Financial Summary of Medi-Cal Managed Care Plans

Quarter Ending June 30, 2019

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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 10.3 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 5 million and 1.9 million Medi-Cal beneficiaries are enrolled in LI and COHS plans, respectively.

In the two GMC counties, Sacramento and San Diego, DHCS contracts with several commercial plans to serve approximately 1.12 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 3.18 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]

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[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 from the counties to the plans for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from any mental health condition defined by the DSM-IV. 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 June 30, 2019. 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, neither plan meets 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:

- Enrollment stabilized in 2017/2018, but most Medi-Cal plans reported a decline in enrollment for the quarter ending June 2019.

- Collectively, most LI, COHS, and NGM plans reported increases in their medical expenses from June 2018 to June 2019.

- Per Member Per Month (PMPM) premium revenue exceeded PMPM medical expenses for almost every LI, COHS, and NGM plan for the period ending June 30, 2019. Revenues and expenses for the MCMC plans have stabilized.

- Net income remained stable for most Medi-Cal plans compared to June 2018 and the previous quarter. The LI plans reported lower 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 maintain 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, DHCS contracts with both a commercial plan and a LI plan. In Tulare County, 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 may choose which of the two plans to enroll in. Beneficiaries who do not make a selection are automatically assigned to a plan. DHCS uses an algorithm based on quality scores 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 June 2019. Over 5 million (97 percent) of the total LI enrollment are Medi-Cal beneficiaries. The remaining 3 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 1.2 percent from June 2018 to June 2019.

- Almost all LI plans' PMPM premium revenue outpaced PMPM medical expenses for June 2019.

- LI plans reported $40 million in net income in June 2019, which was higher than the $13 million net income reported in June 2018, and 76 percent lower than the $170 million net income for the quarter ending March 31, 2019.

- LIs reported TNE that ranged from 517 percent to 859 percent of required TNE.

- LIs reported negative $798 million in cash flow from operations, which was lower than the $76 million reported in June 2018. This is a significant change from March 2019 when LIs reported cash flow from operations of $1.8 billion. 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 1.2 percent since June 2018. 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 June 2018 to June 2019. All LIs reported a slight decline in enrollment, except IEHP and Kern Health Systems, which reported slight enrollment increases.

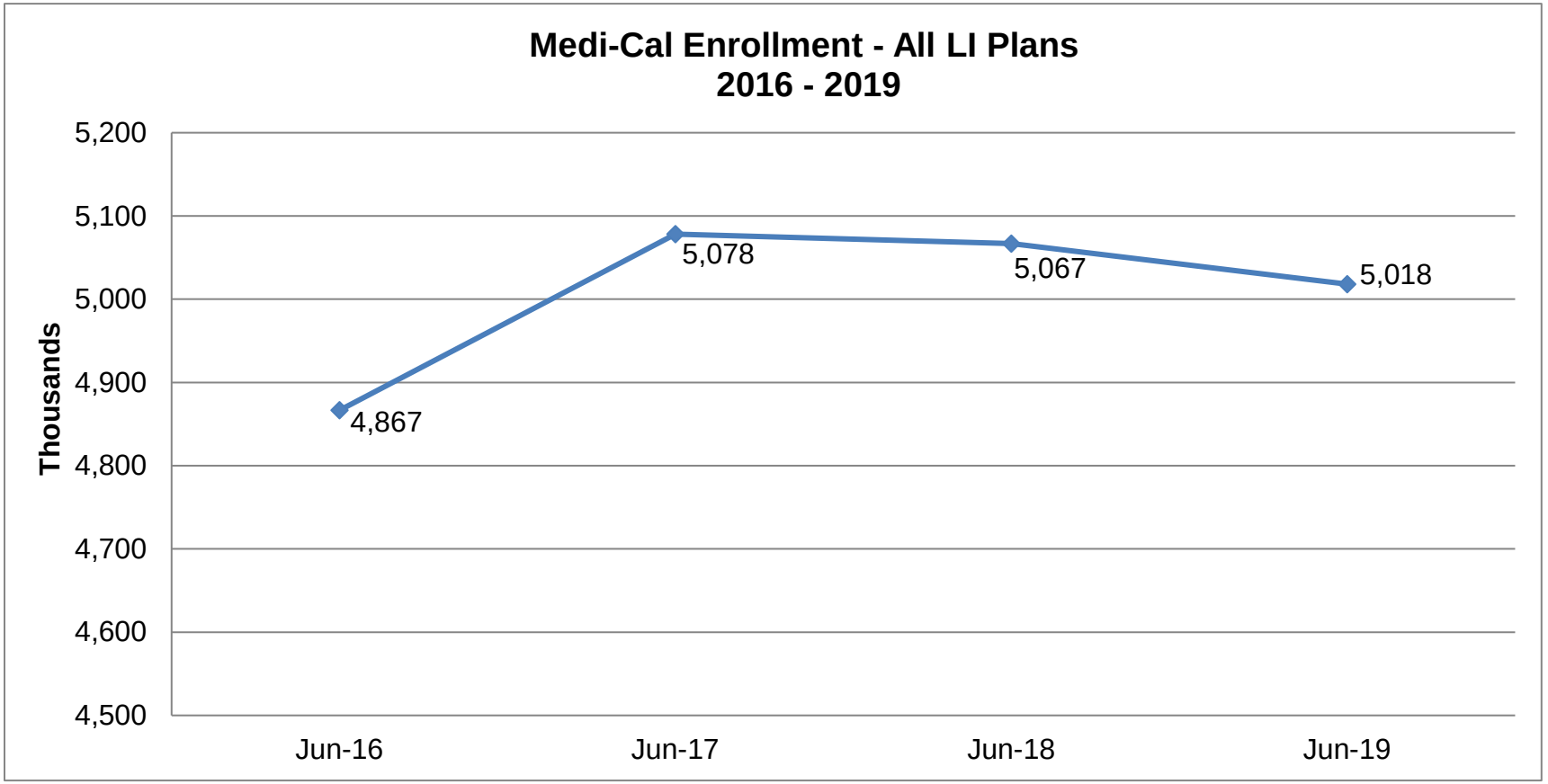
Table 1
Enrollment in Local Initiatives
June 2018–June 2019

Local Initiative	Total Medi-Cal Enrollment June 2019	Percentage of Medi-Cal Enrollment June 2019	Total Enrollment June 2019[4]	Total Enrollment June 2018	Enrollment Change from June 2018 to June 2019	Percentage Enrollment Change from June 2018 to June 2019
Alameda Alliance	253,439	98%	259,406	267,639	-8,233	-3.1%
CalViva Health	357,644	100%	357,644	358,653	-1,009	-0.3%
Contra Costa Health Plan	178,328	95%	186,807	191,568	-4,761	-2.5%
IEHP	1,250,375	100%	1,250,375	1,246,843	3,532	0.3%
Kern Health Systems	250,896	100%	250,896	247,317	3,579	1.4%
L.A. Care Health Plan	2,021,208	94%	2,152,282	2,191,364	-39,082	-1.8%
San Francisco Health Plan	126,585	90%	140,453	141,363	-910	-0.6%
Santa Clara Family Health Plan	237,697	95%	249,205	259,475	-10,270	-4.0%
The Health Plan of San Joaquin	341,885	100%	341,885	347,794	-5,909	-1.7%
Total	**5,018,057**	**97%**	**5,188,953**	**5,252,016**	**-63,063**	**-1.2%**

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

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

Chart 1



Medi-Cal enrollment in LIs remained consistent from June 2018 to June 2019. L.A. Care Health Plan reported the highest number of enrollees (2.15 million) and had a slight decrease in enrollment (1.8 percent) over the last year.

Table 2 shows Medi-Cal Enrollment by LI plan over the past four years.

Table 2
Medi-Cal Enrollment by LI Plan

Local Initiative	QE Jun-16	QE Jun-17	QE Jun-18	QE Jun-19
Alameda Alliance	257,508	262,883	261,832	253,439
CalViva Health	352,082	361,699	358,653	357,644
Contra Costa Health Plan	181,208	182,923	182,544	178,328
IEHP	1,145,102	1,235,923	1,222,097	1,250,375
Kern Health Systems	228,073	241,716	247,317	250,896
L.A. Care Health Plan	1,976,992	2,043,532	2,069,863	2,021,208
San Francisco Health Plan	131,209	135,705	127,863	126,585
Santa Clara Family Health Plan	259,919	265,753	248,776	237,697
The Health Plan of San Joaquin	334,477	348,034	347,794	341,885
Total Medi-Cal Enrollment	**4,866,570**	**5,078,168**	**5,066,739**	**5,018,057**

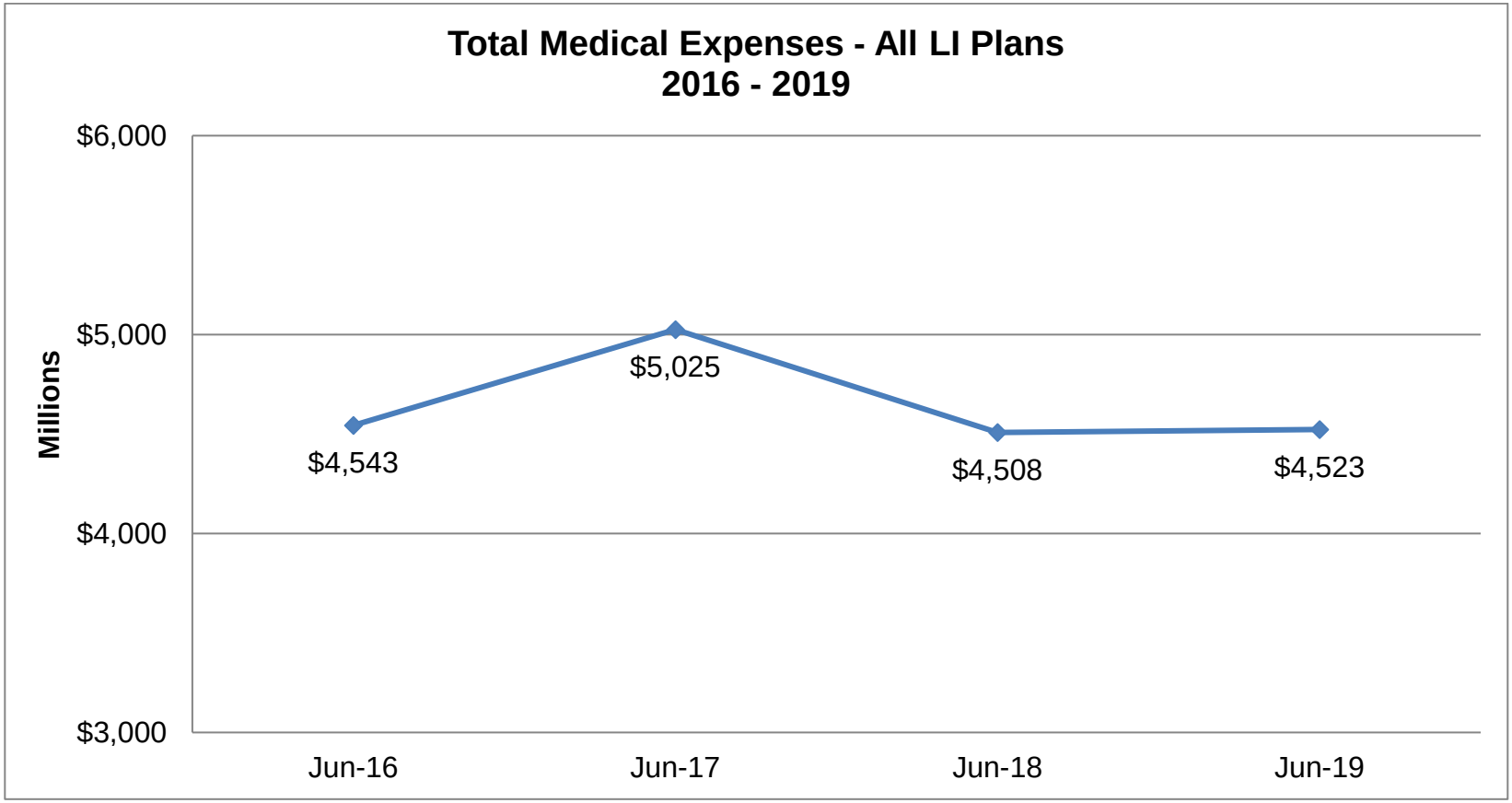
Almost all LIs reported increases in their Medi-Cal enrollment from June 2016 to June 2019. All LI plans, except IEHP and Kern Health Systems, reported a slight decline in Medi-Cal enrollment at June 2019 compared to June 2018. Total Medi-Cal enrollment for LI plans increased by 82% from December 31, 2013 to June 30, 2019.

Financial Trends - LI

Medical Expenses

Chart 2 illustrates total medical expenses for the LIs compared to the same quarter over the last four years. There was a slight increase in total medical expenses for the quarter ending June 2019. Generally, total medical expenses change as enrollment, enrollee mix (healthy or unhealthy, high or low utilizers), and Medi-Cal benefits change.

Chart 2



Per Member Per Month Premium Revenue and Medical Expenses - LI

Table 3 shows the PMPM premium revenue and medical expenses of LIs for the quarters ending in June for the past four years, as well as the difference in PMPM premium revenue and medical expenses for June 2019. Santa Clara Family Health Plan reported the highest PMPM premium revenue, and San Francisco Health Plan reported the highest PMPM medical expenses. All LIs, except Contra Costa Health Plan and San Francisco Health Plan reported positive net premium revenue for June 2019.

Table 3
Per Member Per Month Premium Revenue and Medical Expenses - LI
2016–2019

Local Initiative	Jun-16	Jun-16	Jun-17	Jun-17	Jun-18	Jun-18	Jun-19	Jun-19	Jun-19
	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Net Revenue[5]
Alameda Alliance	$265	$235	$273	$250	$276	$270	$292	$289	$3
CalViva Health	$272	$260	$125	$116	$239	$226	$248	$235	$13
Contra Costa Health Plan	$300	$300	$279	$274	$310	$289	$320	$321	($1)
IEHP	$301	$267	$349	$332	$310	$285	$331	$320	$11
Kern Health Systems	$237	$200	$234	$216	$260	$245	$244	$232	$12
L.A. Care Health Plan	$358	$340	$350	$334	$275	$266	$297	$277	$20
San Francisco Health Plan	$340	$305	$316	$308	$422	$415	$340	$343	($3)
Santa Clara Family Health Plan	$346	$291	$304	$287	$352	$315	$376	$334	$42
The Health Plan of San Joaquin	$243	$217	$280	$246	$251	$233	$256	$235	$21

[5] Difference between June 2019 PMPM Premium Revenue and PMPM Medical Expense.

PMPM premium revenue is calculated by dividing the premium revenue by cumulative member months. PMPM medical expense is calculated by dividing the total medical expenses by cumulative member months. Fluctuations in PMPM premium revenue and medical expenses 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.

Net Income - LI

Table 4 shows the net income for LI plans over the past six quarters. For the quarter ending (QE) June 2019, almost all LI plans reported positive net income. Net income or loss is directly related to premium revenue and medical expenses.

Table 4
LI Net Income by Quarter (in thousands)

Local Initiative	QE Mar-18	QE Jun-18	QE Sep-18	QE Dec-18	QE Mar-19	QE Jun-19
Alameda Alliance	$2,546	($6,035)	($2,883)	$3,257	($2,125)	($8,279)
CalViva Health	$1,452	$3,003	$2,397	$2,204	$2,364	$3,499
Contra Costa Health Plan	$6,729	$12,125	$877	$894	$894	$3,193
IEHP	$916	$23,630	$13,822	$9,397	($836)	($25,723)
Kern Health Systems	$1,563	$606	$2,045	$4,396	$1,360	$2,471
L.A. Care Health Plan	$109,874	($27,010)	$38,913	$58,324	$141,224	$43,816
San Francisco Health Plan	($5,750)	($11,545)	($2,170)	$2,580	($78)	($10,982)
Santa Clara Family Health Plan	$1,923	$2,152	($2)	$8,059	$4,445	$17,737
The Health Plan of San Joaquin	$13,145	$15,695	$768	$2,205	$22,793	$14,296
Total LI Net Income	**$132,398**	**$12,622**	**$53,768**	**$91,317**	**$170,040**	**$40,028**

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., goodwill,[6] 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[7] may be added to the TNE calculation, which serves to increase the plan's TNE. All LIs had TNE that exceeded the regulatory requirements.

Table 5
Percentage TNE - All LI Plans

Local Initiative	QE Jun-18	QE Sep-18	QE Dec-18	QE Mar-19	QE Jun-19
Alameda Alliance	611%	645%	605%	583%	555%
CalViva Health	448%	468%	485%	508%	530%
Contra Costa Health Plan	460%	486%	496%	484%	517%
IEHP	592%	614%	619%	598%	561%
Kern Health Systems	599%	607%	613%	611%	624%
L.A. Care Health Plan	542%	610%	693%	817%	859%
San Francisco Health Plan	774%	761%	782%	778%	778%
Santa Clara Family Health Plan	483%	500%	537%	547%	679%
The Health Plan of San Joaquin	796%	769%	767%	809%	843%

[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 2018, and the trend continued in 2019. For June 2019, the reported TNE ranged from 517 percent to 859 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.

Eight of the nine LI plans reported negative cash flow from operations in June 2019. The cash flow from operations totaled negative $798 million in June 2019 compared to $76 million in June 2018. 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 June 2019.

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 (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.
    - 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 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 June 2019, a decrease of 2.7 percent from June 2018.

- Almost all COHS plans' PMPM premium revenue outpaced medical expenses for June 2019.

- COHS plans reported $41 million in net income in June 2019, which was higher than the negative $49 million net income reported in June 2018, and 76 percent higher than the $24 million net income for the quarter ending March 31, 2019.

- COHS plans reported TNE ranging from 665 percent to 1,102 percent of required TNE.

- COHS plans reported negative $702 million in cash flow from operations compared to the negative $812 million reported in June 2018. This is a significant change from March 2019 when COHS plans reported cash flow from operations of $902 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 2018/2019 fiscal year.

B. Enrollment Trends - COHS

COHS plans reported enrollment of nearly 2 million, a decrease of 2.7 percent compared to June 2018. All COHS plans reported slight decreases in total enrollment from June 2018 to June 2019. CalOptima and Partnership HealthPlan reported the highest enrollment numbers.

Table 6
Enrollment in County Organized Health Systems
June 2018–June 2019

COHS	Total Medi-Cal Enrollment June 2019	Percentage of Medi-Cal Enrollment June 2019	Total Enrollment June 2019[8]	Total Enrollment June 2018	Enrollment Change from June 2018 to June 2019	Percentage Enrollment Change from June 2018 to June 2019
CalOptima	758,059	100%	759,923	780,277	(20,354)	-2.6%
CenCal Health	176,840	100%	176,840	178,229	(1,389)	-0.8%
Central California Alliance for Health	340,115	100%	340,745	352,611	(11,866)	-3.4%
Health Plan of San Mateo	110,281	98%	113,064	119,893	(6,829)	-5.7%
Partnership HealthPlan	544,864	100%	544,864	558,880	(14,016)	-2.5%
Total	**1,930,159**	**99.7%**	**1,935,436**	**1,989,890**	**(54,454)**	**-2.7%**

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

Chart 3 illustrates the Medi-Cal managed care enrollment trend in COHS plans. Medi-Cal enrollment in COHS plans decreased slightly in June 2019.

Chart 3

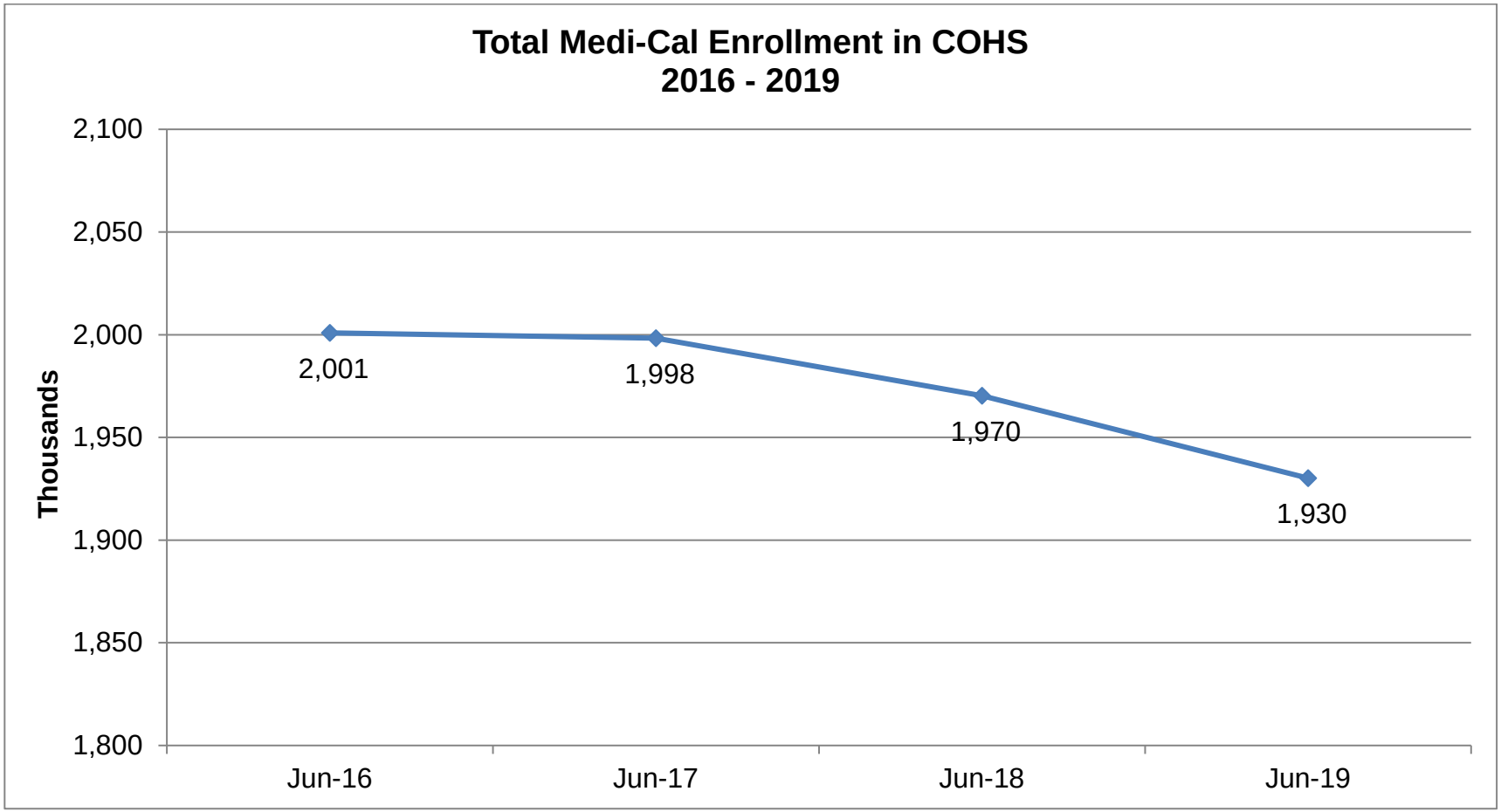


Table 7 shows the enrollment for each COHS plan over the past four years.

Table 7
Medi-Cal Enrollment by COHS Plan

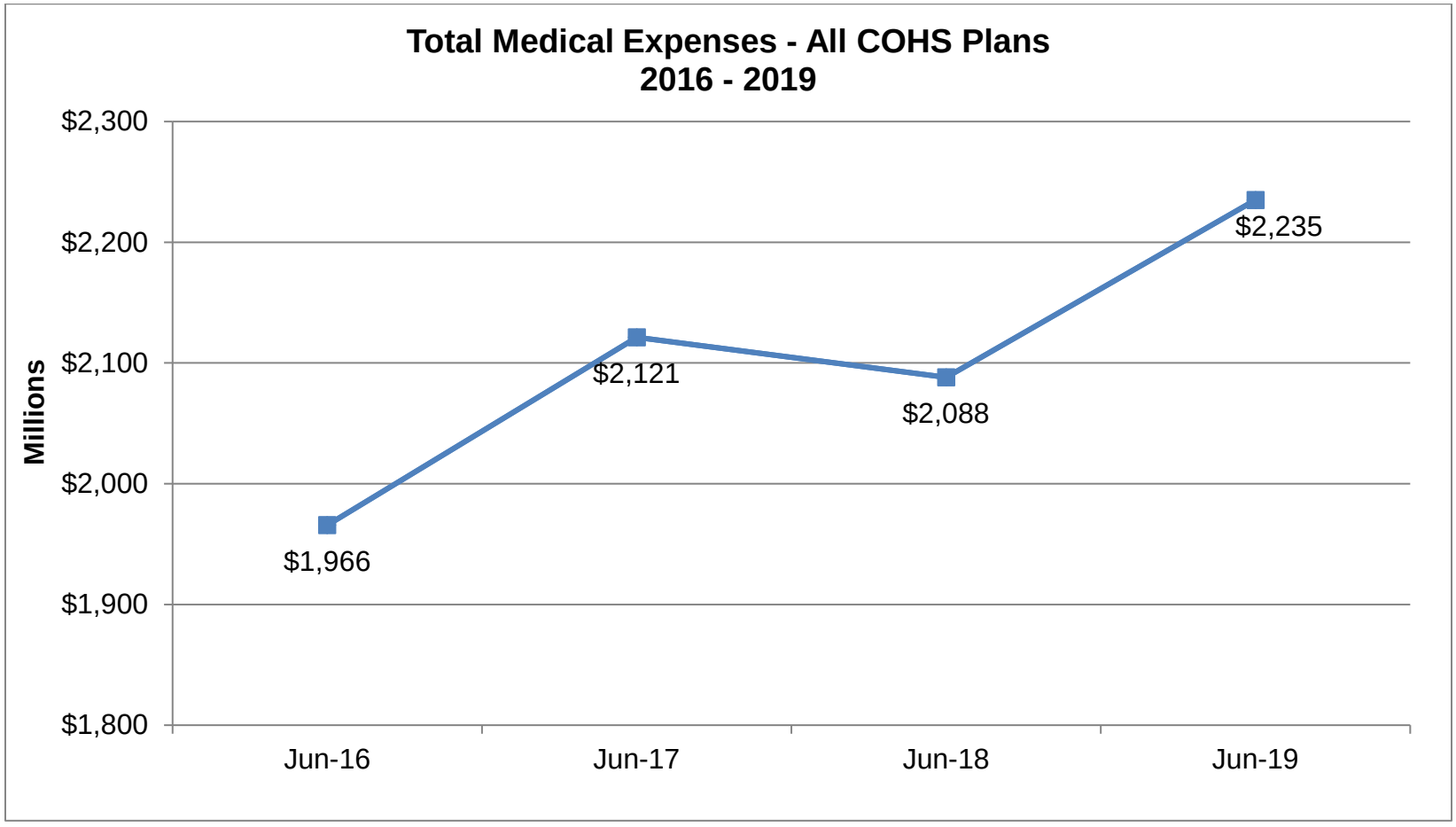
COHS	QE Jun-16	QE Jun-17	QE Jun-18	QE Jun-19
CalOptima	777,174	772,228	763,824	758,059
CenCal Health	177,506	178,853	178,229	176,840
Central California Alliance for Health	350,296	354,060	352,065	340,115
Health Plan of San Mateo	124,374	122,458	117,270	110,281
Partnership HealthPlan	571,542	570,661	558,880	544,864
Total Medi-Cal Enrollment	**2,000,892**	**1,998,260**	**1,970,268**	**1,930,159**

Almost all COHS plans reported decreases in their Medi-Cal enrollment from 2016 to 2019. COHS enrollment overall has decreased in the last three years.

C. Financial Trends - COHS

Chart 4 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 June 2018.

Chart 4



Per Member Per Month Premium Revenue and Medical Expenses - COHS

Table 8 shows the PMPM premium revenue and medical expenses of COHS plans for the quarters ending in June for the past four years, as well as the difference between the PMPM premium revenue and medical expenses for June 2019.

All COHS plans, except CenCal Health and Central California Alliance for Health, reported positive PMPM net revenue for June 2019 and had higher PMPM premium revenue than medical expenses at June 2019. Health Plan of San Mateo reported the highest PMPM premium revenue and medical expenses.

Table 8
Per Member Per Month Premium Revenue and Medical Expenses - COHS
2016–2019

COHS	Jun-16	Jun-16	Jun-17	Jun-17	Jun-18	Jun-18	Jun-19	Jun-19	Jun-19
	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Net Revenue[9]
CalOptima	$374	$361	$431	$402	$404	$376	$398	$363	$35
CenCal Health	$313	$258	$303	$269	$321	$302	$301	$314	($13)
Central California Alliance for Health	$256	$233	$263	$238	$237	$251	$289	$296	($7)
Health Plan of San Mateo	$513	$443	$509	$468	$492	$452	$574	$527	$47
Partnership HealthPlan	$353	$318	$348	$340	$343	$363	$420	$392	$28

[9] Difference between June 2019 PMPM Premium Revenue and PMPM Medical Expense.

Net Income - COHS

Table 9 shows the net income for COHS plans over the past six quarters. For the quarter ending June 2019, an increase in medical expenses translated to negative net income for CenCal Health and Central California Alliance for Health. Both health plans continue to maintain sufficient reserves.

Table 9
COHS Net Income by Quarter (in thousands)

COHS	QE Mar-18	QE Jun-18	QE Sep-18	QE Dec-18	QE Mar-19	QE Jun-19
CalOptima	($7,514)	$28,937	$23,595	$27,420	$60,899	$59,712
CenCal Health	($1,414)	$14,377	$682	($4,328)	$4,836	($16,728)
Central California Alliance for Health	($18,728)	($35,890)	($8,033)	($36,387)	($17,933)	($26,563)
Health Plan of San Mateo	$12,216	$1,927	($20,594)	$6,724	$3,488	$5,959
Partnership HealthPlan	($41,052)	($57,893)	($25,768)	($20,062)	($27,775)	$18,989
Total COHS Net Income	**($56,492)**	**($48,542)**	**($30,118)**	**($26,633)**	**$23,515**	**$41,369**

Tangible Net Equity - COHS

All COHS plans reported over 600 percent of required TNE for June 2019. TNE to required TNE ranged from 665 percent to 1,102 percent. Central California Alliance for Health reported declining TNE for the last four quarters. Even with the declining TNE and negative net income, Central California Alliance for Health maintains sufficient reserves.

Table 10
Percentage of TNE by COHS

COHS	QE Jun-18	QE Sep-18	QE Dec-18	QE Mar-19	QE Jun-19
CalOptima	850%	946%	996%	1047%	1102%
CenCal Health	876%	871%	842%	844%	778%
Central California Alliance for Health	1204%	1139%	1022%	964%	887%
Health Plan of San Mateo	1190%	1099%	1118%	1093%	975%
Partnership HealthPlan	818%	755%	704%	656%	665%

Cash Flow from Operations

COHS plans reported negative $702 million in cash flow from operations in June 2019. 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. For the quarter ending June 30, 2019, COHS plans did not report any claims processing or emerging claims payment deficiencies.

V. Non-Governmental Medi-Cal Plans

A. Highlights

- For the purposes of this report, Non-Governmental Medi-Cal (NGM) plans are health plans with greater than 50 percent Medi-Cal enrollment, that are neither an LI nor a COHS plan.

- Aetna Better Health and UnitedHealthcare Community Plan commenced their operations in December 2017. Therefore, this report includes data beginning June 30, 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 - 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.
    - 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 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 2018 and first two quarters of 2019, California Health and Wellness paid no dividends to its parent company.
- 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 2018, Health Net Community Solutions paid dividends of $400 million to its parent company, but paid no dividends in March and June 2019.
- Molina is a for-profit wholly owned subsidiary of Molina Healthcare, Inc., a publicly traded company. In 2018 and March 2019, Molina paid dividends of $50 million and $75 million respectively to its parent company. However, Molina did not pay any dividends in June 2019.
- 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 1.85 million Medi-Cal enrollees: Anthem Blue Cross with 1,195,336 enrollees and Kaiser Permanente with 654,591 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 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 4.8 percent from June 2018 to June 2019.

- Almost all NGM plans' PMPM premium revenue outpaced medical expenses for June 2019.

- NGM plans reported $106 million in net income in June 2019, which was higher than the $65 million net income reported in June 2018, and 15 percent lower than the quarter ending March 31, 2018.

- Tangible net equity for NGM plans ranged from 151 percent to 1,108 percent of required TNE at June 2019.

- NGM plans reported negative $732 million in cash flow from operations, which was lower than the negative $887 million reported in June 2018. This is a significant change from March 2018 when NGM plans reported cash flow from operations of $1.36 billion. 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

Most NGM plans reported a decline in total enrollment for June 2019 compared to June 2018, except Aetna Better Health, California Health and Wellness and UnitedHealthcare Community Plan, which had increases in total enrollment.

Table 11
Enrollment in Non-Governmental Medi-Cal Plans
June 2018–June 2019

Non-Governmental Medi-Cal Plans	Total Medi-Cal Enrollment June 2019	Percentage of Medi-Cal Enrollment June 2019	Total Enrollment June 2019	Total Enrollment June 2018	Enrollment Change from June 2018 to June 2019	Percentage Enrollment Change from June 2018 to June 2019
Aetna Better Health	16,552	100%	16,552	5,997	10,555	176.0%
Blue Shield of California Promise Health Plan	404,914	87%	467,493	501,109	(33,616)	-6.7%
California Health and Wellness	196,113	100%	196,113	195,440	673	0.3%
Community Health Group	265,107	100%	265,107	281,600	(16,493)	-5.9%
Health Net Community Solutions	1,746,418	99%	1,763,941	1,840,947	(77,006)	-4.2%
Molina	540,101	91%	595,399	646,158	(50,759)	-7.9%
UnitedHealthcare Community Plan	10,846	100%	10,846	9,995	851	8.5%
Total Enrollment in NGMs	**3,180,051**	**96%**	**3,315,451**	**3,481,246**	**(165,795)**	**-4.8%**
Anthem Blue Cross	1,195,336	34%	3,552,662	3,519,581	33,081	0.9%
Kaiser Permanente	654,591	7%	9,102,445	8,934,207	168,238	1.9%
Grand Total	**5,029,978**	**31%**	**15,970,558**	**15,935,034**	**35,524**	**0.2%**

Chart 5 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 5

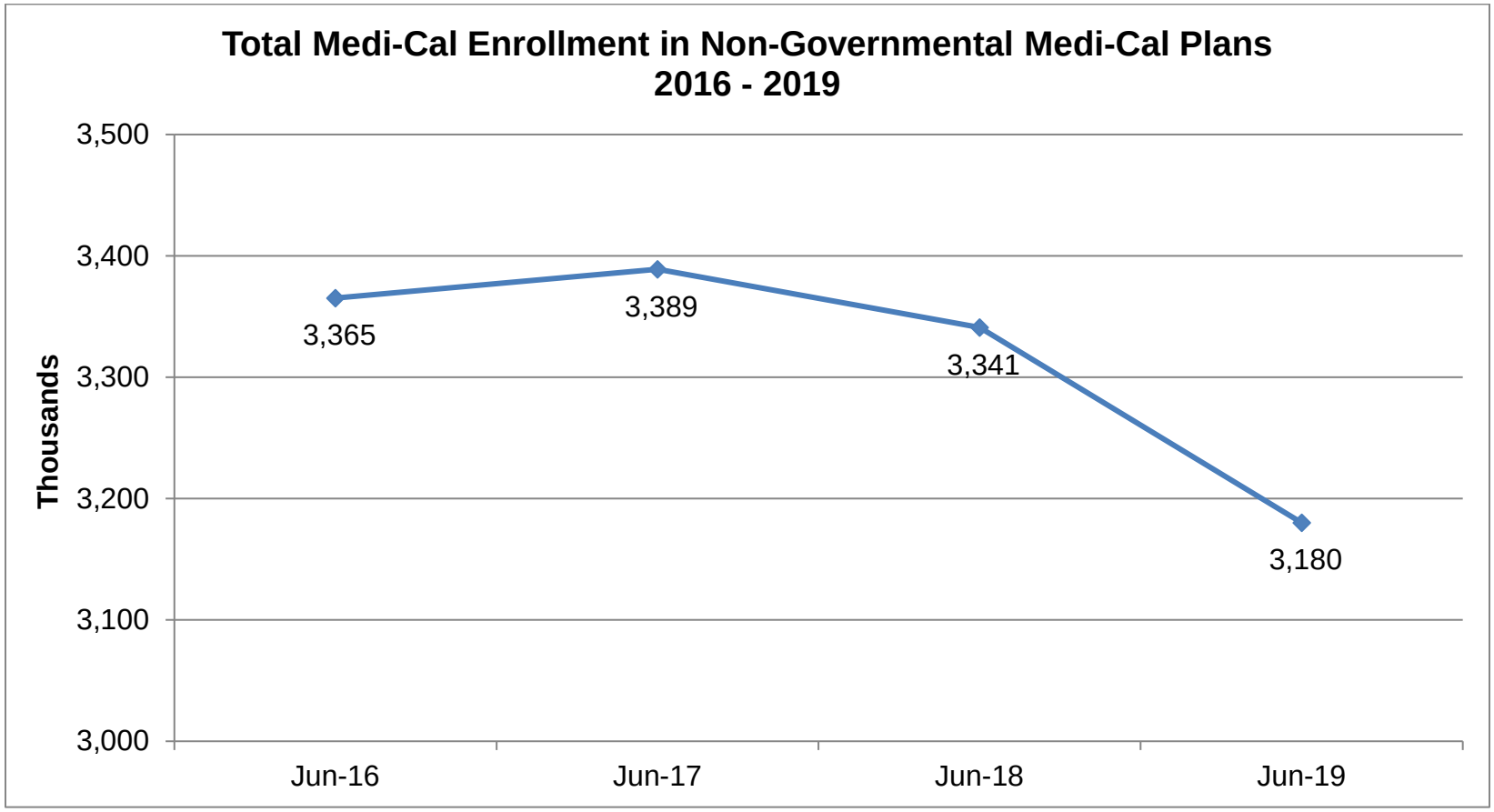


Table 12 shows the enrollment for each NGM plan over the past four years. Aetna Better Health and UnitedHealthcare Community Plan commenced their operations in December 2017; therefore, the table below shows enrollment data as of June 30, 2018 for these two plans.

Table 12
Medi-Cal Enrollment by Non-Governmental Medi-Cal Plan

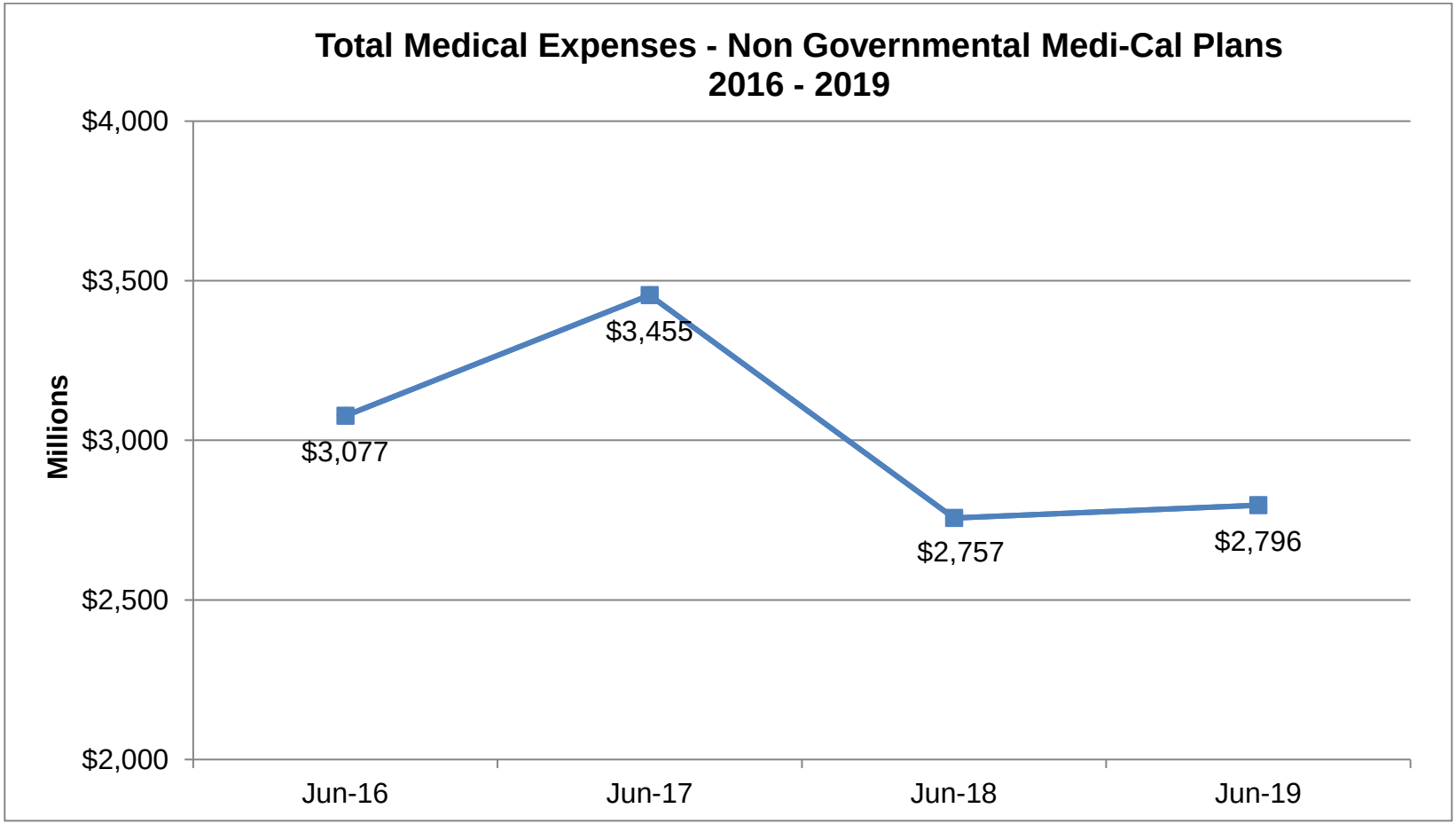
Non-Governmental Medi-Cal Plans	QE Jun-16	QE Jun-17	QE Jun-18	QE Jun-19
Aetna Better Health	0	0	5,997	16,552
Blue Shield of California Promise Health Plan	392,394	420,388	435,204	404,914
California Health and Wellness	189,038	188,900	195,440	196,113
Community Health Group	276,950	290,384	281,600	265,107
Health Net Community Solutions	1,899,407	1,861,724	1,824,091	1,746,418
Molina	607,432	627,590	588,672	540,101
UnitedHealthcare Community Plan	0	0	9,995	10,846
Total Medi-Cal Enrollment	**3,365,221**	**3,388,986**	**3,340,999**	**3,180,051**

All NGM plans except Aetna Better Health, California Health and Wellness and UnitedHealthcare Community Plan reported slight decreases in Medi-Cal enrollment compared to June 2018. Total Medi-Cal enrollment for NGM plans increased by 66 percent from December 31, 2013 to June 30, 2019.

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

Chart 6 shows a slight increase in medical expenses for NGM plans. This chart does not include the medical expenses reported by Anthem Blue Cross and Kaiser Permanente.

Chart 6



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

Table 13 shows the PMPM premium revenue and medical expenses of NGM plans for the quarters ending in June for the past four years, as well as the difference in the PMPM premium revenue and medical expenses for quarter ending June 2019. All NGM plans, except California Health and Wellness and UnitedHealthcare Community Plan, reported positive PMPM net revenue at June 2019. Aetna Better Health and UnitedHealthcare Community Plan commenced their operations in December 2017; therefore, the table below shows data only as of June 30, 2018 for these two plans.

Table 13
Per Member Per Month Premium Revenue and Medical Expenses - Non-Governmental Medi-Cal Plans
2016–2019

Non-Governmental Medi-Cal Plans	Jun-16	Jun-16	Jun-17	Jun-17	Jun-18	Jun-18	Jun-19	Jun-19	Jun-19
	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Net Revenue[10]
Aetna Better Health	NA	NA	NA	NA	$272	$251	$472	$370	$102
Blue Shield of California Promise Health Plan[11]	$353	$316	$506	$452	$383	$355	$366	$341	$25
California Health and Wellness	$259	$221	$271	$240	$263	$255	$282	$314	($32)
Community Health Group	$379	$329	$337	$286	$195	$296	$335	$328	$7
Health Net Community Solutions	$328	$287	$336	$282	$277	$240	$294	$256	$38
Molina	$270	$244	$294	$262	$307	$240	$313	$251	$62
UnitedHealthcare Community Plan	NA	NA	NA	NA	$213	$241	$355	$446	($91)

[10] Difference between June 2019 PMPM Premium Revenue and PMPM Medical Expense.
[11] PMPM information for Blue Shield of California Promise Health Plan includes commercial and other lines of business.

Net Income - Non-Governmental Medi-Cal Plans

Table 14 shows the net income for NGM plans over the past six quarters. Aetna Better Health, Blue Shield of California Promise Health Plan, California Health and Wellness and UnitedHealthcare Community Plan reported negative net income for June 2019.

Table 14
Non-Governmental Medi-Cal Plans Net Income by Quarter (in thousands)

Non-Governmental Medi-Cal Plans	QE Mar-18	QE Jun-18	QE Sep-18	QE Dec-18	QE Mar-19	QE Jun-19
Aetna Better Health	$2,175	$33	$1,791	$2,531	$748	($3,760)
Blue Shield of California Promise Health Plan	$48,482	$3,158	($7,346)	$25,249	$5,529	($1,533)
California Health and Wellness	($859)	($5,950)	($12,617)	($12,750)	$2,005	($27,670)
Community Health Group	$41,885	($94,245)	($36,124)	$42,403	($3,079)	$197
Health Net Community Solutions	$147,004	$101,281	$149,206	$96,389	$110,551	$99,069
Molina	$34,522	$62,229	($30,736)	$19,736	$14,727	$44,607
UnitedHealthcare Community Plan	($11,187)	($1,921)	$6,145	($4,606)	($5,603)	($4,603)
Total Net Income	**$262,022**	**$64,586**	**$70,319**	**$168,953**	**$124,878**	**$106,307**

Tangible Net Equity - Non-Governmental Medi-Cal Plans

NGM plans' TNE to required TNE ranged from 151 percent to 1,108 percent for June 2019. 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, thereby increasing its TNE, which has since been declining.

Table 15
Percentage of TNE by Non-Governmental Medi-Cal Plan

COHS	QE Jun-18	QE Sep-18	QE Dec-18	QE Mar-19	QE Jun-19
Aetna Better Health	1043%	1028%	980%	788%	386%
Blue Shield of California Promise Health Plan	694%	1222%	940%	947%	983%
California Health and Wellness	207%	157%	158%	164%	151%
Community Health Group	1181%	1084%	1199%	1118%	1108%
Health Net Community Solutions	661%	841%	807%	873%	950%
Molina	260%	231%	285%	180%	251%
UnitedHealthcare Community Plan	4795%	4621%	1441%	1069%	850%

Cash Flow from Operations

NGM plans reported negative $732 million in cash flow from operations in June 2019. 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 June 2019.

Conclusion

Enrollment increases for the MCMC plans slowed, and then declined slightly in 2018 and the first half of 2019. Overall, expenses and premium revenue stabilized as the enrollment stabilized. 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.

Medi-Cal Managed Care Plans: Net Income, Medical Expenses and TNE
June 2019

Appendix A – All LI Plan Net Income, Medical Expenses, and TNE

Health Plan	Net Income	Medical Expenses	Excess TNE[12]
Alameda Alliance	($8,278,532)	$225,542,123	$147,651,591
CalViva Health	$3,499,395	$251,338,339	$57,013,991
Contra Costa Health Plan	$3,192,895	$215,697,852	$66,434,448
IEHP	($25,723,389)	$1,201,255,044	$713,651,864
Kern Health Systems	$2,471,000	$173,249,000	$173,485,000
L.A. Care Health Plan	$43,816,222	$1,813,770,638	$937,286,652
San Francisco Health Plan	($10,982,072)	$145,115,132	$85,311,531
Santa Clara Family Health Plan	$17,737,000	$255,737,000	$177,593,000
The Health Plan of San Joaquin	$14,295,751	$241,090,184	$316,374,245
Total	**$40,028,270**	**$4,522,795,312**	**$2,674,802,322**

Appendix B – All COHS Plan Net Income, Medical Expenses and TNE

Health Plan	Net Income	Medical Expenses	Excess TNE
CalOptima	$59,711,983	$828,291,540	$850,962,809
CenCal Health	($16,728,116)	$231,299,319	$188,203,637
Central California Alliance for Health	($26,563,089)	$304,128,810	$421,714,907
Health Plan of San Mateo	$5,959,348	$228,483,721	$313,180,891
Partnership HealthPlan	$18,988,929	$642,863,095	$513,396,707
Total	**$41,369,055**	**$2,235,066,495**	**$2,287,458,951**

[12] Excess TNE is the difference between total TNE and required TNE

Appendix C – All NGM Plan Net Income, Medical Expenses and TNE

Health Plan	Net Income	Medical Expenses	Excess TNE
Aetna Better Health	($3,760,279)	$24,045,817	$9,953,032
Blue Shield of California Promise Health Plan	($1,532,941)	$486,100,901	$533,938,199
California Health and Wellness	($27,669,917)	$186,423,386	$16,285,439
Community Health Group	$196,634	$260,138,846	$438,173,932
Health Net Community Solutions	$99,069,369	$1,375,685,246	$1,173,795,371
Molina	$44,606,676	$449,871,321	$92,687,666
UnitedHealthcare Community Plan	($4,602,956)	$14,136,927	$14,050,744
Total	**$106,306,586**	**$2,796,402,444**	**$2,278,884,383**