Financial Summary of Medi-Cal Managed Care Health Plans

Quarter Ending December 31, 2017

Prepared on April 12, 2018

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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 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 7.2 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 1.17 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.

This report includes enrollment and financial information reported by LI, COHS and Non-Governmental Medi-Cal (NGM) plans as of the quarter ending December 31, 2017. The NGM plans are plans that report greater than 50 percent Medi-Cal enrollment but are neither a LI or a COHS. For December 2017, NGM plans reported 3.4 million Medi-Cal enrollees. 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 also includes Medi-Cal enrollment information for Blue Cross of California (Blue Cross) and Kaiser Foundation Health Plan (Kaiser) 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 and the financial information the DMHC receives for Blue Cross and Kaiser is for their entire book of business.

[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.

II. Summary of Findings

Key findings from this report include:

- Enrollment stabilized in 2016 and the trend continued in 2017 for all Medi-Cal plans. Enrollment increases are slowing compared to the significant growth experienced in 2014 and 2015.

- All LI, COHS and NGM plans reported increases in their Medi-Cal enrollment from December 2014 to December 2017.

- Increased enrollment contributed to increased medical expenses for LI and COHS plans. However, NGM plans experienced a decrease in their medical expenses.

- Per Member per Month (PMPM) premium revenue exceeded PMPM medical expense for almost every LI, COHS and NGM plan for the period ending December 31, 2017. Revenues and expenses for the MCMC plans have stabilized due to the Medicaid Expansion Coverage (MCE) rate adjustments.

- The LI plans reported higher net income than COHS plans, and COHS plans reported higher TNE reserves than LIs. Both LI and COHS plans continue to report healthy TNE reserves. NGM plans 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. In comparison, LI and COHS plans generally hold on to their reserves to cover any needed capital expenditures or future economic downturns.

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. 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) – Contra Costa
    - Fresno-Kings-Madera Regional Health Authority (CalViva) – Fresno, Kings, and Madera
    - Inland Empire Health Plan (IEHP) – 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
    - San Joaquin County Health Commission (San Joaquin) – San Joaquin and Stanislaus
    - Santa Clara County Health Authority (Santa Clara) – Santa Clara

- LI plans reported combined enrollment of 5.4 million individuals as of December, 2017. Over 5.24 million (97%) of the total LI enrollment are Medi-Cal beneficiaries. The remaining 3% 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.

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

- Total LI plan enrollment increased by 4.6% from December 2016 to December 2017.
- All LI plans' PMPM premium revenue outpaced PMPM medical expense for December 2017.
- LI plans reported $46 million in net income in December 2017, which was about 69% lower than the $149 million net income reported in December 2016, and 59% lower than the quarter ending September 30, 2017.
- The LIs reported TNE that ranged from 356% to 1037% of required TNE.
- The LIs reported negative $1.15 billion in cash flow from operations, which was lower than the $14 million reported in December 2016. This is a significant change from September 2017 when the LIs reported cash flow from operations of $33 million. 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.

B. Enrollment Trends – LI

The LI plans serve 5.4 million enrollees in 13 counties in California. Total enrollment increased by 4.6% since December 2016. 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 December 2016 to December 2017. IEHP reported the largest percentage increase in enrollment at 12.8%, while there were slight declines in enrollment in Contra Costa, San Francisco and Santa Clara.

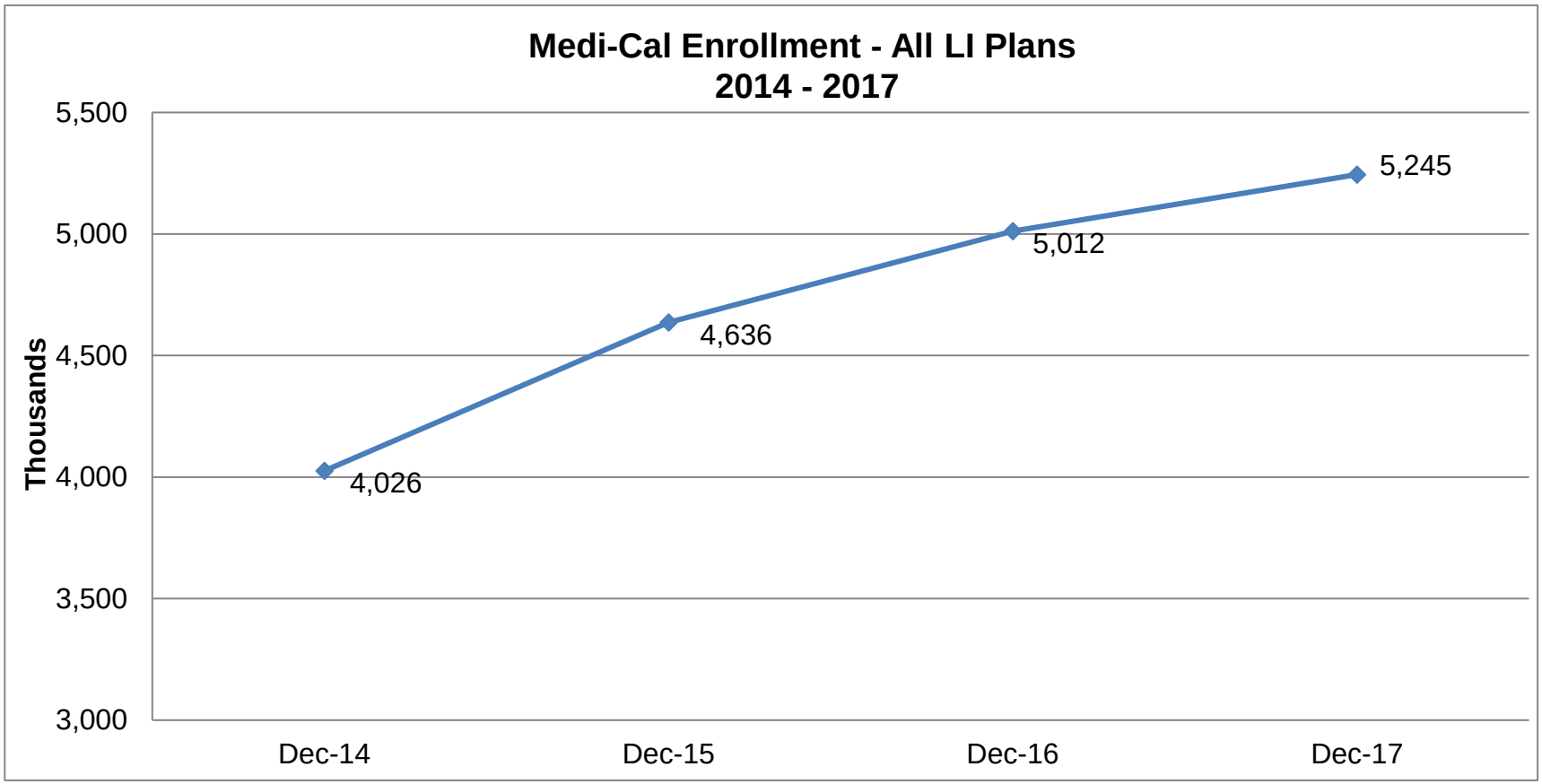
Table 1
Enrollment in Local Initiatives
December 2016 - December 2017

Local Initiative	Total Medi-Cal Enrollment December 2017	Percentage of Medi-Cal Enrollment December 2017	Total Enrollment December 2017[4]	Total Enrollment December 2016	Enrollment Increase	Percentage Enrollment Increase
Alameda Alliance	264,688	98%	270,414	267,040	3,374	1.3%
Contra Costa	184,277	95%	193,232	195,278	-2,046	-1.0%
CalViva	360,546	100%	360,546	359,697	849	0.2%
IEHP	1,391,793	98%	1,418,554	1,257,559	160,995	12.8%
Kern	241,567	100%	241,567	234,491	7,076	3.0%
L.A. Care	2,061,054	97%	2,135,218	2,056,926	78,292	3.8%
San Francisco	132,825	91%	145,866	148,160	-2,294	-1.5%
San Joaquin	349,823	100%	349,823	347,717	2,106	0.6%
Santa Clara	258,106	96%	267,942	280,127	-12,185	-4.3%
Total	**5,244,679**	**97%**	**5,383,162**	**5,146,995**	**236,167**	**4.6%**

[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 December year-over-year data.

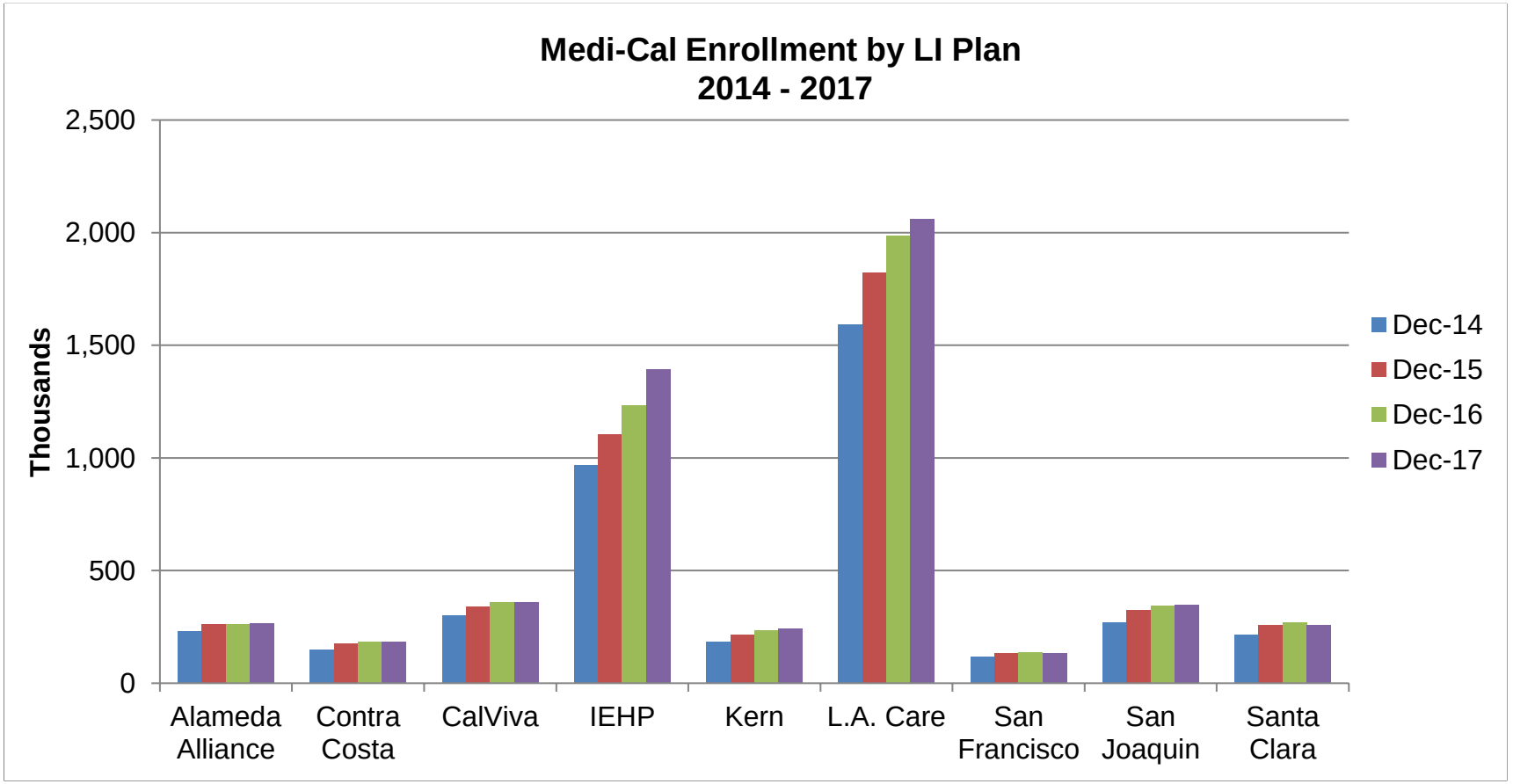
Chart 1



Medi-Cal enrollment in LIs continues to increase. Two Southern California LI plans, L.A. Care and IEHP, reported the highest number of enrollees and make up the majority of the enrollment increase. For the quarter ending December 31, 2017, L.A. Care and IEHP reported Medi-Cal enrollment of 2.06 million and 1.4 million, respectively.

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

Chart 2



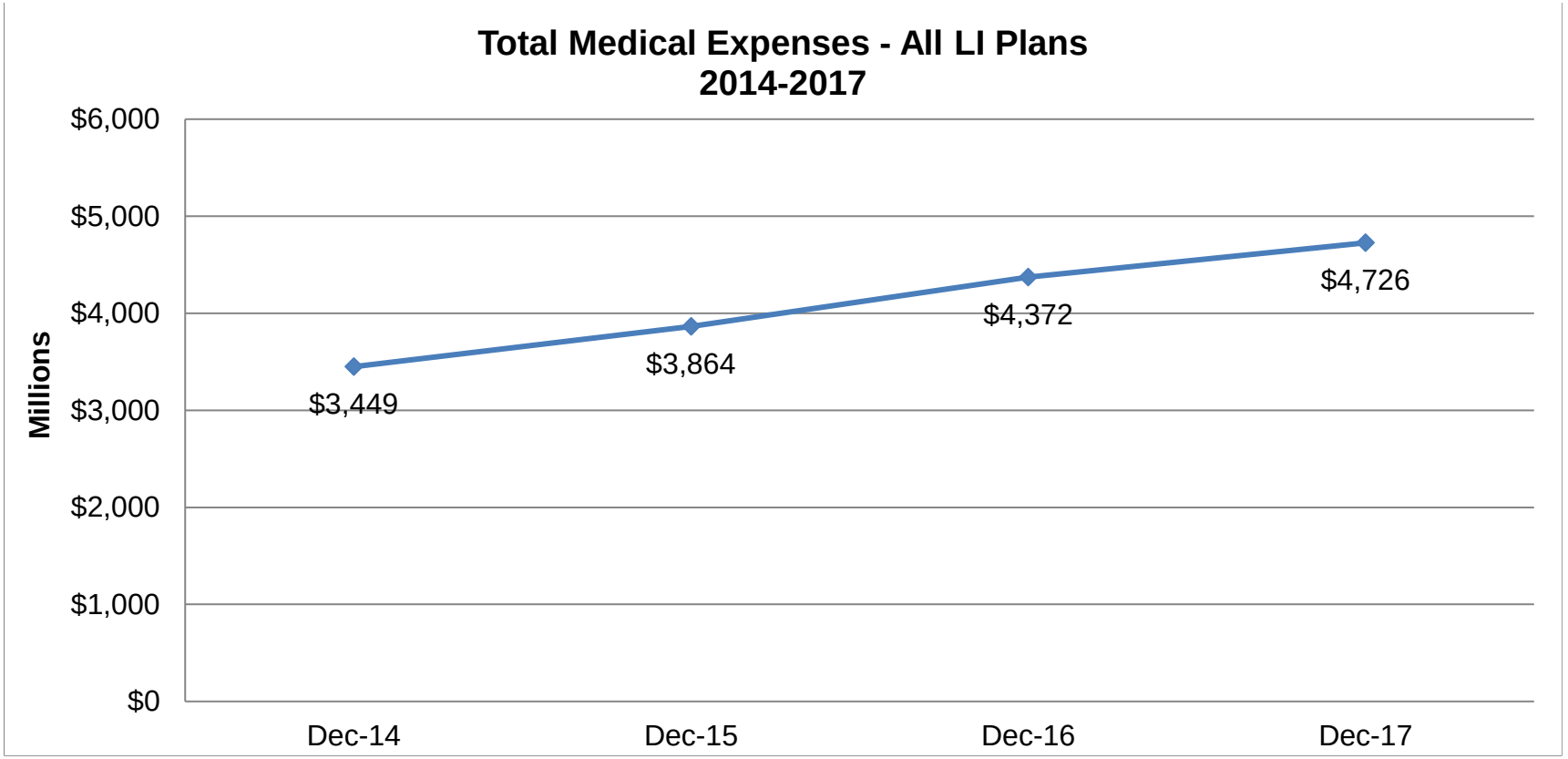
Almost all LIs reported increases in their Medi-Cal enrollment from 2014 to 2017. Contra Costa, San Francisco, and Santa Clara reported small decreases in Medi-Cal enrollment from 2016 to 2017. Total Medi-Cal enrollment for LI plans increased by 91% from December 31, 2013 to December 31, 2017.

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. Total medical expenses continued to increase in the quarter ending December 2017. 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 December for the past four years, as well as the difference in PMPM medical expense and premium revenue for December 2017. L.A. Care and IEHP reported the highest PMPM medical expense and premium revenue. All LIs had higher PMPM premium revenue than medical expenses for December 2017.

Table 2

Per Member Per Month Medical Expenses and Premium Revenue – LI
2014 - 2017

Local Initiative	Dec-14		Dec-15		Dec-16		Dec-17[5]		
	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[6]
Alameda Alliance	$308	$335	$236	$263	$229	$279	$254	$271	$17
Contra Costa	$285	$307	$293	$306	$280	$283	$284	$294	$10
CalViva	$283	$295	$252	$265	$266	$277	$235	$247	$12
IEHP	$275	$301	$270	$304	$269	$301	$297	$325	$28
Kern	$209	$226	$207	$238	$199	$229	$222	$232	$10
L.A. Care	$285	$306	$277	$292	$300	$316	$324	$340	$16
San Francisco	$316	$349	$291	$329	$296	$318	$289	$318	$29
San Joaquin	$241	$267	$222	$240	$201	$239	$238	$244	$6
Santa Clara	$249	$268	$277	$294	$280	$301	$293	$318	$25

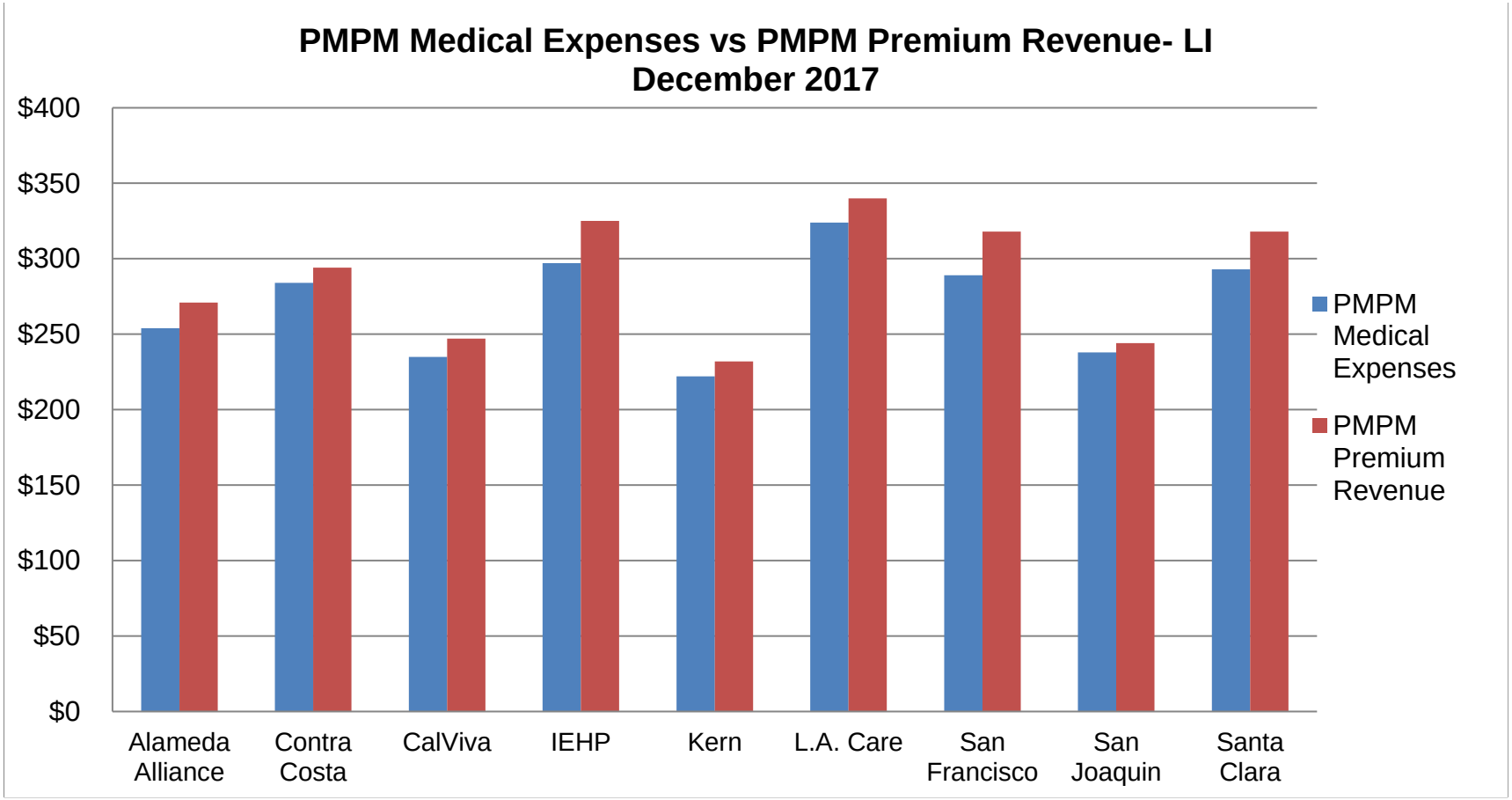
[5] December 2016 and December 2017 PMPM Medical Expense and Premium Revenue information excludes pass through income and expense items.
[6] Difference between December 2017 PMPM Medical Expense and PMPM Premium Revenue.

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 the health plans have to pay such as administrative expenses and taxes.

PMPM Medical Expense vs. PMPM Premium Revenue - LI

Chart 4 illustrates the LI plans' PMPM medical expense vs PMPM premium revenue for December 2017. 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) December 2017, almost all LI plans reported positive net income. Net income or loss is directly related to premium revenue and medical expenses.

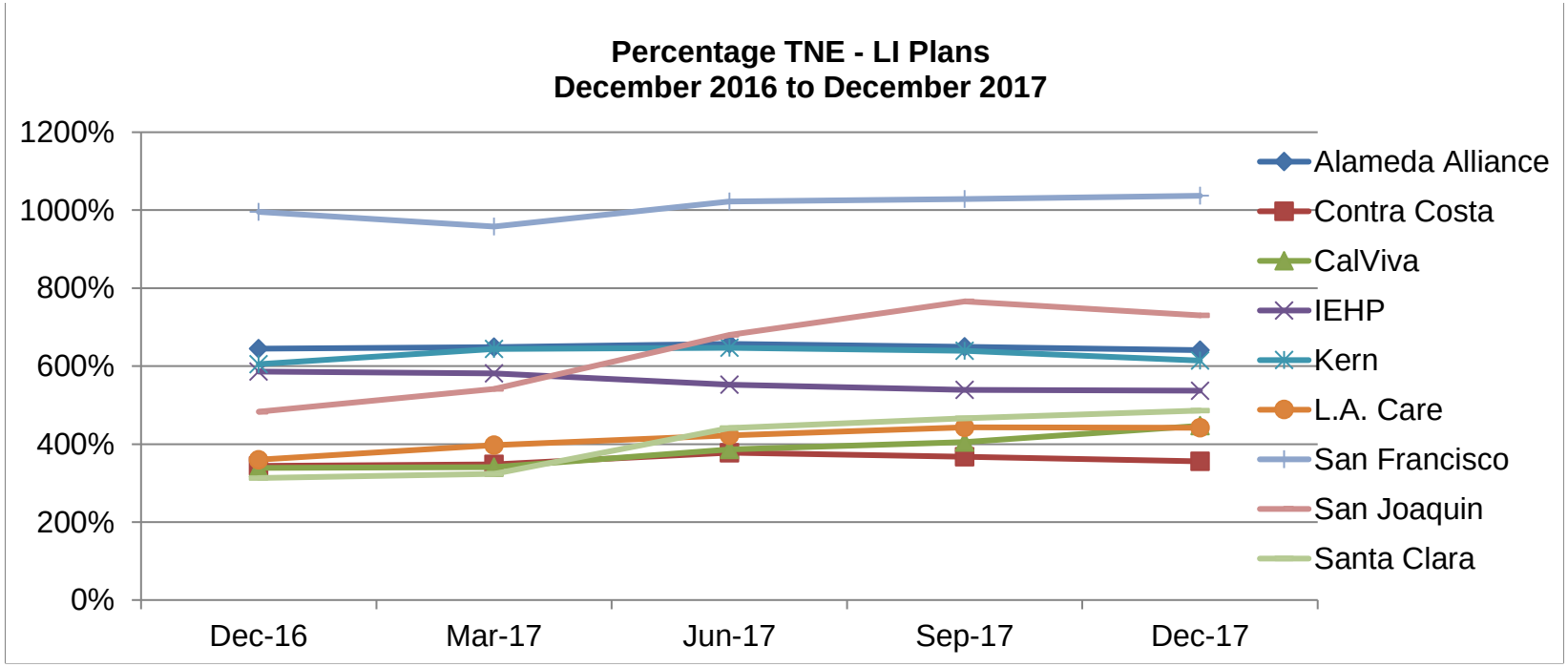
Table 3
LI Net Income by Quarter (in thousands)

Local Initiative	QE Sep-16	QE Dec-16	QE Mar-17	QE Jun-17	QE Sep-17	QE Dec-17
Alameda Alliance	$11,198	$27,886	$13,234	$5,209	$608	$1,493
Contra Costa	$4,290	$35	$2,193	$1,100	$1,776	$1,793
CalViva	$3,320	$3,332	$3,454	$1,161	$3,198	$2,547
IEHP	$46,711	$43,844	$21,974	$16,958	$13,660	$15,411
Kern	$19,447	$15,367	$12,165	$6,335	$3,643	($2,868)
L.A. Care	($39,375)	$21,262	$58,573	$27,000	$46,308	$18,755
San Francisco	$1,165	($185)	($2,663)	$9,807	$2,711	$2,365
San Joaquin	$11,307	$30,508	$18,812	$30,707	$30,194	($1,589)
Santa Clara	$3,655	$7,205	$7,066	$40,162	$7,908	$7,652
Total LI Net Income	**$61,718**	**$149,254**	**$134,808**	**$138,439**	**$110,007**	**$45,559**

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. All the LIs had TNE that exceeded the regulatory requirements.

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 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 LI plans overall was stable in 2016 and the trend continued in 2017. For December 2017, the reported TNE ranged from 356% to 1037% 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.

Eight of the nine LI plans reported negative cash flow from operations in December 2017. The cash flow from operations totaled negative $1.15 billion in December 2017 compared to negative $14 million in December 2016. 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. For the quarter ending December 31, 2017, both Contra Costa and Santa Clara failed to process 95% of their claims within 45 working days and both plans submitted corrective action plans 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:
    - 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 (Gold Coast) – 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, Central California Alliance for 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 remained consistent from December 2016 to December 2017.
- Almost all COHS plans' PMPM premium revenue outpaced medical expenses for December 2017.
- COHS plans reported $10 million in net income in December 2017, which was significantly higher than the negative $58 thousand net income reported in December 2016, and 63% lower than the quarter ending September 30, 2017.
- The COHS plans reported TNE that ranged from 828% to 1383% of required TNE.
- The COHS plans reported negative $871 million in cash flow from operations, which was lower than the $571 million reported in December 2016. This is a significant change from June 2017 when the COHS plans reported cash flow from operations of $484 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 have reported consistent increases in enrollment since 2014; however, enrollment stabilized in the recent quarters. CalOptima and Partnership HealthPlan reported the highest enrollment numbers. All COHS plans reported slight decreases in total enrollment compared to December 2016, except for CenCal Health, which had slight increase in total enrollment.

Table 4
Enrollment in County Organized Health Systems
December 2016 - December 2017

COHS	December 2017 Total Medi-Cal Enrollment	December 2017 Percentage of Medi-Cal Enrollment	December 2017 Total Enrollment	December 2016 Total Enrollment[10]	Enrollment Change from December 2016 to December 2017	Percentage Enrollment Change from December 2016 to December 2017
CalOptima	774,646	98%	791,476	800,001	(8,525)	-1.1%
CenCal Health	180,439	100%	180,439	179,155	1,284	0.7%
Central California Alliance for Health	351,112	100%	351,661	352,112	(451)	-0.1%
Partnership HealthPlan	567,337	100%	567,337	571,581	(4,244)	-0.7%
Health Plan of San Mateo	120,409	98%	122,852	126,440	(3,588)	-2.8%
Total	**1,993,943**	**99%**	**2,013,765**	**2,029,289**	**(15,524)**	**-0.8%**

[10] 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 slightly decreased in December 2017, compared to significant growth experienced in 2015 and 2016.

Chart 6

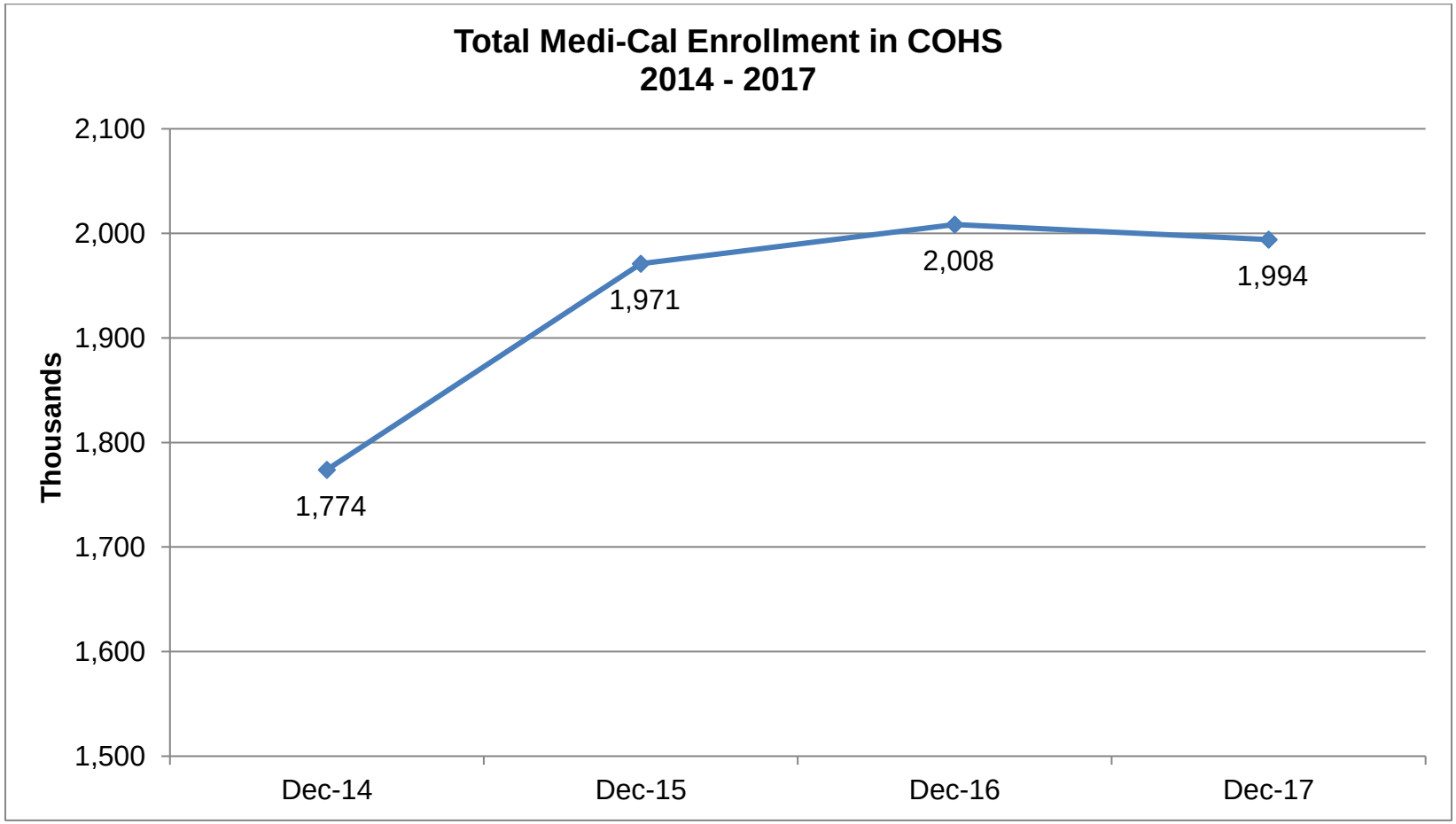
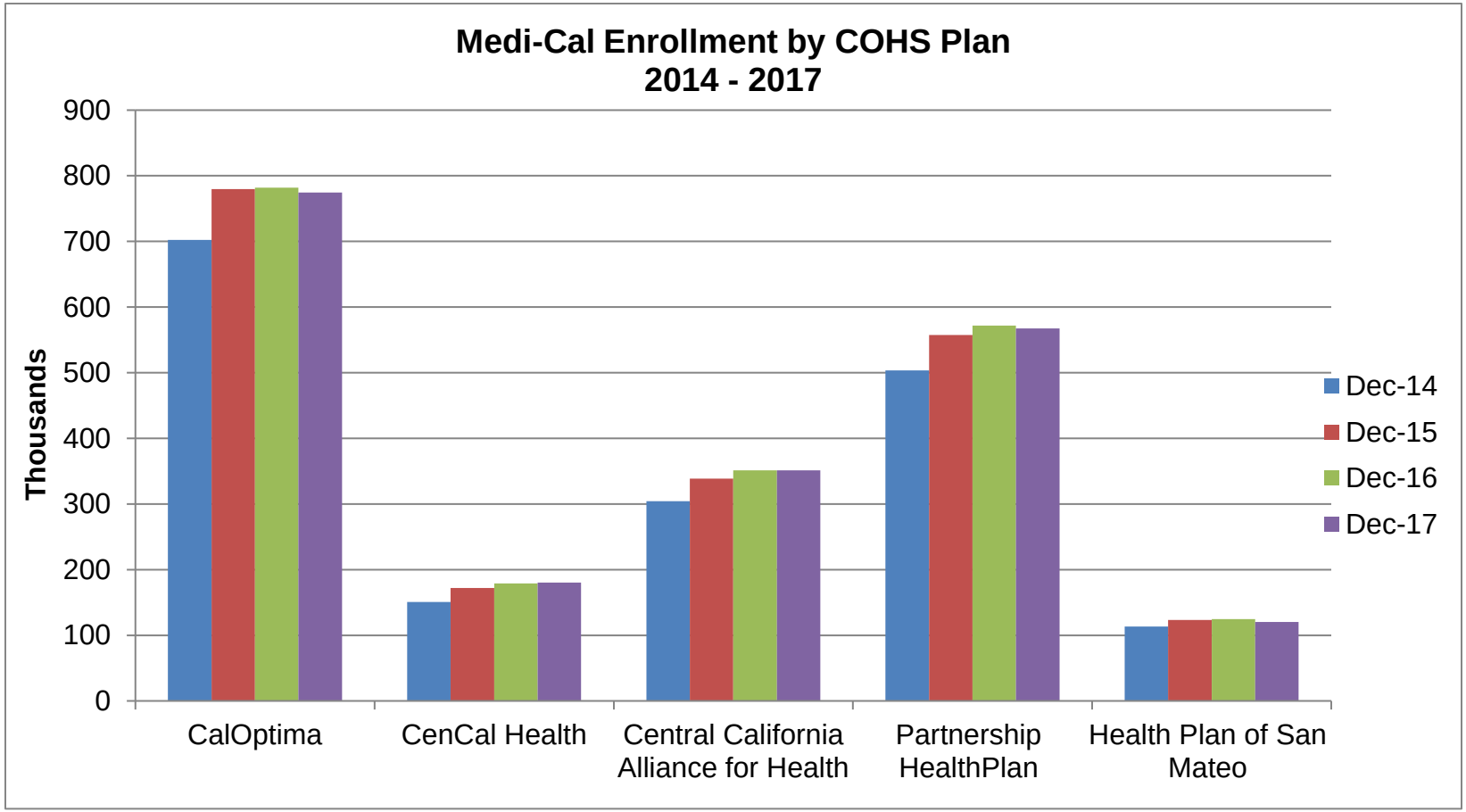


Chart 7 shows the enrollment growth for each COHS plan over the past four years.

Chart 7

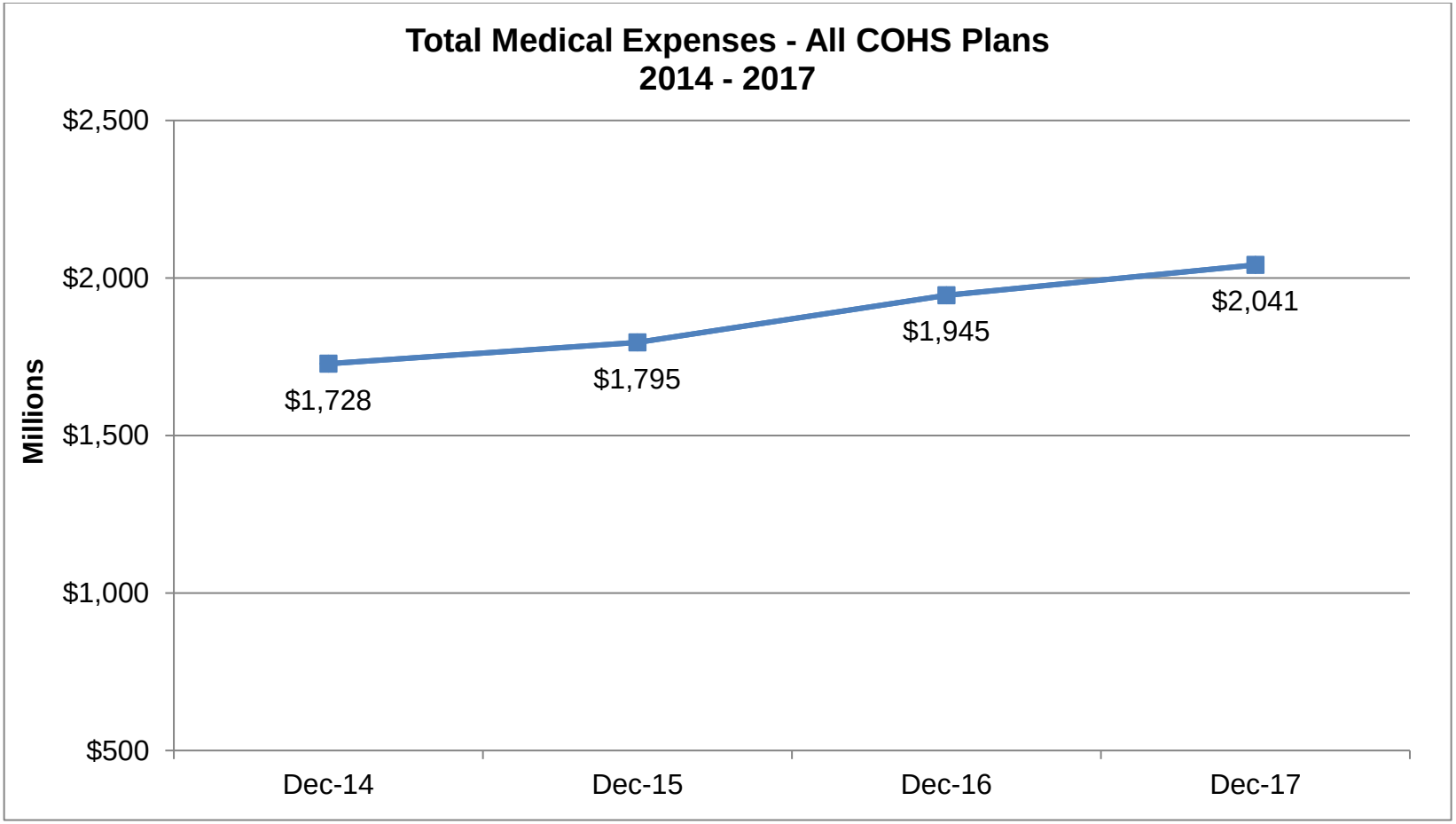


Almost all COHS plans reported increases in their Medi-Cal enrollment from 2014 to 2017. All COHS plans except the CenCal Health, reported slight decreases in Medi-Cal enrollment compared to December 2016. Total Medi-Cal enrollment for COHS plans increased by 63% from December 31, 2013 to December 31, 2017.

C. 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 December for the past four years, as well as the difference between the PMPM medical expense and premium revenue for December 2017.

All COHS plans except Partnership HealthPlan had higher PMPM premium revenue than medical expenses at December 2017. 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
2014 - 2017

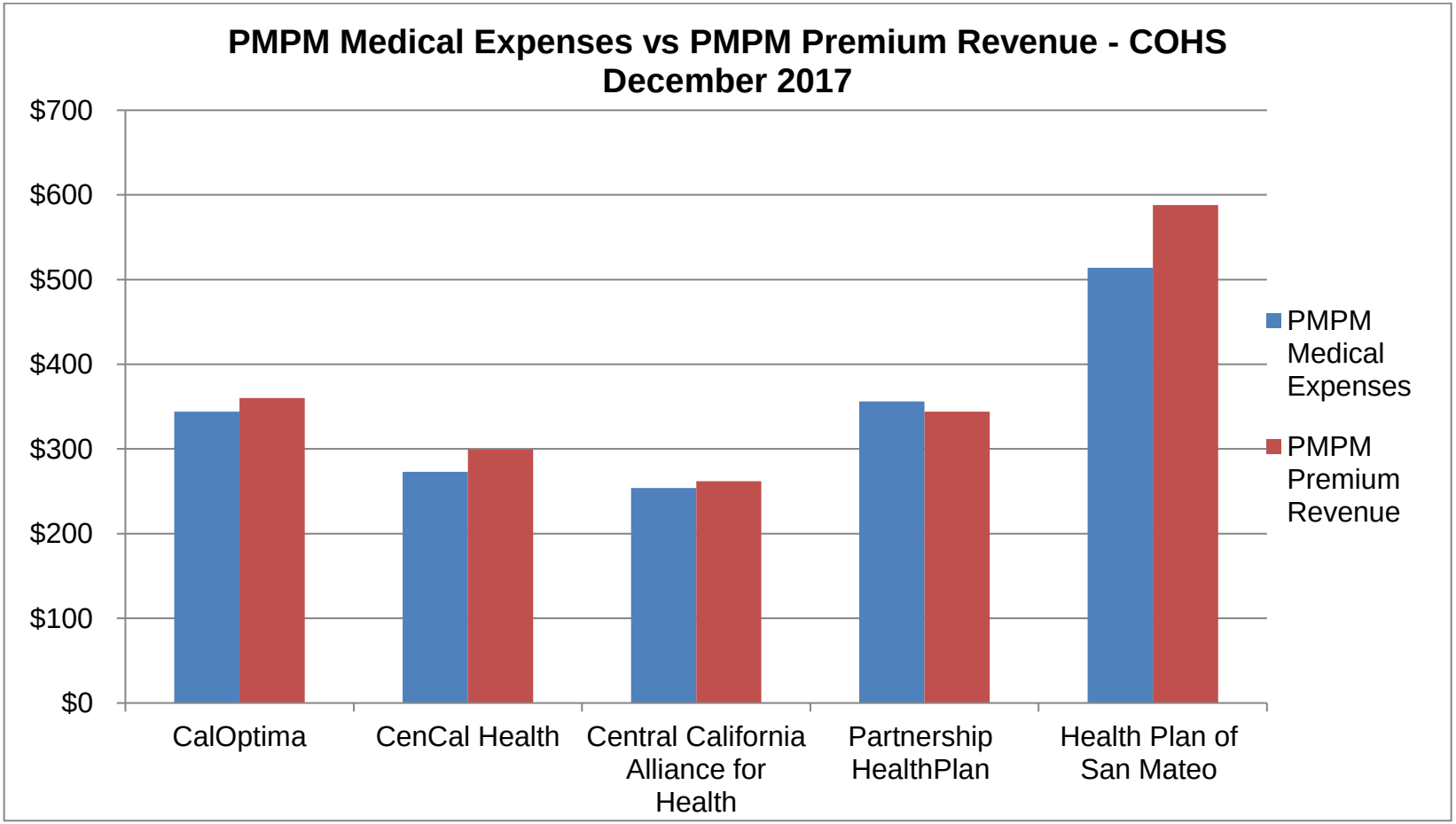
COHS	Dec-14		Dec-15		Dec-16		Dec-17[11]		
	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Net Revenue[12]
CalOptima	$367	$402	$310	$322	$341	$352	$344	$360	$16
CenCal Health	$266	$308	$269	$340	$248	$291	$273	$299	$26
Central California Alliance for Health	$205	$262	$227	$264	$232	$274	$254	$262	$8
Partnership HealthPlan	$299	$358	$304	$349	$328	$347	$356	$344	($12)
Health Plan of San Mateo	$469	$613	$450	$597	$466	$382	$514	$588	$74

[11] December 2016 and December 2017 PMPM Medical Expense and PMPM Premium Revenue information excludes pass through income and expense items.
[12] Difference between December 2017 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 December 2017. All plans except Partnership HealthPlan reported premium revenue that was higher than PMPM expenses.

Chart 9



Net Income - COHS

Favorable PMPM premium revenue ratios translated to positive net income for almost all of the COHS plans. Central California Alliance for Health and Partnership HealthPlan reported a negative net income.

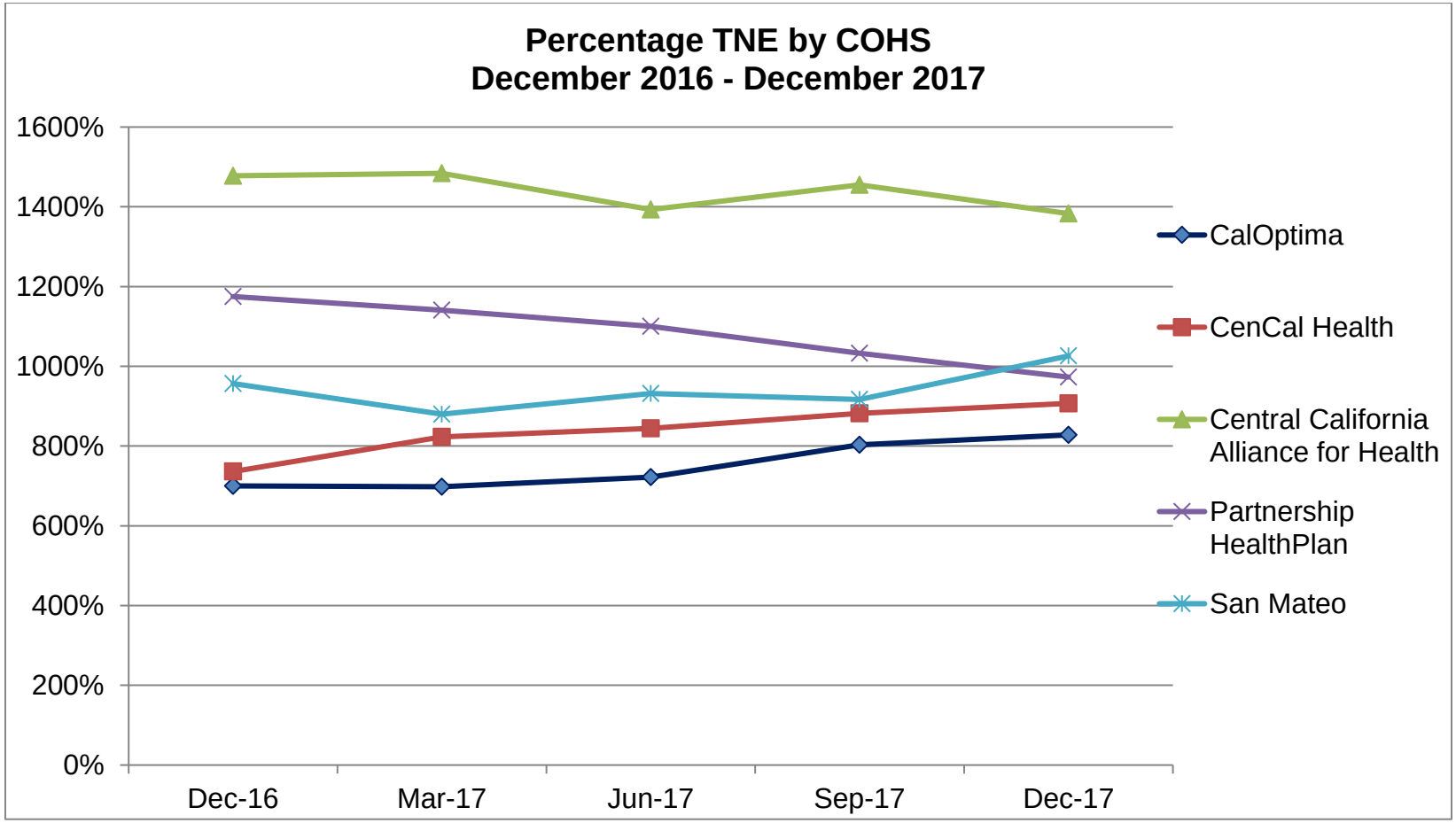
Table 6
COHS Net Income by Quarter (in thousands)

COHS	QE Sep-16	QE Dec-16	QE Mar-17	QE Jun-17	QE Sep-17	QE Dec-17
CalOptima	$2,564	$501	$3,160	$45,706	$11,309	$11,691
CenCal Health	$15,802	$15,878	$10,162	$12,662	$6,361	$7,060
Central California Alliance for Health	$10,986	$23,381	$9,014	$7,613	$33,313	($16,633)
Partnership HealthPlan	$18,771	$6,132	$2,070	($18,665)	($25,621)	($42,410)
Health Plan of San Mateo	($376)	($45,950)	($3,220)	$6,084	$1,582	$50,378
Total COHS Net Income	**$47,749**	**($58)**	**$21,186**	**$53,400**	**$26,944**	**$10,086**

Tangible Net Equity – COHS

All COHS plans reported over 800% of required TNE for December 2017. TNE to required TNE ranged from 828% to 1,383%. Partnership HealthPlan reported a decrease in TNE from 1033% to 973% from September 2017 to December 2017.

Chart 10



Cash Flow from Operations

COHS plans reported negative $871 million in cash flow from operations in December 2017. 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 December 2017.

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.

- Five NGM plans currently serve 31 counties. The NGM plans and the counties in which they provide services are:
    - California Health and Wellness Plan (CHWP) – 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 (CHG) – San Diego.
    - Health Net Community Solutions, Inc. (HNCS) – 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.

- The structure among the NGM plans varies in the following ways:
    - CHWP is a for-profit wholly owned subsidiary of Centene Corporation (Centene), a publicly traded company. In 2017, CHWP 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).
    - CHG is a not-for-profit health plan.
    - HNCS is a for-profit wholly owned subsidiary of Health Net, Inc., which is a subsidiary of Centene, a publicly traded company. In 2016 and 2017, HNCS paid dividends of $350 million and $150 million respectively to its parent company.
    - Molina is a for-profit wholly owned subsidiary of Molina Healthcare, Inc., a publicly traded company. In 2016 and 2017, Molina paid dividends of $50 million and $130 million respectively to its parent company.

- There are two other plans that serve another 1.9 million Medi-Cal enrollees: Blue Cross of California (Blue Cross) with 1,246,036 enrollees and Kaiser Foundation Health Plan (Kaiser) with 651,502 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 Blue Cross and Kaiser 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 subcontracts its Medi-Cal enrollment to Care1st and Molina in Los Angeles County.

- NGM plans' enrollment increased 1.5% from December 2016 to December 2017.

- Per member per month expenses and premium revenue rose for NGM plans in conjunction with increased enrollment. All NGM plans' PMPM premium revenue outpaced expenses for December 2017.

- NGM plans reported $168 million in net income in December 2017, which was about 59% lower than the $411 million net income reported in December 2016, and 21% higher than the quarter ending September 30, 2017.

- Tangible net equity for NGM plans ranged from 177% to 1377% of required TNE at December 2017.

- The NGM plans reported negative $418 million in cash flow from operations, which was lower than the $971 million reported in December 2016. This is a significant change from September 2017 when the NGM plans reported cash flow from operations of negative $75 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. All NGM plans reported increases in total enrollment compared to December 2016, except CHG, which had slight decrease in total enrollment. As noted earlier, two other plans, Blue Cross and Kaiser, serve 1.9 million Medi-Cal enrollees. From December 2016 to December 2017, Blue Cross and Kaiser reported a slight change in Medi- Cal enrollment at -2% and 1%, respectively.

Table 7
Enrollment in Non-Governmental Medi-Cal Plans
December 2016 - December 2017

Non-Governmental Medi-Cal Plans	December 2017 Total Medi-Cal Enrollment	December 2017 Percentage of Medi-Cal Enrollment	December 2017 Total Enrollment	December 2016 Total Enrollment	Enrollment Change from December 2016 to December 2017	Percentage Enrollment Change from December 2016 to December 2017
CHWP	192,101	100%	192,101	188,366	3,735	2.0%
Care1st	441,371	88%	502,124	478,897	23,227	4.9%
CHG	288,151	100%	288,151	291,313	(3,162)	-1.1%
HNCS	1,861,905	99%	1,879,340	1,873,457	5,883	0.3%
Molina	611,579	81%	754,308	684,342	69,966	10.2%
Total Medi-Cal Enrollment in NGMs	**3,395,107**	**94%**	**3,616,024**	**3,516,375**	**99,649**	**2.8%**
Blue Cross	1,246,036	32%	3,884,263	4,066,964	(182,701)	-4.5%
Kaiser	651,502	8%	8,678,546	8,362,879	315,667	3.8%
Grand Total	**5,292,645**	**33%**	**16,178,833**	**15,946,218**	**232,615**	**1.5%**

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 Blue Cross and Kaiser.

Chart 11

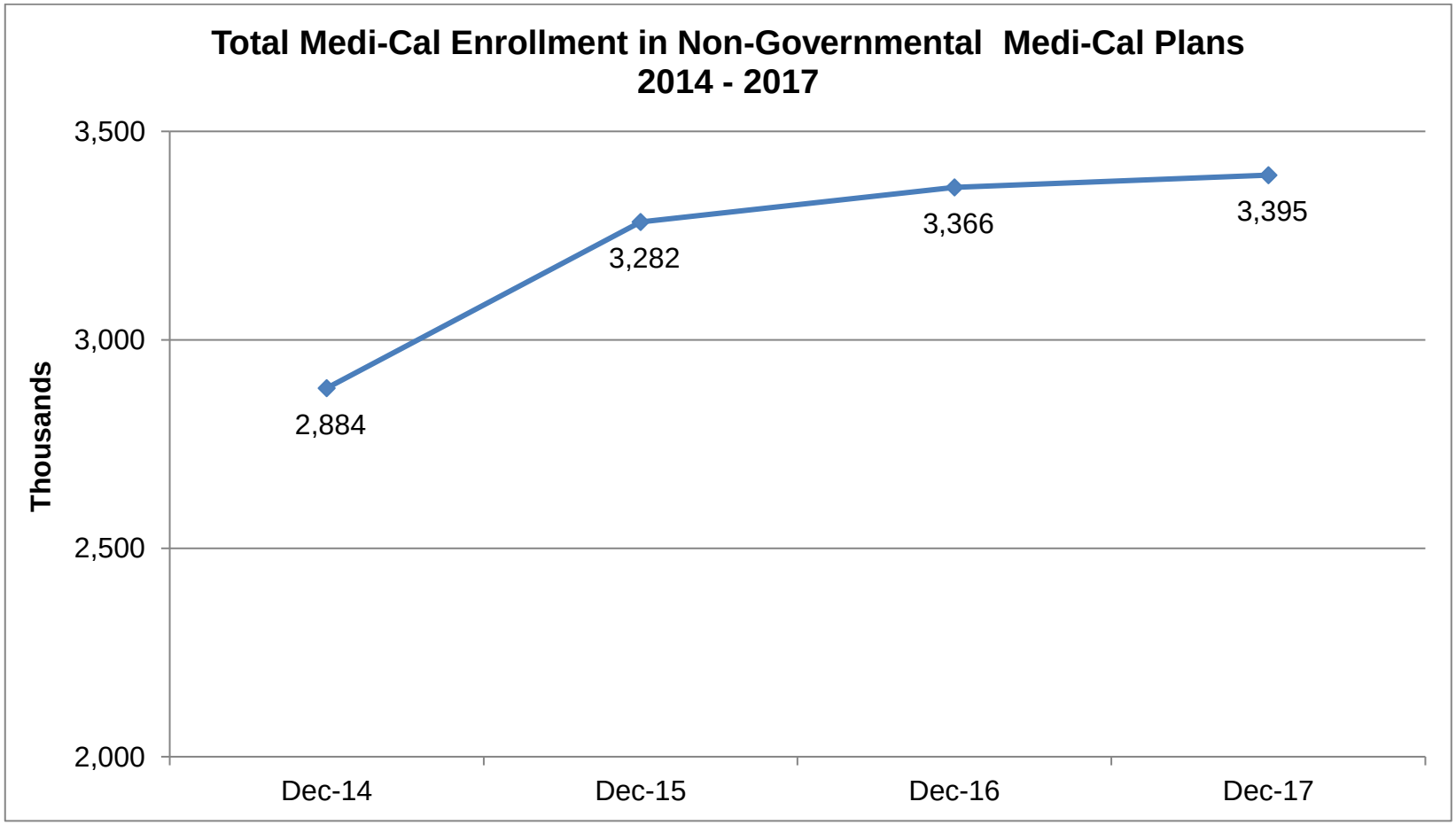
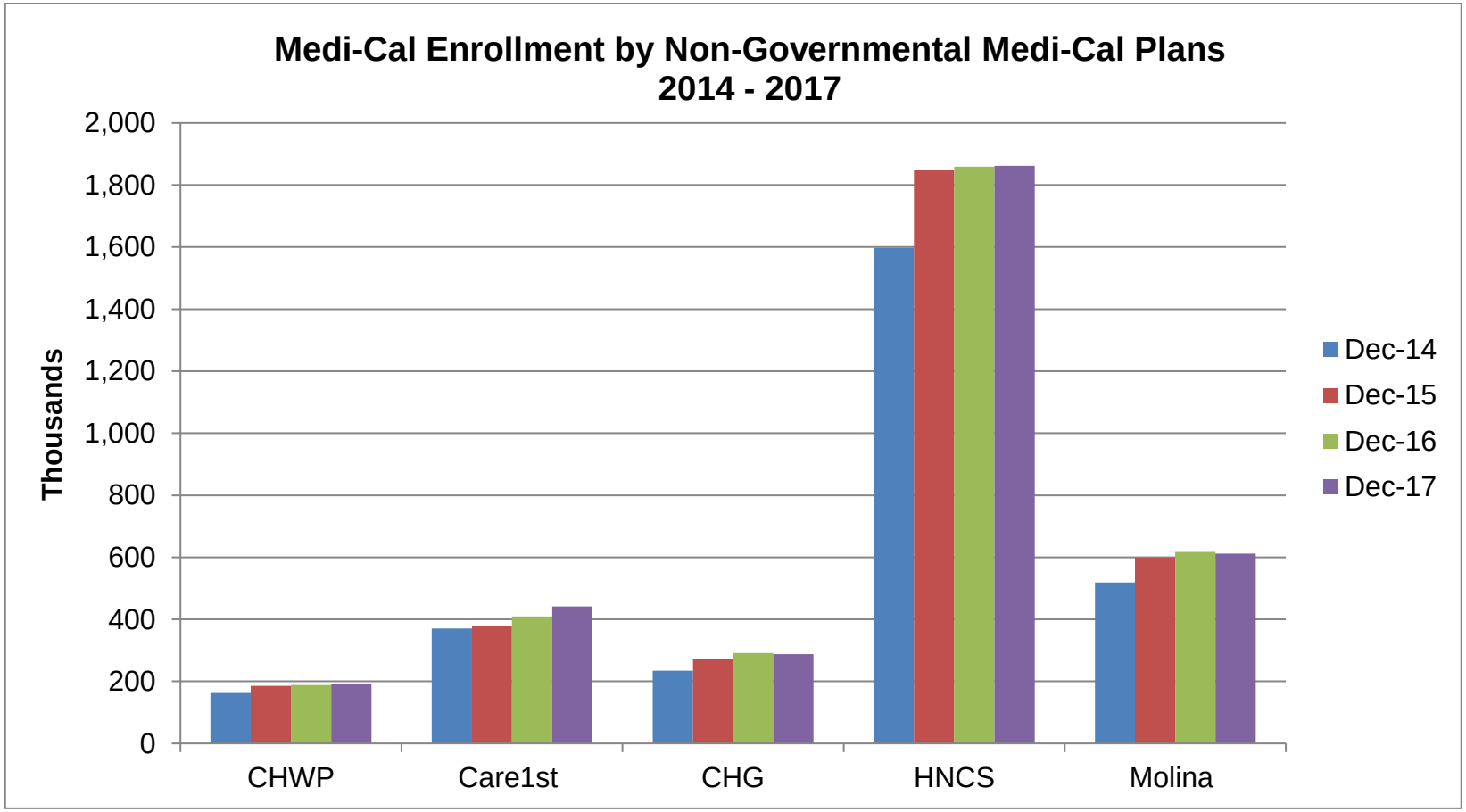


Chart 12 shows the enrollment growth for each NGM plan over the past four years.

Chart 12

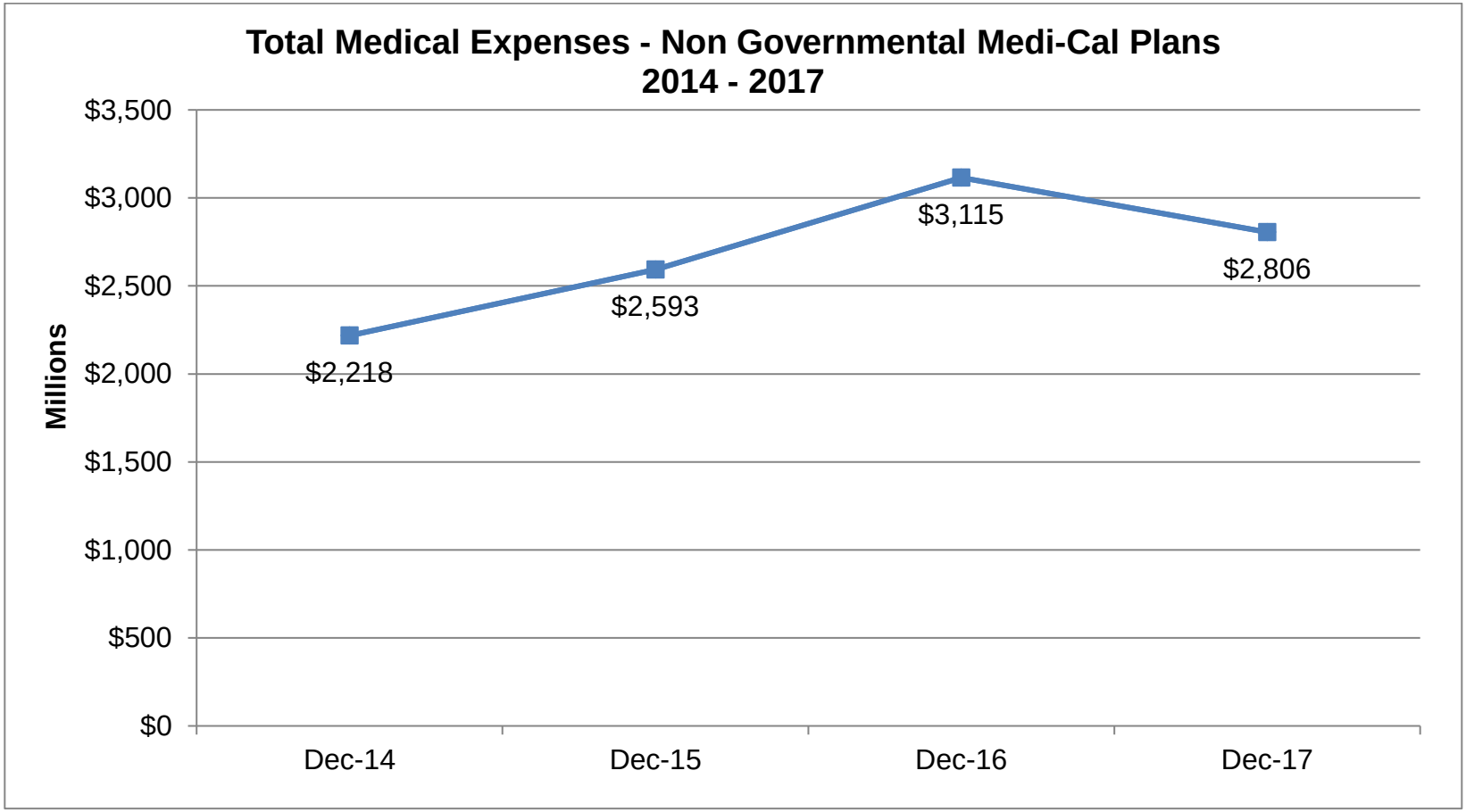


All NGM plans except CHG, reported increases in Medi-Cal enrollment from December 2016 to December 2017. Total Medi-Cal enrollment for NGM plans increased by 77% from December 31, 2013 to December 31, 2017.

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

Chart 13 shows a decrease in medical expenses for NGM plans, mainly caused by prior period revenue and expense adjustments reported by Care 1st. This chart does not include the medical expenses reported by Blue Cross and Kaiser.

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 December for the past four years, as well as the difference in the PMPM medical expense and premium revenue for quarter ending December 2017. All NGM plans had higher PMPM premium revenue than medical expenses at December 2017. CHG and HNCS reported the highest PMPM medical expense and PMPM premium revenue.

Table 8
Per Member Per Month Medical Expenses and Premium Revenue – Non-Governmental Medi-Cal Plans
2014-2017

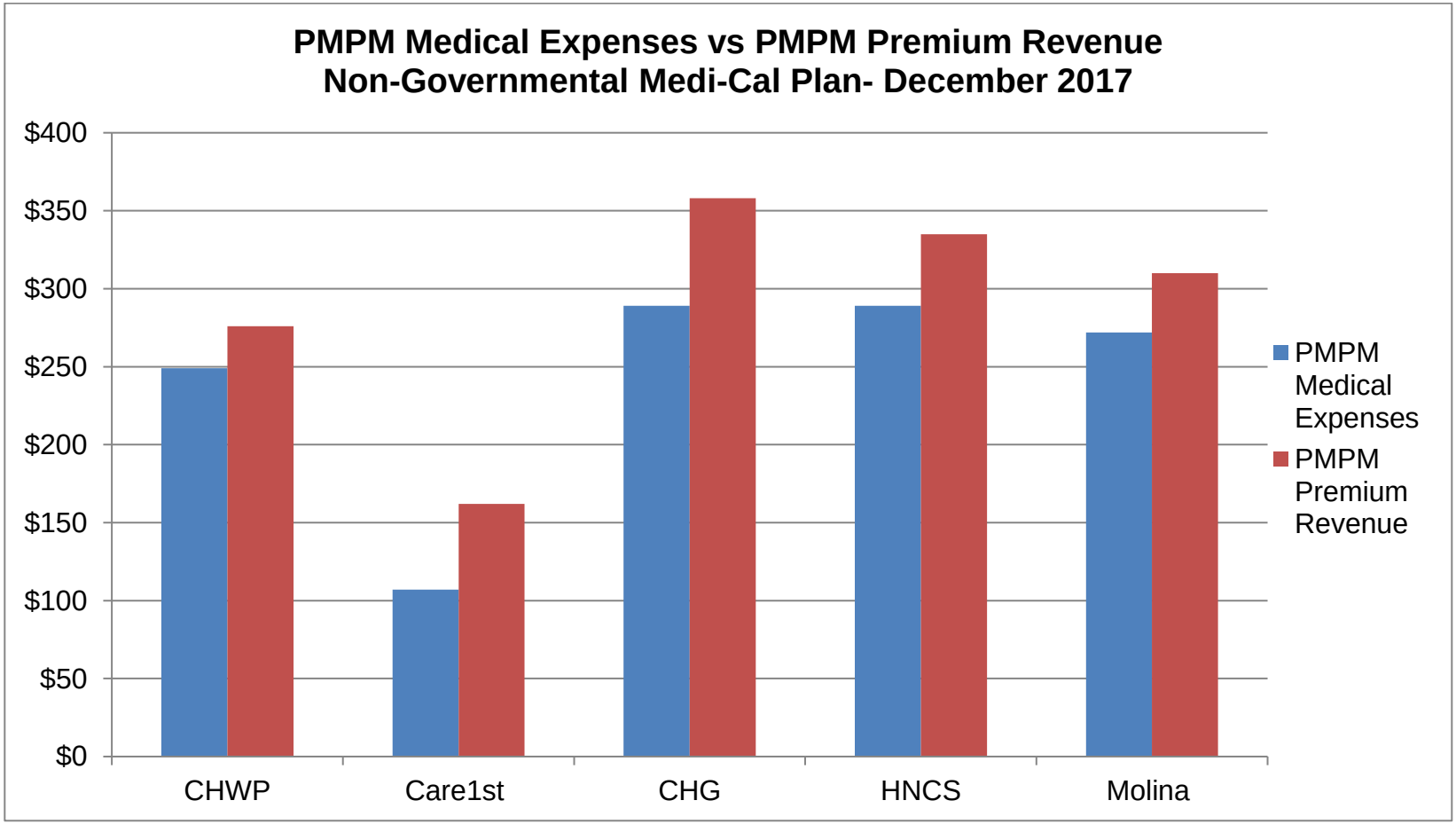
Non-Governmental Medi-Cal Plans	Dec-14		Dec-15		Dec-16		Dec-17[13]		
	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Net Revenue[14]
CHWP	$179	$238	$217	$267	$217	$284	$249	$276	$27
Care1st[15]	$283	$334	$337	$367	$448	$517	$107	$162	$55
CHG	$298	$337	$283	$360	$272	$337	$289	$358	$69
HNCS	$232	$219	$221	$295	$289	$385	$289	$335	$46
Molina	$243	$302	$266	$319	$265	$287	$272	$310	$38

[13] December 2017 PMPM Medical Expense and PMPM Premium Revenue information excludes pass through income and expense items.
[14] Difference between December 2017 PMPM Medical Expense and PMPM Premium Revenue.
[15] PMPM information for Care1st includes commercial and other lines of business for 2014-2017. Additionally, Care 1st reported significant prior period revenue and expense adjustments which explain Care 1st's low PMPM medical expense and revenue at December 2017.

PMPM Medical Expense vs PMPM Premium Revenue

Chart 9 illustrates the NGM plans' PMPM medical expense vs PMPM premium revenue for December 2017. 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. CHWP reported a negative net income for December 2017.

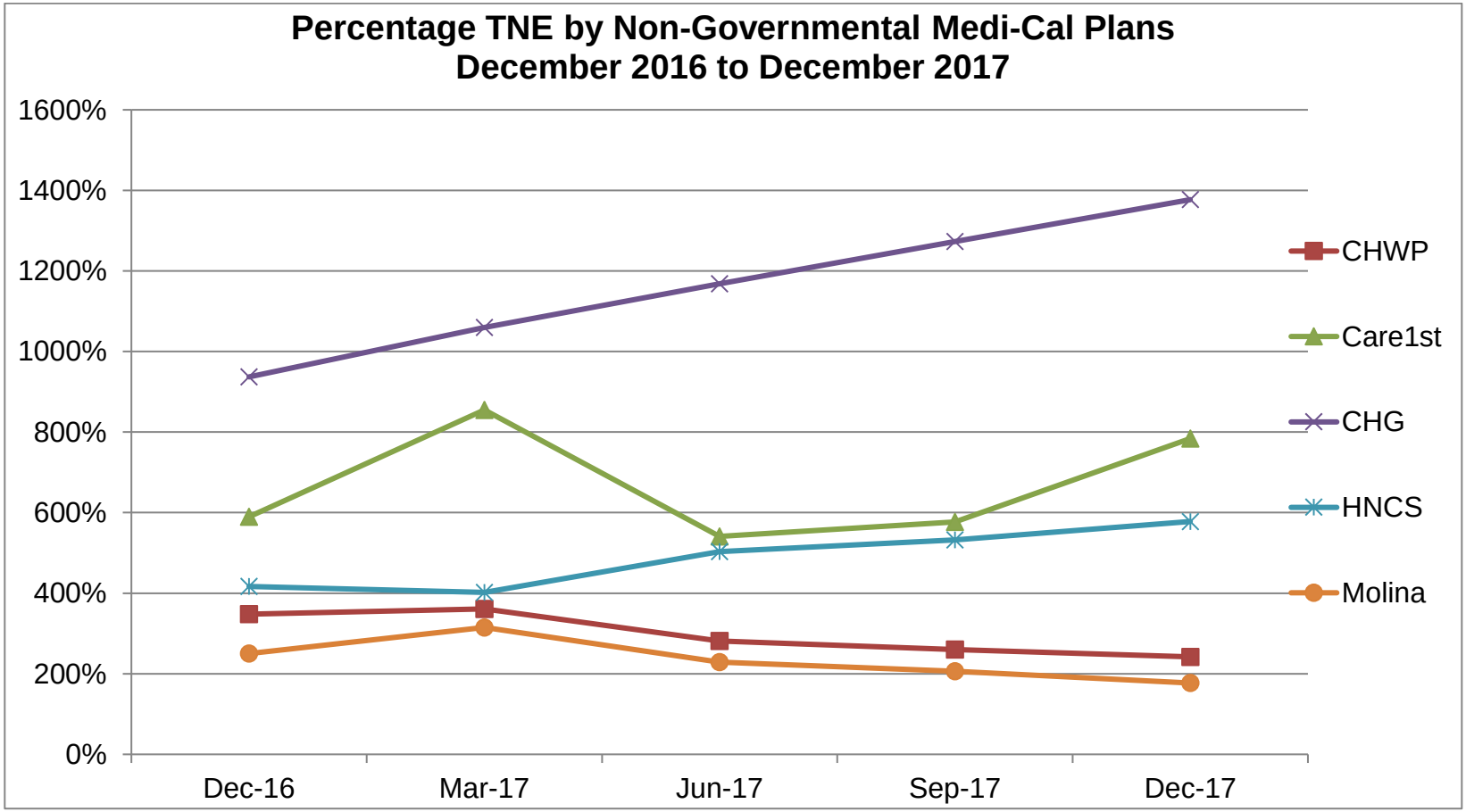
Table 9
Non-Governmental Medi-Cal Plans Net Income by Quarter (in thousands)

Non-Governmental Medi-Cal Plans	QE Sep-16	QE Dec-16	QE Mar-17	QE Jun-17	QE Sep-17	QE Dec-17
CHWP	$4,285	$15,196	$5,452	$1,112	($3,868)	($1,992)
Care1st	$28,400	$108,610	$19,800	$34,182	$21,603	$25,019
CHG	$81,095	$15,446	$53,428	$35,439	$54,334	$49,886
HNCS	$124,738	$272,079	$126,690	$144,170	$76,723	$85,423
Molina	$22,329	($300)	$45,397	$7,547	($9,425)	$10,095
Total Net Income	**$260,847**	**$411,031**	**$250,767**	**$222,450**	**$139,367**	**$168,431**

Tangible Net Equity – Non-Governmental Medi-Cal Plans

NGM plans' TNE to Required TNE ranged from 177% to 1377% for December, 2017. 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. CHG, a not-for-profit, reported TNE comparable to LIs and COHS. Molina's TNE dropped below 200% at December 2017.

Chart 15



Cash Flow from Operations

NGM plans reported negative $418 million in cash flow from operations in December 2017. 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 December 2017.

Conclusion

After the initial surge in LI and COHS plan's enrollment brought on by the Affordable Care Act in 2014, the rate of increase in enrollment slowed down in 2017. Most Medi-Cal managed care plans continue to see moderate increases in enrollment. Overall, expenses and premium revenue continue to rise as enrollment increases. 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 LI, COHS and NGM plans reporting to the Department.

Appendix

Medi-Cal Managed Care Plans: Net Income, Medical Expenses and TNE
December 2017

Health Plan	Net Income	Medical Expenses	Excess TNE*
Local Initiatives			
Alameda Alliance	$1,493,008	$206,388,238	$163,415,349
Contra Costa Health Plan	$1,792,710	$189,408,617	$38,601,579
CalViva Health	$2,546,921	$254,187,991	$42,971,311
IEHP	$15,410,514	$1,164,697,721	$689,622,722
Kern Health Systems	($2,868,000)	$160,042,000	$160,370,000
L.A. Care	$18,754,716	$2,090,400,625	$538,230,587
San Francisco Community Health Authority	$2,365,199	$127,880,294	$113,698,156
Health Plan of San Joaquin	($1,588,984)	$249,418,272	$250,353,486
Santa Clara Family Health Plan	$7,652,000	$283,354,000	$138,120,000
Total	**$45,558,084**	**$4,725,777,758**	**$2,135,383,190**
County Organized Health Systems			
CalOptima	$11,690,695	$811,806,099	$647,195,612
CenCal Health	$7,059,735	$148,290,167	$194,429,978
Central California Alliance for Health	($16,632,978)	$268,639,098	$580,433,085
Partnership HealthPlan	($42,409,839)	$608,406,873	$693,036,208
Health Plan of San Mateo	$50,378,269	$204,234,424	$317,923,226
Total	**$10,085,882**	**$2,041,376,661**	**$2,433,018,109**
Non-Governmental Medi-Cal Plans			
California Health and Wellness	($1,991,553)	$144,497,938	$38,552,522
Care1st	$25,018,733	$160,291,579	$434,544,110
Community Health Group	$49,886,495	$248,889,441	$535,681,096
Health Net Community Solutions, Inc.	$85,423,000	$1,646,529,756	$825,931,548
Molina	$10,094,868	$605,842,974	$54,897,608
Total	**$168,431,543**	**$2,806,051,688**	**$1,889,606,884**

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