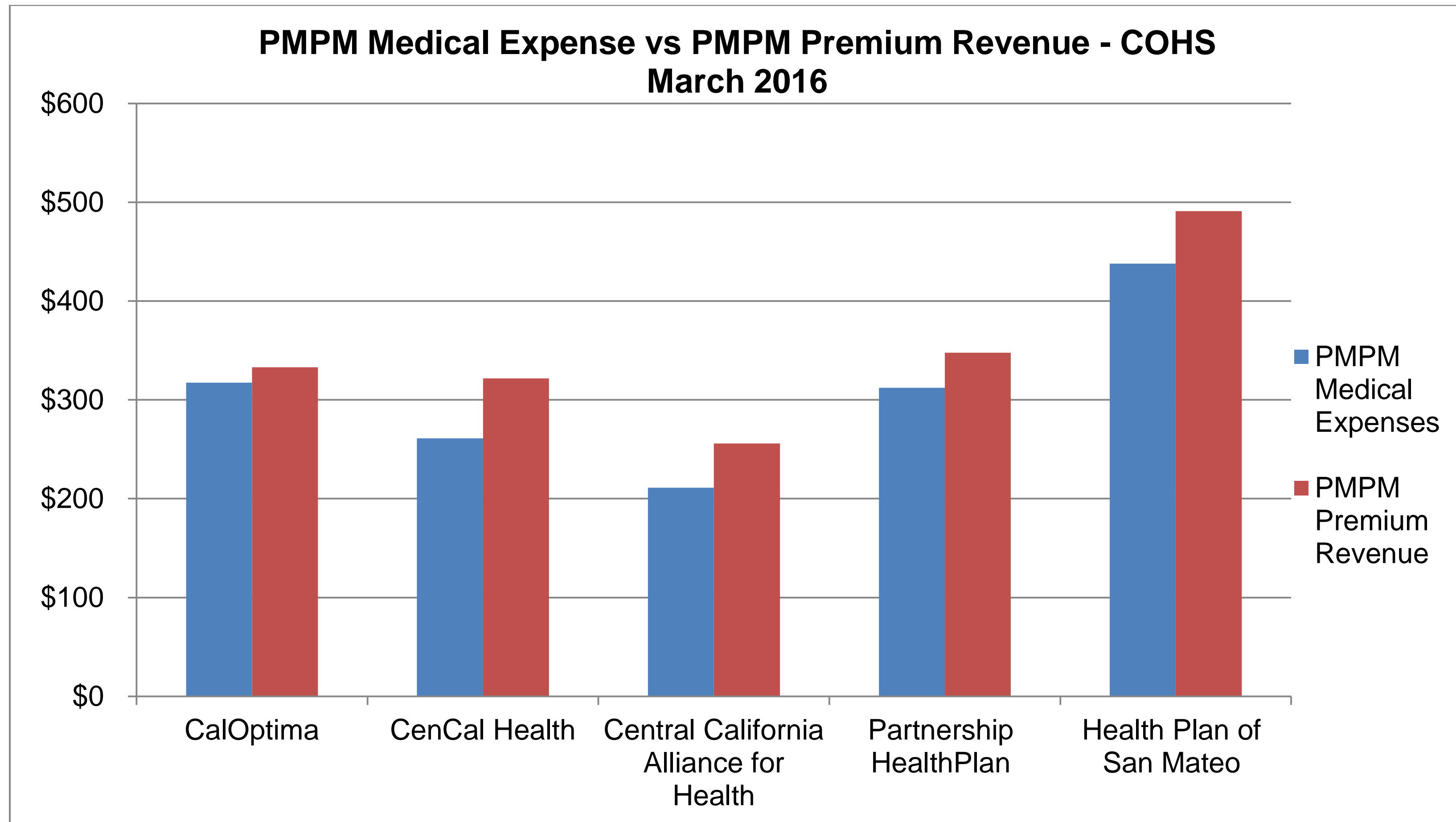
COHS	Mar-13		Mar-14		Mar-15		Mar-16[10]		
	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	Net Revenue[11]
CalOptima	$232	$269	$285	$389	$310	$345	$317	$333	$16
CenCal Health	239	288	247	270	251	315	261	322	$61
Central California Alliance for Health	204	219	205	242	198	239	211	256	$45
Partnership HealthPlan	313	378	320	384	282	339	312	348	$35
Health Plan of San Mateo	451	471	526	578	523	602	438	491	$53

[10] March 2015 and March 2016 PMPM Medical Expense and PMPM Premium Revenue information excludes pass through income and expense items
[11] Difference between March 2016 PMPM Medical Expense and PMPM Premium Revenue.

PMPM Medical Expense vs PMPM Premium Revenue

Chart 9 illustrates the COHS plans' PMPM medical expense vs PMPM premium revenue for March 2016. All plans reported premium revenue that was higher than per member per month expenses.

Chart 9



Net Income - COHS

Favorable PMPM premium revenue ratios translated to positive net income for all COHS plans. Almost all COHS plans reported positive net income for the last five quarters.

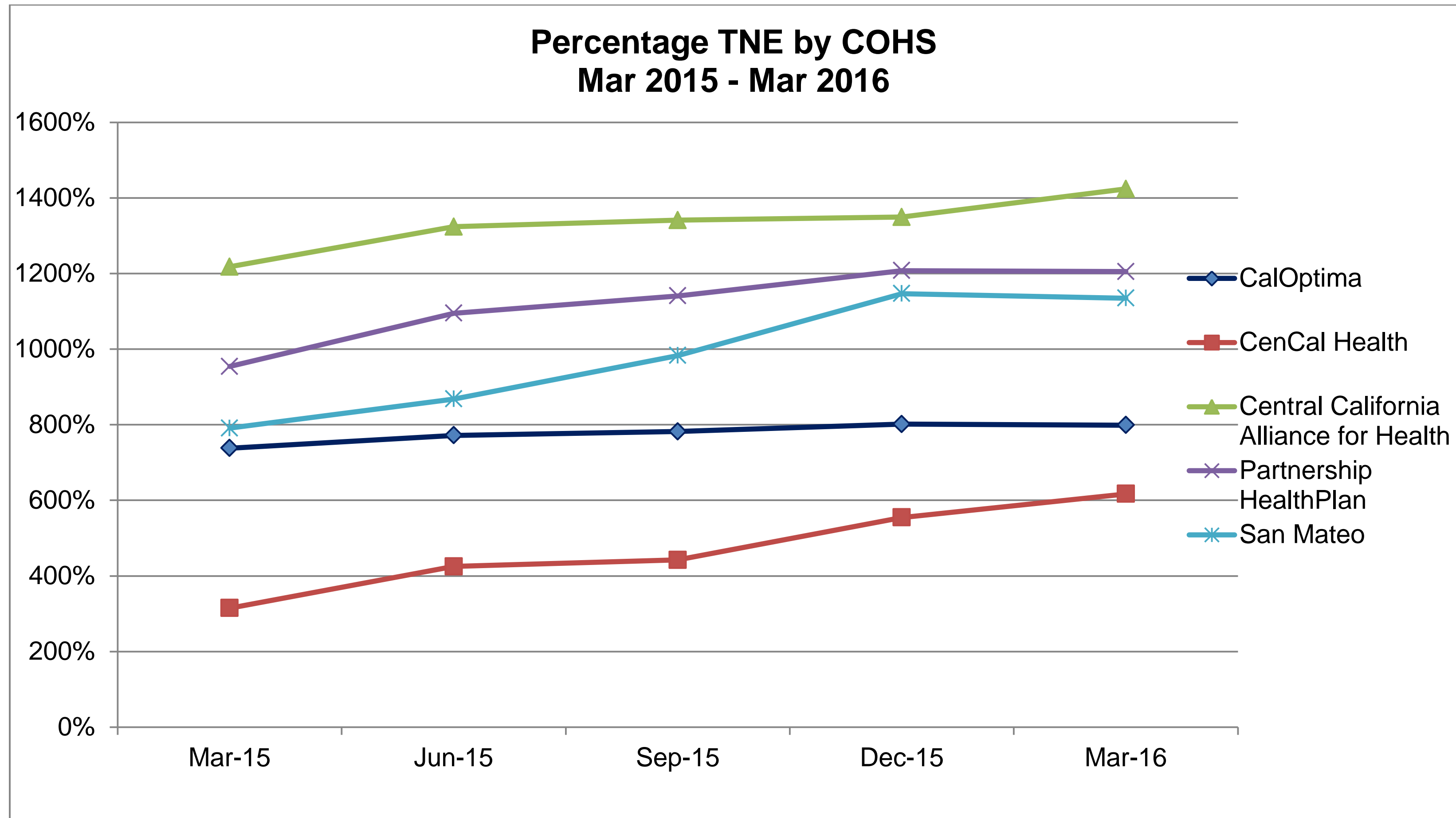
Table 6
COHS Net Income by Quarter (in thousands)

COHS	QE Dec-14	QE Mar-15	QE Jun-15	QE Sep-15	QE Dec-15	QE Mar-16
CalOptima	53,672	57,600	61,289	9,338	(1,228)	15,025
CenCal Health	8,206	15,690	33,178	8,664	24,117	19,769
Central California Alliance for Health	40,480	28,188	32,229	24,434	23,696	34,169
Partnership HealthPlan	71,141	68,147	97,270	52,384	50,926	34,908
Health Plan of San Mateo	37,804	14,497	15,315	28,861	44,758	11,976
Total COHS Net Income	**$211,303**	**$184,122**	**$239,281**	**$123,681**	**$ 142,269**	**$115,847**

Tangible Net Equity – COHS

All COHS plans reported over 600% of required TNE for March 2016. TNE to Required TNE ranged from 617% to 1,424%. CenCal Health's reported TNE increased to 617% at March 2016.

Chart 10



Cash Flow from Operations

COHS plans reported negative $176 million in cash flow from operations in March 2016. Similar to the LIs, COHS plans' variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and the MCE rate adjustments for the 2015/2016 fiscal year.

Claims

Pursuant to the Knox-Keene Act, full service health plans are required to process 95% of their claims within 45 working days. COHS plans did not report any claims processing or emerging claims payment deficiencies for March 2016.

V. Non-Governmental Medi-Cal Plans

A. Highlights

- For the purposes of this report, Non-Governmental Medi-Cal (NGM) plans include plans with greater than 50% Medi-Cal enrollment.
- Five NGM plans currently serve approximately 31 counties. The NGM plans and the counties in which they provide services are:
  - California Health and Wellness Plan - Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. California Health and Wellness Plan is a wholly owned subsidiary of Centene Corporation (Centene), a publicly traded company.
  - Care 1st Health Plan – Los Angeles and San Diego. Care 1st Health Plan was recently acquired by California Physicians' Services (Blue Shield) in October 2015 and was converted from a for-profit plan to a not-for-profit plan
  - Community Health Group – San Diego. Community Health Group participates in the GMC model and contracts directly with DHCS. Community Health Group is a not-for-profit health plan.
  - Health Net Community Solutions, Inc. (HNCS) - Fresno, Kern, Kings, Los Angeles, Madera, Sacramento, San Diego, San Joaquin, Stanislaus, and Tulare counties. In Kern, Los Angeles, San Joaquin, Stanislaus and Tulare counties, HNCS participates in the two-plan model and competes with the LI plans for enrollment. In Sacramento and San Diego counties, HNCS participates in the GMC model and contracts directly with DHCS. Health Net Community Solutions, Inc. is a wholly owned subsidiary of Health Net, Inc., which was recently acquired by Centene.
  - Molina Healthcare of California (Molina Healthcare) - Imperial, Los Angeles, Sacramento, Riverside, San Bernardino, and San Diego. In San Diego county, Molina Healthcare participates in the GMC model and contracts directly with DHCS. Molina Healthcare of California is a wholly owned subsidiary of Molina Healthcare, Inc., a publicly traded company.

- NGM plans provide and administer health care services to Medi-Cal beneficiaries either as a direct contractor to DHCS, or as subcontractors to other health plans that contract under such programs with the DHCS.
- There also are two commercial plans that serve 1.9 million Medi-Cal enrollees (Blue Cross of California – 1,244,787 and Kaiser Foundation Health Plan – 671,583). Enrollment information for these two plans was included. Financial solvency indicators were not included since both of these plans report over 50% of other types of enrollment (Commercial, Medicare) and their financial solvency is significantly impacted by these other lines of business.
- NGM plans' enrollment increased 14% from March 2015 to March 2016. Similar to LI and COHS plans, per member per month expenses and premium revenue rose for NGM plans in conjunction with increased enrollment and expanded Medi-Cal benefits. NGM plans' PMPM premium revenue outpaced expenses for March 2016.
- NGM plans reported $162 million in net income in March 2016, a significant increase compared to net income of $102 million reported in March 2015.
- Tangible net equity for NGM plans ranged from 258% to 587% of required TNE at March 2016. Four of the five reporting NGM plans reported progressively higher TNE from March 2015 to March 2016.
- NGM plans reported $459 million in cash flow from operations in March 2016 compared to $1.47 billion at March 2015.

B. Enrollment Trends - Non-Governmental Medi-Cal Plans

Like LI and COHS plans, NGM plans have reported consistent increases in enrollment since 2013. Health Net Community Solutions, Inc. and Molina Healthcare of California reported the highest enrollment numbers. In 2016, all NGM plans reported an increase in total enrollment. There are two commercial plans that serve 1.9 million Medi-Cal enrollees (Blue Cross of California – 1,244,787, and Kaiser Foundation Health Plan – 671,583).

Table 7
Enrollment in Non-Governmental Medi-Cal Plans
March 2015 – March 2016

Non-Governmental Medi-Cal Plans	March 2016 Total Medi-Cal Enrollment	March 2016 Percentage of Medi-Cal Enrollment	March 2016 Total Enrollment	March 2015 Total Enrollment	Enrollment Change from March 2015 to March 2016	Percentage Enrollment Change from March 2015 to March 2016
California Health and Wellness Plan	186,063	100%	186,063	169,374	16,689	10%
Care 1st Health Plan	389,024	68%	568,971	527,507	41,464	8%
Community Health Group	271,591	100%	271,591	246,538	25,053	10%
Health Net Community Solutions	1,885,210	99.5%	1,894,070	1,650,546	243,524	15%
Molina Healthcare	600,832	89%	676,010	572,593	103,417	18%
Total Medi-Cal Enrollment in NGMs	**3,332,720**	**93%**	**3,596,705**	**3,166,558**	**430,147**	**14%**
Blue Cross of California[12]	1,244,787	31%	4,010,637	3,822,057	188,580	5%
Kaiser Foundation Health Plan	671,583	8%	8,303,678	7,893,686	409,992	5%

[12] Enrollment information for these two plans was included. Financial solvency indicators were not included since both of these plans report over 50% of other types of enrollment (Commercial, Medicare) and their financial solvency is significantly impacted by these other lines of business.

Chart 11 illustrates the Medi-Cal managed care enrollment trend in NGM plans.

Chart 11

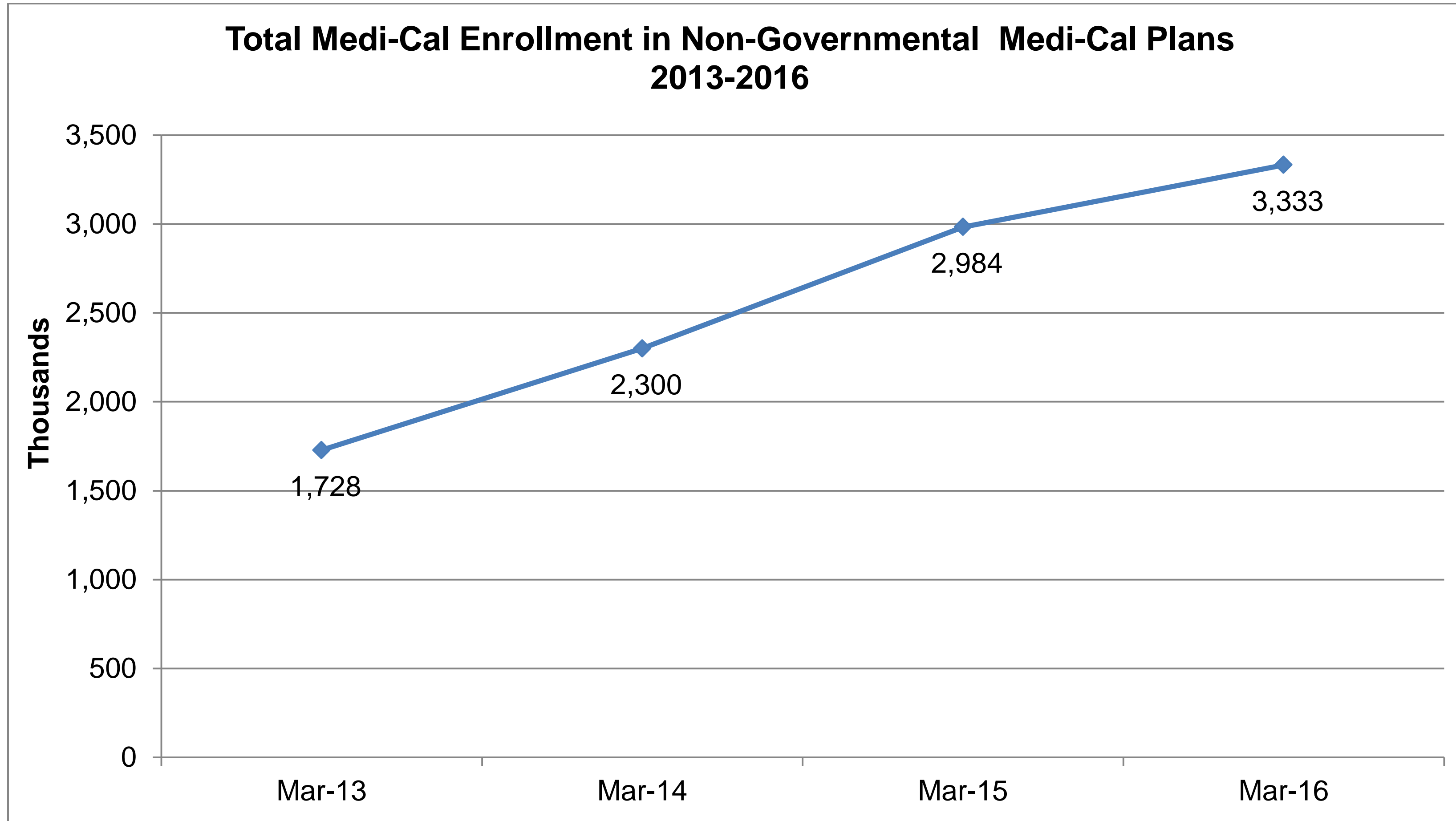
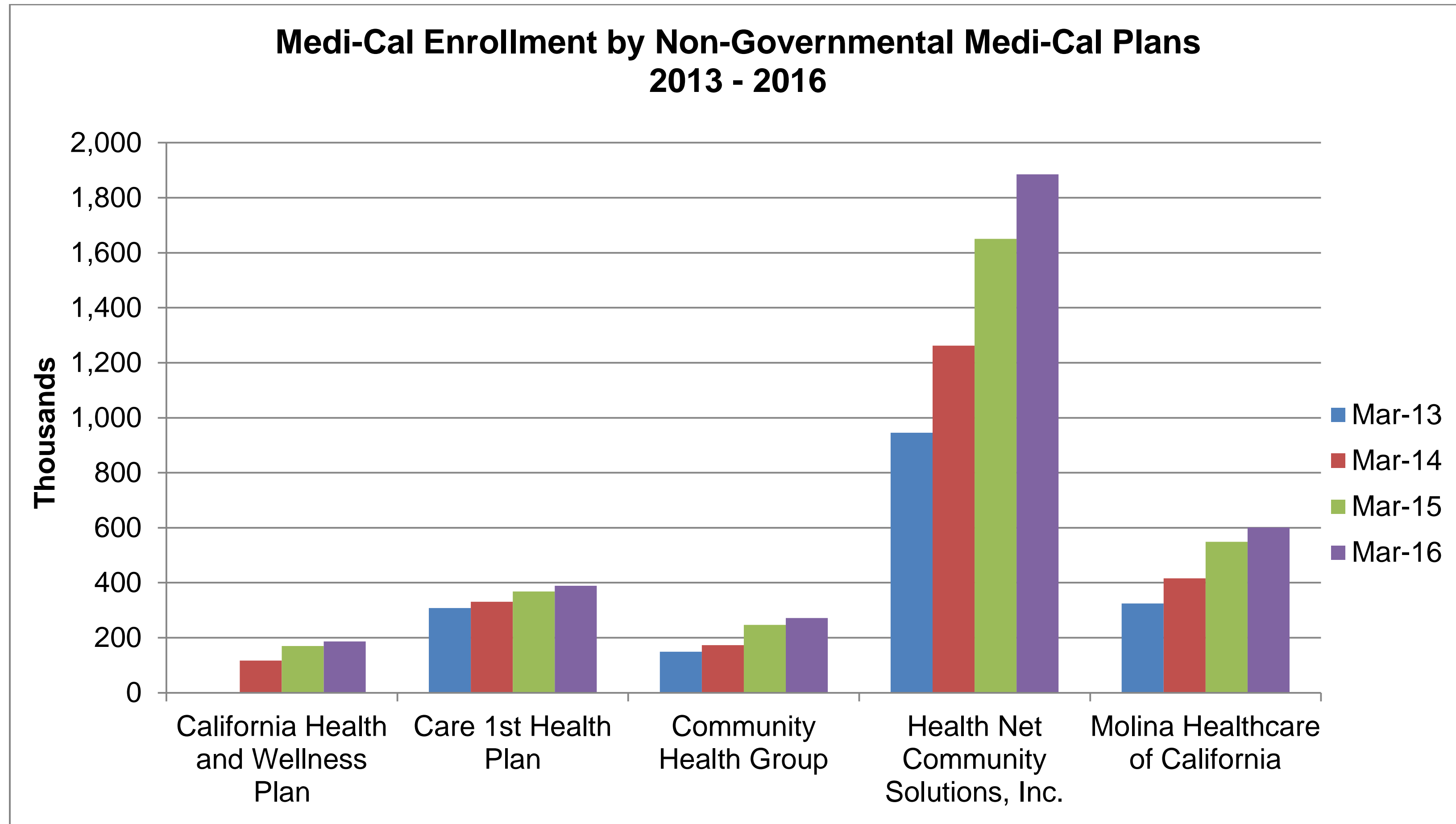


Chart 12 shows the enrollment growth for each NGM plan over the past four years.

Chart 12

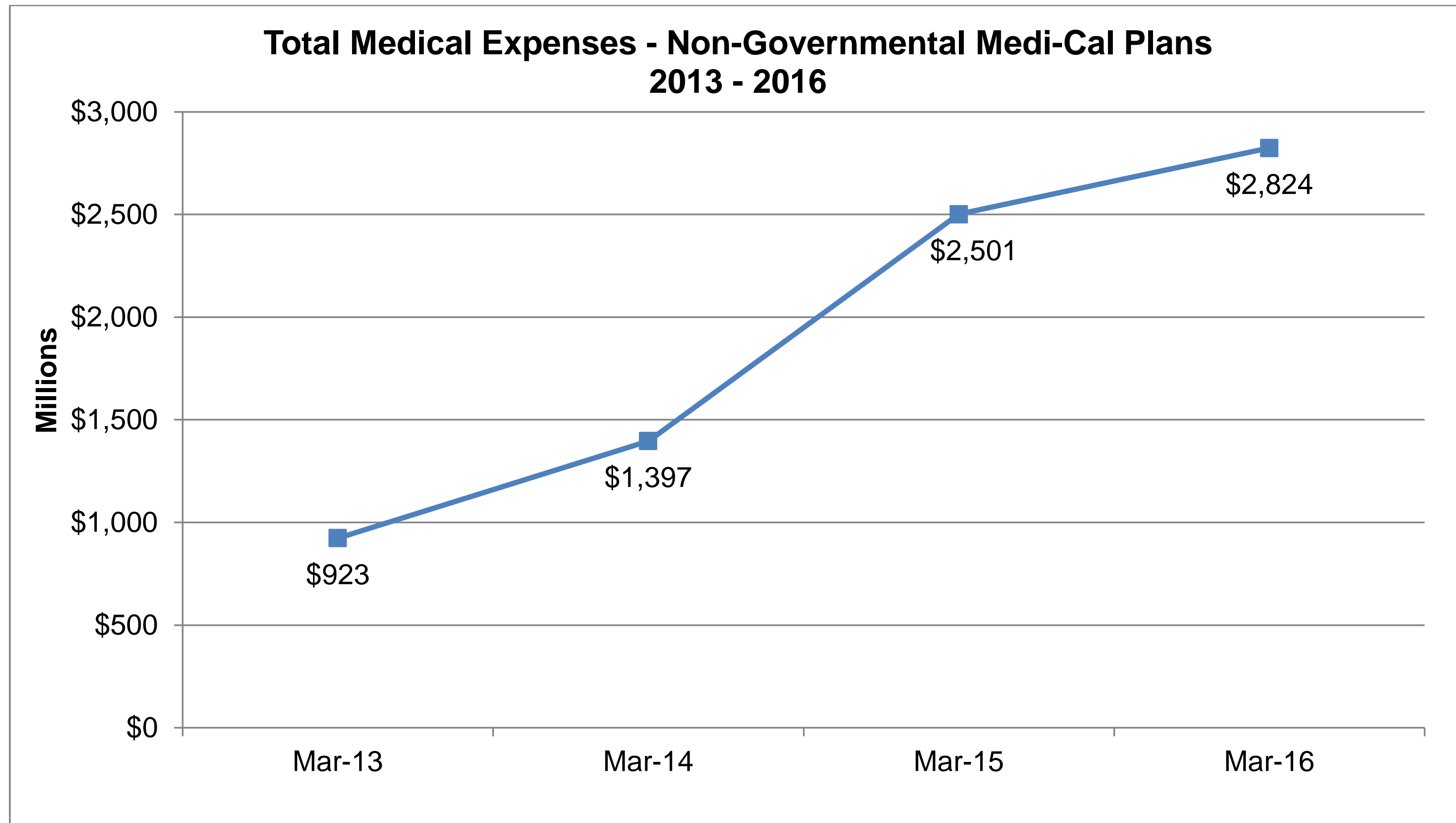


All NGM plans reported enrollment increases of 8% or more from March 2015 to March 2016. Total Medi-Cal enrollment for NGM Plans increased by 93% from 2013 to 2016.

Financial Trends – Non-Governmental Medi-Cal Plans

Similar to LI and COHS plans, Chart 13 shows an increase in medical expenses for NGM plans.

Chart 13



Per Member Per Month Medical Expenses and Premium Revenue - Non-Governmental Medi-Cal Plans

Table 8 shows the PMPM medical expense and premium revenue of the NGM plans for the quarter ending in March for the past four years, as well as the difference in the PMPM medical expense and premium revenue for March 2016. All NGM plans had higher PMPM premium revenue than medical expenses at March 2016. Care 1st Health Plan reported the highest PMPM medical expense and premium revenue.

Table 8
Per Member Per Month Medical Expenses and Premium Revenue – Non-Governmental Medi-Cal Plans
2013-2016

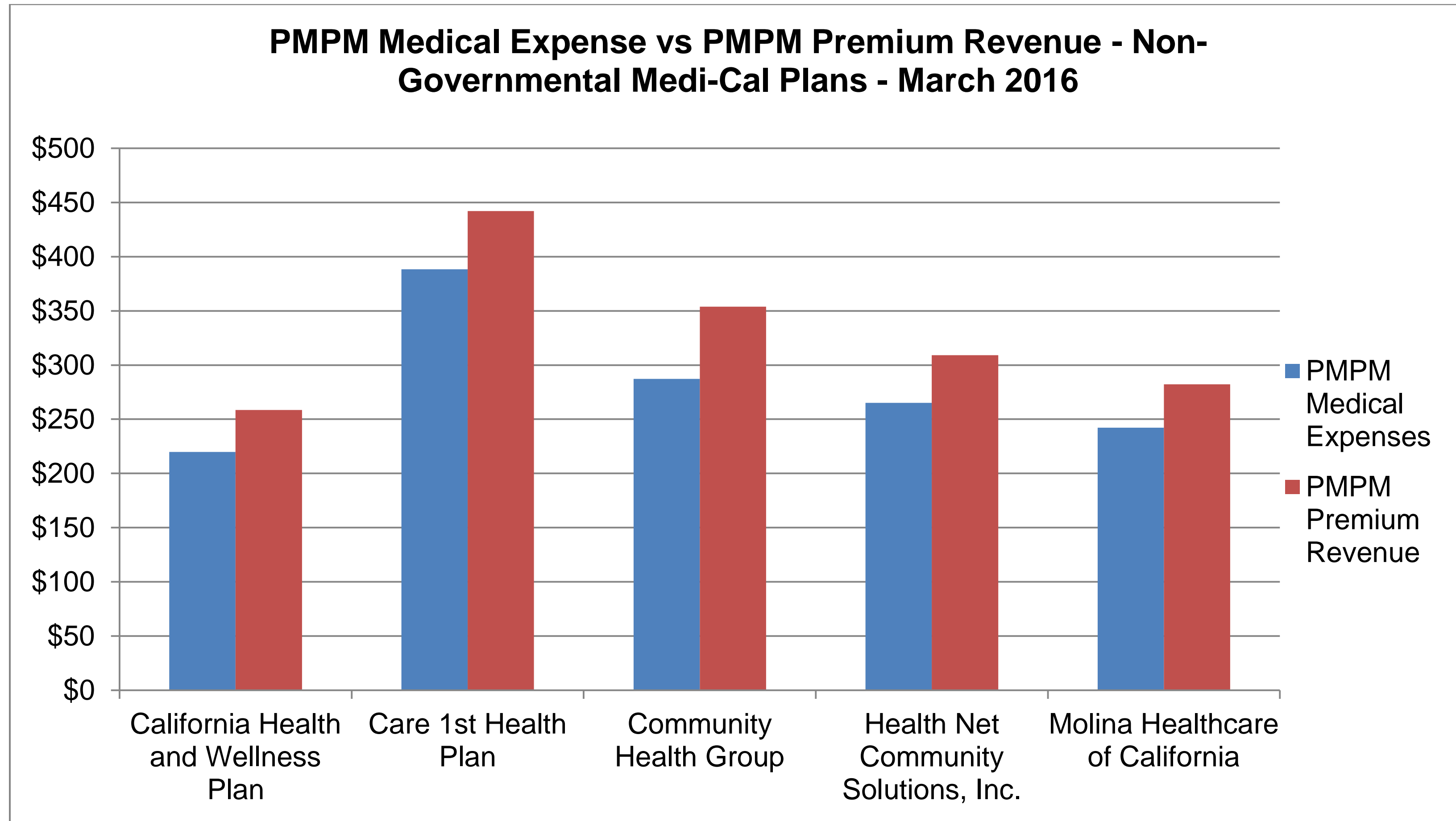
	Mar-13		Mar-14		Mar-15		Mar-16[13]		
Non-Governmental Medi-Cal Plans	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	Net [14] Revenue
California Health and Wellness Plan	N/A	N/A	$186	$198	$253	$296	$220	$259	$39
Care 1st Health Plan[15]	194	200	232	260	268	325	388	442	$54
Community Health Group	195	186	216	227	286	316	287	354	$67
Health Net Community Solutions	156	194	177	215	261	304	265	309	$44
Molina Health of California	163	188	194	228	275	315	242	282	$40

[13] March 2016 PMPM Medical Expense and PMPM Premium Revenue information excludes pass through income and expense items
[14] Difference between March 2016 PMPM Medical Expense and PMPM Premium Revenue.
[15] PMPM information for Care 1st includes commercial and other lines of business.

PMPM Medical Expense vs PMPM Premium Revenue

Chart 9 illustrates the NGM plans' PMPM medical expense vs PMPM premium revenue for March 2016. All plans reported premium revenue that was higher than per member per month expenses.

Chart 14



Net Income - Non-Governmental Medi-Cal Plans

Favorable PMPM premium revenue ratios translated to positive net income for all NGM plans.

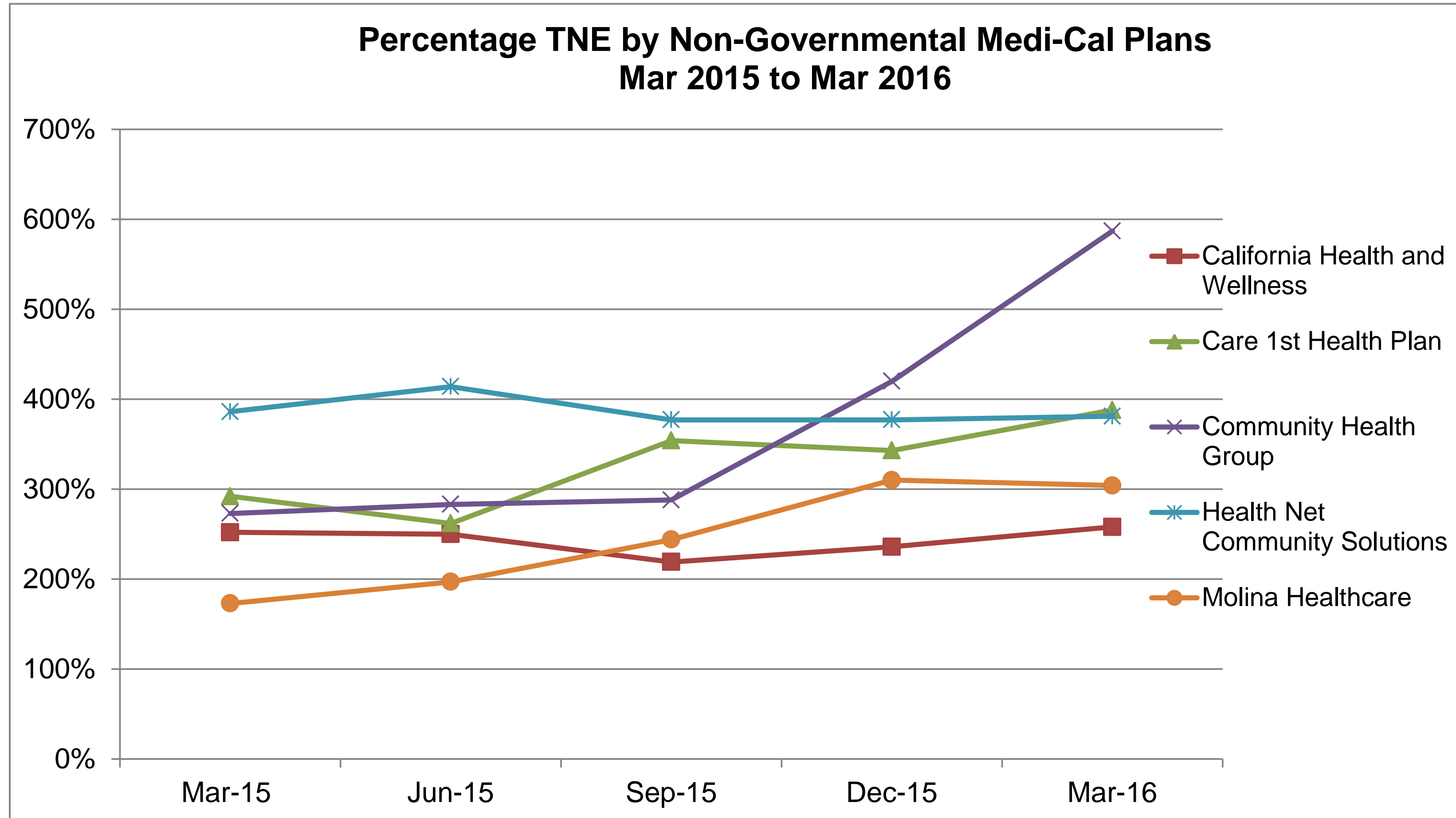
Table 9
Non-Governmental Medi-Cal Plans Net Income by Quarter (in thousands)

Non-Governmental Medi-Cal Plans	QE Dec-14	QE Mar-15	QE Jun-15	QE Sep-15	QE Dec-15	QE Mar-16
California Health and Wellness Plan	$8,640	$2,912	$4,796	$507	$6,973	$3,940
Care 1st Health Plan	23,166	12,537	(4,203)	15,960	7,201	22,111
Community Health Group	20,448	15,111	12,251	9,296	77,057	47,400
Health Net Community	79,389	66,032	140,021	149,653	177,541	77,507
Molina Health of California	27,739	5,025	10,374	24,991	26,879	10,675
Total Net Income	**$159,382**	**$101,617**	**$163,239**	**$200,407**	**$295,651**	**$161,633**

Tangible Net Equity – Non-Governmental Medi-Cal Plans

NGM plans' TNE to Required TNE ranged from 258% to 587%. TNE reported by NGM plans is lower than the LI and COHS plans. This may be in part due to a majority of the NGM plans declaring dividends to parent companies or shareholders thereby reducing the reserve levels.

Chart 15



Cash Flow from Operations

NGM plans reported $459 million in cash flow from operations in March 2016. NGM plans' cash inflow from operations is primarily attributed to the Medi-Cal premium revenue paid by DHCS and/or capitation revenue from their plan-to-plan arrangement with plans directly contracted with DHCS.

Claims

Pursuant to the Knox-Keene Act, full service health plans are required to process 95% of their claims within 45 working days. NGM plans did not report any claims processing or emerging claims payment deficiencies for March 2016.

VI. Conclusion

After the initial surge in LI and COHS plan's enrollment brought on by the ACA in 2014, the rate of increase in enrollment slowed down for the later part of 2015 and similar trends continued in the first quarter of 2016. Most Medi-Cal managed care plans continue to see increases in enrollment and this trend is expected to continue in subsequent years. Expenses and premium revenue continue to rise as enrollment increases. The DMHC will continue to monitor the enrollment trends and financial solvency of all LI, COHS and NGM plans reporting to the Department.