Financial Summary of Local Initiative Health Plans and County Organized Health Systems

June 17, 2015

Office of Financial Review

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DEPARTMENT OF Managed HealthCare

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I. Overview

Medi-Cal, California's Medicaid program has experienced significantly increased enrollment in the last two 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. Locally-sponsored plans known as Local Initiatives (LIs) participate as MCMC plans under the Two-Plan Model, while County Organized Health Systems (COHS) plans serve Medi-Cal enrollees under the COHS Model.[*] Both LI and COHS plans are local agencies established by county boards of supervisors to contract with the Medi-Cal program. Approximately 5.8 million Medi-Cal beneficiaries are enrolled in LI and COHS plans under the Two-Plan and COHS Models.

This report details the significant increases in 2014 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 December 31, 2014. 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.[†]

[*] 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. This report looks at the financial performance only of LI and COHS plans, not the commercial plans participating in MCMC.

[†] 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

LI and COHS plans experienced unprecedented growth in 2014. All LI and COHS plans reported enrollment increases of at least 35% from December 2013 to December 2014. Per member per month (PMPM) medical expenses and premium revenue both experienced an upward trend during this time period. PMPM premium revenue exceeded PMPM medical expense for every LI and COHS plan for the quarter ending December 2014. While the COHS plans reported higher net income and TNE reserves compared to LIs, only one LI reported TNE under 100% of required TNE, and this plan is under conservatorship by the Department.

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 one county, the DHCS contracts with two commercial plans. 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 the safety net to distribute 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.[‡]

- 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

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

- LI plans reported combined enrollment of 4.2 million individuals as of quarter end (QE) December 31, 2014. Four million (96%) of the total LI enrollment were Medi-Cal beneficiaries. The remaining 4% 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 45% from December 2013 to December 2014.

- Per member per month expenses and premium revenue rose in conjunction with increased enrollment. LI plans PMPM premium revenue outpaced expenses for December 2014.

- LI plans reported $145.6 million in net income in December 2014, which was significantly greater than the $1.1 million net income reported in December 2013.

- The LIs reported a range of TNE as of December 2014, from 89% to 701% of required TNE. The one health plan that reported below 200% of required TNE, Alameda Alliance (89%), is currently under conservatorship by the Department of Managed Health Care (Department).

- The LIs reported $677.6 million in cash flow from operations at December 2014, which was significantly greater than the $23.3 million reported in December 2013.

B. Enrollment Trends - LI

The LI plans serve 4.2 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 December 2013 (pre-expansion) to December 2014. In 2014, nearly all LIs reported over 40% increases in total enrollment. San Francisco reported a 63% increase.

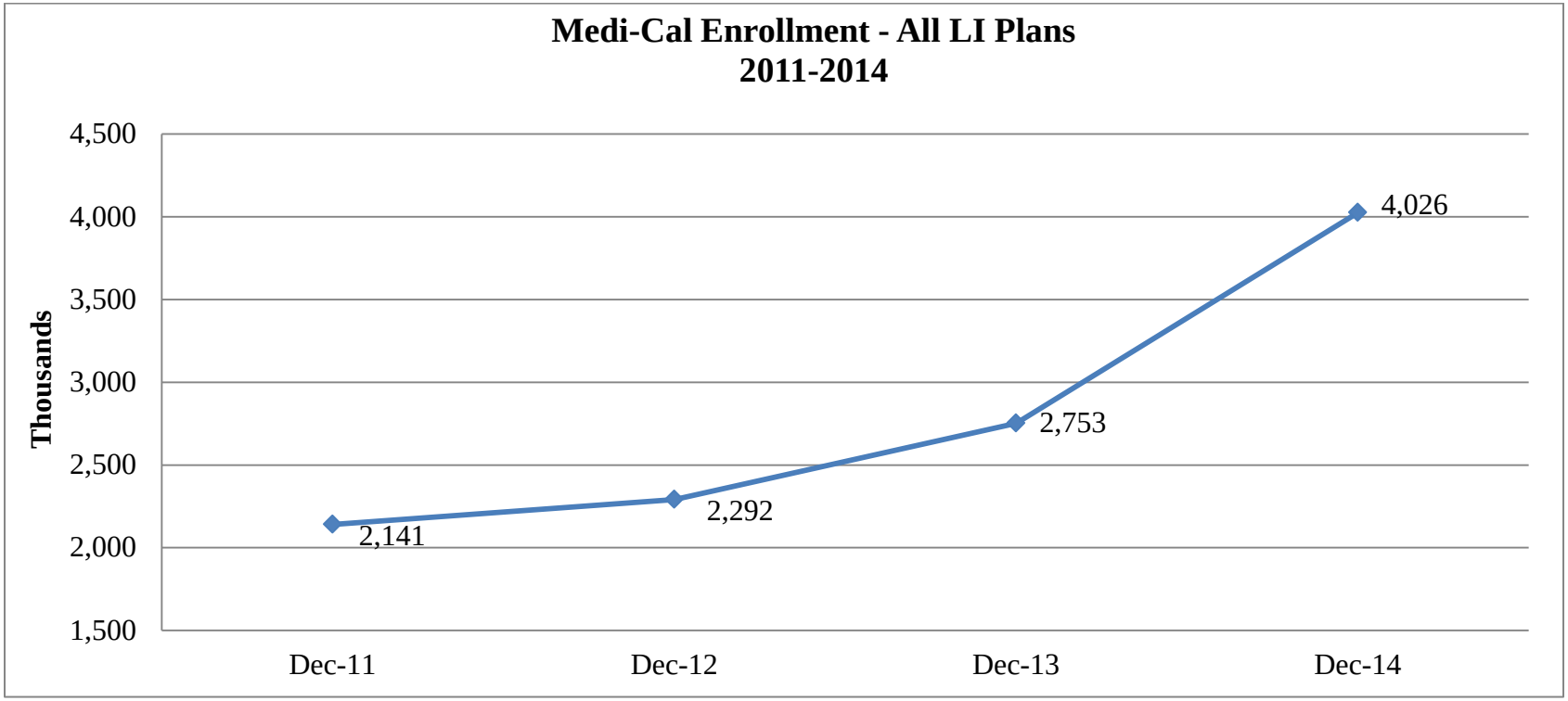
Table 1
Enrollment in Local Initiatives
Dec 2013 – Dec 2014

Local Initiative	Total Medi-Cal Enrollment Dec 2014	Percentage of Medi-Cal Enrollment Dec 2014	Total Enrollment* Dec 2014	Total Enrollment Dec 2013	Enrollment Increase	Percentage Enrollment Increase
Alameda Alliance For Health	228,977	95%	240,108	162,588	77,520	48%
Contra Costa County Medical Services	151,201	92%	164,188	119,904	44,284	37%
Fresno-Kings-Madera Regional Health Authority	299,412	100%	299,412	212,931	86,481	41%
Inland Empire Health Plan	968,646	98%	991,386	640,227	351,159	55%
Kern Health Systems	182,716	100%	182,716	126,404	56,312	45%
Local Initiative Health Authority for L.A County	1,592,455	95%	1,672,550	1,196,599	475,951	40%
San Francisco Community Health Authority	118,897	89%	133,268	81,671	51,597	63%
Health Plan of San Joaquin	267,591	98%	271,903	191,782	80,121	42%
Santa Clara County Health Authority	215,924	98%	220,857	153,310	67,547	44%
Total	**4,025,819**	**96%**	**4,176,388**	**2,885,416**	**1,290,972**	**45%**

*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 December year-over -year data.

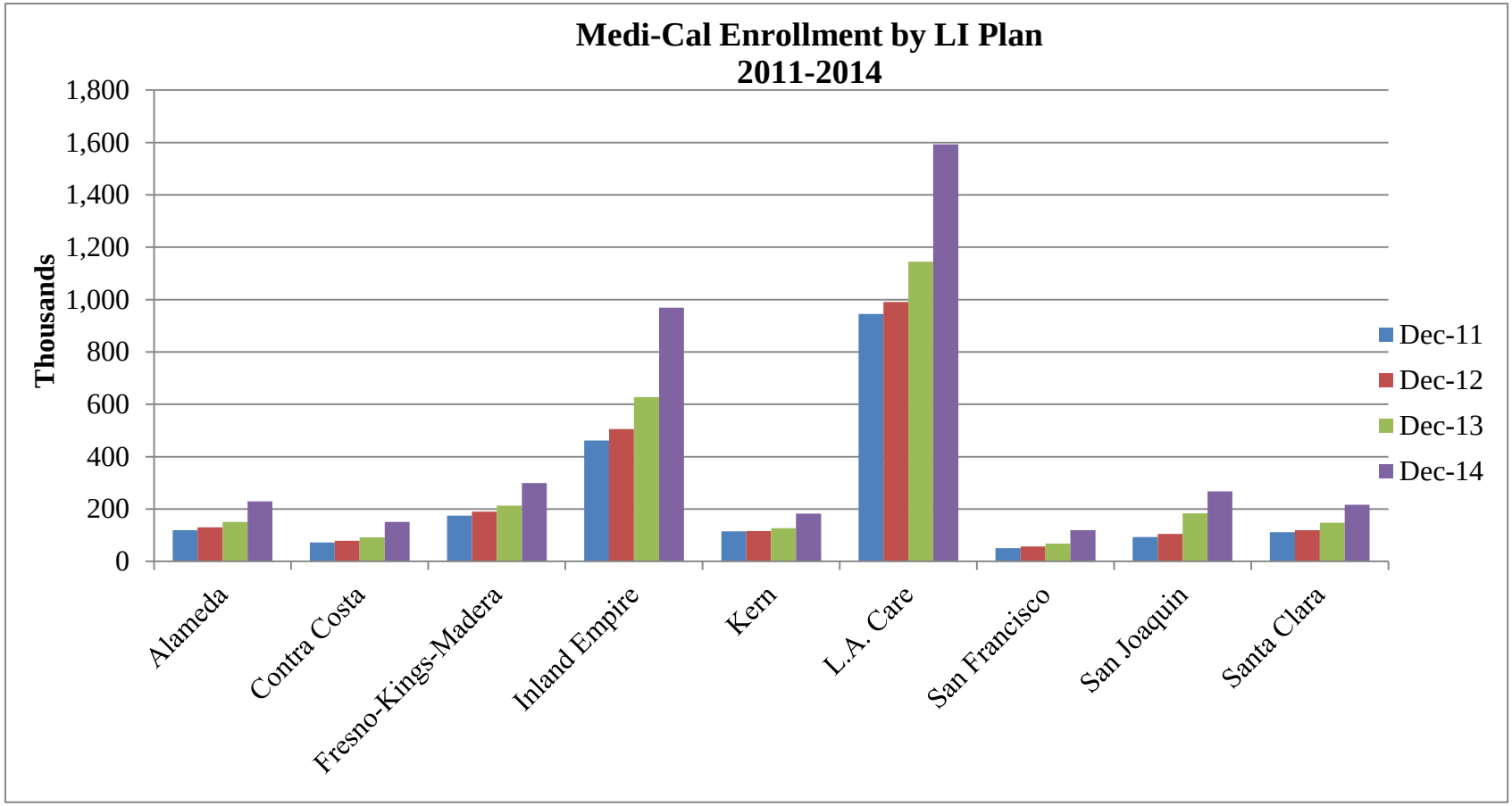
Chart 1



Medi-Cal enrollment in LIs continues to increase with a significant jump at the beginning of 2014. Two Southern California LIs reported the highest number of enrollees and make up the majority of the enrollment increase. L.A. Care reported 1.6 million Medi-Cal enrollees, and Inland Empire reported 968,000 enrollees.

Chart 2 shows the LI growth by plan over the past four years.

Chart 2



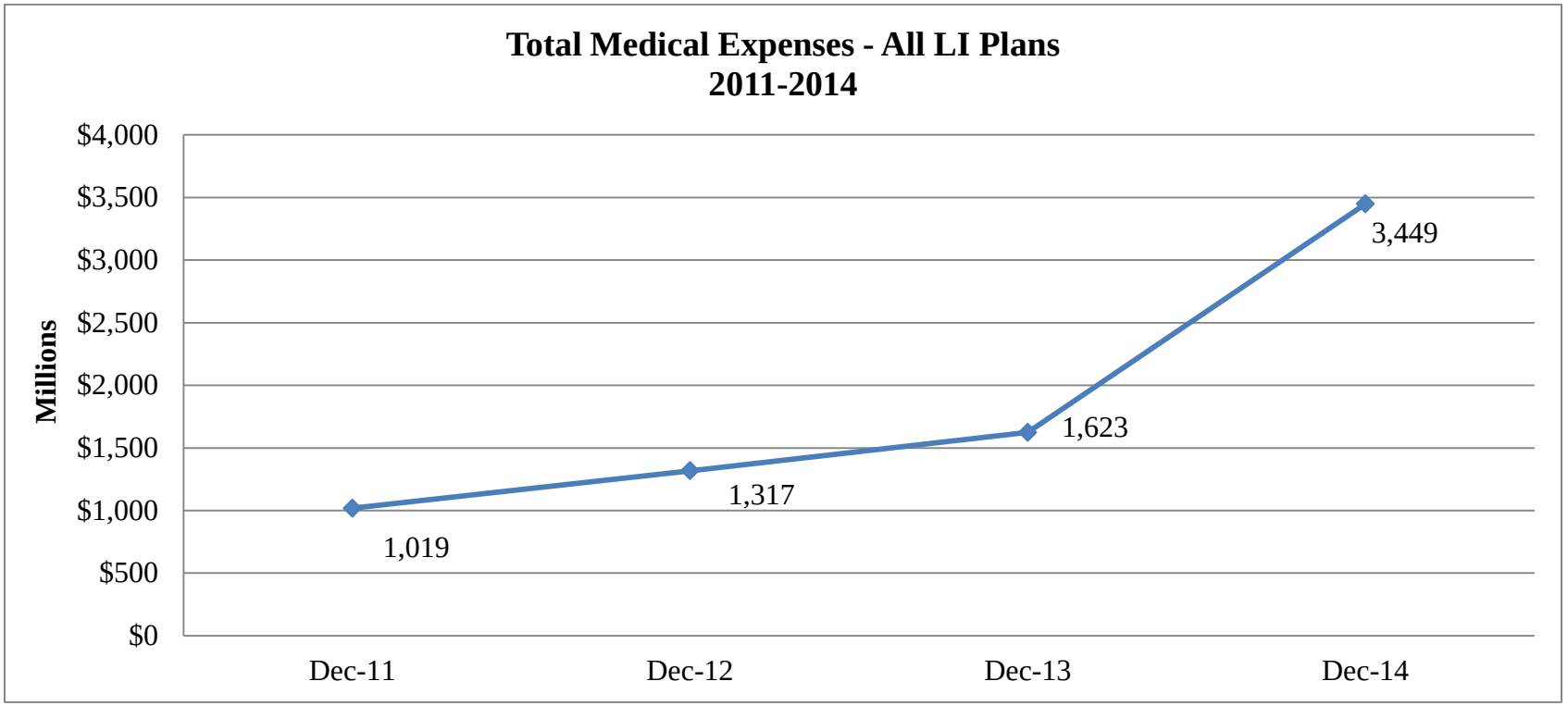
All nine LIs have experienced increases in enrollment. The majority of the increases were from their Medi-Cal lines of business. From December 2013 to December 2014, L.A. Care experienced a 40% increase in enrollment. San Francisco and Inland Empire experienced 63% and 55% increases in enrollment over this same period, respectively.

C. Financial Trends - LI

Medical Expenses

Chart 3 illustrates total medical expenses for the LIs. There was a significant increase in total medical expenses in the quarter ending December 2014 compared to the quarter ending in December 2013. The increase in medical expenses is correlated to the increase in the LIs' enrollment and expanded Medi-Cal benefits. Total medical expense changes as enrollment increases or decreases and as the enrollee mix (healthy or unhealthy, high or low utilizers) changes.

Chart 3



Per Member Per Month Medical Expenses and Premium Revenue - LI

Table 2 shows the PMPM medical expenses and premium revenue of the LIs for the quarter ending in December for the past 4 years, as well as the percentage change in the PMPM medical expenses and premium revenue between December 2013 and December 2014.

San Francisco and Alameda Alliance reported the highest PMPM medical expenses and premium revenue. All LIs had higher PMPM premium revenue than medical expenses at December 2014.

Table 2
Per Member Per Month Medical Expenses and Premium Revenue – LI
2011-2014

Local Initiative	11-Dec		12-Dec		13-Dec		14-Dec[§]		
	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	Net[**]
Alameda Alliance For Health	$196	$212	$222	$243	$239	$226	$308	$335	$27
Contra Costa County Medical Services	110	110	106	98	134	132	285	308	23
Fresno-Kings-Madera Regional Health Authority	155	174	165	180	163	182	271	295	24
Inland Empire Health Plan	131	151	166	164	163	172	258	301	43
Kern Health Systems	143	136	151	155	212	172	161	207	46
Local Initiative Health Authority for L.A. County	133	138	170	175	188	196	285	306	21
San Francisco Community Health Authority	202	211	230	248	231	265	316	349	33
Health Plan of San Joaquin	129	143	146	152	171	175	217	253	36
Santa Clara County Health Authority	140	153	151	176	155	186	272	353	81

[§] December 2014 PMPM Medical Expenses and PMPM Premium Revenue information excludes pass-through income and expense items.
[**] Difference between 2014 PMPM Medical Expenses and PMPM Premium Revenue

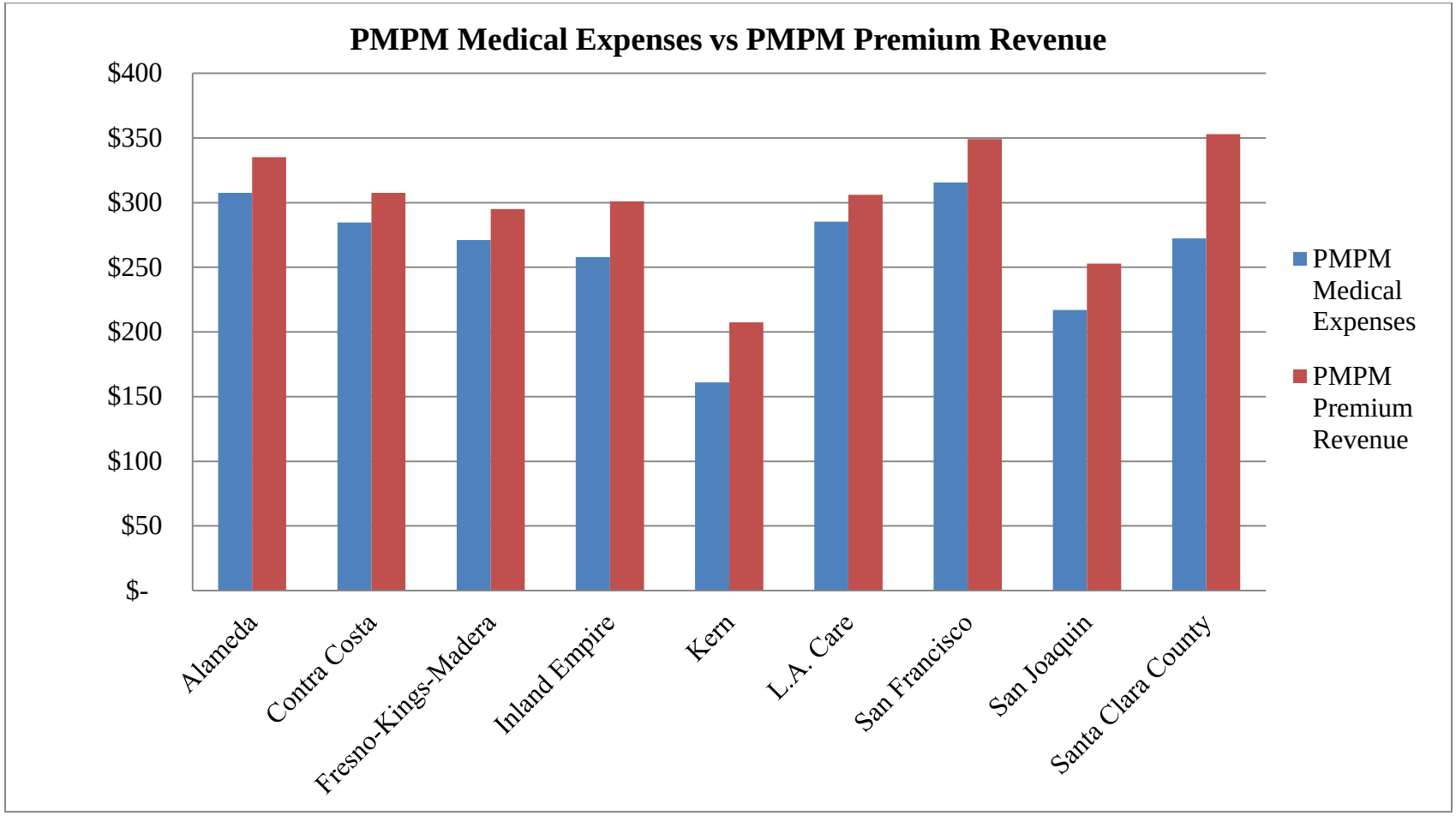
Fluctuations in PMPM medical expenses and premium revenue can be due to a number of factors including utilization of medical services by enrollees, the timing of pass-through revenues and expenses, and premium rate adjustments. Although pass-through revenues and expenses have zero net effect on a health plan's financial performance, they can cause added volatility to a plan's revenue and expenses. An example of pass-through is the Intergovernmental Transfer (IGT). IGT is a process where California tax authorities participating in MCMC may enter into an agreement with the DHCS and the MCMC plan to increase federal revenue. Utilizing local funds, the DHCS draws down additional federal funding from the Centers for Medicare and Medicaid Services (CMS). These funds are then transferred to the plan which, after retention of its administrative fee, transfers the funds to its County and/or community partners to provide additional health care services to its Medi-Cal beneficiaries.

Currently, MCMC plans include pass-through expenses under medical expenses and premium revenue. This inclusion may be a reason why PMPM medical expenses and premium revenue have continued to fluctuate. The Department was able to gather information from the LI and COHS plans regarding the pass-through income and expenses reported under medical expenses and premium revenue for December, 2014. Additionally, the Department is in the process of implementing a financial statement redesign that will add an additional schedule which would list the pass-through expenses and revenue reported under medical expenses and premium revenue.

PMPM Medical Expense vs. PMPM Premium Revenue - LI

Chart 4 illustrates the LIs' PMPM medical expense vs PMPM premium revenue for December 2014. The PMPM premium revenue received exceeded the PMPM medical expenses for each LI, demonstrating that the LIs' premium revenue covered increased medical costs.

Chart 4



Net Income - LI

Table 3 shows the Net Income for LIs over the past six quarters. For the quarter ending December 2014, Net Income for each LI was positive. Net income or loss is directly related to premium revenue and medical expenses.

Table 3
LI Net Income by Quarter (in thousands)

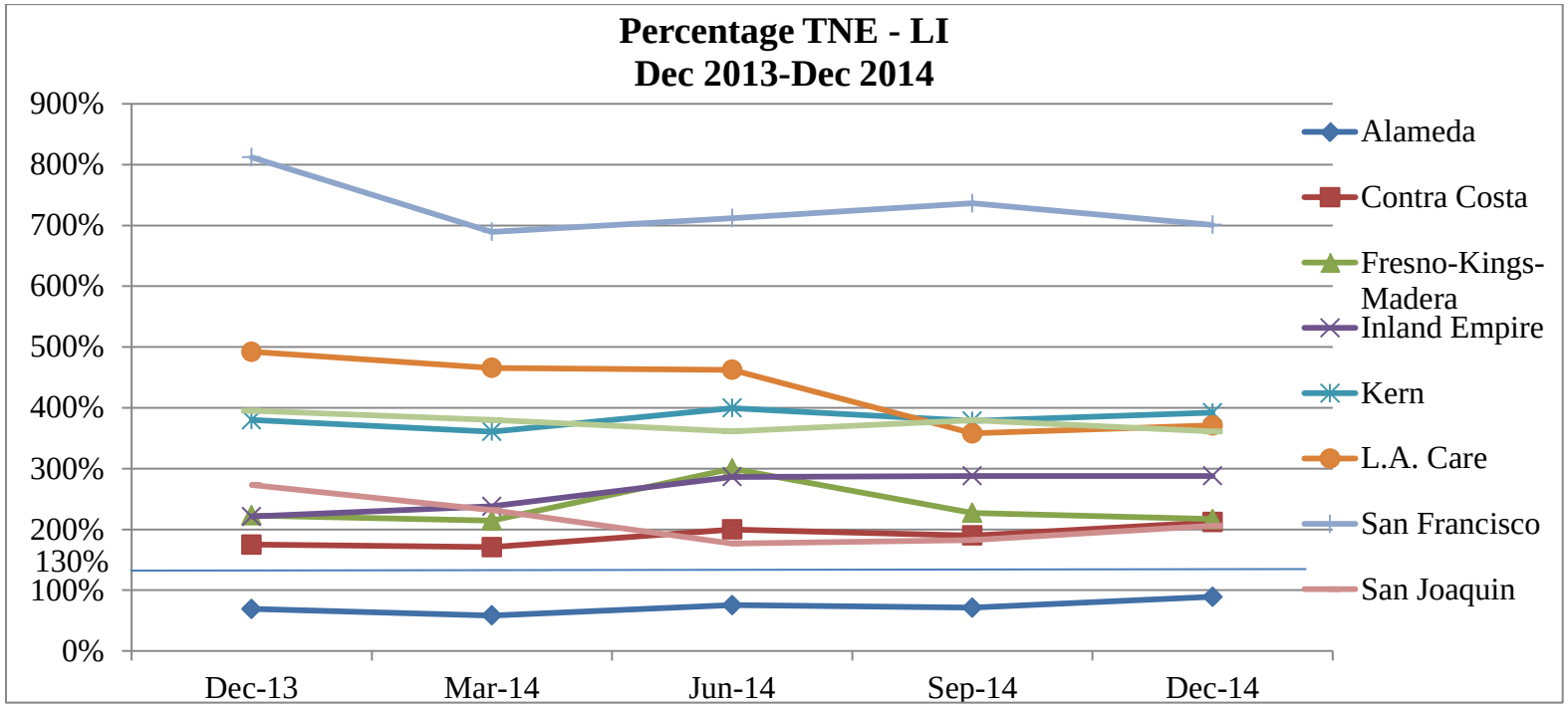
Local Initiative	QE Sep-13	QE Dec-13	QE Mar-14	QE Jun-14	QE Sep-14	QE Dec-14
Alameda Alliance For Health	(6,602)	5,205	(785)	401	1,189	7,677
Contra Costa County Medical Services	459	436	613	6,053	1,138	4,842
Fresno-Kings-Madera Regional Health Authority	725	592	990	1,276	2,048	2,496
Inland Empire Health Plan	(17,926)	(1,244)	15,667	45,371	38,200	46,787
Kern Health Systems	(7,332)	(847)	(1,532)	(723)	(3,099)	7,148
Local Initiative Health Authority for L.A County	26,498	(4,176)	18,383	30,129	(205)	52,923
San Francisco Community Health Authority	704	3,434	1,427	5,661	5,640	7,489
Health Plan of San Joaquin	1,339	(3,411)	(4,695)	(7,253)	7,596	13,116
Santa Clara County Health Authority	(816)	1,144	1,471	6,968	10,246	3,105
Total LI Net Income	**$(2,951)**	**$1,133**	**$31,539**	**$87,883**	**$62,753**	**$145,583**

Although Kern reported five consecutive quarters of net loss prior to its December 2014 net income, it has over $59 million of excess TNE, or approximately 250% of the minimum required TNE.

Tangible Net Equity - LI

TNE is a reserve requirement described in section 1300.76 of the Knox-Keene regulations[††] 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[‡‡], 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[§§] may be added to the TNE calculation, which serves to increase the plan's TNE.

Chart 5



[††] "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.

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

[§§] 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 Plan's TNE falls below 130%, the health plan must file monthly financial statements with the Department. If the health plan reports a TNE deficiency (TNE below 100%), the Department assesses whether to take enforcement action against the plan.

The average TNE for the LIs overall was relatively stable in 2014. For December 2014, reported TNE ranged from 89% of required to 701% of required TNE. All but one plan reported TNE over 100%. Alameda Alliance, which reported 89% of required TNE, is currently under conservatorship by the Department.

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.

Total cash flow from operations for all LIs increased significantly in December 2014. The increase was due to premium revenue paid by the DHCS for the Medi-Cal expansion population.

The cash flow from operations totaled $677.6 million in December 2014 compared to $23.3 million in December 2013.

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 ended December 31, 2014, Alameda Alliance reported deficiencies relating to claims processing payment deficiencies. Alameda Alliance submitted a corrective action plan with the Department outlining measures it is 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

- 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 all COHS plan providers.

- COHS plans reported combined enrollment of 1.81 million as of December 31, 2014; 98% of COHS plans' total enrollment (1.78 million) are Medi-Cal enrollees and the other 2% are other lines of business such as Healthy Kids, AIM, etc.

- COHS plans' enrollment increased 44% from December 2013 to December 2014.[***] Per member per month expenses and premium revenue rose for COHS plans in conjunction with increased enrollment. COHS plans' PMPM premium revenue outpaced expenses for December 2014.
- COHS plans reported $207 million in net income in December 2014, which was greater than the $154 million net income reported in December 2013.
- Tangible net equity for COHS plans ranged from 228% to 1,262% of required TNE for December 2014. Four of the five reporting COHS plans reported progressively higher TNE from December 2013 to December 2014.
- COHS plans reported $420 million in cash flows from operations in December 2014 compared to ($153) million at December 2013.

[***] This number excludes Gold Coast Health Plan, which does not report to the Department.

B. Enrollment Trends - COHS

Like LI plans, COHS plans have reported consistent increases in enrollment since 2011. CalOptima and Partnership HealthPlan reported the highest enrollment numbers.

Table 4
Enrollment in County Organized Health Systems
Dec 2013 – Dec 2014

COHS	Total Medi-Cal Enrollment Dec 2014	Percentage of Medi-Cal Enrollment Dec 2014	Total Enrollment Dec 2014	Total Enrollment Dec 2013	Enrollment Change from Dec 2013 - Dec 2014	Percentage Enrollment Change from Dec 2013 - Dec 2014
CalOptima	702,202	98%	715,706	491,540	224,166	46%
CenCal Health	151,819	99%	152,819	111,674	41,145	37%
Central California Alliance for Health	304,194	100%	305,635	220,029	85,606	39%
Partnership HealthPlan	503,441	98%	512,239	350,875	161,364	46%
Health Plan of San Mateo	113,520	88%	129,137	89,787	39,350	44%
Total	**1,775,176**	**98%**	**1,815,536**	**1,263,905**	**551,631**	**44%**

Chart 6 illustrates the Medi-Cal managed care enrollment trend in COHS plans.

Chart 6

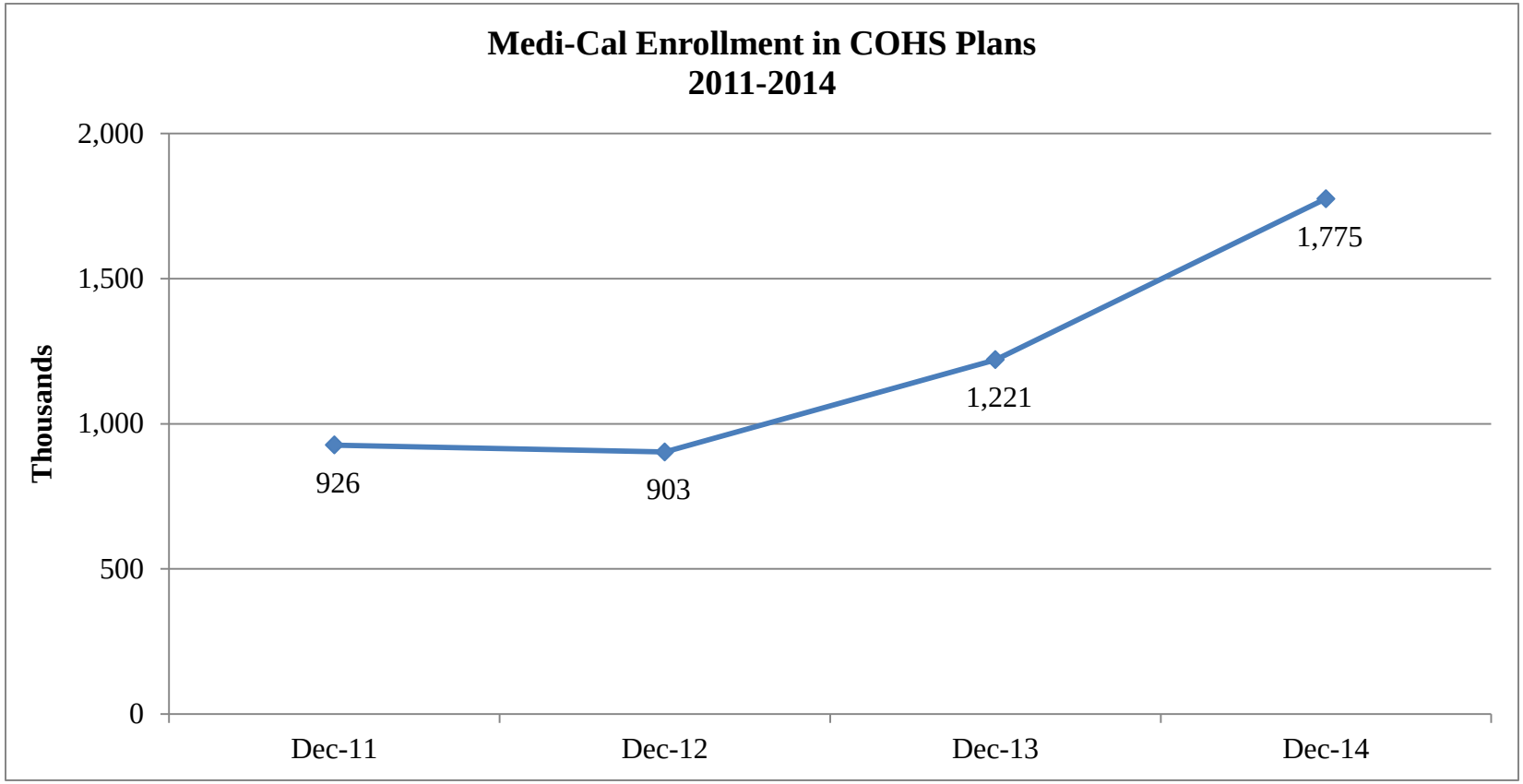
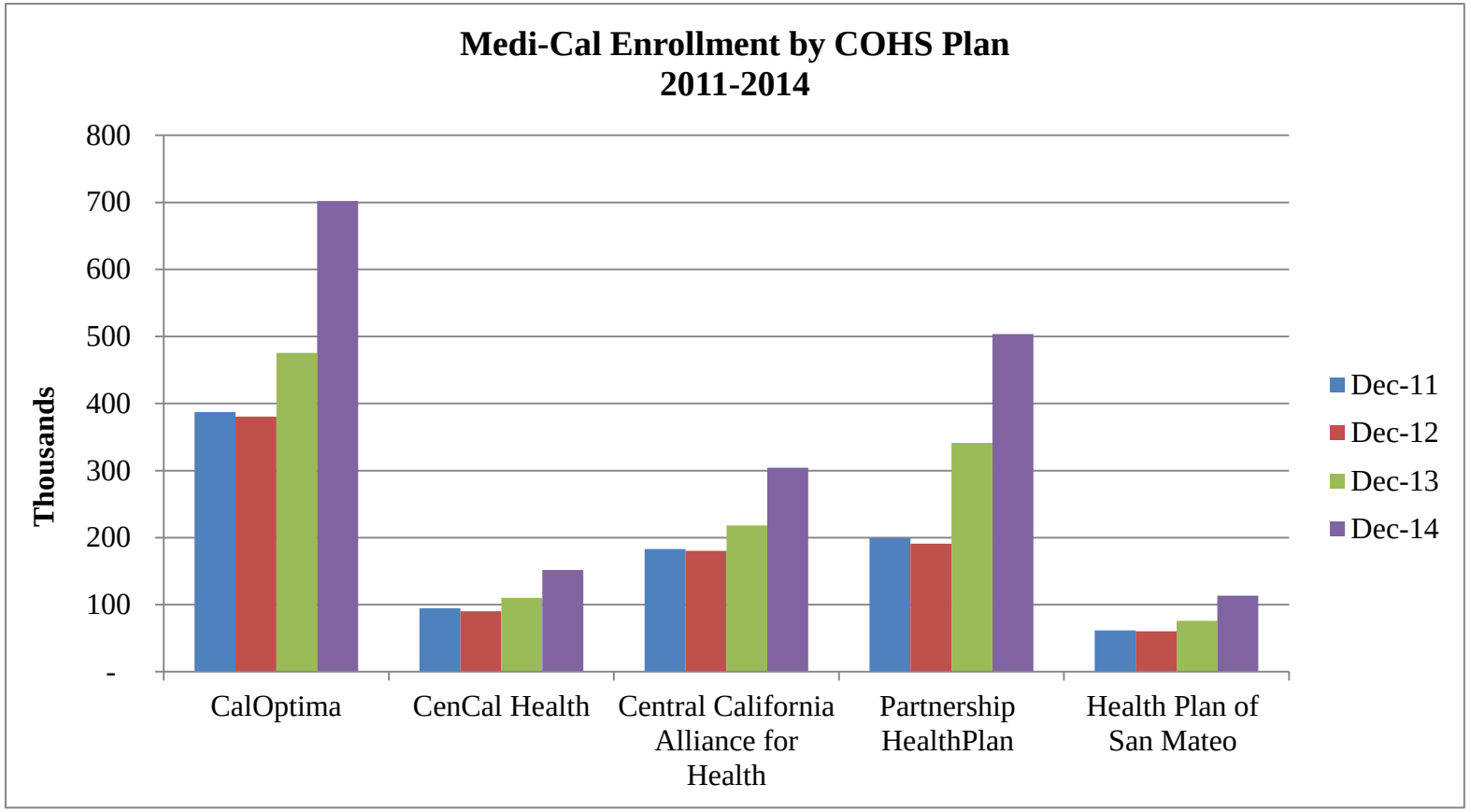


Chart 7 shows the enrollment growth by each COHS plan over the past four years.

Chart 7

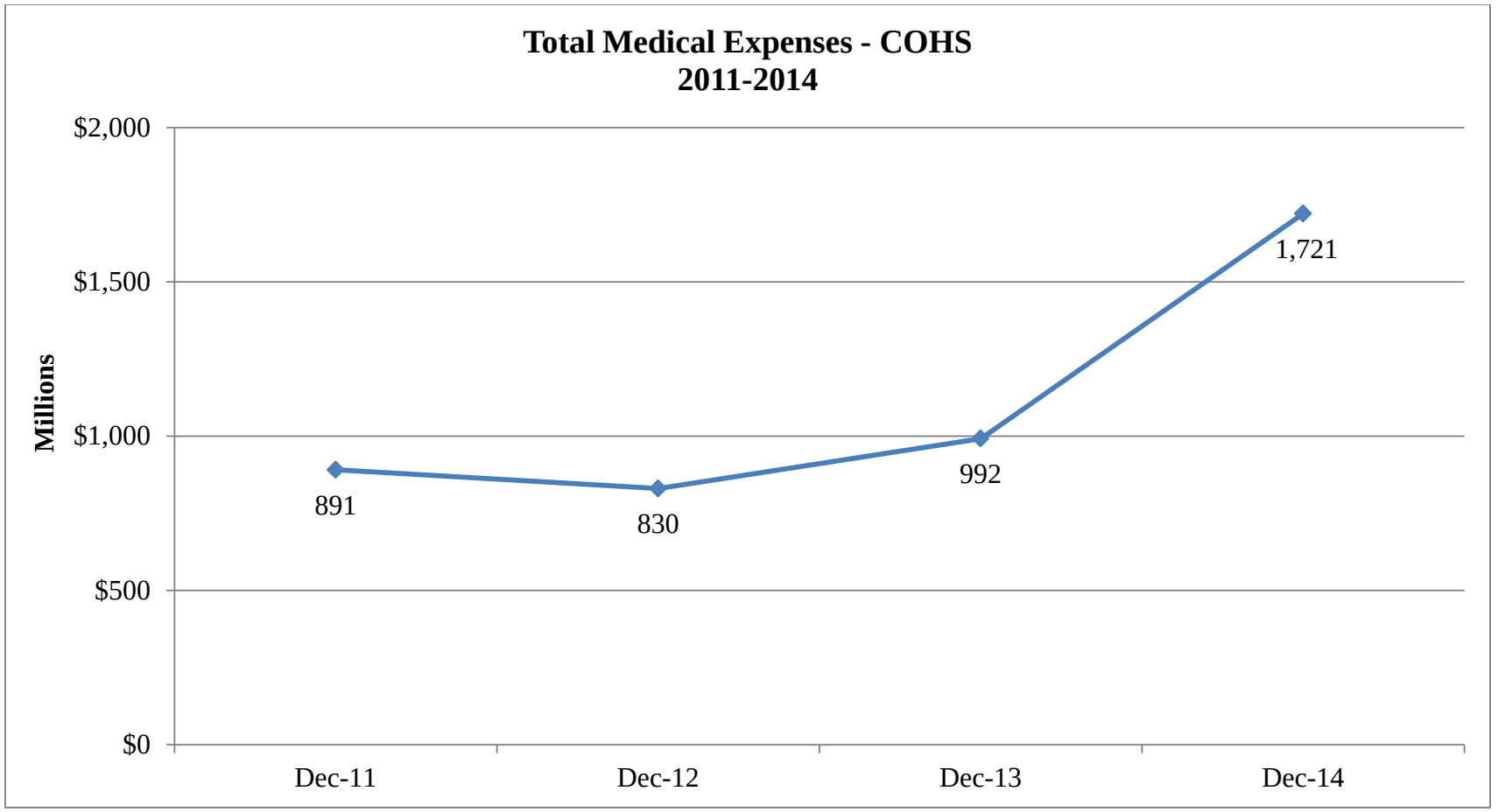


All COHS plans reported enrollment increases of 35% or more from December 2013 to December 2014.

C. Financial Trends - COHS

Chart 8 shows a similar increase in medical expenses for COHS plans as medical expenses reported by LIs.

Chart 8



Per Member Per Month Medical Expenses and Premium Revenue - COHS

Table 5 shows the PMPM medical expenses and premium revenue of the COHS plans for the quarter ending in December for the past 4 years, as well as the percentage change in the PMPM medical expenses and premium revenue between December 2013 and December 2014.

San Mateo reported the highest PMPM medical expense and premium revenue in December 2014.

Table 5
Per Member Per Month Medical Expenses and Premium Revenue – COHS
2011-2014

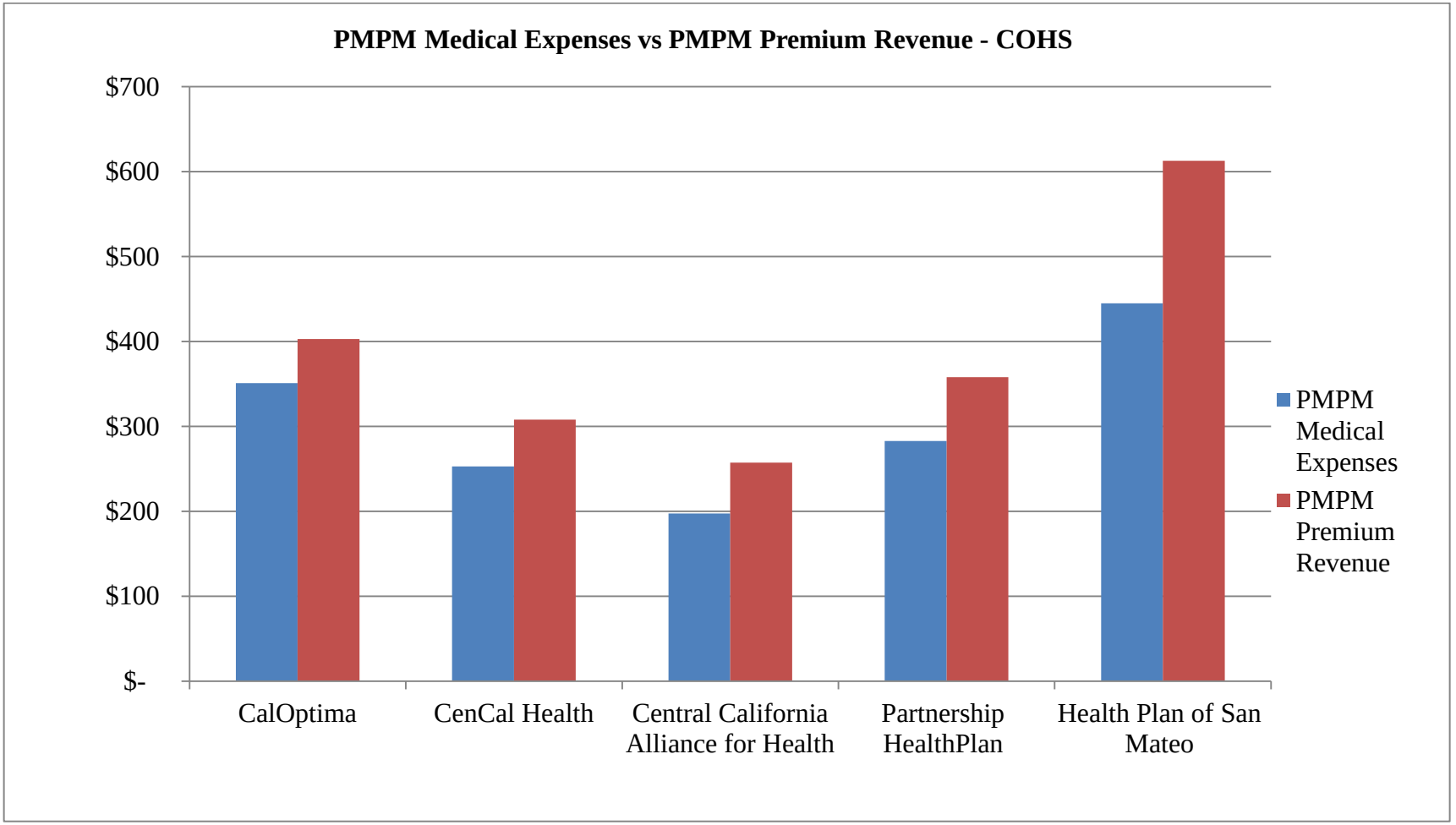
COHS	11-Dec		12-Dec		13-Dec		14-Dec†††		
	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	Net‡‡‡
CalOptima	$296	$311	$240	$266	$240	$266	$351	$402	$51
CenCal Health	238	261	243	251	236	260	253	308	55
Central California Alliance for Health	193	125	214	229	202	349	205	262	57
Partnership HealthPlan	329	379	319	351	297	343	283	358	75
Health Plan of San Mateo	418	522	471	567	420	614	445	613	168

††† December 2014 PMPM Medical Expenses and PMPM Premium Revenue information excludes pass through income and expense items.
‡‡‡ Difference between 2014 PMPM Medical Expenses 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 2014. All plans reported higher per member per month premium revenue than medical expenses.

Chart 9



Net Income - COHS

Favorable PMPM premium revenue ratios translated to positive net income for all COHS plans reporting to the Department. CenCal recorded net losses for the March and June quarters but income from September and December 2014 put the plan in a positive income position for the year. All other plans reported net income for the four quarter period ending December 2014.

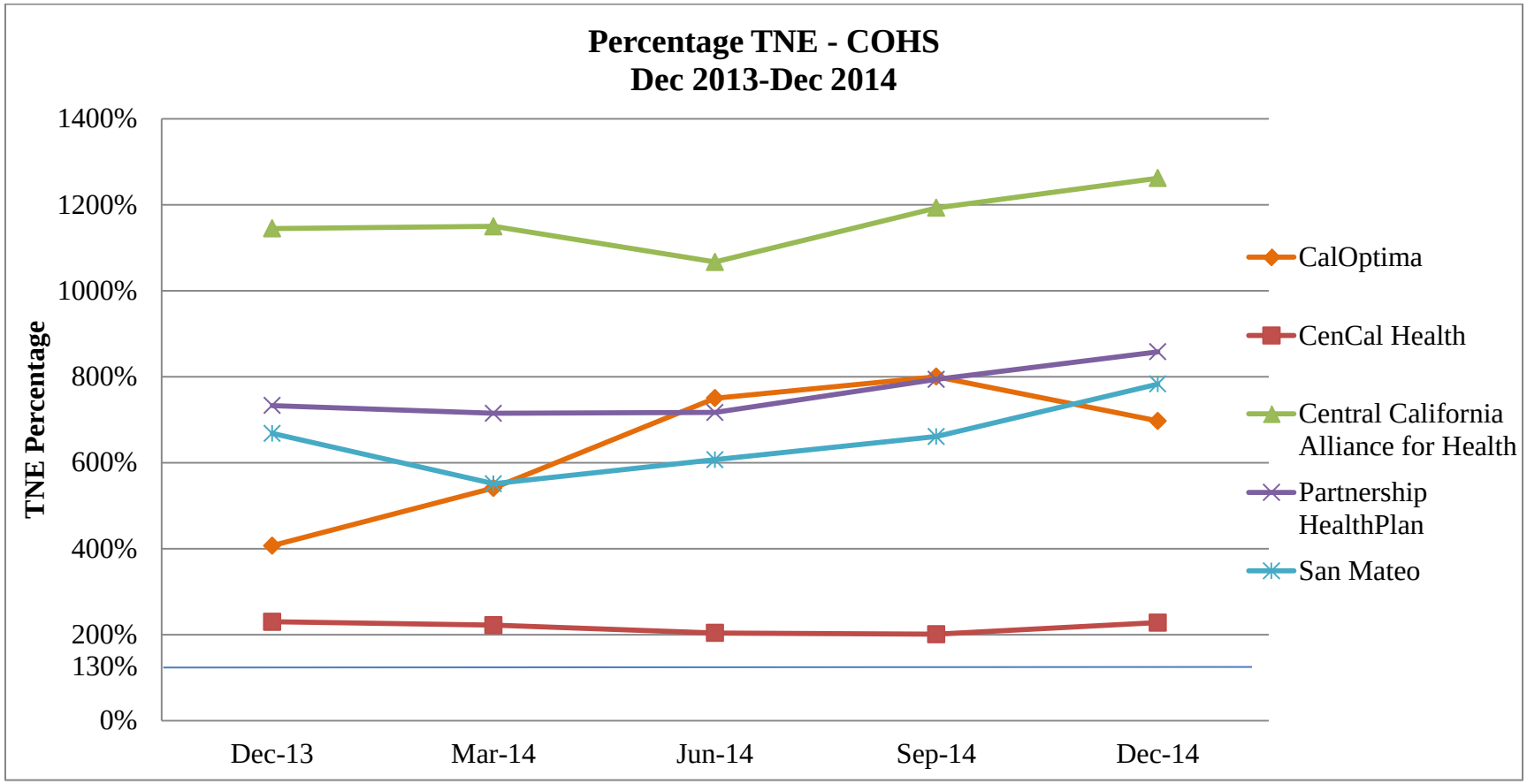
Table 6
COHS Net Income by Quarter (in thousands)

COHS	QE Sep-13	QE Dec-13	QE Mar-14	QE Jun-14	QE Sep-14	QE Dec-14
CalOptima	4,106	8,687	99,978	75,607	53,407	53,672
CenCal Health	4,115	543	(161)	(1,695)	1,876	8,206
Central California Alliance for Health	32,866	87,291	16,474	16,975	13,756	43,341
Partnership HealthPlan	29,590	20,641	42,328	40,665	42,897	71,141
Health Plan of San Mateo	14,066	37,171	6,617	6,888	17,858	30,714
Total COHS Net Income	**$84,743**	**$154,333**	**$165,236**	**$138,440**	**$129,794**	**$207,074**

Tangible Net Equity - COHS

All COHS plans reported over 200% of required TNE for December 2014. Excess TNE ranged from 228% to 1262%. CenCal's reported TNE has hovered around 200% for the past couple of years, all other plans report 500% or more of required TNE.

Chart 10



Cash Flow from Operations

COHS plans reported $420 million in cash flow from operations in December 2014. This is a $573 million increase from December 2013. Similar to the LIs, COHS plans' cash inflow is primarily attributed to Medi-Cal premium revenue paid by DHCS for the Medi-Cal expansion population.

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 2014.

V. Conclusion

The Department anticipates continued enrollment increases for both LI and COHS plans in 2015. However, after the initial surge in enrollment brought on by the ACA in 2014, the rate of increase should slow down for 2015 and beyond. Expenses and revenue will continue to rise as enrollment increases. There has been much discussion around Medi-Cal capitation rates for plans in the future and the general consensus is rates might be reduced from 2014 levels. It is unknown whether, or to what extent, capitation rates might be reduced. The DMHC will continue to monitor the enrollment trends and financial solvency of all LI and COHS plans reporting to the Department.