

Financial Summary of Medi-Cal Managed Care Health Plans Quarter Ending December 31, 2018

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Prepared by: Office of Financial Review

Pritika Dutt, Deputy Director

Karanveer Singh, Financial Examiner

Table of Contents

	<u>Page Number</u>
I. Overview	1
II. Summary of Findings	2
III. Local Initiative Health Plans (LIs)	
A. Highlights	3
B. Enrollment Trends	5
C. Financial Trends	8
IV. County Organized Health Systems (COHS)	
A. Highlights	15
B. Enrollment Trends	17
C. Financial Trends	20
V. Non-Governmental Medi-Cal Plans (NGMs)	
A. Highlights	26

B. Enrollment Trends	29
C. Financial Trends	32
VI. Conclusion	37
VII. Appendix	38

Tables

Table 1	Enrollment in Local Initiatives December 2017-December 2018	5
Table 2	Per Member Per Month Medical Expenses and Premium Revenue – LI	9
Table 3	LI Net Income by Quarter	12
Table 4	Enrollment in County Organized Health Systems December 2017-December 2018	17
Table 5	Per Member Per Month Medical Expenses and Premium Revenue – COHS	21
Table 6	COHS Net Income by Quarter	23
Table 7	Enrollment in Non-Governmental Medi-Cal Plans December 2017-December 2018	29
Table 8	Per Member Per Month Medical Expenses and Premium Revenue – Non-Governmental Medi-Cal Plans	33
Table 9	Non-Governmental Medi-Cal Plans Net Income by Quarter	35

Charts

Chart 1	Medi-Cal Enrollment - All LI Plans 2015-2018	6
Chart 2	Medi-Cal Enrollment by LI Plan 2015-2018	7
Chart 3	Total Medical Expenses – All LI Plans 2015-2018	8
Chart 4	PMPM Medical Expenses vs. PMPM Premium Revenue – LI	11
Chart 5	Percentage TNE – All LI Plans December 2017-December 2018	13
Chart 6	Medi-Cal Enrollment – All COHS Plans 2015-2018	18
Chart 7	Medi-Cal Enrollment by COHS Plan 2015-2018	19
Chart 8	Total Medical Expenses – All COHS Plans 2015-2018	20
Chart 9	PMPM Medical Expenses vs. PMPM Premium Revenue – COHS	22
Chart 10	Percentage of TNE by COHS December 2017-December 2018	24
Chart 11	Medi-Cal Enrollment in Non-Governmental Medi-Cal Plans 2015-2018	30
Chart 12	Medi-Cal Enrollment by Non-Governmental Medi-Cal Plan 2015-2018	31
Chart 13	Total Medical Expenses – Non-Governmental Medi-Cal Plans 2015-2018	32
Chart 14	PMPM Medical Expenses vs. PMPM Premium Revenue – Non-Governmental Medi-Cal Plans	34
Chart 15	Percentage of TNE by Non-Governmental Medi-Cal Plan December 2017-December 2018	36

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 10.6 million Medi-Cal beneficiaries in all 58 California counties receive their health care through six 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 1.13 million Medi-Cal beneficiaries. There are about 378,000 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 3.25 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

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 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.

This report includes enrollment and financial information reported by LI, COHS, and NGM plans as of the quarter ending December 31, 2018. This report also includes Medi-Cal enrollment information for Blue Cross of California (Anthem Blue Cross) and Kaiser Foundation Health Plan Inc. (Kaiser Permanente) for comparison purposes. However, because Anthem Blue Cross and Kaiser Permanente's Medi-Cal enrollment was less than 50 percent of each plan's 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, rather than by line of business. Therefore, financial information specific to their Medi-Cal lines of business is not available to the DMHC.

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 December 2018.
- Collectively, most LI, COHS and NGM plans reported a decrease in medical expenses compared to December 2017, which was likely triggered by the decline in Medi-Cal enrollment.
- Per Member Per Month (PMPM) premium revenue exceeded PMPM medical expenses for almost every LI, COHS and NGM plan for the period ending December 31, 2018. Revenues and expenses for the MCMC plans have stabilized after significant growth experienced from 2014 to 2016 brought on by the Affordable Care Act.
- Net income remained stable for most Medi-Cal plans compared to December 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 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.

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 (Knox-Keene Act), as codified in Health and Safety Code section 1340 et seq., 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 <https://www.chcf.org/wp-content/uploads/2017/12/PDF-MonitoringPerformanceLocalVersusCommericalMediCalPlans.pdf>

- LI plans reported combined enrollment of 5.2 million individuals as of December 2018. Over 5 million (96 percent) of the total LI enrollment are Medi-Cal beneficiaries. The remaining 4 percent of non-Medi-Cal LI enrollment includes other lines of business such as Commercial (Individual, Small Group and Large Group), Medicare Advantage, Medicare Supplement, In-Home Supportive Services (IHSS) and Healthy Kids.
- Total LI plan enrollment decreased by 0.1 percent from December 2017 to December 2018.
- All LI plans' PMPM premium revenue outpaced PMPM medical expenses for December 2018.
- LI plans reported \$91 million in net income in December 2018, which was double the \$45.5 million net income reported in December 2017, and 70 percent higher than the \$54 million net income for the quarter ending September 30, 2018.
- LIs reported TNE that ranged from 485 percent to 782 percent of required TNE.
- LIs reported negative \$338 million in cash flow from operations, which was higher than the negative \$1.1 billion reported in December 2017. This is a significant change from September 2018 when LIs reported positive cash flow from operations of \$55 million. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and the Medi-Cal rate adjustments.

B. Enrollment Trends - LI

LI plans serve nearly 5.2 million enrollees in 13 counties in California. Total enrollment decreased by 0.1 percent since December 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 decrease in enrollment from December 2017 to December 2018. All LIs reported a slight decline in enrollment, except Kern Health Systems and L.A. Care Health Plan, which reported enrollment increases of 1.3 percent and 1.6 percent, respectively.

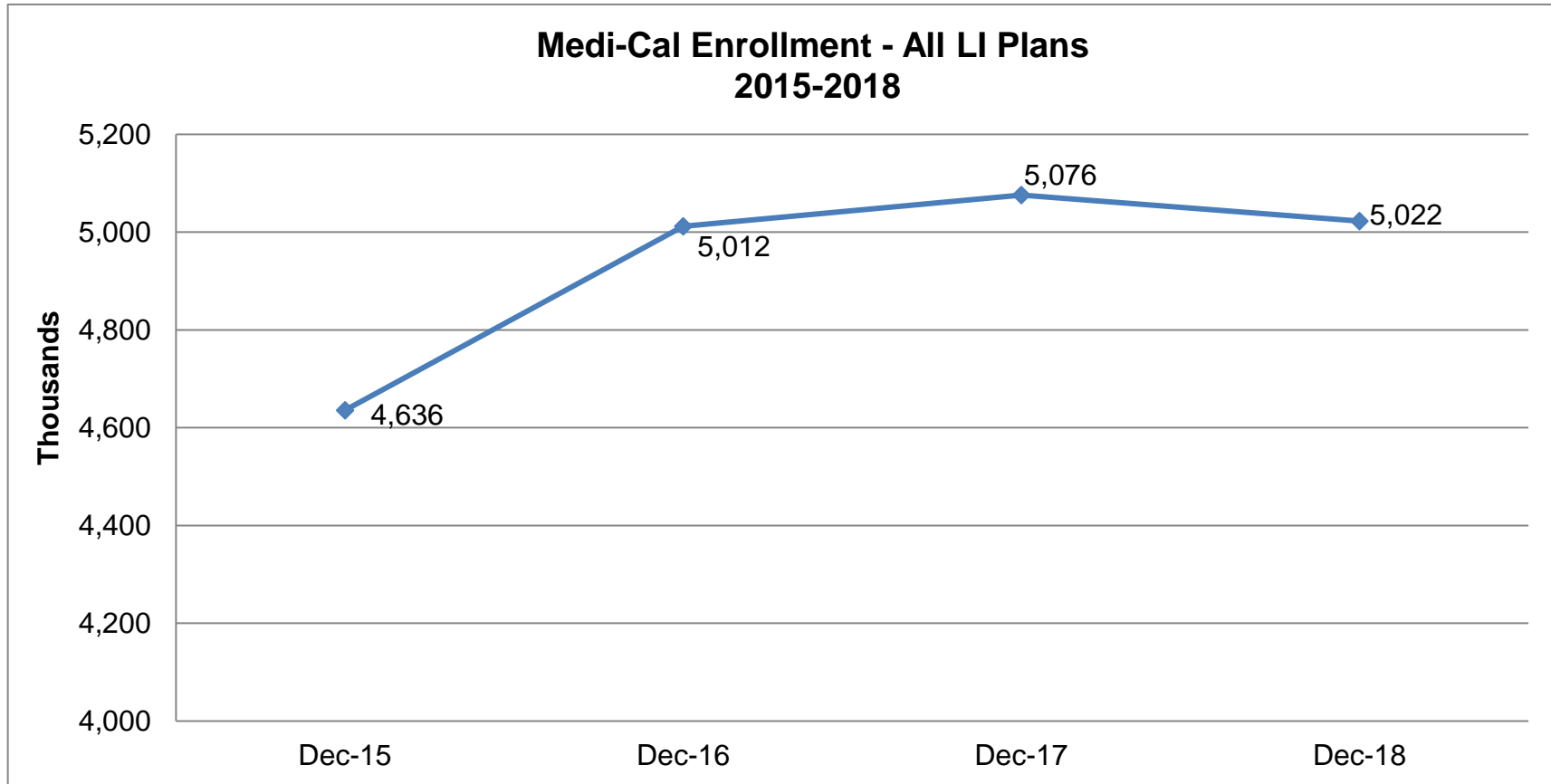
Table 1
Enrollment in Local Initiatives
December 2017-December 2018

Local Initiative	Total Medi-Cal Enrollment December 2018	Percentage of Medi-Cal Enrollment December 2018	Total Enrollment December 2018 ⁴	Total Enrollment December 2017	Enrollment Change from December 2017 to December 2018	Percentage Enrollment Change from December 2017 to December 2018
Alameda Alliance	259,342	98%	265,228	270,414	-5,186	-1.9%
CalViva Health	355,728	100%	355,728	360,546	-4,818	-1.3%
Contra Costa Health Plan	179,185	95%	188,354	193,232	-4,878	-2.5%
IEHP	1,219,009	98%	1,244,864	1,247,397	-2,533	-0.2%
Kern Health Systems	244,683	100%	244,683	241,567	3,116	1.3%
L.A. Care Health Plan	2,051,959	95%	2,170,343	2,135,218	35,125	1.6%
San Francisco Health Plan	127,248	90%	140,960	145,866	-4,906	-3.4%
Santa Clara Family Health Plan	242,695	96%	253,735	267,942	-14,207	-5.3%
The Health Plan of San Joaquin	342,521	100%	342,521	349,823	-7,302	-2.1%
Total	5,022,370	96%	5,206,416	5,212,005	-5,589	-0.1%

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.

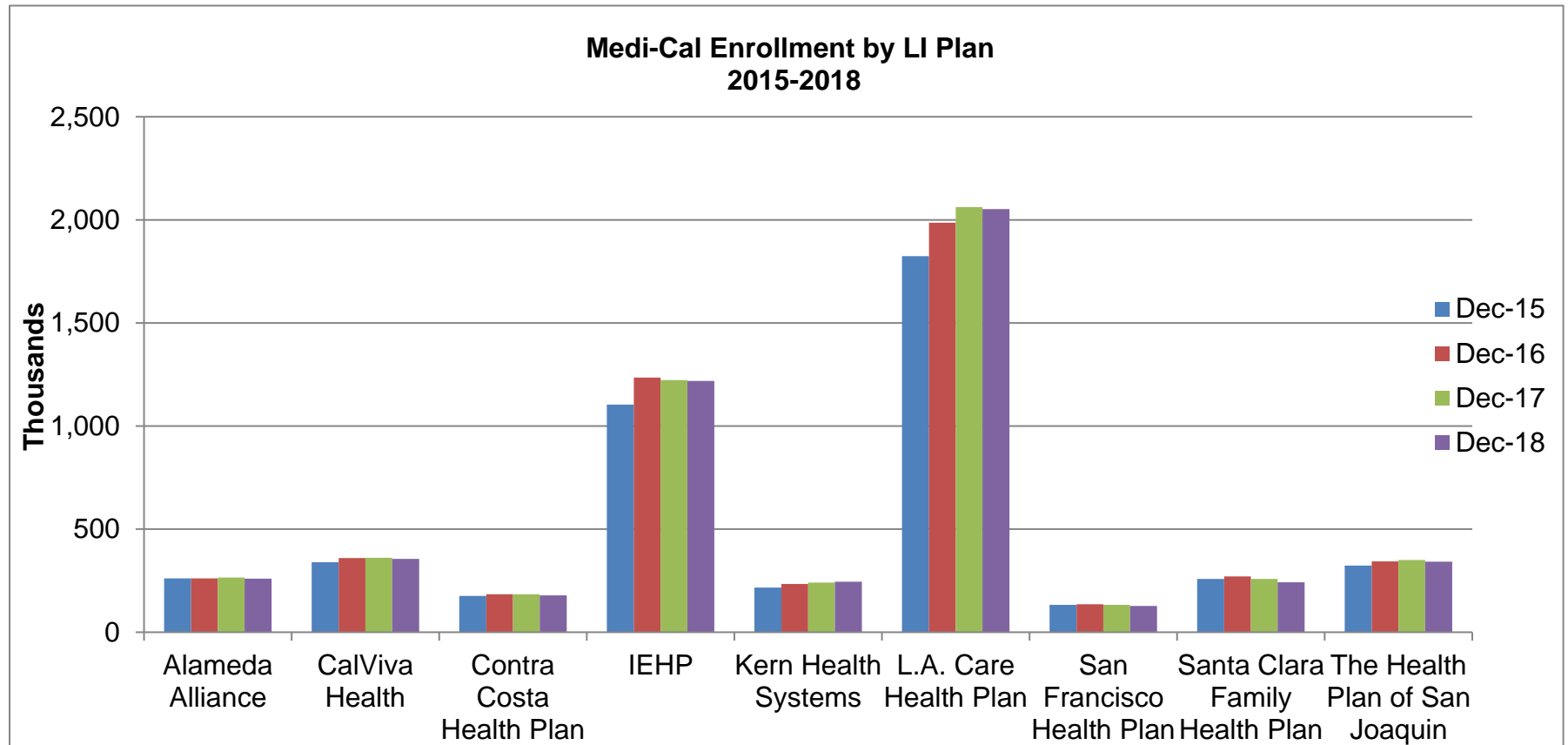
Chart 1



Medi-Cal enrollment in LIs remained consistent from December 2017 to December 2018. L.A. Care Health Plan reported the highest number of enrollees (2.2 million) and had the greatest increase in enrollment (1.6 percent) over the last year.

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

Chart 2



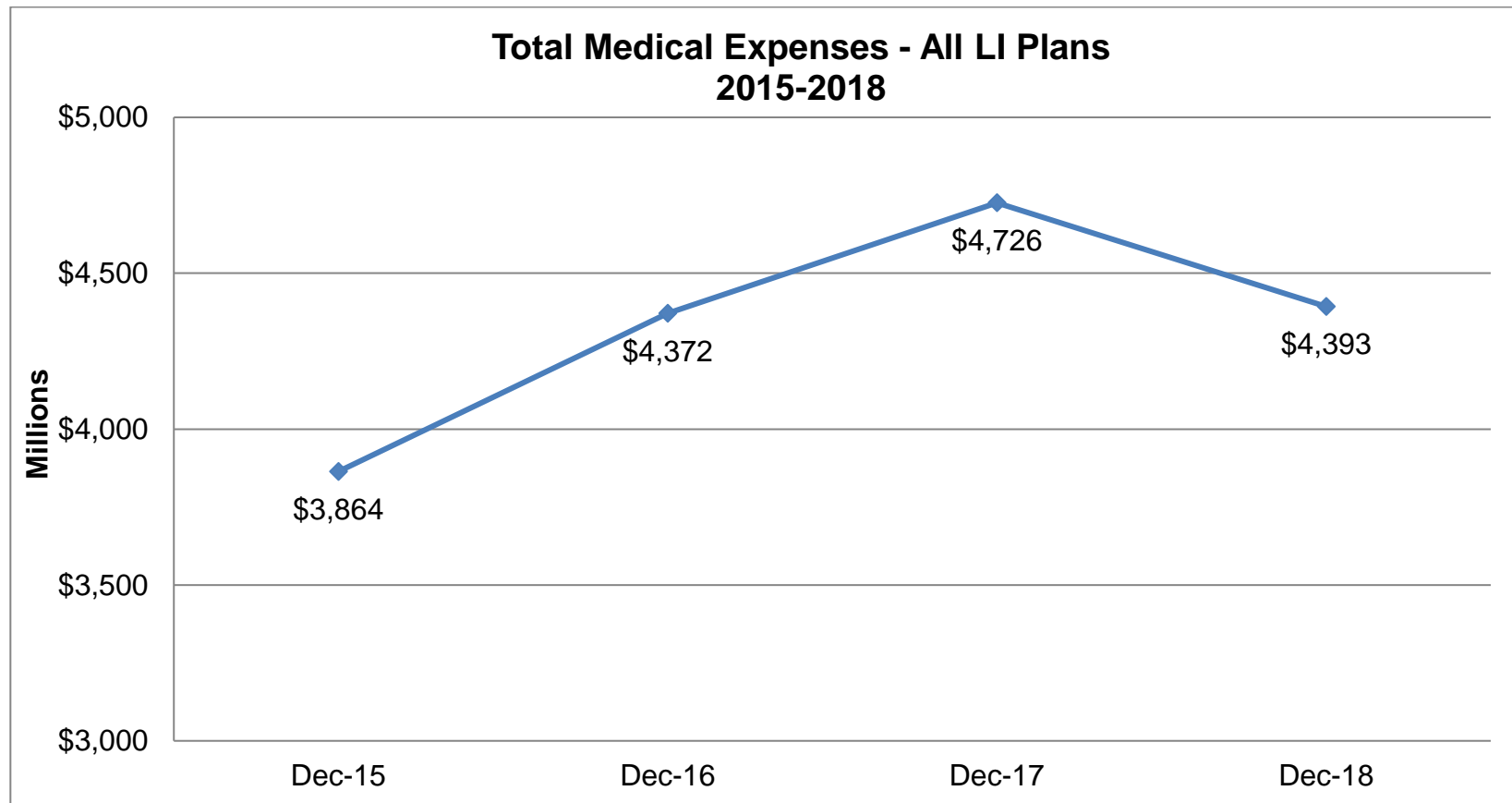
Almost all LIs reported increases in their Medi-Cal enrollment from 2015 to 2018. All LI plans except, L.A. Care Health Plan and Kern Health Systems, reported a slight decline in Medi-Cal enrollment at December 2018 compared to December 2017.

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 December 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 Expenses and Premium Revenue - LI

Table 2 shows the PMPM medical expenses and premium revenue of LIs for the quarters ending in December for the past four years, as well as the difference in PMPM medical expenses and premium revenue for December 2018. IEHP reported the highest PMPM medical expenses, and Santa Clara Family Health Plan reported the highest PMPM premium revenue. All LIs reported positive net premium revenue for December 2018.

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

Local Initiative	Dec-15		Dec-16		Dec-17		Dec-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	\$236	\$263	\$229	\$279	\$254	\$271	\$264	\$283	\$19
CalViva Health	\$252	\$265	\$266	\$277	\$235	\$247	\$235	\$247	\$12
Contra Costa Health Plan	\$293	\$306	\$280	\$283	\$284	\$294	\$295	\$304	\$9
IEHP	\$270	\$304	\$269	\$301	\$297	\$325	\$312	\$328	\$16
Kern Health Systems	\$207	\$238	\$199	\$229	\$222	\$232	\$231	\$248	\$17
L.A. Care Health Plan	\$277	\$292	\$300	\$316	\$324	\$340	\$268	\$291	\$23
San Francisco Health Plan	\$291	\$329	\$296	\$318	\$289	\$318	\$301	\$335	\$34
Santa Clara Family Health Plan	\$277	\$294	\$280	\$301	\$293	\$318	\$310	\$338	\$28
The Health Plan of San Joaquin	\$222	\$240	\$201	\$239	\$238	\$244	\$252	\$261	\$9

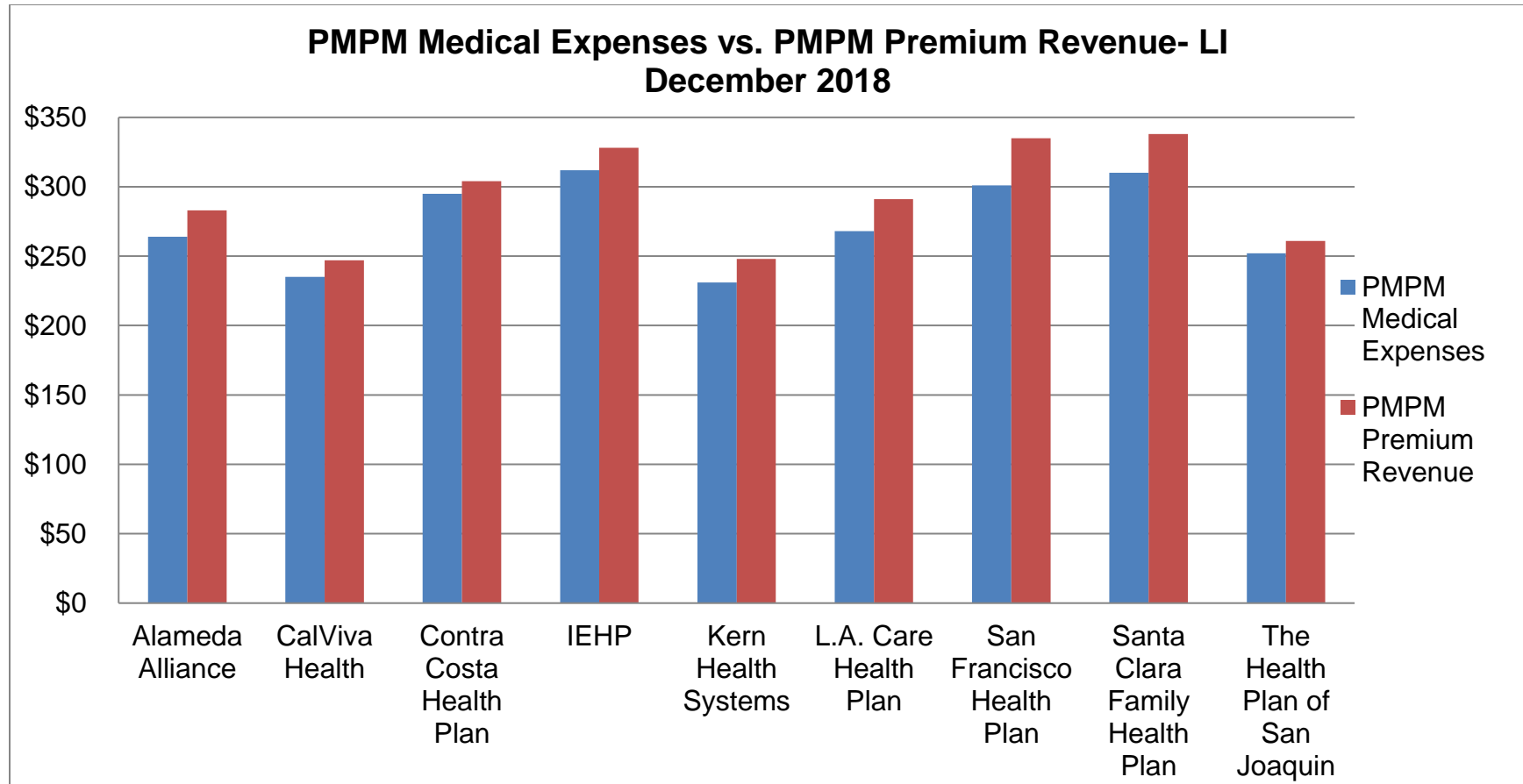
⁵ Difference between December 2018 PMPM Medical Expense and PMPM Premium Revenue.

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 expenses 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 Expenses vs. PMPM Premium Revenue - LI

Chart 4 illustrates LI plans' PMPM medical expenses compared with PMPM premium revenue for December 2018. The PMPM premium revenue received exceeded the PMPM medical expenses 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 2018, all LI plans reported positive net income. Net income or loss is directly related to premium revenue and medical expenses.

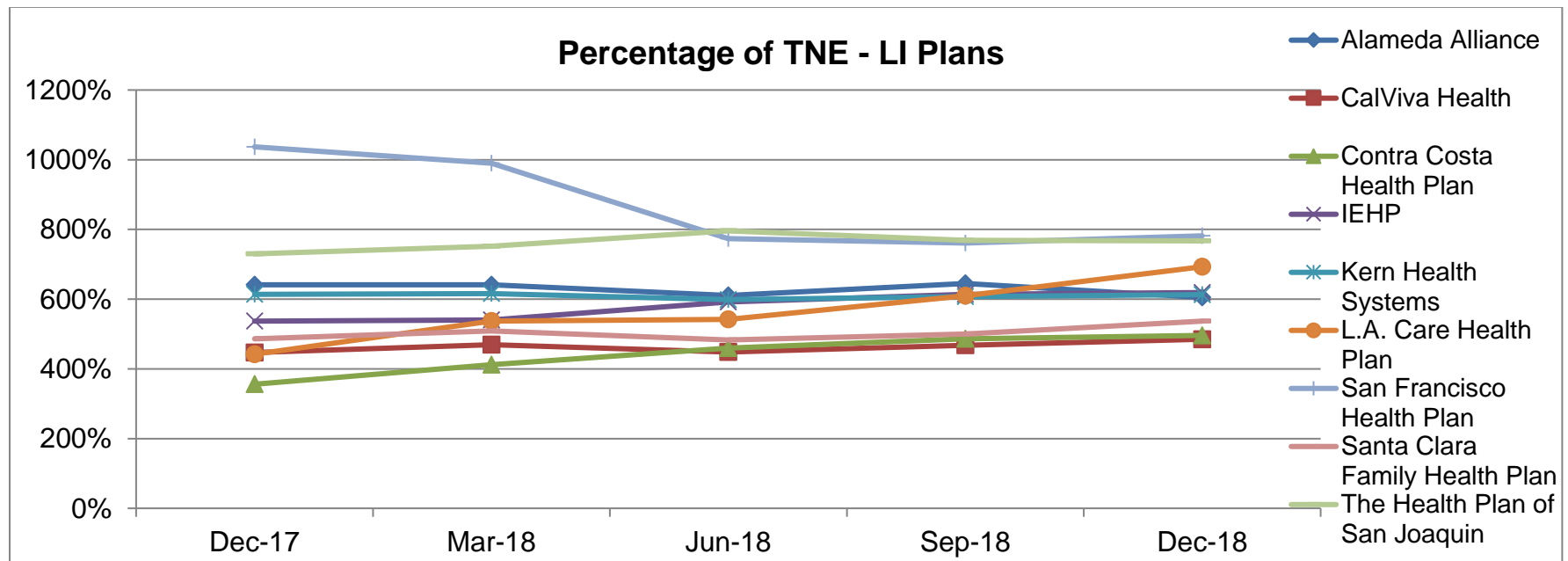
Table 3
LI Net Income by Quarter (in thousands)

Local Initiative	QE Sep-17	QE Dec-17	QE Mar-18	QE Jun-18	QE Sep-18	QE Dec-18
Alameda Alliance	\$608	\$1,493	\$2,546	(\$6,035)	(\$2,883)	\$3,257
CalViva Health	\$3,198	\$2,547	\$1,452	\$3,003	\$2,397	\$2,204
Contra Costa Health Plan	\$1,776	\$1,793	\$6,729	\$12,125	\$877	\$894
IEHP	\$13,660	\$15,411	\$916	\$23,630	\$13,822	\$9,397
Kern Health Systems	\$3,643	(\$2,868)	\$1,563	\$606	\$2,045	\$4,396
L.A. Care Health Plan	\$46,308	\$18,755	\$109,874	(\$27,010)	\$38,913	\$58,324
San Francisco Health Plan	\$2,711	\$2,365	(\$5,750)	(\$11,545)	(\$2,170)	\$2,580
Santa Clara Family Health Plan	\$7,908	\$7,652	\$1,923	\$2,152	(\$2)	\$8,059
The Health Plan of San Joaquin	\$30,194	(\$1,589)	\$13,145	\$15,695	\$768	\$2,205
Total LI Net Income	\$110,007	\$45,559	\$132,398	\$12,622	\$53,768	\$91,317

Tangible Net Equity - LI

Plans must meet the TNE reserve requirement described in California Code of Regulations, Title 28, Section 1300.76. TNE is defined as a health plan’s total assets minus total liabilities reduced by the value of intangible assets (i.e., goodwill⁶, 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 subordinated⁷ may be added to the TNE calculation, which serves to increase the plan’s TNE. All LIs had TNE that exceeded the regulatory requirements.

Chart 5



⁶ “Goodwill” is an intangible asset that arises as a result of the acquisition of one company by another for a premium value.

⁷ “Subordinated debt” is a loan that ranks below other loans with regard to claims on assets or earnings. In the case of default, creditors with subordinated debt are not paid until after the other creditors are paid in full.

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

The average TNE for LI plans overall was stable in 2017, and the trend continued in 2018. For December 2018, the reported TNE ranged from 485 percent to 782 percent 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.

Six of the nine LI plans reported negative cash flow from operations in December 2018. The cash flow from operations totaled negative \$338 million in December 2018 compared to negative \$1.2 billion in December 2017. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and Medi-Cal rate adjustments.

Claims

Pursuant to the Knox-Keene Act, full service health plans are required to process 95 percent of their claims within 45 working days. A health plan is required to submit to the Department, on a quarterly basis, a claims settlement practice report if the plan fails to process 95 percent 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 December 2018.

IV. County Organized Health Systems (COHS)

A. Highlights

- Six COHS plans currently serve 22 counties. 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 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.
 - Health Plan of San Mateo has voluntarily included its Medi-Cal enrollment under its Knox-Keene license.
 - 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).
 - Central California Alliance for Health has filed an application to include its Medi-Cal business under its Knox-Keene license.
 - Gold Coast Health Plan has only a Medi-Cal line of business and no Knox-Keene License. Therefore, this report does not include information for Gold Coast.

- Enrolled beneficiaries either choose their health care provider or are assigned one from among COHS plan contracted providers.
- COHS plans reported combined enrollment of 1.9 million individuals as of December 2018, a decrease of 3.2 percent from December 2017.
- Almost all COHS plans' PMPM premium revenue outpaced medical expenses for December 2018.
- COHS plans reported negative \$27 million in net income in December 2018, which was higher than the negative \$3 million net income reported in December 2017.
- COHS plans reported TNE that ranged from 704 percent to 1,118 percent of required TNE.
- COHS plans reported negative \$955 million in cash flow from operations compared to the negative \$871 million reported in December 2017. This is a significant change from September 2018 when COHS plans reported cash flow from operations of \$64 million. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium payments by DHCS and the Medicaid Coverage Expansion (MCE) rate adjustments for the 2017/2018 fiscal year.

B. Enrollment Trends - COHS

COHS plans reported enrollment of nearly 2 million, a decrease of 3.2 percent compared to December 2017. All COHS plan reported slight decreases in total enrollment from December 2017 to December 2018. CalOptima and Partnership HealthPlan reported the highest enrollment numbers.

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

COHS	Total Medi-Cal Enrollment December 2018	Percentage of Medi-Cal Enrollment December 2018	Total Enrollment December 2018⁸	Total Enrollment December 2017	Enrollment Change from December 2017 to December 2018	Percentage Enrollment Change from December 2017 to December 2018
CalOptima	750,159	98%	766,194	791,476	(25,282)	-3.2%
CenCal Health	175,637	100%	175,637	180,439	(4,802)	-2.7%
Central California Alliance for Health	341,205	100%	341,840	351,661	(9,821)	-2.8%
Health Plan of San Mateo	112,506	98%	115,241	122,852	(7,611)	-6.2%
Partnership HealthPlan	551,393	100%	551,393	567,337	(15,944)	-2.8%
Total	1,930,900	99%	1,950,305	2,013,765	(63,460)	-3.2%

⁸ 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 December 2018.

Chart 6

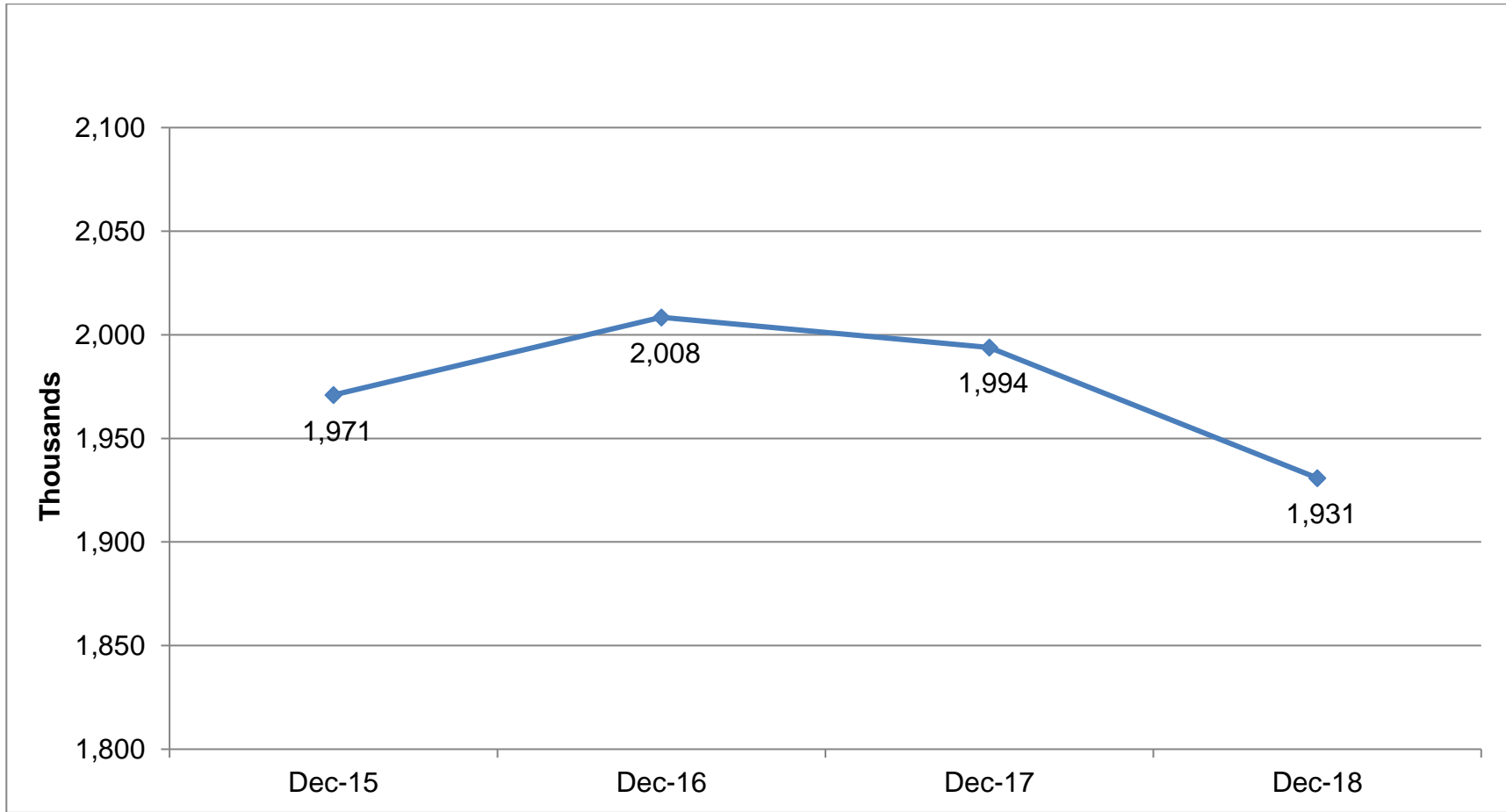
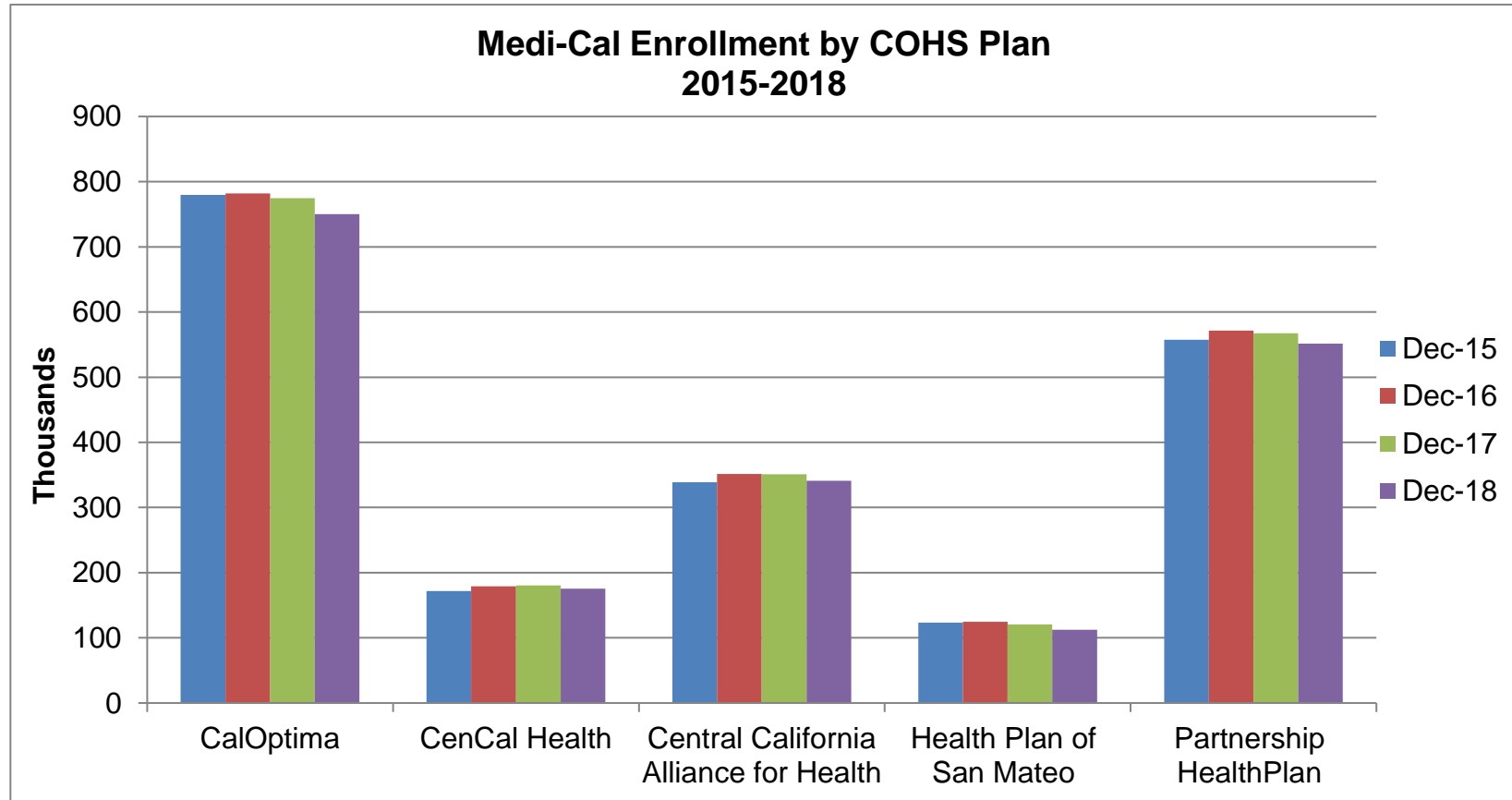


Chart 7 shows the enrollment for each COHS plan over the past four years.

Chart 7

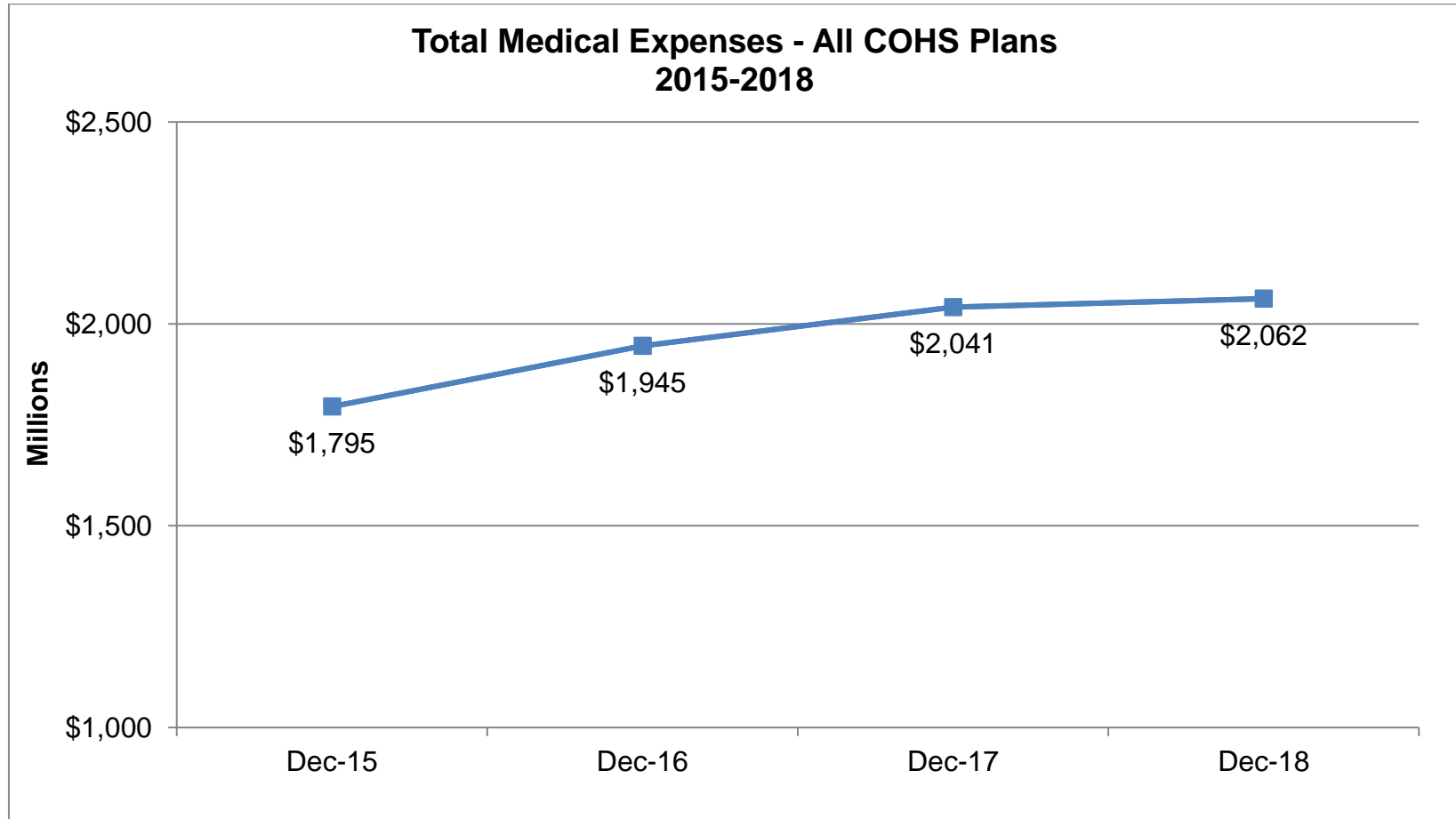


Almost all COHS plans reported increases in their Medi-Cal enrollment from 2015 to 2018. All COHS plans reported slight decreases in Medi-Cal enrollment compared to December 2017. Total Medi-Cal enrollment for COHS plans increased by 58 percent from December 31, 2013 to December 31, 2018.

C. Financial Trends - COHS

Chart 8 illustrates total medical expenses for COHS plans compared to the same quarter over the last four years. Despite declines in enrollment, medical expenses for COHS plans increased slightly from December 2017.

Chart 8



Per Member Per Month Medical Expenses and Premium Revenue - COHS

Table 5 shows the PMPM medical expenses and premium revenue of COHS plans for the quarters ending in December for the past four years, as well as the difference between the PMPM medical expenses and premium revenue for December 2018.

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

**Table 5
Per Member Per Month Medical Expenses and Premium Revenue - COHS
2015-2018**

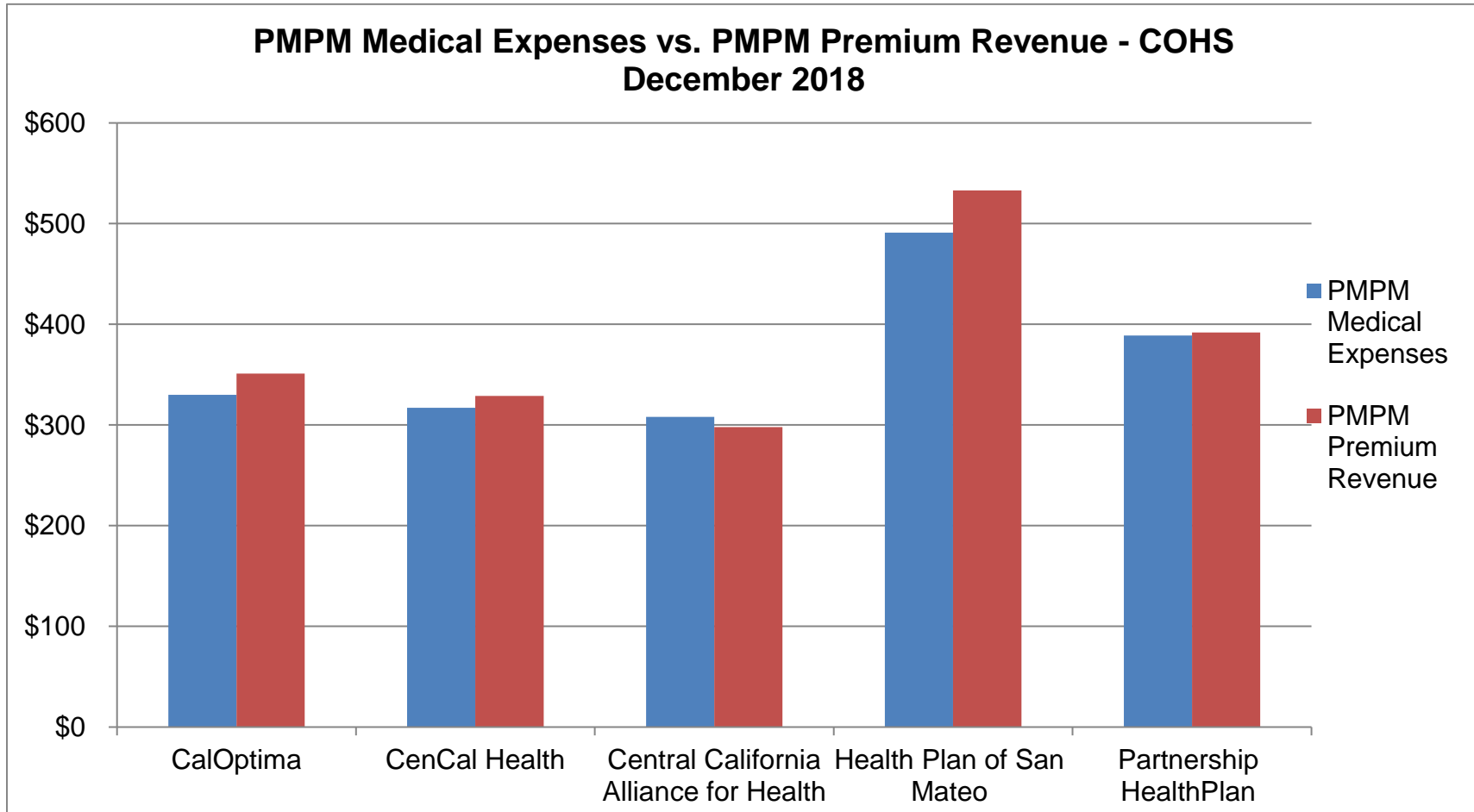
COHS	Dec-15		Dec-16		Dec-17		Dec-18		
	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Net Revenue ⁹
CalOptima	\$310	\$322	\$341	\$352	\$344	\$360	\$330	\$351	\$21
CenCal Health	\$269	\$340	\$248	\$291	\$273	\$299	\$317	\$329	\$12
Central California Alliance for Health	\$227	\$264	\$232	\$274	\$254	\$262	\$308	\$298	(\$10)
Health Plan of San Mateo	\$450	\$597	\$466	\$382	\$514	\$588	\$491	\$533	\$42
Partnership HealthPlan	\$304	\$349	\$328	\$347	\$356	\$344	\$389	\$392	\$3

⁹ Difference between December 2018 PMPM Medical Expense and PMPM Premium Revenue.

PMPM Medical Expenses vs. PMPM Premium Revenue

Chart 9 illustrates COHS plans' PMPM medical expenses compared with PMPM premium revenue for December 2018. All plans, except Central California Alliance for Health, 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 December 2018, an increase in medical expenses translated to negative net income for most COHS plans.

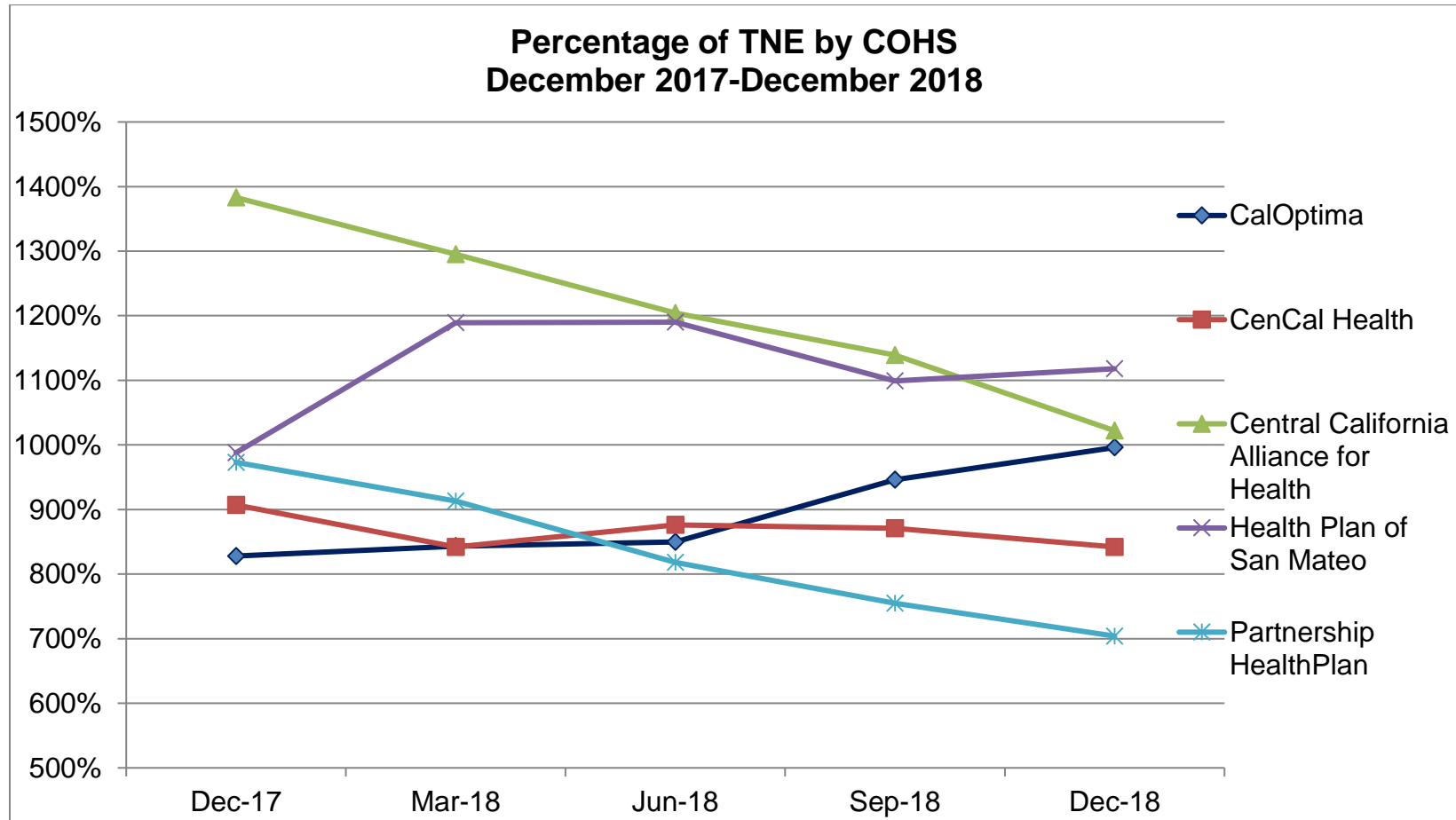
Table 6
COHS Net Income by Quarter (in thousands)

COHS	QE Sep-17	QE Dec-17	QE Mar-18	QE Jun-18	QE Sep-18	QE Dec-18
CalOptima	\$11,309	\$11,691	(\$7,514)	\$28,937	\$23,595	\$27,420
CenCal Health	\$6,361	\$7,060	(\$1,414)	\$14,377	\$682	(\$4,328)
Central California Alliance for Health	\$33,313	(\$16,633)	(\$18,728)	(\$35,890)	(\$8,033)	(\$36,387)
Health Plan of San Mateo	\$1,582	\$37,378	\$12,216	\$1,927	(\$20,594)	\$6,724
Partnership HealthPlan	(\$25,621)	(\$42,410)	(\$41,052)	(\$57,893)	(\$25,768)	(\$20,062)
Total COHS Net Income	\$26,944	(\$2,914)	(\$56,492)	(\$48,542)	(\$30,118)	(\$26,633)

Tangible Net Equity - COHS

All COHS plans reported over 700 percent of required TNE for December 2018. TNE to required TNE ranged from 704 percent to 1,118 percent. Partnership HealthPlan and Central California Alliance for Health reported declining TNE for the last four quarters.

Chart 10



Cash Flow from Operations

COHS plans reported negative \$955 million in cash flow from operations in December 2018. Similar to LIs, COHS plans' variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and Medi-Cal rate adjustments.

Claims

Pursuant to the Knox-Keene Act, full service health plans are required to process 95 percent of their claims within 45 working days if the plans are health maintenance organizations. For the quarter ending December 31, 2018, Health Plan of San Mateo failed to process 95 percent of their claims within 45 working days, and submitted a corrective action plan outlining measures it is taking to comply with the regulations.

V. Non-Governmental Medi-Cal Plans

A. Highlights

- For the purposes of this report, Non-Governmental Medi-Cal (NGM) plans are those health plans with greater than 50 percent Medi-Cal enrollment.
- Aetna Better Health and UnitedHealthcare Community Plan commenced their operations in December 2017. Therefore, this report includes data as of December 31, 2018 for these two plans.
- Seven NGM plans currently serve 31 counties. NGM plans and the counties in which they provide services are:
 - Aetna Better Health - Sacramento and San Diego.
 - Blue Shield of California Promise Health Plan (formerly known as Care 1st Health Plan) - Los Angeles 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.
 - 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 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.

- Blue Shield of California Promise Health Plan (formerly known as Care 1st Health Plan) is a not-for-profit health plan owned by California Physicians' Services (Blue Shield of California).
 - 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, but paid no dividends in 2018.
 - 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 \$400 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 1.92 million Medi-Cal enrollees: Anthem Blue Cross with 1,270,892 enrollees and Kaiser Permanente with 650,079 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 percent 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 financially healthy.
 - 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 has subcontracted with both Blue Shield of California Promise Health Plan and Molina in Los Angeles County.
 - NGM plans' enrollment decreased 6.4 percent from December 2017 to December 2018.

- All NGM plans' PMPM premium revenue outpaced medical expenses for December 2018.
- NGM plans reported \$169 million in net income in December 2018, which was about 5 percent higher than the \$161 million net income reported in December 2017, and 140 percent higher than the quarter ending September 30, 2018.
- Tangible net equity for NGM plans ranged from 285 percent to 1,441 percent of required TNE at December 2018.
- NGM plans reported negative \$494 million in cash flow from operations, which was lower than the negative \$418 million reported in December 2017. This is a significant change from September 2018 when NGM plans reported cash flow from operations of negative \$263 million. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and Medi-Cal rate adjustments.

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

Like LI and COHS plans, NGM plans have reported increases in enrollment since 2014. However, most NGM plans reported a decline in total enrollment for December 2018, except California Health and Wellness and UnitedHealthcare Community Plan, which had slight increases in total enrollment.

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

Non-Governmental Medi-Cal Plans	Total Medi-Cal Enrollment December 2018	Percentage of Medi-Cal Enrollment December 2018	Total Enrollment December 2018	Total Enrollment December 2017	Enrollment Change from December 2017 to December 2018	Percentage Enrollment Change from December 2017 to December 2018
Aetna Better Health	11,029	100%	11,029	0	NA	NA
Blue Shield of California Promise Health Plan	426,267	86%	493,311	502,124	(8,813)	-1.8%
California Health and Wellness	195,230	100%	195,230	192,101	3,129	1.6%
Community Health Group	271,680	100%	271,680	288,151	(16,471)	-5.7%
Health Net Community Solutions	1,775,646	99%	1,792,464	1,879,340	(86,876)	-4.6%
Molina	564,419	92%	614,627	754,308	(139,681)	-18.5%
UnitedHealthcare Community Plan	7,944	100%	7,944	1,579	6,365	403.1%
Total Medi-Cal Enrollment in NGMs	3,252,215	96%	3,386,285	3,617,603	(231,318)	-6.4%
Anthem Blue Cross	1,270,892	36%	3,552,136	3,884,263	(332,127)	-8.6%
Kaiser Permanente	650,079	7%	8,943,853	8,678,546	265,307	3.1%
Grand Total	5,173,186	33%	15,882,274	16,178,833	(296,559)	-1.8%

Chart 11 illustrates the MCMC enrollment trend in NGM plans. This chart does not include the MCMC enrollment reported by Anthem Blue Cross and Kaiser Permanente.

Chart 11

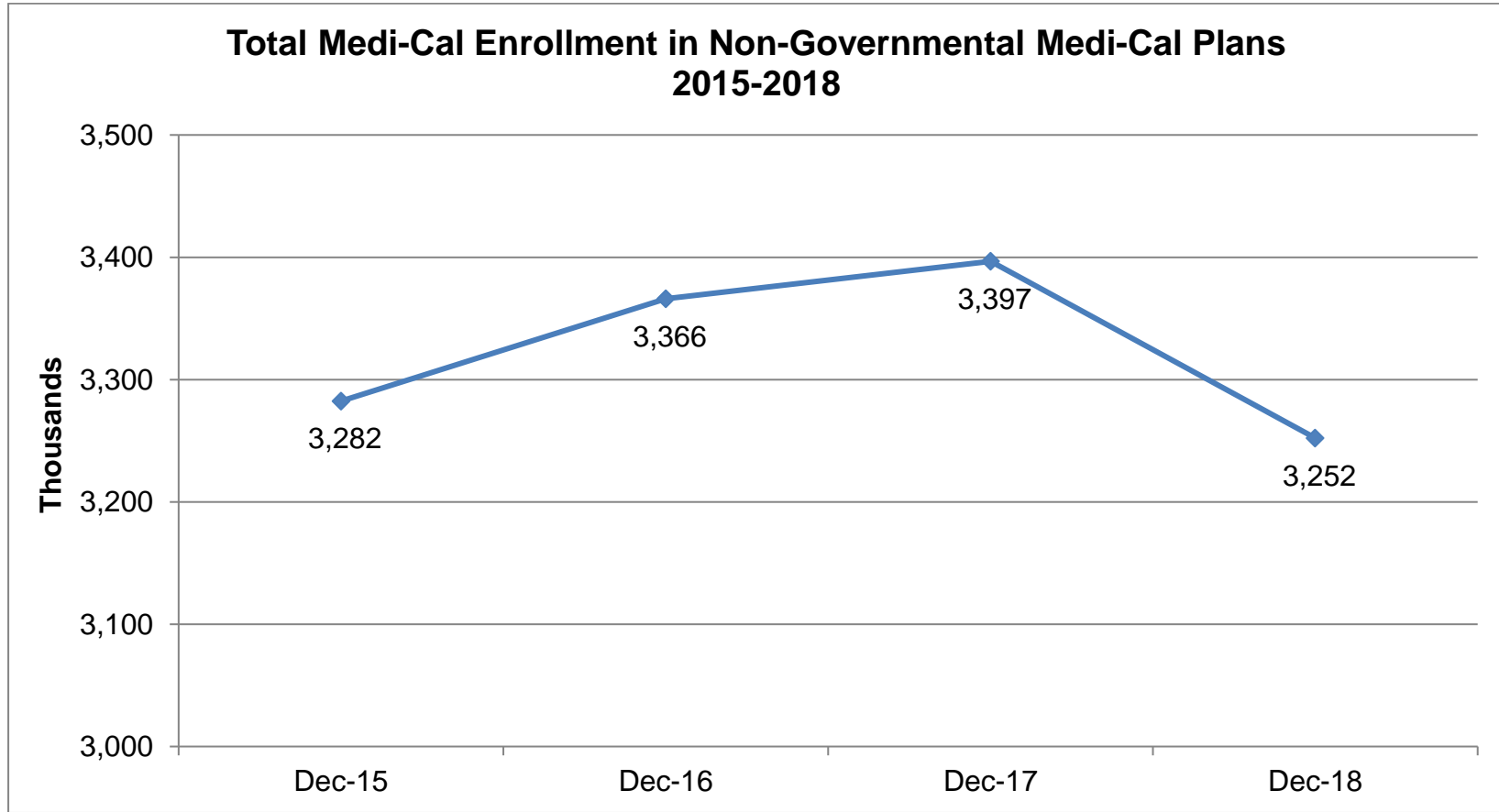
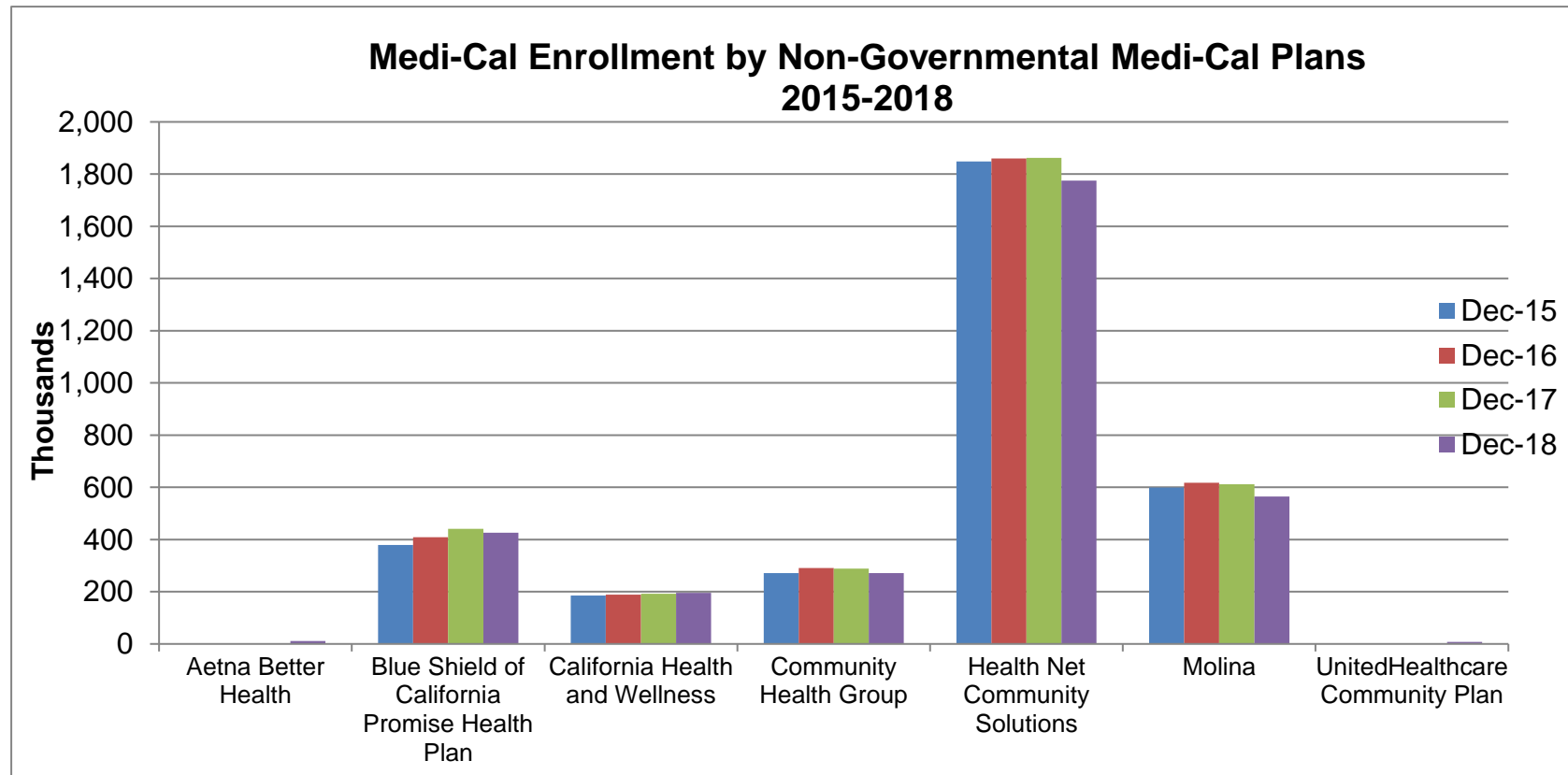


Chart 12 shows the enrollment for each NGM plan over the past four years. Aetna Better Health and UnitedHealthcare Community Plan commenced their operations in December 2017; therefore, the chart below shows enrollment data as of December 31, 2018 for these two plans.

Chart 12

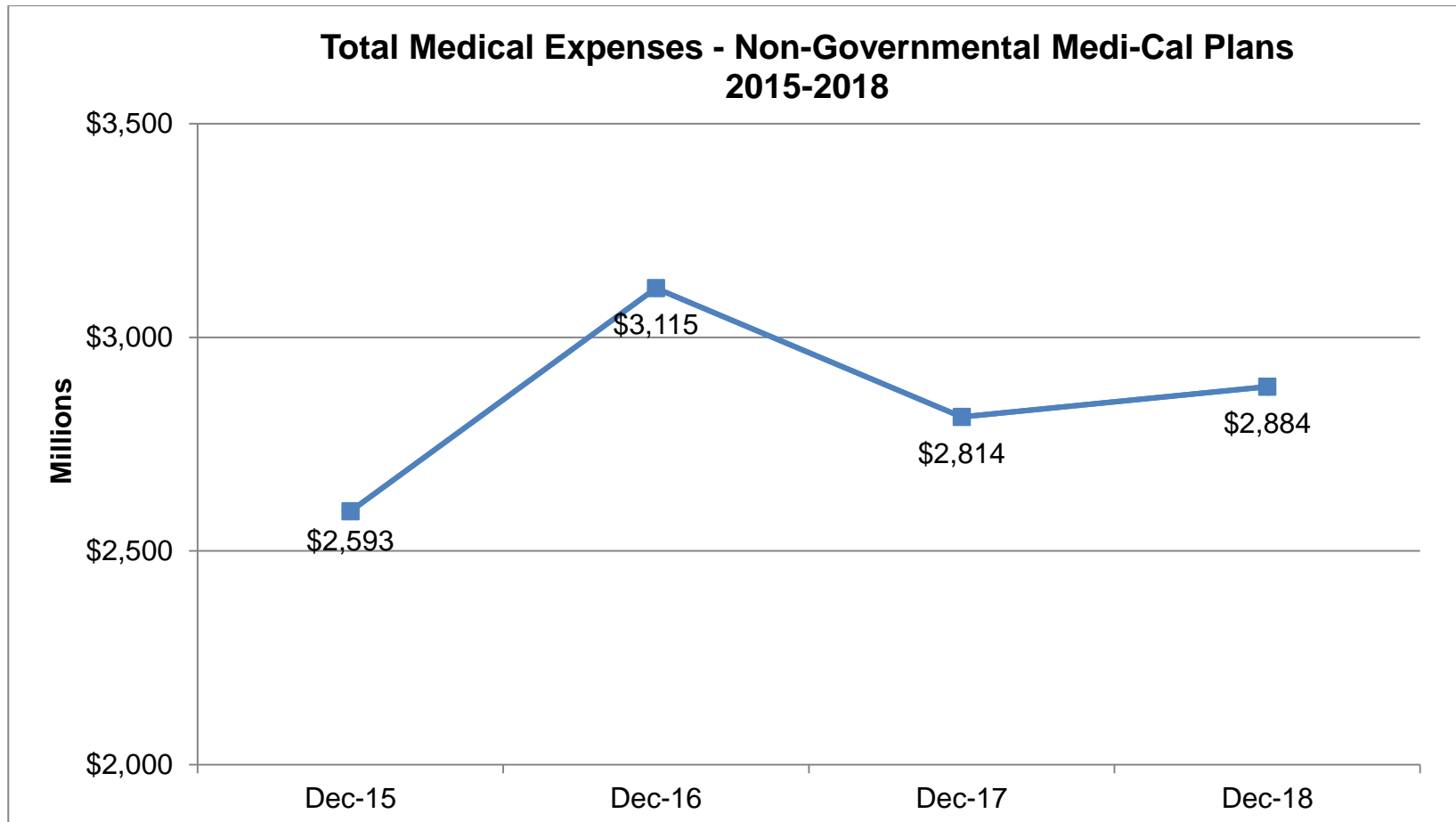


All NGM plans except California Health and Wellness and UnitedHealthcare Community Plan reported slight decreases in Medi-Cal enrollment compared to December 2017. Total Medi-Cal enrollment for NGM plans increased by 70 percent from December 31, 2013 to December 31, 2018.

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

Chart 13 shows a slight increase in medical expenses for NGM plans. This was mainly caused by Blue Shield of California Promise Health Plan, which had a substantial increase in medical expenses during 2017/2018. 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 expenses and premium revenue of NGM plans for the quarters ending in December for the past four years, as well as the difference in the PMPM medical expenses and premium revenue for quarter ending December 2018. All NGM plans reported positive PMPM net revenue at December 2018. Aetna Better Health and UnitedHealthcare Community Plan commenced their operations in December 2017; therefore, the table below shows data as of December 31, 2018 for these two plans.

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

Non-Governmental Medi-Cal Plans	Dec-15		Dec-16		Dec-17		Dec-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
Aetna Better Health	NA	NA	NA	NA	NA	NA ¹¹	\$243	\$290	\$47
Blue Shield of California Promise Health Plan ¹²	\$337	\$367	\$448	\$517	\$107	\$162	\$376	\$428	\$52
California Health and Wellness	\$217	\$267	\$217	\$284	\$249	\$276	\$307	\$311	\$4
Community Health Group	\$283	\$360	\$272	\$337	\$289	\$358	\$290	\$352	\$62
Health Net Community Solutions	\$221	\$295	\$289	\$385	\$289	\$335	\$261	\$301	\$40
Molina	\$266	\$319	\$265	\$287	\$272	\$310	\$248	\$287	\$39
UnitedHealthcare Community Plan	NA	NA	NA	NA	\$547	\$280	\$264	\$272	\$8

¹⁰ Difference between December 2018 PMPM Medical Expense and PMPM Premium Revenue.

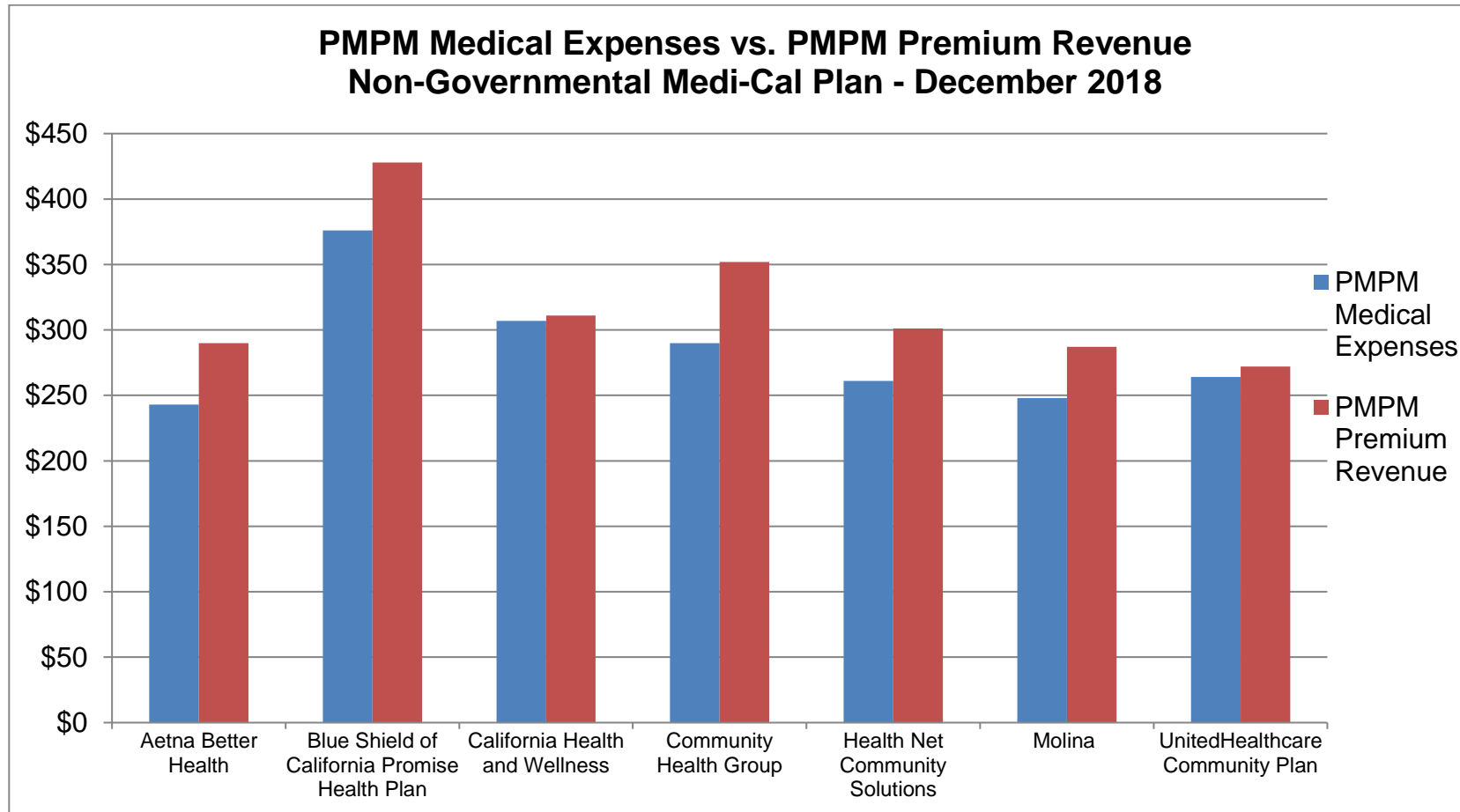
¹¹ Aetna Better Health had zero enrollment at December 31, 2017.

¹² PMPM information for Blue Shield of California Promise Health Plan includes commercial and other lines of business

PMPM Medical Expenses vs. PMPM Premium Revenue

Chart 9 illustrates NGM plans' PMPM medical expenses compared with PMPM premium revenue for December 2018. All NGM plans reported PMPM premium revenue that was higher than PMPM medical expenses.

Chart 14



Net Income - Non-Governmental Medi-Cal Plans

Table 9 shows the net income for NGM plans over the past six quarters. California Health and Wellness and UnitedHealthcare Community Plan reported negative net income for December 2018.

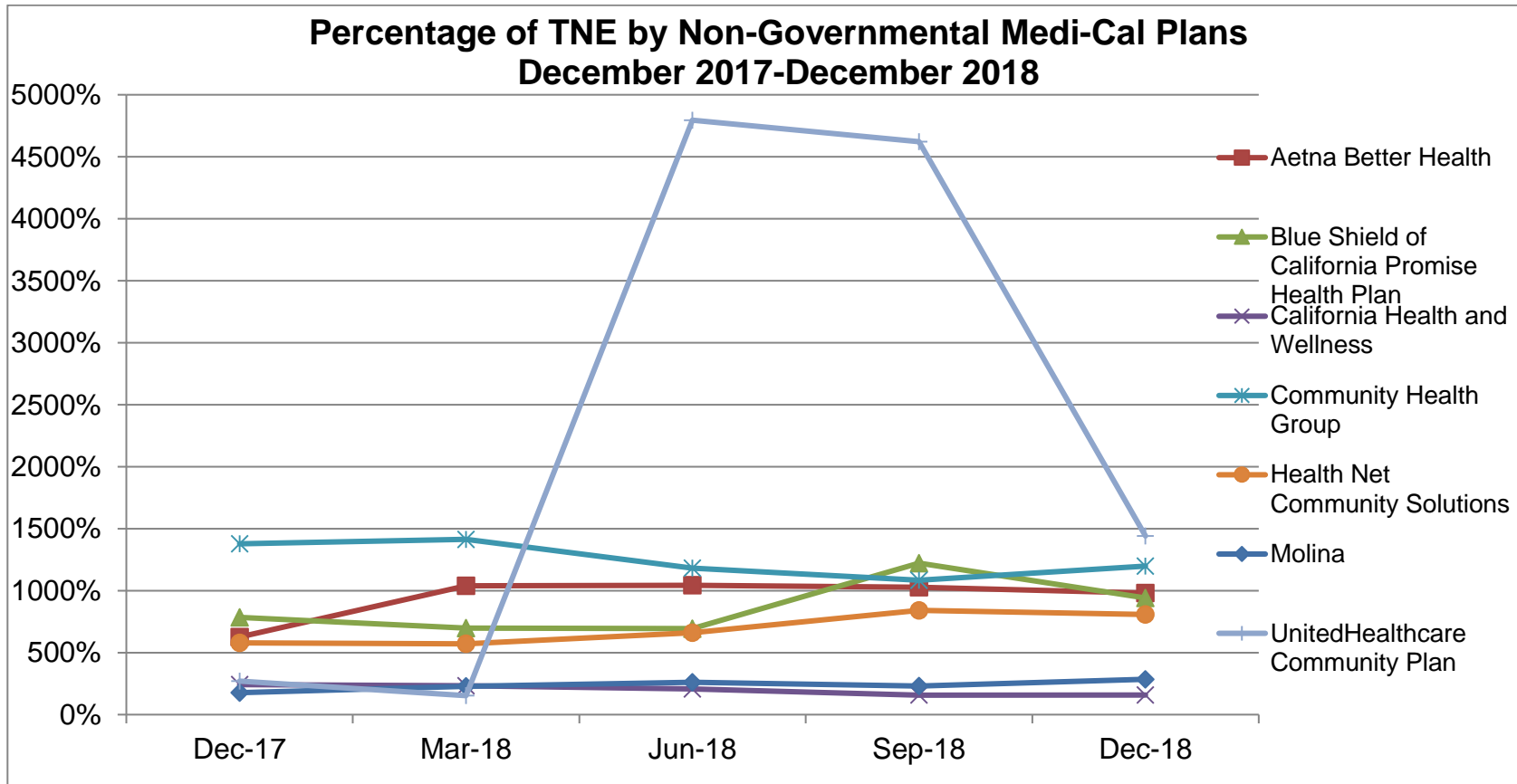
Table 9
Non-Governmental Medi-Cal Plans Net Income by Quarter (in thousands)

Non-Governmental Medi-Cal Plans	QE Sep-17	QE Dec-17	QE Mar-18	QE Jun-18	QE Sep-18	QE Dec-18
Aetna Better Health	NA	(\$8,769)	\$2,175	\$33	\$1,791	\$2,531
Blue Shield of California Promise Health Plan	\$21,603	\$25,019	\$48,482	\$3,158	(\$7,346)	\$25,249
California Health and Wellness	(\$3,868)	(\$1,992)	(\$859)	(\$5,950)	(\$12,617)	(\$12,750)
Community Health Group	\$54,334	\$49,886	\$41,885	(\$94,245)	(\$36,124)	\$42,403
Health Net Community Solutions	\$76,723	\$85,423	\$147,004	\$101,281	\$149,206	\$96,389
Molina	(\$9,425)	\$13,530	\$34,522	\$62,229	(\$30,736)	\$19,736
UnitedHealthcare Community Plan	NA	(\$1,827)	(\$11,187)	(\$1,921)	\$6,145	(\$4,606)
Total Net Income	\$139,367	\$161,493	\$262,022	\$64,586	\$70,319	\$168,953

Tangible Net Equity - Non-Governmental Medi-Cal Plans

NGM plans' TNE to required TNE ranged from 285 percent to 1,441 percent for December 2018. TNE reported by most NGM plans is lower than 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 \$494 million in cash flow from operations in December 2018. NGM plans' cash flow 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 percent of their claims within 45 working days. NGM plans did not report any claims processing or emerging claims payment deficiencies for December 2018.

Conclusion

After the initial surge in MCMC enrollment brought on by the Affordable Care Act in 2014, the rate of increase in enrollment slowed in 2017 and 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 December 2018

Health Plan	Net Income	Medical Expenses	Excess TNE ¹³
Local Initiatives			
Alameda Alliance	\$3,257,450	\$210,351,415	\$159,026,211
CalViva Health	\$2,203,692	\$250,454,211	\$51,139,282
Contra Costa Health Plan	\$894,034	\$191,532,016	\$62,495,708
IEHP	\$9,396,824	\$1,170,521,685	\$750,557,498
Kern Health Systems	\$4,396,000	\$169,863,000	\$167,562,000
L.A. Care Health Plan	\$58,324,480	\$1,766,226,665	\$749,435,922
San Francisco Health Plan	\$2,580,482	\$128,840,722	\$95,027,327
Santa Clara Family Health Plan	\$8,059,000	\$245,596,000	\$151,448,000
The Health Plan of San Joaquin	\$2,205,401	\$260,041,179	\$280,060,674
Total	\$91,317,363	\$4,393,426,893	\$2,466,752,622
County Organized Health Systems			
CalOptima	\$27,420,005	\$761,807,692	\$730,811,466
CenCal Health	(\$4,327,724)	\$167,786,449	\$200,787,977
Central California Alliance for Health	(\$36,387,498)	\$318,276,974	\$466,177,936
Health Plan of San Mateo	\$6,724,092	\$169,042,519	\$309,141,307
Partnership HealthPlan	(\$20,061,635)	\$645,215,335	\$525,883,114
Total	(\$26,632,760)	\$2,062,128,969	\$2,232,801,800
Non-Governmental Medi-Cal Plans			
Aetna Better Health	\$2,531,164	\$5,116,863	\$13,265,147
Blue Shield of California Promise Health Plan	\$25,249,279	\$557,774,760	\$511,239,900
California Health and Wellness	(\$12,750,174)	\$181,678,589	\$17,409,113
Community Health Group	\$42,403,450	\$237,548,870	\$457,039,995
Health Net Community Solutions	\$96,389,497	\$1,431,154,943	\$944,229,750

¹³ Excess TNE is the difference between total TNE and required TNE

Molina	\$19,735,968	\$461,261,842	\$108,363,174
UnitedHealthcare Community Plan	(\$4,606,316)	\$9,800,206	\$24,311,496
Total	\$168,952,868	\$2,884,336,073	\$2,075,858,575