Financial Summary of Medi-Cal Managed Care Health Plans

Quarter Ending June 30, 2018

Prepared on September 19, 2018

Prepared by: Office of Financial Review

Pritika Dutt, Deputy Director

Stephen Babich, Supervising Examiner

Karanveer Singh, Financial Examiner

Table of Contents

Tables

Charts

I. Overview

Medi-Cal, California's Medicaid program provides high quality, accessible, and cost-effective health care through managed care delivery systems. 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 10.7 million Medi-Cal beneficiaries in all 58 California counties receive their health care through six main models of managed care: Two-Plan Model, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Imperial Model, San Benito Model, and Regional Model.

Locally-sponsored plans, known as Local Initiatives (LIs), participate as MCMC plans under the Two-Plan Model, while COHS 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 7 million Medi-Cal beneficiaries are enrolled in LI and COHS plans.

In the two GMC counties, Sacramento and San Diego, DHCS contracts with several commercial plans to serve approximately 1.15 million Medi-Cal beneficiaries. There are about 385,000 Medi-Cal beneficiaries served under the Imperial, San Benito, and Regional models combined. Medi-Cal providers who wish to provide services to the MCMC enrollees must participate in the managed care plan's provider network.

In addition to the MCMC plans, Non-Governmental Medi-Cal (NGM) plans serve 3.3 million Medi-Cal enrollees. NGM plans are plans that report greater than 50 percent Medi-Cal enrollment but are neither a LI nor a COHS. Because LI, COHS, and NGM 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 report includes enrollment and financial information reported by LI, COHS, and NGM plans as of the quarter ending June 30, 2018. This report also includes Medi-Cal enrollment information for Blue Cross of California (Anthem Blue Cross)

[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 enacted in 2014 that transferred the provision of outpatient mental health benefits for beneficiaries with mild to moderate impairment of mental, emotional or behavioral functioning resulting from any mental health condition defined by the DSM-IV from the counties to the plans. The legislation also clarified that the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit includes a provision for Behavioral Health Treatment to all Medi-Cal children and adolescent beneficiaries 0 to 21 years of age that are diagnosed with Autism Spectrum Disorder.

and Kaiser Foundation Health Plan Inc. (Kaiser Permanente) for comparison purposes. However, because their Medi-Cal enrollment was less than 50% of their total enrollment, they do not meet the definition of a NGM Plan. Furthermore, the financial information the Department of Managed Health Care (DMHC) receives from Anthem Blue Cross and Kaiser Permanente is for their entire book of business.

II. Summary of Findings

Key findings from this report include:

- While the LI, COHS and NGM plans experienced increases in their Medi-Cal enrollment from 2014 to 2016, enrollment stabilized in 2017 and most Medi-Cal plans reported a decline in enrollment for the quarter ending June 2018.

- Collectively, most LI, COHS and NGM plans reported a decrease in their medical expenses compared to June 2017, which was triggered by a decline in Medi-Cal enrollment.

- Per Member per Month (PMPM) premium revenue exceeded PMPM medical expense for almost every LI, COHS and NGM plan for the period ending June 30, 2018. Revenues and expenses for the MCMC plans have stabilized compared to significant growth experienced from 2014 to 2016 brought on by the Affordable Care Act in 2014.

- Net income declined sharply for all Medi-Cal plans compared to June 2017 and the previous quarter. The LI plans reported higher net income than COHS plans, and COHS plans reported higher tangible net equity (TNE) reserves than LIs. Both LI and COHS plans continue to report healthy TNE reserves. In comparison to NGM plans, LI and COHS plans generally hold on to their higher reserves to cover any needed capital expenditures or future economic downturns.

- NGM plans generally reported higher net income and lower TNE reserves than both LI and COHS plans. Several NGM plans pay dividends to their parent companies and/or shareholders thereby reducing reserve levels.

- Two new NGM plans entered the Medi-Cal market in December 2017 - Aetna Better Health of California Inc. (Aetna Better Health) and UnitedHealthcare Community Plan of California, Inc. (UnitedHealthcare Community Plan) and are included in this report for the first time.

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 a commercial plan and a LI plan; in Tulare County, the DHCS contracts with two commercial plans: Anthem Blue Cross and Health Net of California, Inc. (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. 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 than in commercial plans in Two-Plan Model counties.[3]

- 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 Health Plan) – Contra Costa
    - Fresno-Kings-Madera Regional Health Authority (CalViva Health) – Fresno, Kings, and Madera
    - Inland Empire Health Plan (IEHP) – Riverside and San Bernardino
    - Kern Health Systems – Kern
    - Local Initiative Health Authority for L.A. County (L.A. Care Health Plan) – Los Angeles
    - San Francisco Community Health Authority (San Francisco Health Plan) – San Francisco
    - San Joaquin County Health Commission (The Health Plan of San Joaquin) – San Joaquin and Stanislaus
    - Santa Clara County Health Authority (Santa Clara Family Health Plan) – Santa Clara

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

- LI plans reported combined enrollment of 5.3 million individuals as of June 2018. Over 5.1 million (96%) of the total LI enrollment are Medi-Cal beneficiaries. The remaining 4% of non-Medi-Cal LI enrollment includes other lines of business such as Commercial (Individual and Large Group), Medicare Advantage, Medicare Supplement, In-Home Supportive Services (IHSS) and Healthy Kids.

- Total LI plan enrollment increased by 0.7% from June 2017 to June 2018.

- All LI plans' PMPM premium revenue outpaced PMPM medical expense for June 2018.

- LI plans reported $30 million in net income in June 2018, which was about 78% lower than the $138 million net income reported in June 2017, and 77% lower than the $132 million net income for the quarter ending March 31, 2018.

- The LIs reported TNE that ranged from 448% to 789% of required TNE.

- The LIs reported $75 million in cash flow from operations, which was higher than the negative $1.04 billion reported in June 2017. This is a significant change from March 2018 when the LIs reported cash flow from operations of negative $381 million. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and the Medicaid Coverage Expansion (MCE) rate adjustments.

B. Enrollment Trends – LI

The LI plans serve nearly 5.3 million enrollees in 13 counties in California. Total enrollment increased by 0.7% since June 2017. 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 June 2017 to June 2018. All LIs reported a slight decline in enrollment, except Kern Health Systems and L.A. Care Health Plan, which reported enrollment increases of 2.3% and 3.5%, respectively.

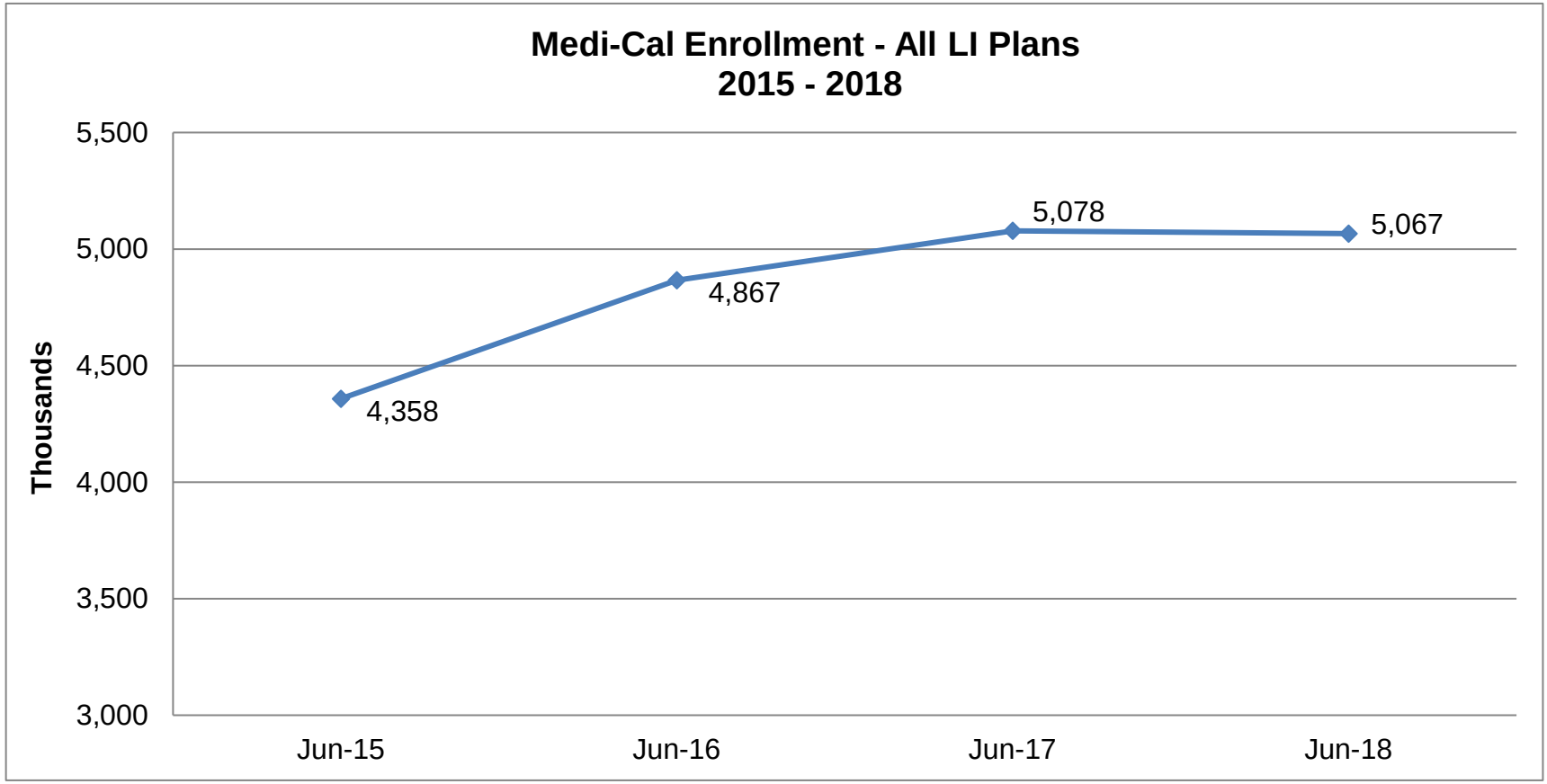
Table 1
Enrollment in Local Initiatives
June 2017 - June 2018

Local Initiative	Total Medi-Cal Enrollment June 2018	Percentage of Medi-Cal Enrollment June 2018	Total Enrollment June 2018[4]	Total Enrollment June 2017	Enrollment Change from June 2017 to June 2018	Percentage Enrollment Change from June 2017 to June 2018
Alameda Alliance for Health	261,832	98%	267,639	268,590	-951	-0.4%
CalViva Health	358,653	100%	358,653	361,699	-3,046	-0.8%
Contra Costa Health Plan	182,544	95%	191,568	192,017	-449	-0.2%
IEHP	1,222,097	98%	1,246,843	1,260,053	-13,210	-1.0%
Kern Health Systems	247,317	100%	247,317	241,716	5,601	2.3%
L.A. Care Health Plan	2,069,863	94%	2,191,364	2,116,991	74,373	3.5%
San Francisco Health Plan	127,863	90%	141,363	148,254	-6,891	-4.6%
Santa Clara Family Health Plan	248,776	96%	259,475	276,028	-16,553	-6.0%
The Health Plan of San Joaquin	347,794	100%	347,794	348,035	-241	-0.1%
Total	**5,066,739**	**96%**	**5,252,016**	**5,213,383**	**38,633**	**0.7%**

[4] The total enrollment includes Commercial (Individual and Large Group), Medicare Advantage, Medicare Supplement, Medi-Cal Risk, IHSS and Healthy Kids.

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

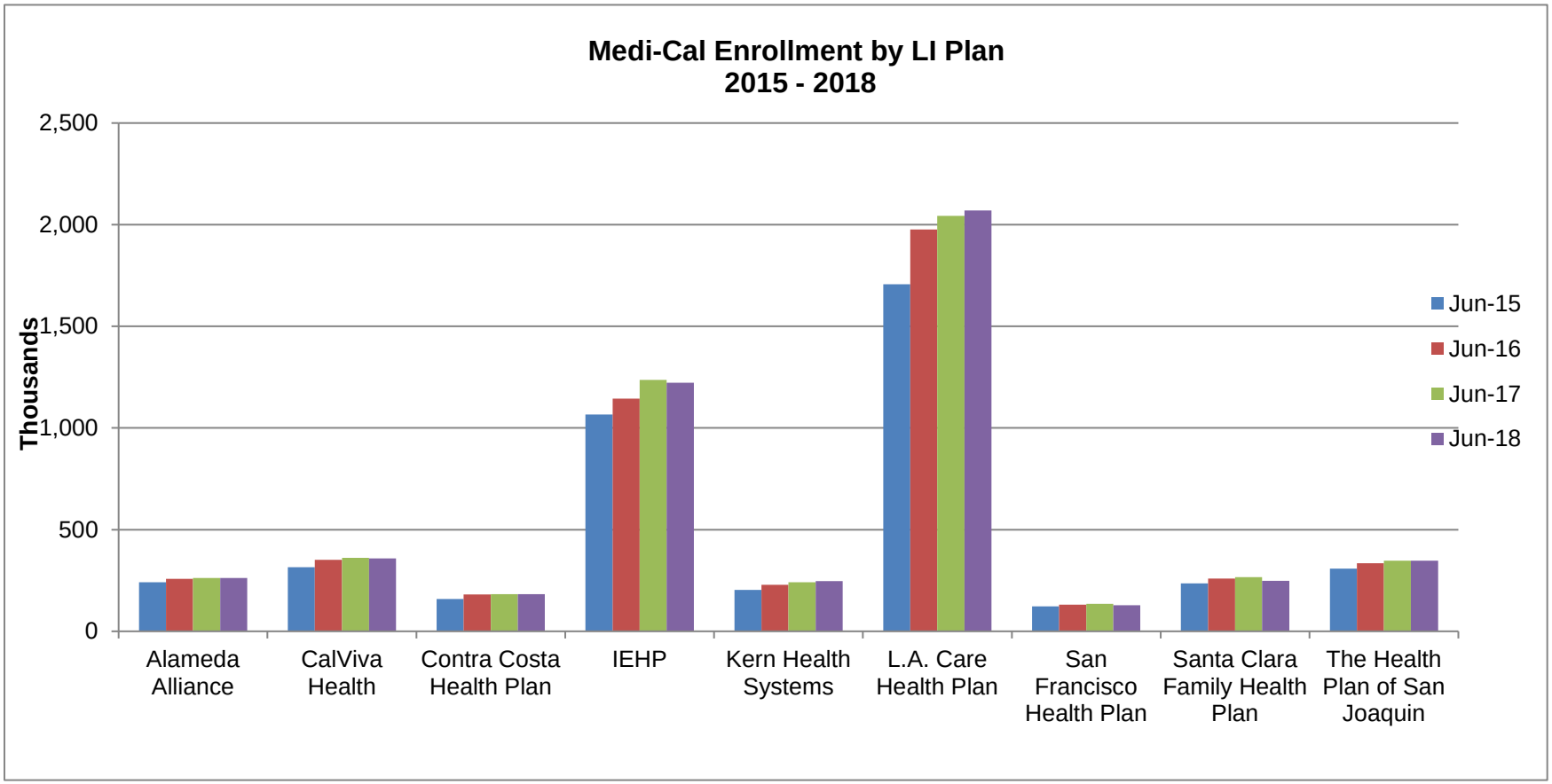
Chart 1



Medi-Cal enrollment in LIs remained consistent from June 2017 to June 2018. L.A. Care Health Plan reported the highest number of enrollees (2.1 million) and had the greatest increase in enrollment (3.5%) over the last year.

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

Chart 2



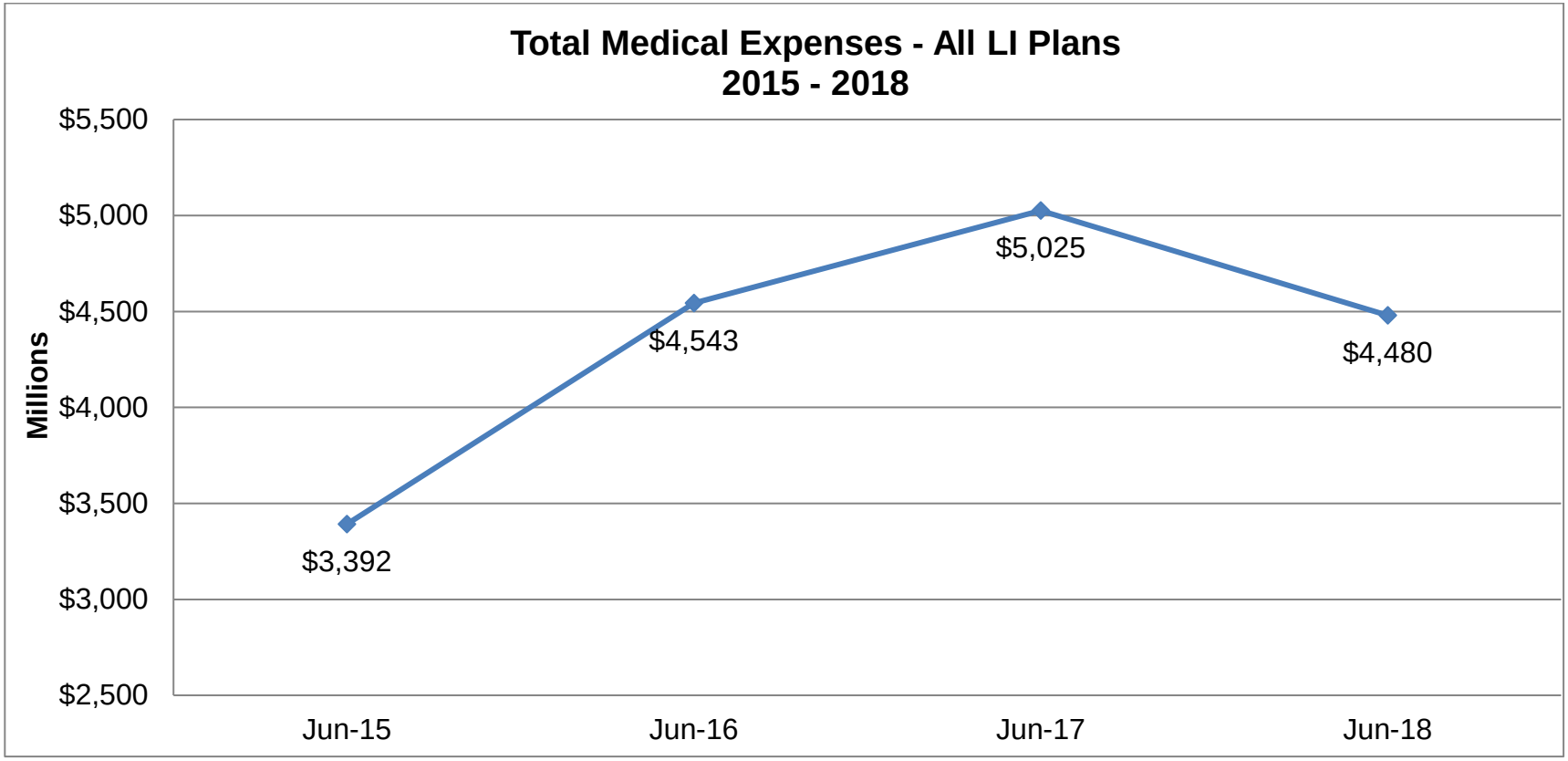
All LIs reported increases in their Medi-Cal enrollment from 2015 to 2017. All LI plans except, L.A. Care Health Plan and Kern Health Systems, reported a slight decline in Medi-Cal enrollment compared to June 2017. Total Medi-Cal enrollment for LI plans increased by 84% from December 31, 2013 to June 30, 2018.

C. Financial Trends - LI

Medical Expenses

Chart 3 illustrates total medical expenses for the LIs compared to the same quarter over the last four years. There was a decline in total medical expenses for the quarter ending June 2018. 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 June for the past four years, as well as the difference in PMPM medical expense and premium revenue for June 2018. San Francisco Health Plan reported the highest PMPM medical expense and premium revenue. All LIs reported positive net premium revenue for June 2018.

Table 2
Per Member Per Month Medical Expenses and Premium Revenue – LI
2015 - 2018

Local Initiative	Jun-15		Jun-16		Jun-17		Jun-18		
	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Net Revenue[5]
Alameda Alliance	$29	$111	$235	$265	$250	$273	$273	$276	$3
CalViva Health	$255	$271	$260	$272	$116	$125	$226	$239	$13
Contra Costa Health Plan	$260	$303	$300	$300	$274	$279	$289	$310	$21
IEHP	$291	$326	$267	$301	$332	$349	$285	$310	$25
Kern Health Systems	$205	$226	$200	$237	$216	$234	$245	$260	$15
L.A. Care Health Plan	$266	$292	$340	$358	$334	$350	$266	$275	$9
San Francisco Health Plan	$306	$371	$305	$340	$308	$316	$415	$422	$7
Santa Clara Family Health Plan	$256	$310	$291	$346	$287	$304	$315	$352	$37
The Health Plan of San Joaquin	$79	$127	$217	$243	$246	$280	$233	$251	$18

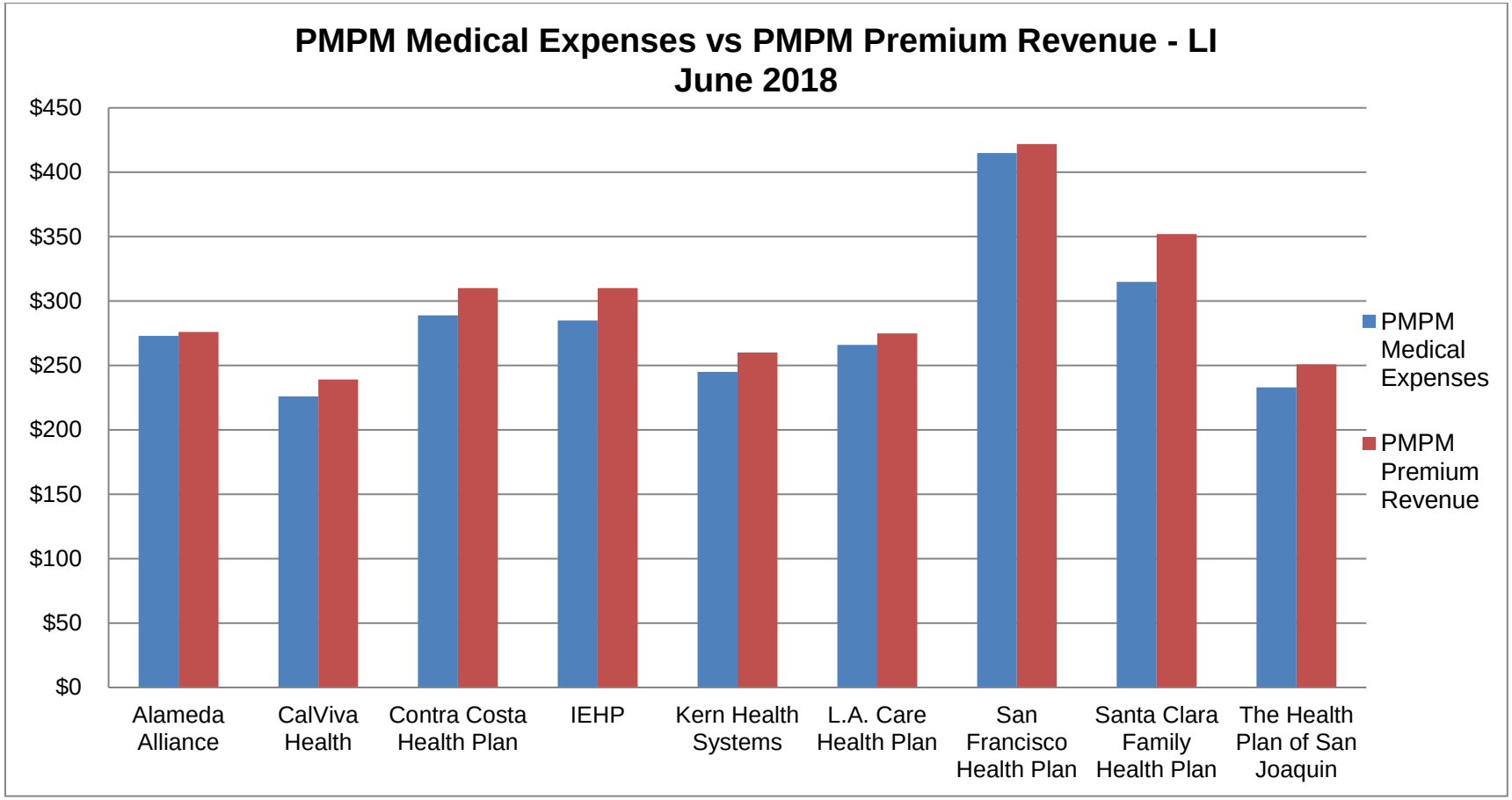
[5] Difference between June 2018 PMPM Medical Expense and PMPM Premium Revenue.

PMPM medical expense is calculated by dividing the total medical expenses by cumulative member months. PMPM premium revenue is calculated by dividing the premium revenue 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. The difference between PMPM premium revenue and medical expenses does not equate to net income. There are other non-medical expenses health plans have to pay such as administrative expenses and taxes that impact net income.

PMPM Medical Expense vs. PMPM Premium Revenue - LI

Chart 4 illustrates the LI plans' PMPM medical expense vs PMPM premium revenue for June 2018. 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) June 2018, Alameda Alliance, L.A. Care Health Plan and San Francisco Health Plan reported a negative net income. Net income or loss is directly related to premium revenue and medical expenses.

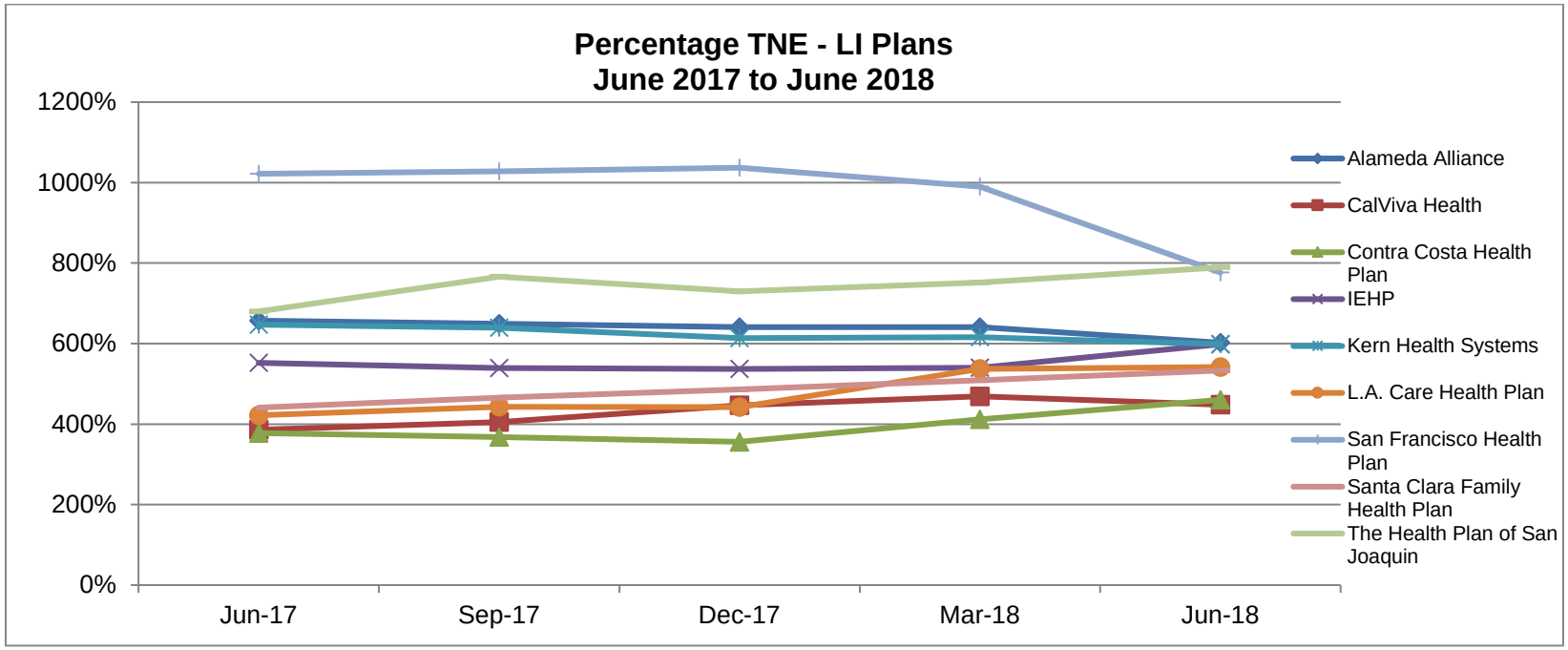
Table 3
LI Net Income by Quarter (in thousands)

Local Initiative	QE Mar-17	QE Jun-17	QE Sep-17	QE Dec-17	QE Mar-18	QE Jun-18
Alameda Alliance for Health	$13,234	$5,209	$608	$1,493	$2,546	($8,072)
CalViva Health	$3,454	$1,161	$3,198	$2,547	$1,452	$3,003
Contra Costa Health Plan	$2,193	$1,100	$1,776	$1,793	$6,729	$12,125
IEHP	$21,974	$16,958	$13,660	$15,411	$916	$31,660
Kern Health Systems	$12,165	$6,335	$3,643	($2,868)	$1,563	$606
L.A. Care Health Plan	$58,573	$27,000	$46,308	$18,755	$109,874	($27,010)
San Francisco Health Plan	($2,663)	$9,807	$2,711	$2,365	($5,750)	($11,342)
Santa Clara Family Health Plan	$7,066	$40,162	$7,908	$7,652	$1,923	$16,262
The Health Plan of San Joaquin	$18,812	$30,707	$30,194	($1,589)	$13,145	$12,944
Total LI Net Income	**$134,808**	**$138,439**	**$110,007**	**$45,559**	**$132,398**	**$30,178**

Tangible Net Equity - LI

TNE is a reserve requirement described in section 1300.76 of the Knox-Keene regulations[6] 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[7], 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[8] may be added to the TNE calculation, which serves to increase the plan's TNE. All the LIs had TNE that exceeded the regulatory requirements.

Chart 5



[6] "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.
[7] Goodwill is an intangible asset that arises as a result of the acquisition of one company by another for a premium value.
[8] 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 until after the other creditors were paid in full.

The Department's minimum requirement for TNE reserves is 100% of required TNE. If a 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 LI plans overall was stable in 2017 and the trend continued in 2018. For June 2018, the reported TNE ranged from 448% to 789% of required TNE. The TNE for one plan, San Francisco Health Plan, declined from 990% in March 2018 to 777% in June 2018, but was still well above the minimum TNE requirement.

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.

Five of the nine LI plans reported negative cash flow from operations in June 2018. The cash flow from operations totaled $75 million in June 2018 compared to negative $1.04 billion in June 2017. 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 2017/2018 fiscal year, which occurred in July 2017. Additionally, there are retroactive payment adjustments from DHCS.

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. LI plans did not report any claims processing or emerging claims payment deficiencies for June 2018.

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:
    - Orange County Health Authority (CalOptima) – Orange
    - Partnership HealthPlan of California (Partnership HealthPlan) – Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo
    - Santa Barbara San Luis Obispo Regional Health Authority (CenCal Health) – Santa Barbara and San Luis Obispo
    - Santa Cruz-Monterey-Merced Managed Medical Care Commission (Central California Alliance for Health) – Merced, Monterey, and Santa Cruz
    - San Mateo Health Commission (Health Plan of San Mateo) – San Mateo
    - Gold Coast Health Plan – Ventura
- Medi-Cal beneficiaries in COHS counties have only one Medi-Cal plan 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 the Health Plan of San Mateo has voluntarily included its Medi-Cal enrollment under its Knox-Keene license, however, CalOptima, CenCal Health and Partnership HealthPlan have Knox-Keene licenses for other lines of business such as Medicare Advantage, IHSS, Healthy Kids, and Program of All Inclusive Care for the Elderly (PACE). The DMHC is currently reviewing Central California Alliance for Health's application to include its Medi-Cal business under its Knox-Keene license. Gold Coast Health Plan has no Knox-Keene license, and 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.

- Total COHS plans' enrollment decreased by 1.2% from June 2017 to June 2018.
- Almost all COHS plans' PMPM premium revenue outpaced medical expenses for June 2018.
- COHS plans reported negative $60 million in net income in June 2018, which was lower than the negative $53 million net income reported in June 2017.
- The COHS plans reported TNE that ranged from 818% to 1,204% of required TNE.
- The COHS plans reported negative $811 million in cash flow from operations compared to the negative $862 million reported in June 2017. This is a significant change from March 2018 when the COHS plans reported cash flow from operations of $30 million. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium payments by DHCS and the MCE rate adjustments for the 2017/2018 fiscal year.

B. Enrollment Trends - COHS

COHS plans reported enrollment of nearly 2 million, a slight decrease of 1.2% compared to June 2017. CenCal Health was the only COHS plan that reported an increase in enrollment (2.2%) from June 2017 to June 2018. CalOptima and Partnership HealthPlan reported the highest enrollment numbers.

Table 4
Enrollment in County Organized Health Systems
June 2017 - June 2018

COHS	Total Medi-Cal Enrollment June 2018	Percentage of Medi-Cal Enrollment June 2018	Total Enrollment June 2018[9]	Total Enrollment June 2017	Enrollment Change from June 2017 to June 2018	Percentage Enrollment Change from June 2017 to June 2018
CalOptima	763,824	98%	780,277	789,066	(8,789)	-1.1%
CenCal Health	182,850	100%	182,850	178,856	3,994	2.2%
Central California Alliance for Health	352,065	100%	352,611	354,649	(2,038)	-0.6%
Partnership HealthPlan	558,880	100%	558,880	570,661	(11,781)	-2.1%
Health Plan of San Mateo	117,270	98%	119,893	124,691	(4,798)	-3.8%
Total	**1,974,889**	**99%**	**1,994,511**	**2,017,923**	**(23,412)**	**-1.2%**

[9] The total enrollment includes Medicare Advantage, Medi-Cal Risk, IHSS, Healthy Kids and PACE.

Chart 6 illustrates the Medi-Cal managed care enrollment trend in COHS plans. Medi-Cal enrollment in COHS plans decreased slightly in June 2018.

Chart 6

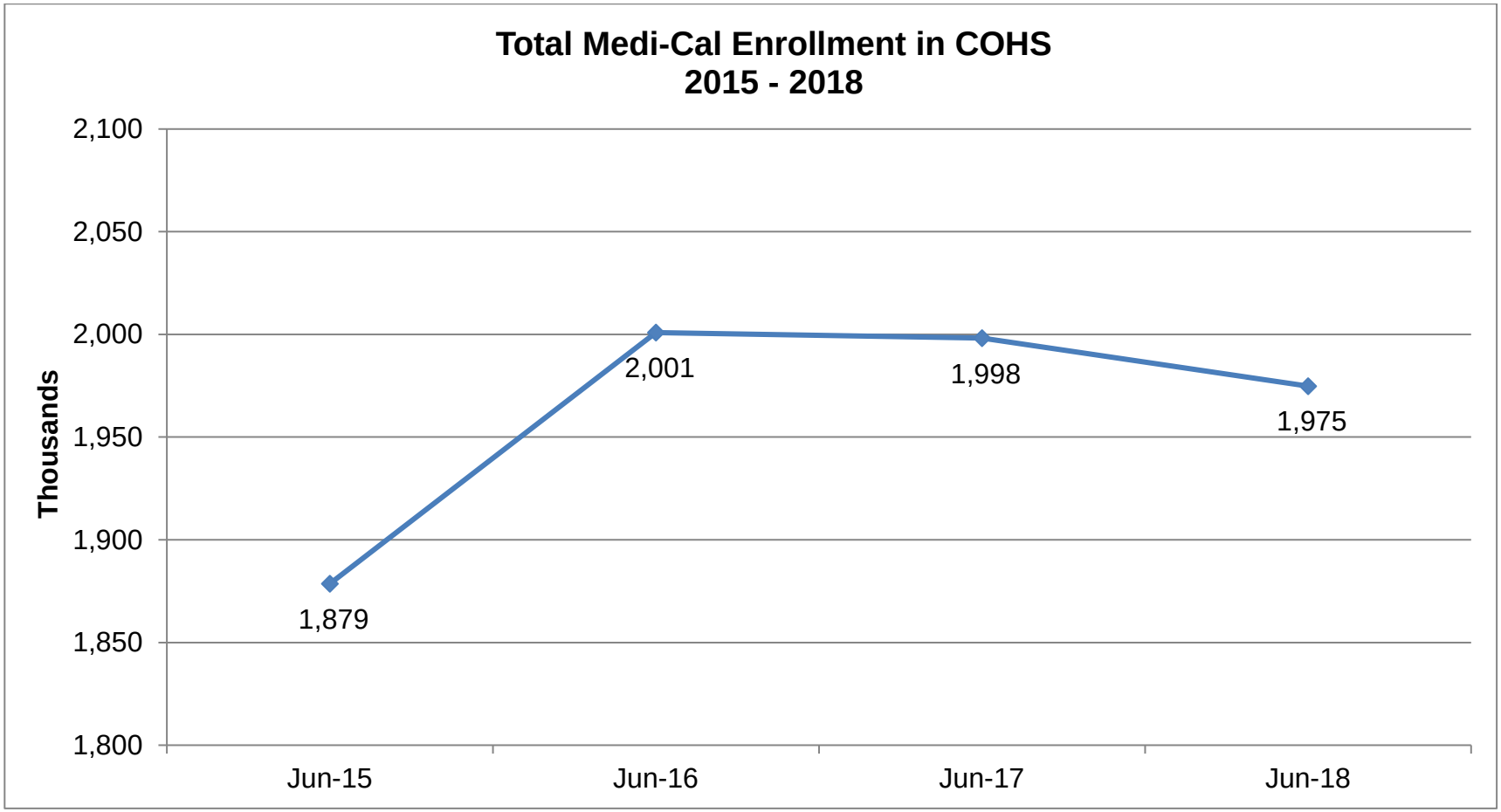
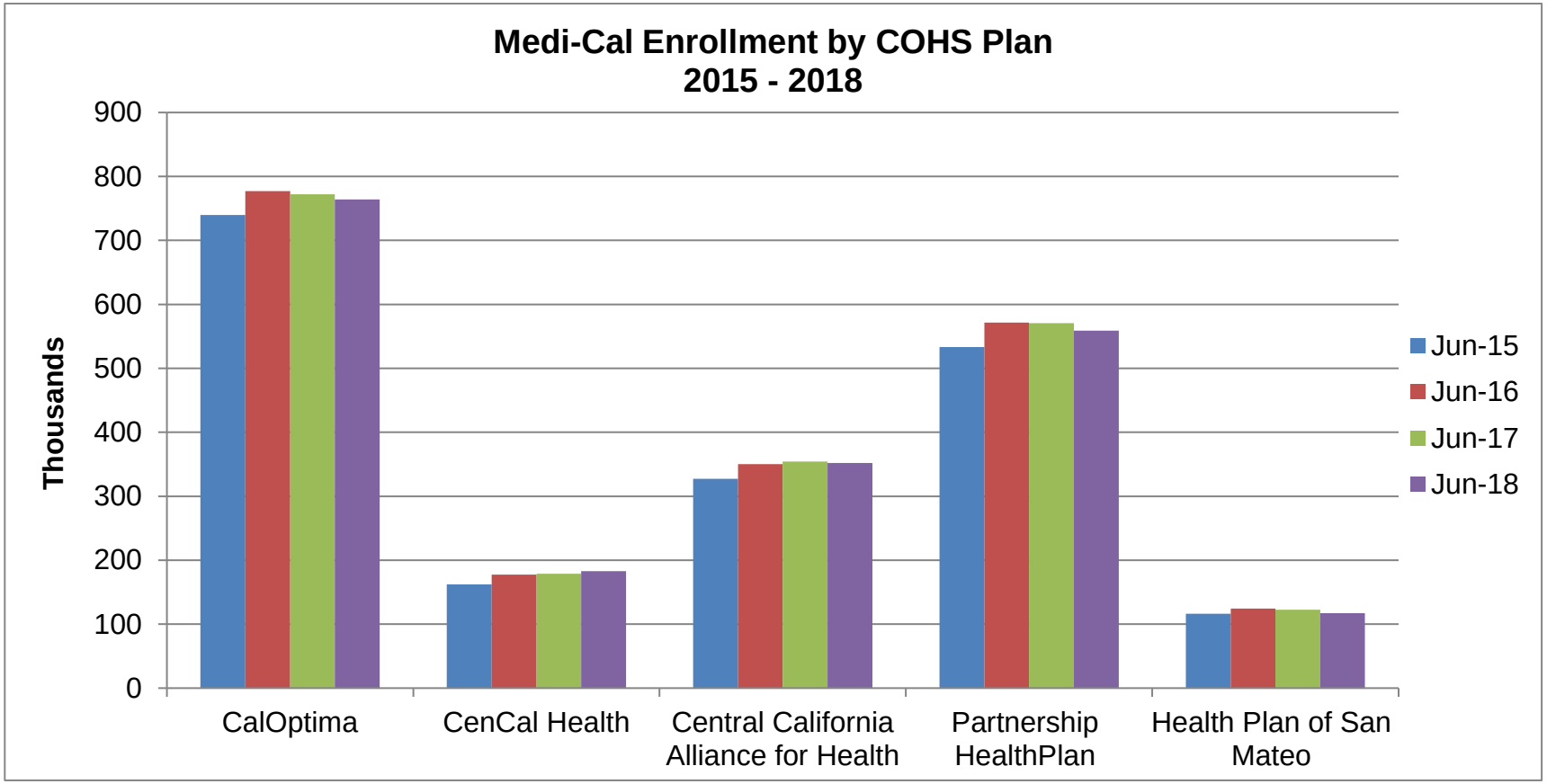


Chart 7 shows the enrollment growth for each COHS plan over the past four years.

Chart 7

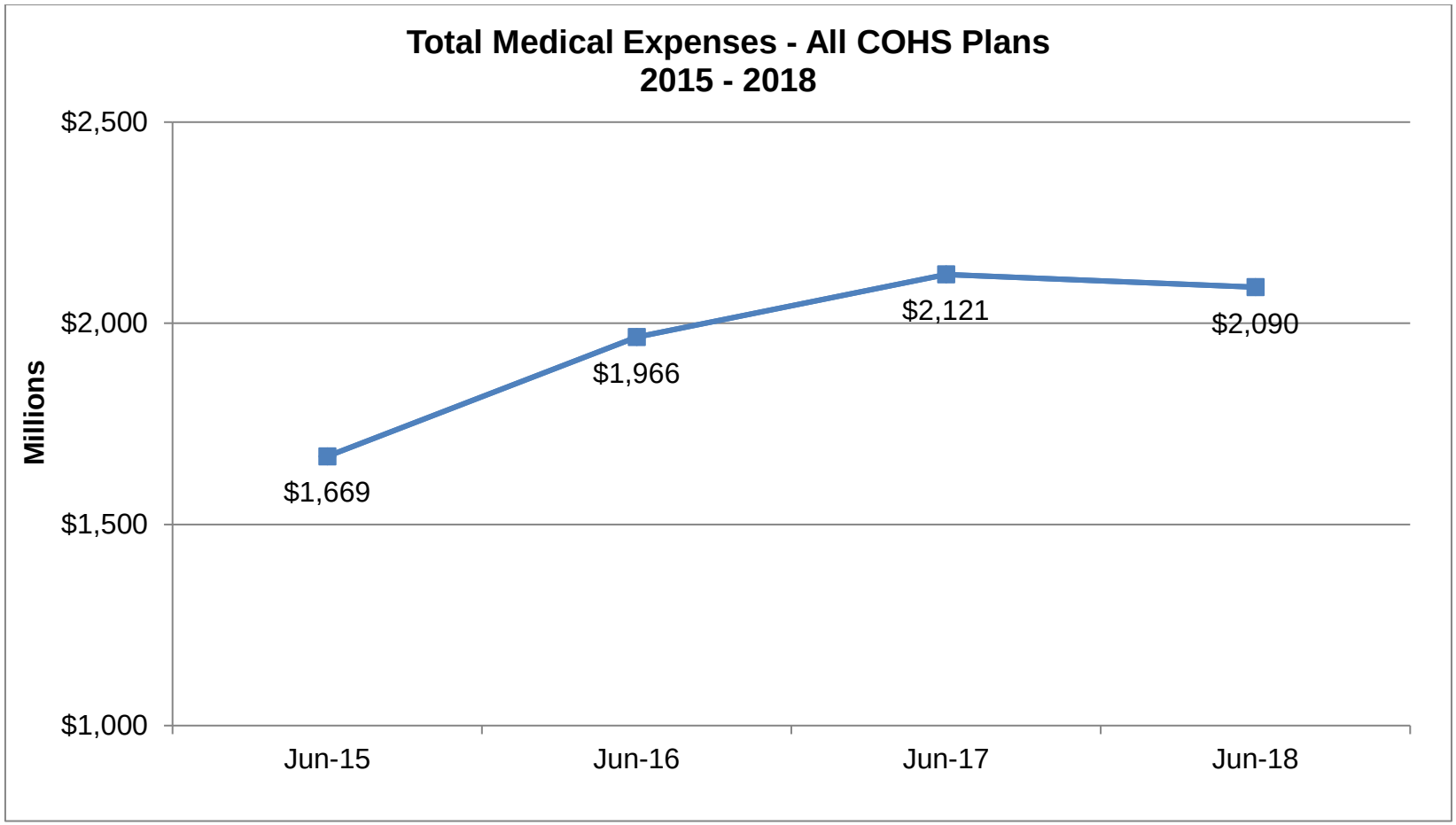


Almost all COHS plans reported increases in their Medi-Cal enrollment from 2015 to 2017. All COHS plans except CenCal Health reported slight decreases in Medi-Cal enrollment compared to June 2017. Total Medi-Cal enrollment for COHS plans increased by 62% from December 31, 2013 to June 30, 2018.

C. Financial Trends - COHS

Chart 8 illustrates total medical expenses for the COHS plans compared to the same quarter over the last four years.

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 June for the past four years, as well as the difference between the PMPM medical expense and premium revenue for June 2018.

All COHS plans, except Central California Alliance for Health and Partnership HealthPlan, reported positive PMPM net revenue for June 2018 and had higher PMPM premium revenue than medical expenses at June 2018. Health Plan of San Mateo reported the highest PMPM medical expense, premium revenue and net revenue.

Table 5
Per Member Per Month Medical Expense and Premium Revenue – COHS
2015 – 2018

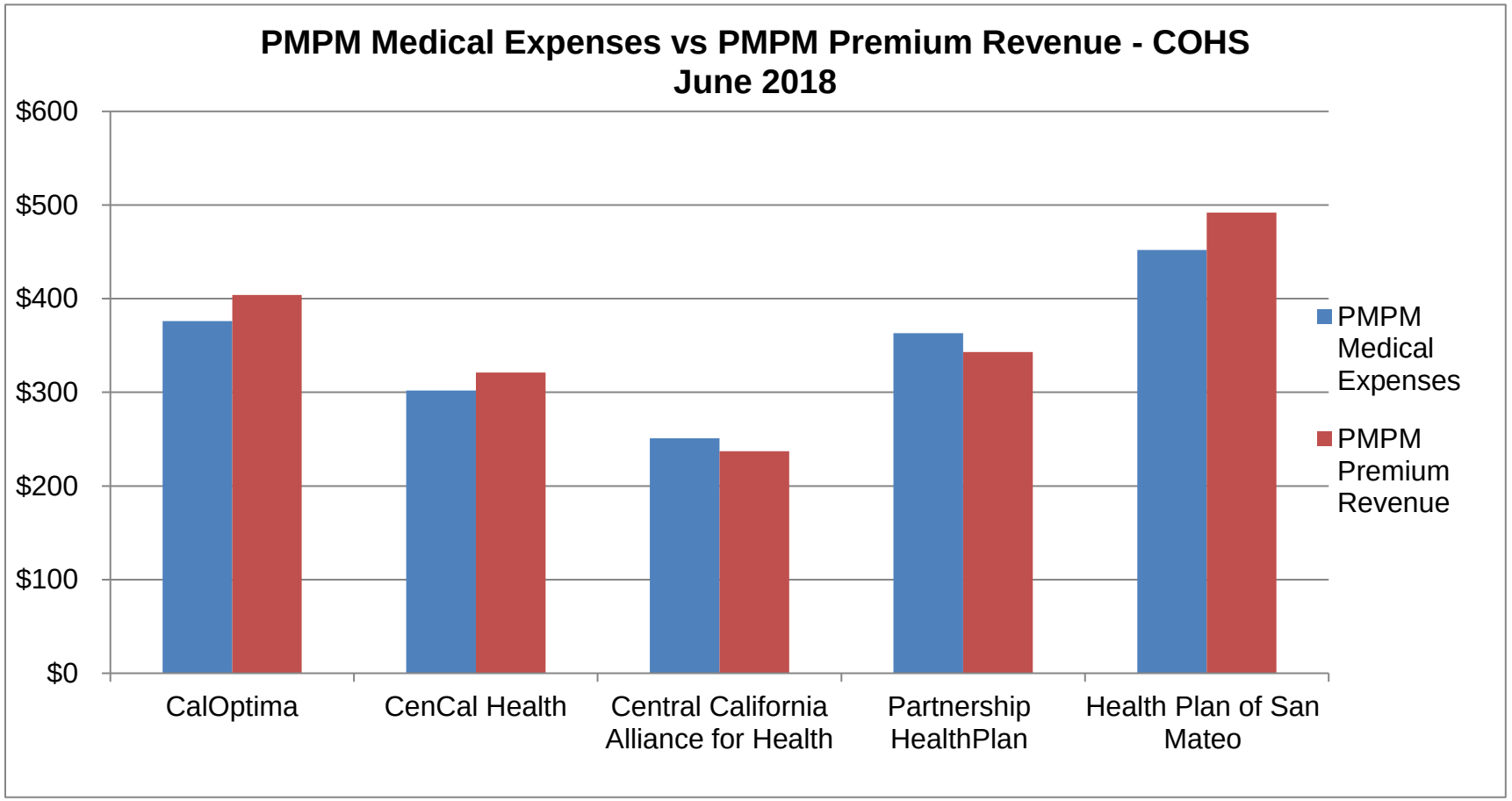
COHS	Jun-15		Jun-16		Jun-17		Jun-18		
	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Net Revenue[10]
CalOptima	$315	$353	$361	$374	$402	$431	$376	$404	$28
CenCal Health	$304	$386	$258	$313	$269	$303	$302	$321	$19
Central California Alliance for Health	$199	$245	$233	$256	$238	$263	$251	$237	($14)
Partnership HealthPlan	$275	$350	$318	$353	$340	$348	$363	$343	($20)
Health Plan of San Mateo	$451	$512	$443	$513	$468	$509	$452	$492	$40

[10] Difference between June 2018 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 June 2018. All plans except Central California Alliance for Health and Partnership HealthPlan reported premium revenue that was higher than PMPM expenses.

Chart 9



Net Income - COHS

Table 6 shows the Net Income for COHS plans over the past six quarters. For the quarter ending June 2018, MCE rate adjustments translated to negative net income for most of the COHS plans.

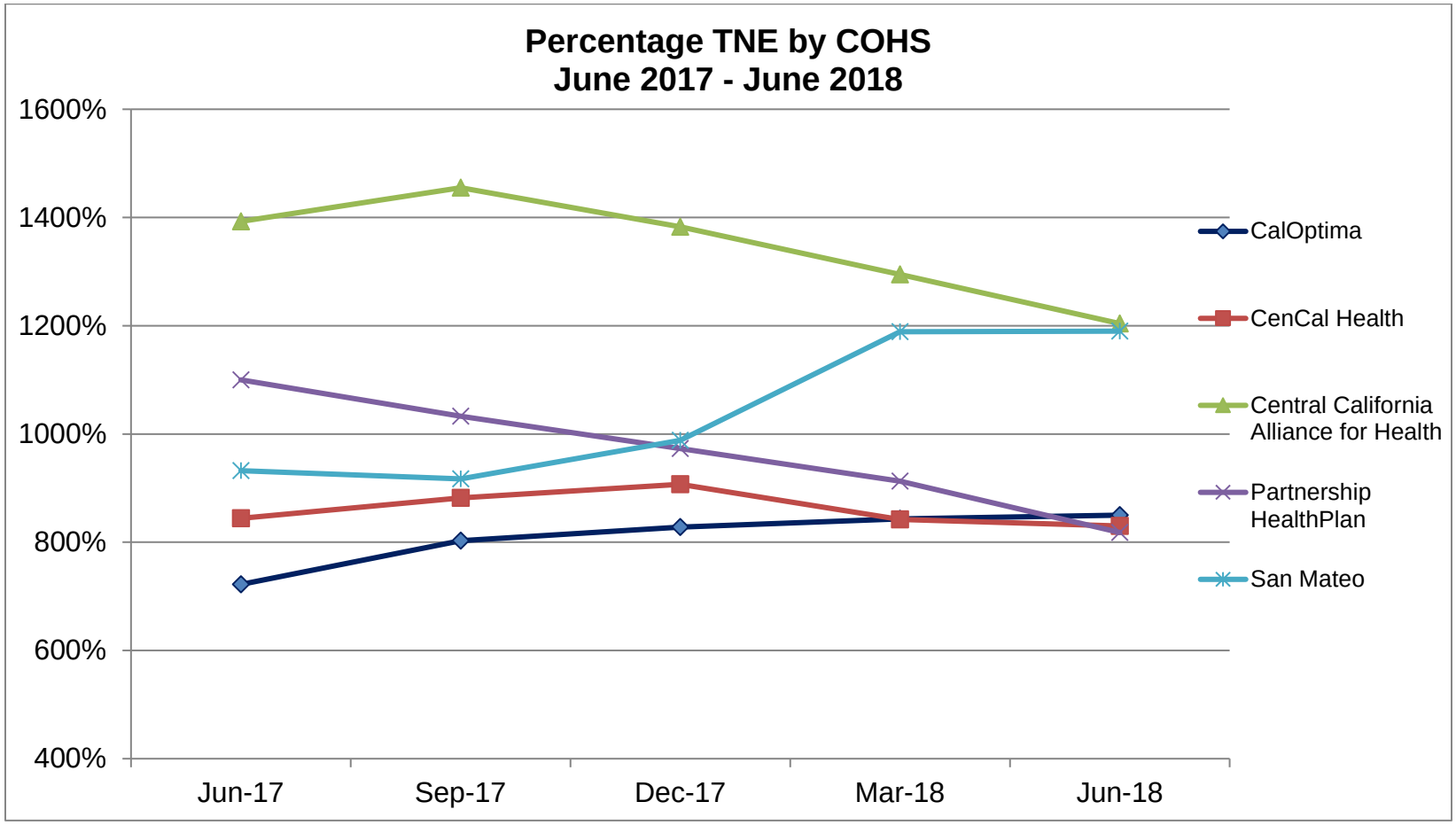
Table 6
COHS Net Income by Quarter (in thousands)

COHS	QE Mar-17	QE Jun-17	QE Sep-17	QE Dec-17	QE Mar-18	QE Jun-18
CalOptima	$3,160	$45,706	$11,309	$11,691	($7,514)	$28,937
CenCal Health	$10,162	$12,662	$6,361	$7,060	($1,414)	$2,639
Central California Alliance for Health	$9,014	$7,613	$33,313	($16,633)	($18,728)	($35,890)
Partnership HealthPlan	$2,070	($18,665)	($25,621)	($42,410)	($41,052)	($57,893)
Health Plan of San Mateo	($3,220)	$6,084	$1,582	$37,378	$12,216	$1,927
Total COHS Net Income	**$21,186**	**$53,400**	**$26,944**	**($2,914)**	**($56,492)**	**($60,280)**

Tangible Net Equity – COHS

All COHS plans reported over 800% of required TNE for June 2018. TNE to required TNE ranged from 818% to 1,204%. Partnership HealthPlan and Central California Alliance for Health over the last year.

Chart 10



Cash Flow from Operations

COHS plans reported negative $811 million in cash flow from operations in June 2018. 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, retroactive payment adjustments and the MCE rate adjustments for the 2017/2018 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 June 2018.

V. Non-Governmental Medi-Cal Plans

A. Highlights

- For the purposes of this report, Non-Governmental Medi-Cal (NGM) plans are plans with greater than 50% Medi-Cal enrollment.
- Aetna Better Health and UnitedHealthcare Community Plan commenced their operations in December 2017. Therefore, this report includes only June 2018 data for these two plans.
- Seven NGM plans currently serve 31 counties. The NGM plans and the counties in which they provide services are:
    - Aetna Better Health – Sacramento and San Diego.
    - California Health and Wellness Plan (California Health and Wellness) – Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba.
    - Care1st Health Plan (Care1st) – Los Angeles and San Diego.
    - Community Health Group – San Diego.
    - Health Net Community Solutions, Inc. (Health Net Community Solutions) – Fresno, Kern, Kings, Los Angeles, Madera, Sacramento, San Diego, San Joaquin, Stanislaus, and Tulare counties.
    - Molina Healthcare of California (Molina) – Imperial, Los Angeles, Sacramento, Riverside, San Bernardino, and San Diego.
    - UnitedHealthcare Community Plan – San Diego
- The structure among the NGM plans varies in the following ways:
    - Aetna Better Health is a for-profit wholly owned subsidiary of Aetna Health Holdings, LLC, which is a subsidiary of Aetna Inc., a publicly traded company.

  - California Health and Wellness is a for-profit wholly owned subsidiary of Centene Corporation (Centene), a publicly traded company. In 2017, California Health and Wellness paid dividends of $20 million to its parent company.
  - Care1st is a not-for-profit health plan owned by California Physicians' Services (Blue Shield of California).
  - Community Health Group is a not-for-profit health plan.
  - Health Net Community Solutions is a for-profit wholly owned subsidiary of Health Net, Inc., which is a subsidiary of Centene, a publicly traded company. In 2017 and 2018, Health Net Community Solutions paid dividends of $150 million and $200 million respectively to its parent company.
  - Molina is a for-profit wholly owned subsidiary of Molina Healthcare, Inc., a publicly traded company. In 2017 and 2018, Molina paid dividends of $130 million and $50 million respectively to its parent company.
  - UnitedHealthcare Community Plan is a for-profit wholly owned subsidiary of United HealthCare Services, Inc., which is subsidiary of UnitedHealth Group, a publicly traded company.
- There are two other plans that serve another 1.88 million Medi-Cal enrollees: Anthem Blue Cross with 1,227,475 enrollees and Kaiser Permanente with 655,880 enrollees. Enrollment information for these two plans is included in this report. However, financial solvency indicators are not included since neither of these plans report more than 50% of their enrollment as Medi-Cal. Their financial solvency is significantly impacted by other lines of business including Commercial and Medicare. Both Anthem Blue Cross and Kaiser Permanente are in solid financial health.

- 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 with the DHCS. For example, L.A. Care Health Plan subcontracts its Medi-Cal enrollment to Care1st and Molina in Los Angeles County.

- NGM plans' enrollment decreased 3.7% from June 2017 to June 2018.

- Almost all NGM plans' PMPM premium revenue outpaced medical expenses for June 2018.

- NGM plans reported $65 million in net income in June 2018, which was about 71% lower than the $222 million net income reported in June 2017, and 75% lower than the quarter ending March 31, 2018.

- Tangible net equity for NGM plans ranged from 207% to 4,795% of required TNE at June 2018.

- The NGM plans reported negative $887 million in cash flow from operations, which was lower than the negative $418 million reported in June 2017. This is a significant change from March 2018 when the NGM plans reported cash flow from operations of $855 million. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS, retroactive payment adjustments and the MCE rate adjustments for the 2017/2018 fiscal year.

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

Like LI and COHS plans, NGM plans have reported increases in enrollment since 2014. Most NGM plans reported a decline in total enrollment compared to June 2017, except California Health and Wellness and Care1st, which had slight increases in total enrollment. As noted earlier, two other plans, Anthem Blue Cross and Kaiser Permanente, serve 1.88 million Medi-Cal enrollees. From June 2017 to June 2018, Anthem Blue Cross and Kaiser Permanente reported a slight change in Medi- Cal enrollment at negative 12% and 3.5%, respectively.

Table 7
Enrollment in Non-Governmental Medi-Cal Plans
June 2017 - June 2018

Non-Governmental Medi-Cal Plans	Total Medi-Cal Enrollment June 2018	Percentage of Medi-Cal Enrollment June 2018	Total Enrollment June 2018	Total Enrollment June 2017	Enrollment Change from June 2017 to June 2018	Percentage Enrollment Change from June 2017 to June 2018
Aetna Better Health	5,997	100%	5,997	NA	NA	NA
California Health and Wellness	195,440	100%	195,440	188,900	6,540	3.5%
Care1st	435,204	87%	501,109	480,280	20,829	4.3%
Community Health Group	281,600	100%	281,600	290,384	(8,784)	-3.0%
Health Net Community Solutions	1,824,091	99%	1,840,947	1,878,315	(37,368)	-2.0%
Molina	588,672	91%	646,158	776,008	(129,850)	-16.7%
UnitedHealthcare Community Plan	9,995	100%	9,995	NA	NA	NA
Total Medi-Cal Enrollment in NGMs	**3,340,999**	**96%**	**3,481,246**	**3,613,887**	**(132,641)**	**-3.7%**
Anthem Blue Cross	1,227,475	35%	3,519,581	3,987,508	(467,927)	-11.7%
Kaiser Permanente	655,880	7%	8,934,207	8,630,410	303,797	3.5%
Grand Total	**5,224,354**	**33%**	**15,935,034**	**16,231,805**	**(296,771)**	**-1.8%**

Chart 11 illustrates the Medi-Cal Managed Care enrollment trend in NGM plans. This chart does not include the Medi-Cal Managed Care enrollment reported by Anthem Blue Cross and Kaiser Permanente.

Chart 11

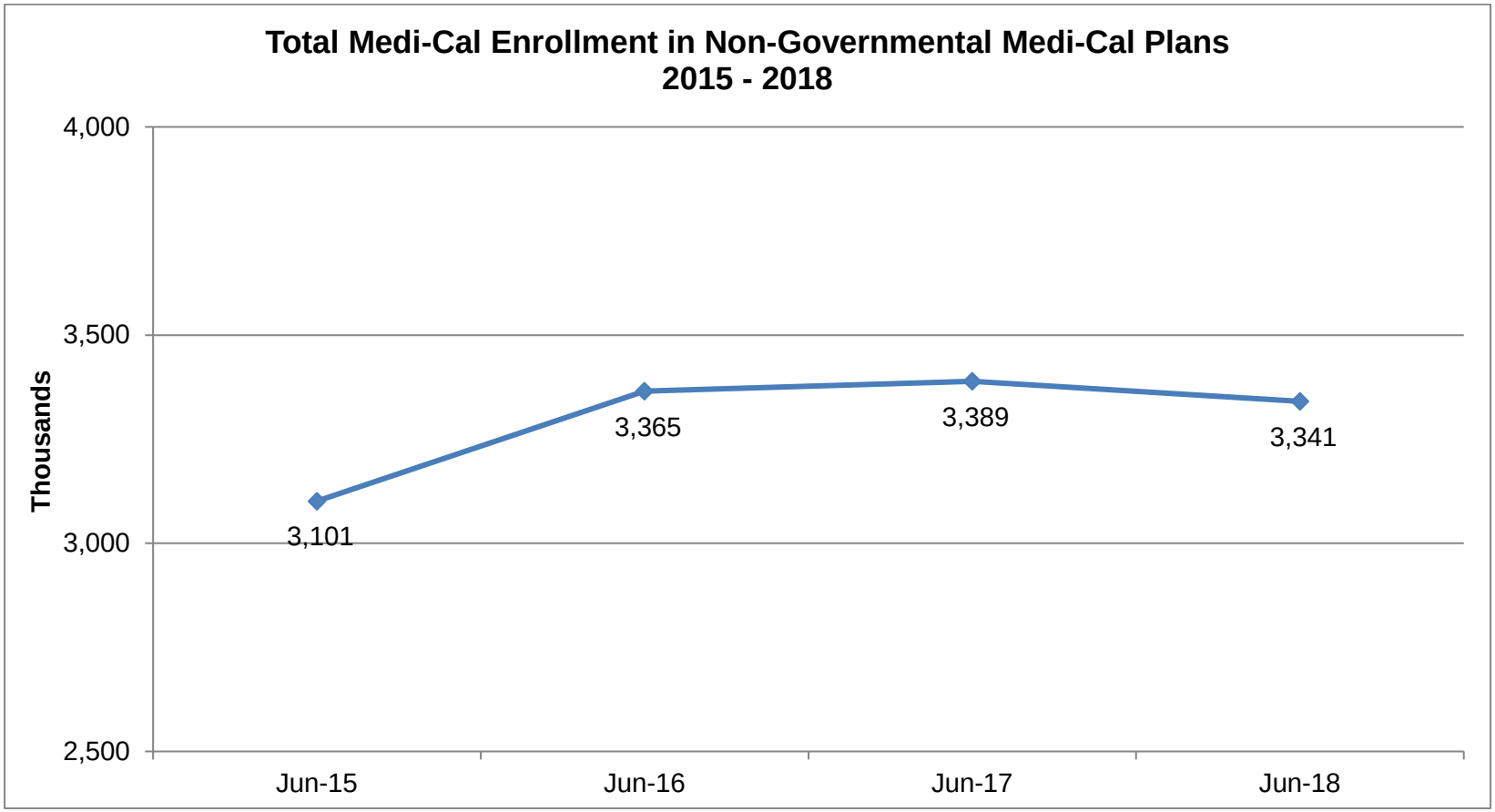
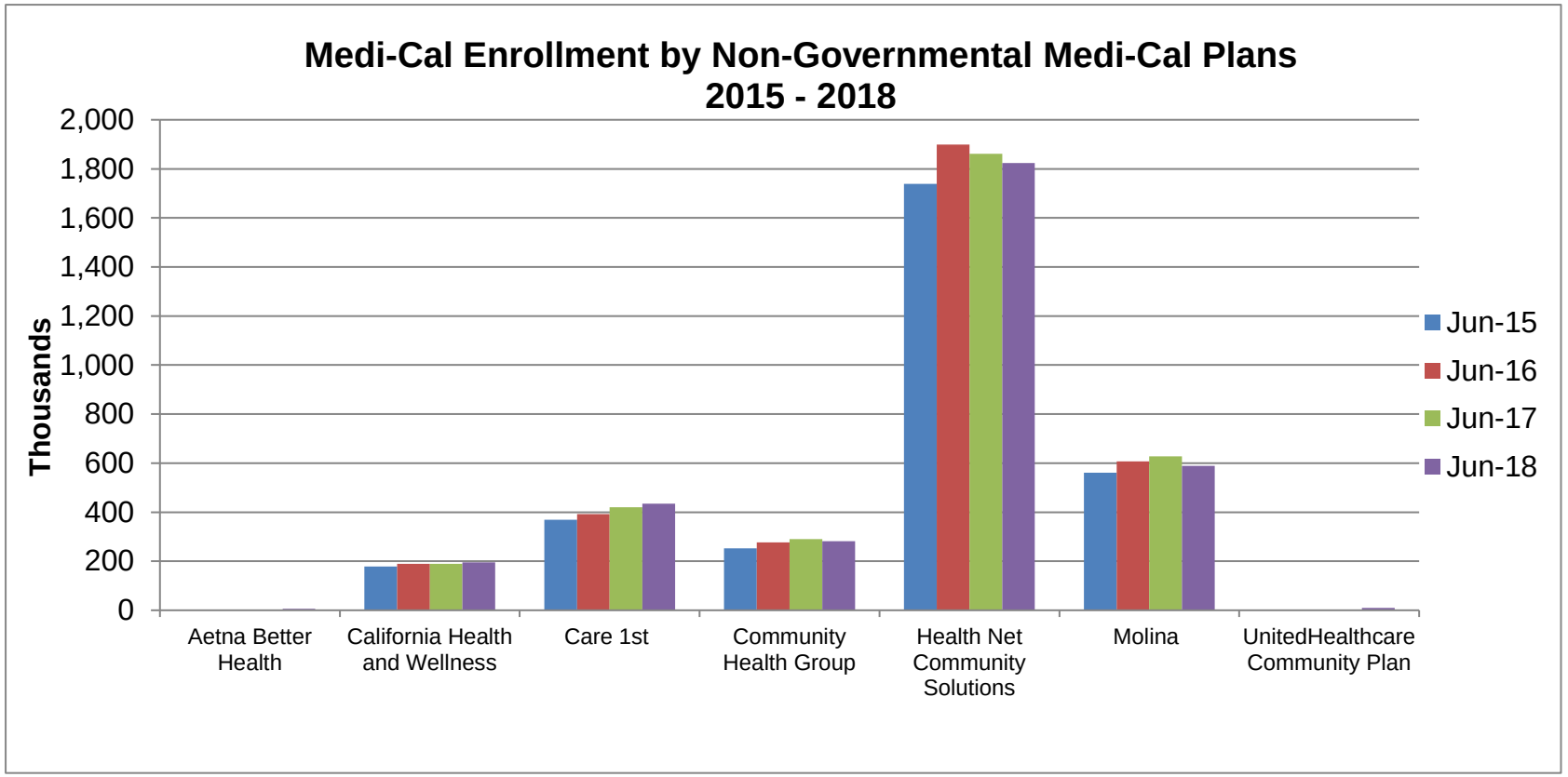


Chart 12 shows the enrollment growth for each NGM plan over the past four years. Aetna Better Health and UnitedHealthcare Community Plan commenced their operations in December 2017, therefore chart below shows only June 2018 enrollment numbers for these two plans.

Chart 12

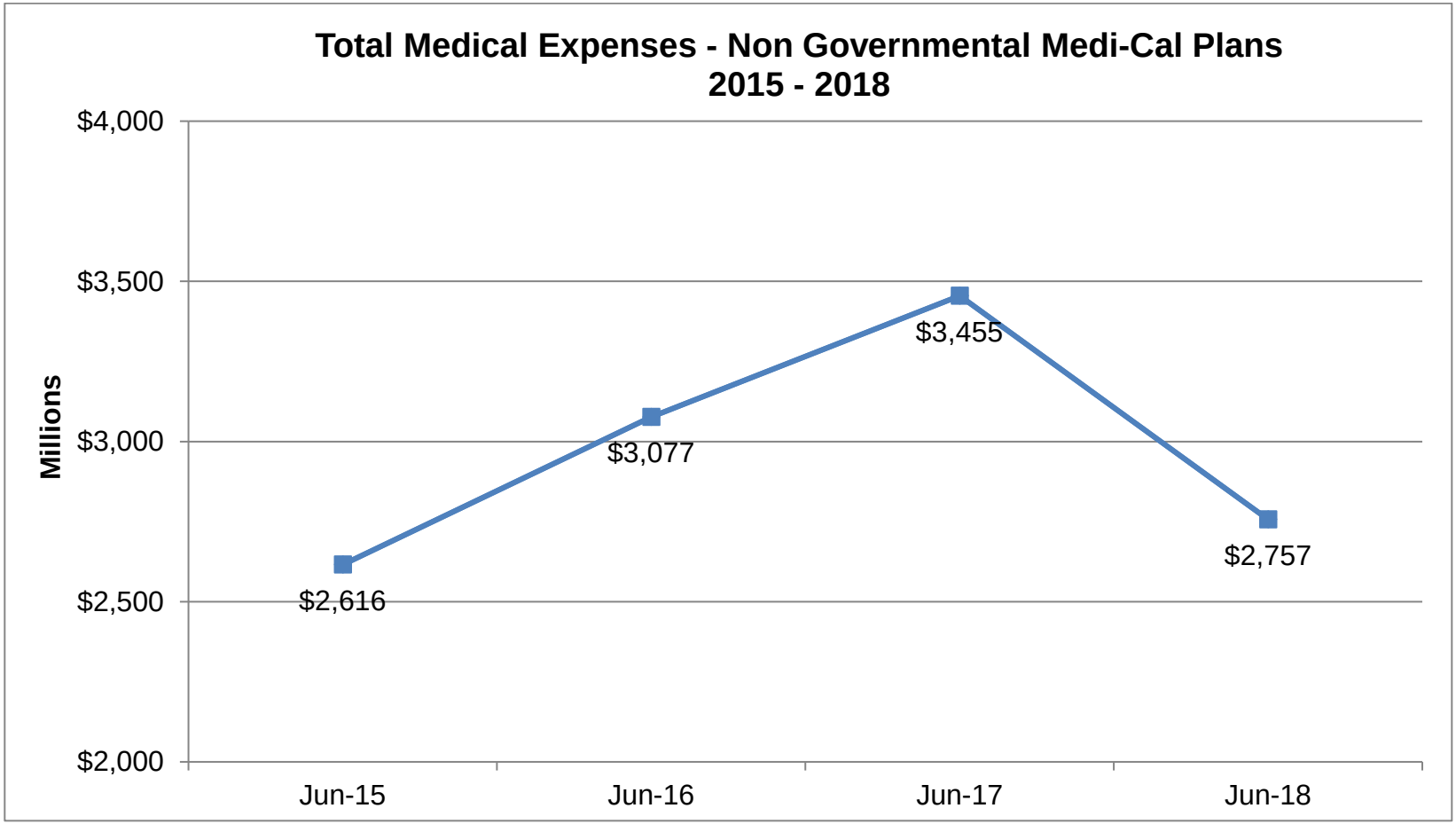


Community Health Group, Health Net Community Solutions and Molina, reported a decline in Medi-Cal enrollment from June 2017 to June 2018. Total Medi-Cal enrollment for NGM plans increased by 74% from December 31, 2013 to June 30, 2018.

C. Financial Trends – Non-Governmental Medi-Cal Plans

Chart 13 shows a decrease in medical expenses for NGM plans, mainly caused by a decline in total enrollment for most NGM plans. This chart does not include the medical expenses reported by Anthem Blue Cross and Kaiser Permanente.

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 June for the past four years, as well as the difference in the PMPM medical expense and premium revenue for quarter ending June 2018. All NGM plans, except Community Health Group and UnitedHealthcare Community Plan, reported positive PMPM net revenue at June 2018.

Table 8
Per Member Per Month Medical Expenses and Premium Revenue – Non-Governmental Medi-Cal Plans
2015 – 2018

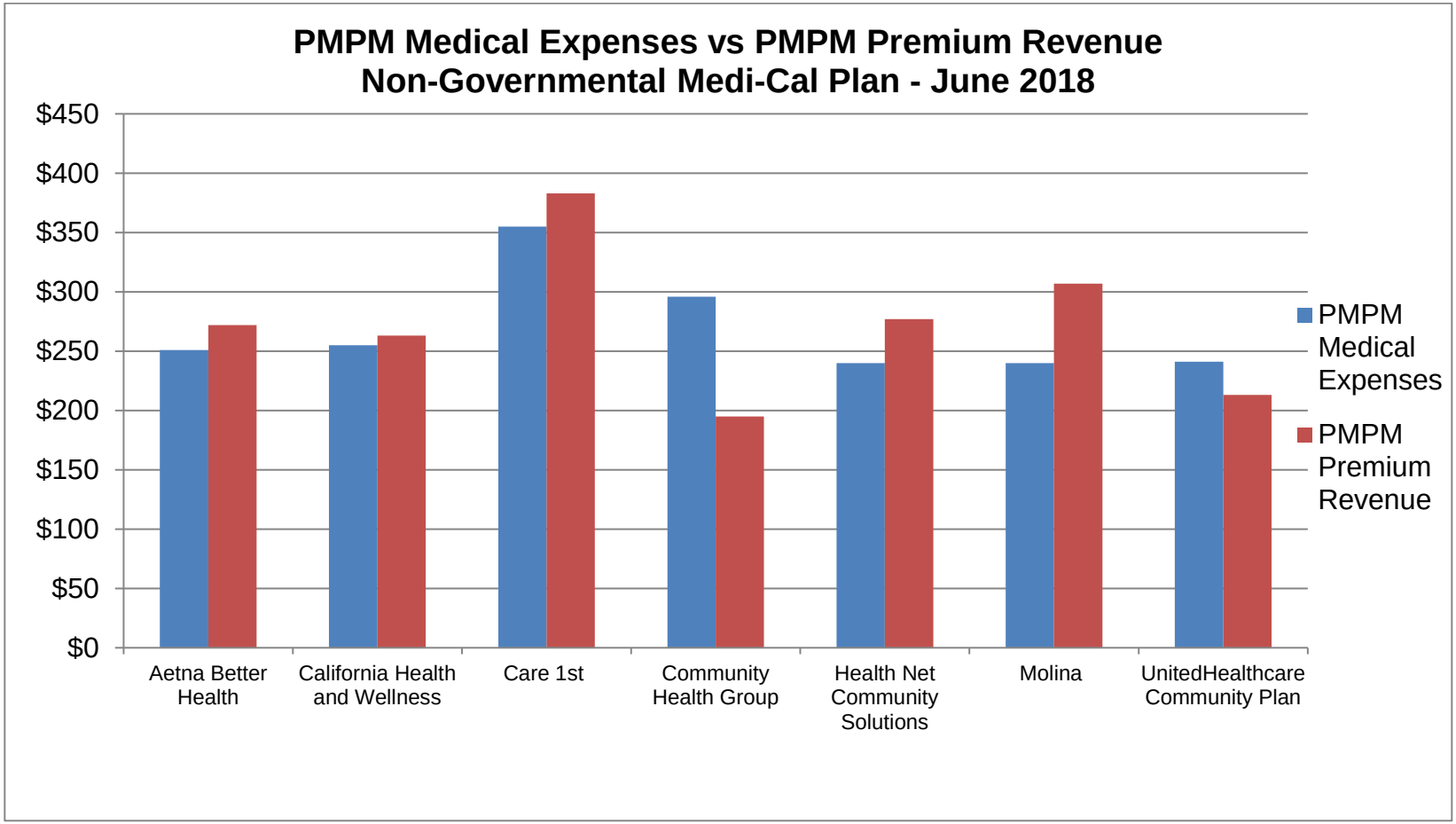
Non-Governmental Medi-Cal Plans	Jun-15		Jun-16		Jun-17		Jun-18		
	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Net Revenue[11]
Aetna Better Health	NA	NA	NA	NA	NA	NA	$251	$272	$21
California Health and Wellness	$219	$263	$221	$259	$240	$271	$255	$263	$8
Care1st[12]	$298	$324	$316	$353	$452	$506	$355	$383	$28
Community Health Group	$295	$320	$329	$379	$286	$337	$296	$195	($101)
Health Net Community Solutions	$260	$326	$287	$328	$282	$336	$240	$277	$37
Molina	$265	$310	$244	$270	$262	$294	$240	$307	$67
UnitedHealthcare Community Plan	NA	NA	NA	NA	NA	NA	$241	$213	($28)

[11] Difference between June 2018 PMPM Medical Expense and PMPM Premium Revenue.
[12] PMPM information for Care1st includes commercial and other lines of business for 2015-2018.

PMPM Medical Expense vs PMPM Premium Revenue

Chart 9 illustrates the NGM plans' PMPM medical expense vs PMPM premium revenue for June 2018. Almost all plans reported PMPM premium revenue that was higher than PMPM medical expenses.

Chart 14



Net Income - Non-Governmental Medi-Cal Plans

Favorable PMPM premium revenue ratios translated to positive net income for almost all NGM plans. California Health and Wellness, Community Health Group and UnitedHealthcare Community Plan reported negative net income for June 2018.

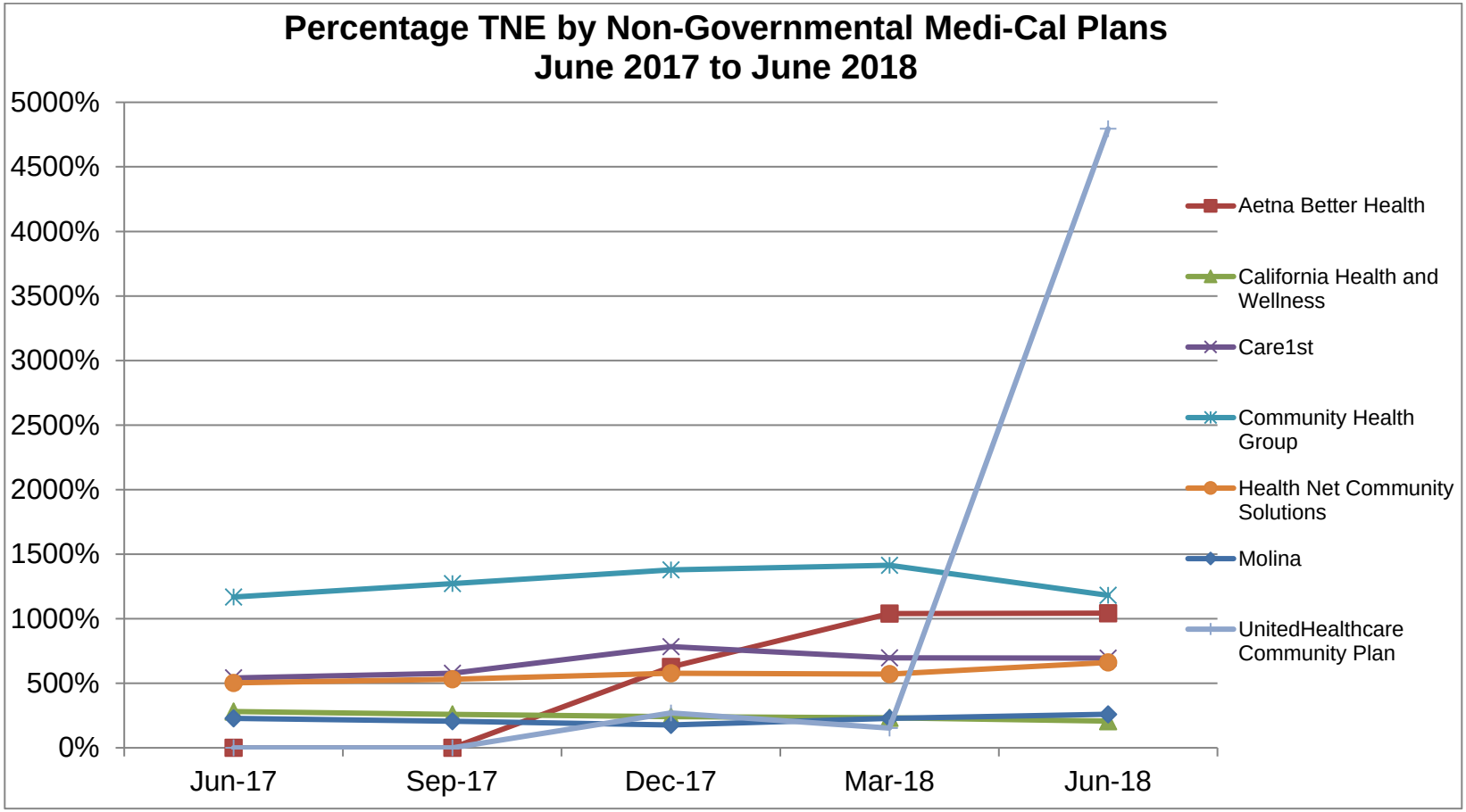
Table 9
Non-Governmental Medi-Cal Plans Net Income by Quarter (in thousands)

Non-Governmental Medi-Cal Plans	QE Mar-17	QE Jun-17	QE Sep-17	QE Dec-17	QE Mar-18	QE Jun-18
Aetna Better Health	NA	NA	NA	NA	$2,175	$33
California Health and Wellness	$5,452	$1,112	($3,868)	($1,992)	($859)	($5,950)
Care1st	$19,800	$34,182	$21,603	$25,019	$48,482	$3,158
Community Health Group	$53,428	$35,439	$54,334	$49,886	$41,885	($94,245)
Health Net Community Solutions	$126,690	$144,170	$76,723	$85,423	$147,004	$101,281
Molina	$45,397	$7,547	($9,425)	$13,350	$34,522	$62,229
UnitedHealthcare Community Plan	NA	NA	NA	NA	($11,187)	($1,921)
Total Net Income	**$250,767**	**$222,450**	**$139,367**	**$171,866**	**$262,022**	**$64,586**

Tangible Net Equity – Non-Governmental Medi-Cal Plans

NGM plans' TNE to Required TNE ranged from 207% to 4,795% for June 2018. TNE reported by most NGM plans is lower than the LI and COHS plans. Many NGM plans pay dividends to parent companies or shareholders thereby reducing the reserve levels. In June 2018, UnitedHealthcare Community Plan received a cash infusion of $50 million from its Parent, which increased its TNE significantly.

Chart 15



Cash Flow from Operations

NGM plans reported negative $887 million in cash flow from operations in June 2018. 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 arrangements 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 June 2018.

Conclusion

After the initial surge in Medi-Cal managed care plans' enrollment brought on by the Affordable Care Act in 2014, the rate of increase in enrollment slowed in 2017 and in the first two quarters of 2018. Overall, expenses and premium revenue stabilized as enrollment slowed down. The Medi-Cal managed care plans continue to meet or significantly exceed the minimum TNE requirement. The DMHC will continue to monitor the enrollment trends and financial solvency of all Medi-Cal managed care plans.

Appendix

Medi-Cal Managed Care Plans: Net Income, Medical Expenses and TNE

June 2018

Health Plan	Net Income	Medical Expenses	Excess TNE*
Local Initiatives			
Alameda Alliance for Health	($8,071,553)	$218,531,367	$156,886,213
CalViva Health	$3,003,384	$242,592,618	$46,468,435
Contra Costa Health Plan	$12,125,136	$238,550,955	$56,767,015
IEHP	$31,659,892	$1,069,495,755	$732,820,191
Kern Health Systems	$606,000	$181,756,000	$161,427,000
L.A. Care Health Plan	($27,009,660)	$1,763,953,023	$634,866,503
San Francisco Health Plan	($11,341,626)	$182,821,760	$94,743,552
Santa Clara Family Health Plan	$16,262,000	$339,661,000	$156,089,000
The Health Plan of San Joaquin	$12,944,391	$242,476,845	$276,103,034
Total	**$30,177,964**	**$4,479,839,323**	**$2,316,170,943**
County Organized Health Systems			
CalOptima	$28,937,110	$885,916,342	$668,337,694
CenCal Health	$2,639,110	$163,221,878	$193,282,322
Central California Alliance for Health	($35,890,404)	$265,597,664	$514,553,424
Partnership HealthPlan	($57,893,016)	$610,302,786	$591,105,103
Health Plan of San Mateo	$1,927,003	$164,550,146	$323,692,472
Total	**($60,280,197)**	**$2,089,588,816**	**$2,290,971,015**
Non-Governmental Medi-Cal Plans			
Aetna Better Health	$33,442	$3,805,746	$9,433,059
California Health and Wellness	($5,950,453)	$151,325,613	$29,867,371
Care1st	$3,158,495	$534,165,210	$470,258,384
Community Health Group	($94,245,071)	$250,463,908	$450,507,111
Health Net Community Solutions	$101,281,318	$1,345,781,320	$877,004,041
Molina	$62,229,094	$461,615,037	$108,442,125
UnitedHealthcare Community Plan	($1,921,227)	$9,421,498	$63,252,701
Total	**$64,585,598**	**$2,756,578,332**	**$2,008,764,792**

* Excess TNE is the difference between total TNE and required TNE.