

Financial Summary of Medi-Cal Managed Care Health Plans Quarter Ending December 31, 2016

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I. Overview

Medi-Cal, California's Medicaid program, has experienced significantly increased enrollment in the last three 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. Approximately 10.7 million Medi-Cal beneficiaries in all 58 California counties receive their health care through six main models of managed care: Two-Plan Model, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Imperial Model, San Benito Model, and Regional Model. Locally-sponsored plans known as Local Initiatives (LIs) participate as MCMC plans under the Two-Plan Model, while County Organized Health Systems plans serve Medi-Cal enrollees under the COHS Model.¹ Both LI and COHS plans are local agencies established by county boards of supervisors to contract with the Medi-Cal program. Approximately 7 million Medi-Cal beneficiaries are enrolled in LI and COHS plans under the Two-Plan and COHS Models. In the two GMC counties, Sacramento and San Diego, DHCS contracts with several commercial plans to serve approximately 1.17 million Medi-Cal beneficiaries. There are about 387,000 Medi-Cal beneficiaries served under the Imperial, San Benito, and Regional models combined.

This report includes enrollment and financial information reported by LI and COHS plans as of the quarter ending December 31, 2016. This report also includes financial results for the Non-Governmental Medi-Cal (NGM) plans. The NGM plans are categorized as any non LI or COHS plan that reports greater than 50% Medi-Cal enrollment. For quarter ending December 31, 2016, NGM plans reported 3.4 million Medi-Cal enrollees. Because LI, COHS, and NGM plans serve primarily Medi-Cal enrollees, Medi-Cal enrollment increases and the rates provided by DHCS are driving factors for the financial performance of these plans.²

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 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

Key findings from this report include:

- The financial information for LI and COHS plans was compared to Non-Governmental Medi-Cal (NGM) plans. For the purposes of this report, NGM plans include for-profit and not-for-profit plans with greater than 50% Medi-Cal enrollment. Enrollment information for Blue Cross of California and Kaiser Foundation Health Plan was also included due to the large number of Medi-Cal enrollees they reported. However, they do not meet the definition of a NGM Plan as their Medi-Cal enrollment was less than 50% of their total enrollment.
- LI and COHS enrollment stabilized in 2016, compared to significant growth experienced in 2014 and 2015. NGM plans experienced similar trends.
- All LI, COHS and NGM plans reported increases in their Medi-Cal enrollment from December 2013 to December 2016.
- Increased enrollment contributed to increased medical expenses for LI, COHS and NGM plans.
- Per Member Per Month (PMPM) premium revenue exceeded PMPM medical expense for almost every LI, COHS and NGM plan for December 2016.
- The LI plans reported higher net income than COHS, and COHS reported higher Tangible Net Equity (TNE) reserves than LIs. However, both the LI and COHS plans continue to report healthy TNE reserves. In comparison, NGM plans reported higher net income with lower TNE reserves. This is in part due to a majority of the NGM plans paying dividends to parent companies/shareholders thereby reducing the reserve levels. In comparison, LI and COHS plans may need to hold on to higher reserves to alleviate any potential capital expenditure needs or future economic downturn.

III. Local Initiative Health Plans (LI)

A. Highlights

- At present, 14 counties participate in the Two-Plan Model of Medi-Cal managed care. In 13 of these counties, the DHCS contracts with both a commercial plan and a LI plan; in Tulare County, the DHCS contracts with two commercial plans: Anthem Blue Cross and Health Net. The LIs must be licensed under the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act), for their Medi-Cal lines of business.
- Beneficiaries in the Two-Plan Model have a choice between the two plans. Beneficiaries who do not make a selection are automatically assigned to a plan. The DHCS uses an algorithm based on quality and use of safety net providers to make the assignments. Overall, there are nearly three times as many Medi-Cal beneficiaries enrolled in LI plans as in commercial plans in Two-Plan Model counties.³
- 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 Health Plan or Contra Costa) – Contra Costa
 - Fresno-Kings-Madera Regional Health Authority (CalViva) – Fresno, Kings, and Madera
 - San Joaquin County Health Commission (Health Plan of San Joaquin or San Joaquin) – San Joaquin and Stanislaus
 - Inland Empire Health Plan (IEHP) – Riverside and San Bernardino
 - Kern Health Systems (Kern) - Kern
 - Local Initiative Health Authority for L.A County (L.A. Care) – Los Angeles
 - San Francisco Community Health Authority (San Francisco) – San Francisco
 - Santa Clara County Health Authority (Santa Clara) – Santa Clara

³ http://www.chcf.org/~media/MEDIA_LIBRARY_Files/PDF/PDF_M/PDF_MonitoringPerformanceLocalVersusCommericalMediCalPlans.pdf

- LI plans reported combined enrollment of 5.1 million individuals as of December 31, 2016. Over 5 million (97%) of the total LI enrollment are Medi-Cal beneficiaries. The remaining 3% of non-Medi-Cal LI enrollment includes other lines of business such as In-Home Supportive Services (IHSS), Healthy Kids, or the Access for Infants and Mothers Program (AIM).
- Total LI plan enrollment increased by 8% from December 2015 to December 2016.
- Per member per month medical (PMPM) expenses and premium revenue stabilized at December 2016 as a result of Medi-Cal Coverage Expansion (MCE) rate adjustments for the 2016/2017 fiscal year. All LI plans' PMPM premium revenue outpaced expenses for December 2016.
- LI plans reported \$149 million in net income in December 2016, which was about 6% higher than the \$141 million net income reported in December 2015, and 142% higher than the quarter ending September 30, 2016.
- The LIs reported TNE that ranged from 313% to 996% of required TNE.
- The LIs reported negative \$14 million in cash flow from operations, which was significantly lower than the \$503 million reported in December 2015. This is a significant change from September 2016 when the LIs reported cash flow from operations of \$1.3 billion. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and the MCE rate adjustments for the 2016/2017 fiscal year.

B. Enrollment Trends – LI

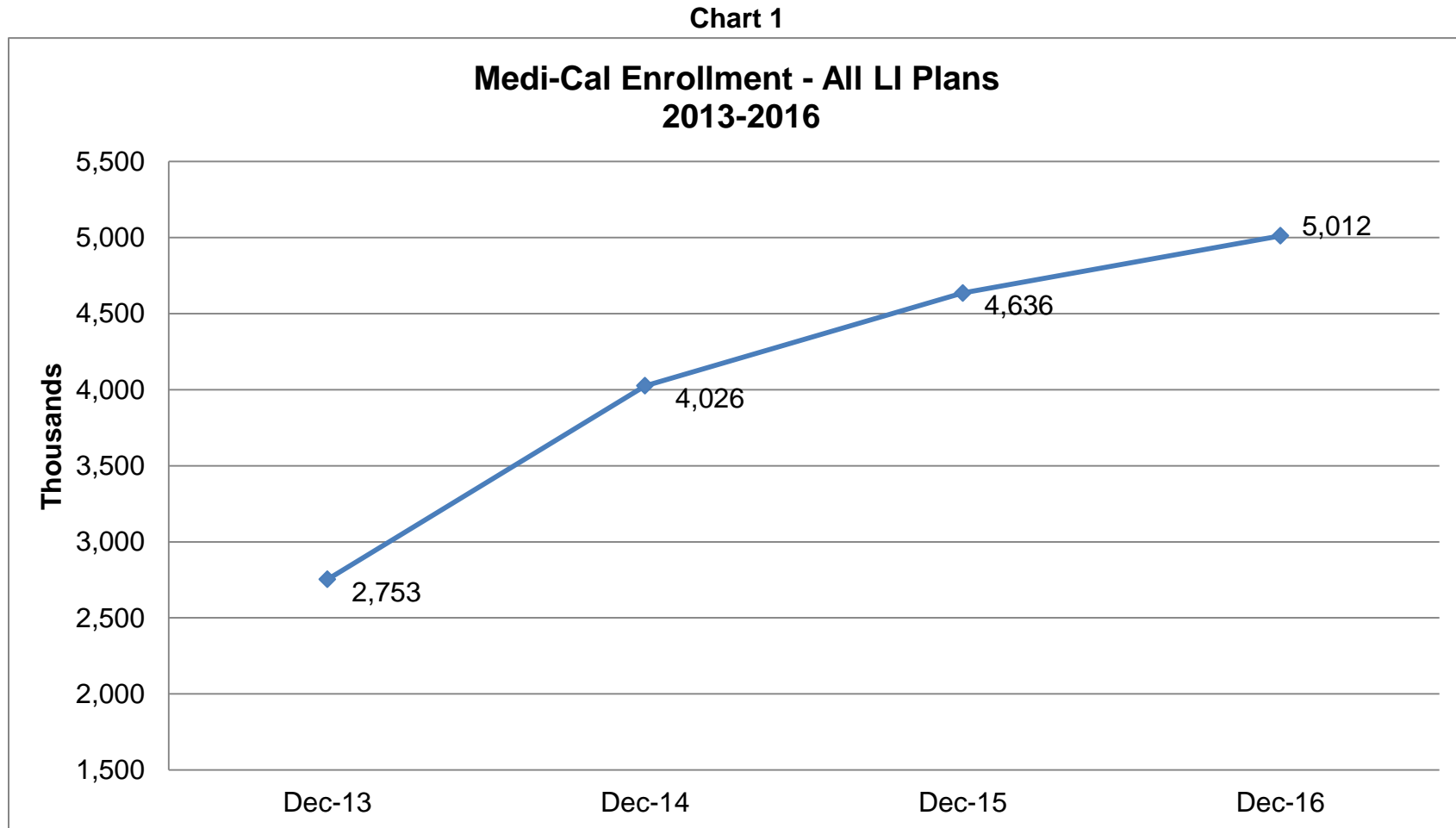
The LI plans serve 5.1 million enrollees in 13 counties in California. Total enrollment increased by 8% since December 2015. The table below lists LI total enrollment and the percentage of total LI enrollment accounted for by Medi-Cal lives. The table also shows the increase in enrollment from December 2015 to December 2016. L.A. Care and IEHP reported the largest percentage increases in enrollment at 9% and 12%, respectively.

Table 1
Enrollment in Local Initiatives
December 2015 – December 2016

Local Initiative	Total Medi-Cal Enrollment December 2016	Percentage of Medi-Cal Enrollment December 2016	Total Enrollment December 2016 ⁴	Total Enrollment December 2015	Enrollment Increase	Percentage Enrollment Increase
Alameda Alliance	261,424	98%	267,040	266,603	437	0.2%
Contra Costa	184,751	95%	195,278	187,885	7,393	3.9%
CalViva	359,697	100%	359,697	340,104	19,593	5.8%
IEHP	1,235,065	98%	1,257,559	1,127,581	129,978	11.5%
Kern	234,491	100%	234,491	216,581	17,910	8.3%
L.A. Care	1,986,581	97%	2,056,926	1,894,463	162,463	8.6%
San Francisco	136,055	92%	148,160	146,784	1,376	0.9%
San Joaquin	343,803	99%	347,717	326,800	20,917	6.4%
Santa Clara	270,000	96%	280,127	271,984	8,143	3.0%
Total	5,011,867	97%	5,146,995	4,778,785	368,210	7.7%

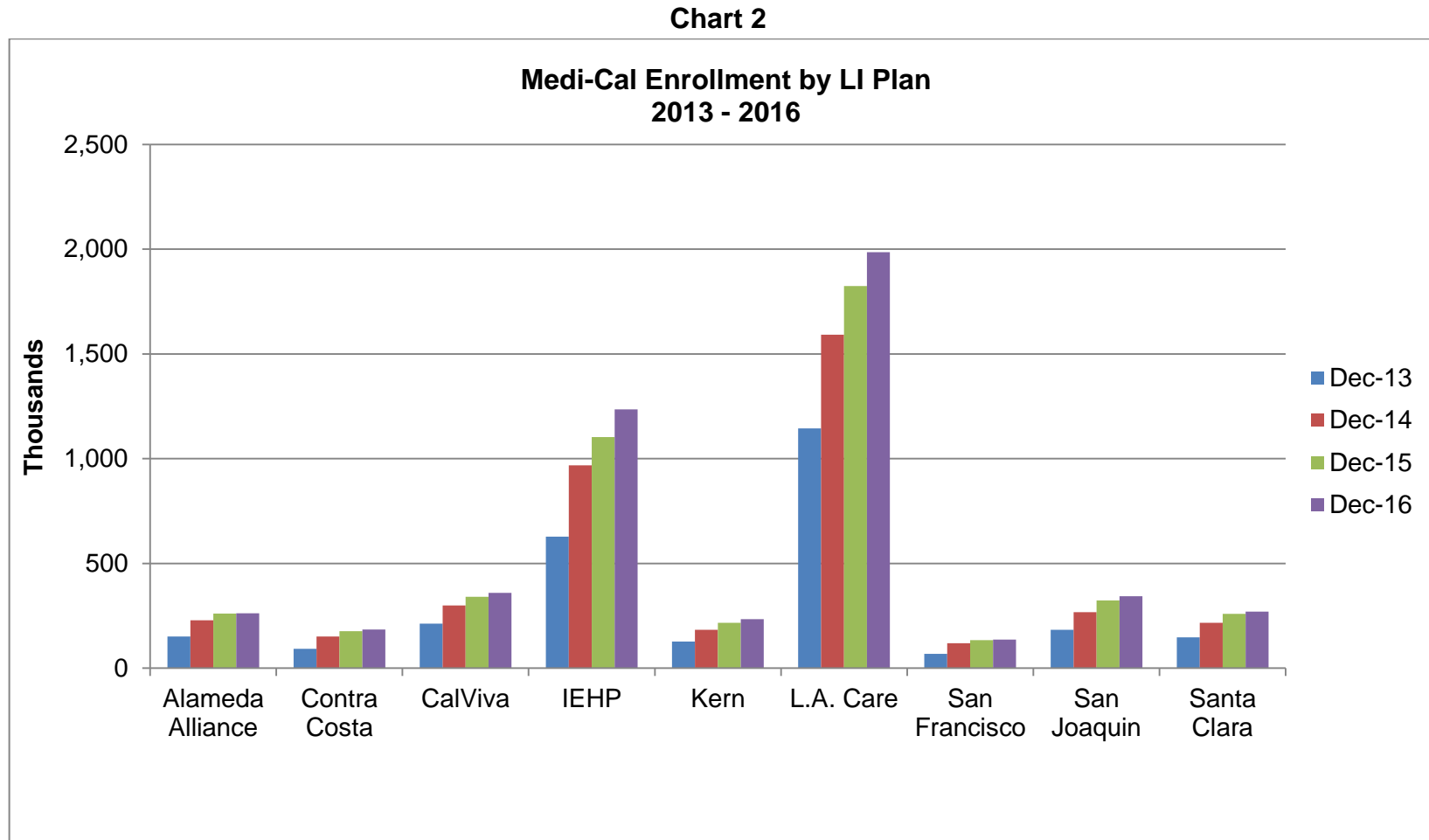
⁴ The total enrollment consists of Large Group Commercial, Medicare Risk, Medicare Supplement, Medi-Cal Risk, ASO, IHSS, and contracted from other plans.

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



Medi-Cal enrollment in LIs continues to increase. Two Southern California LI plans, L.A. Care and IEHP, reported the highest number of enrollees and make up the majority of the enrollment increase. L.A. Care and IEHP reported Medi-Cal enrollment of 2 million and 1.25 million, respectively.

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



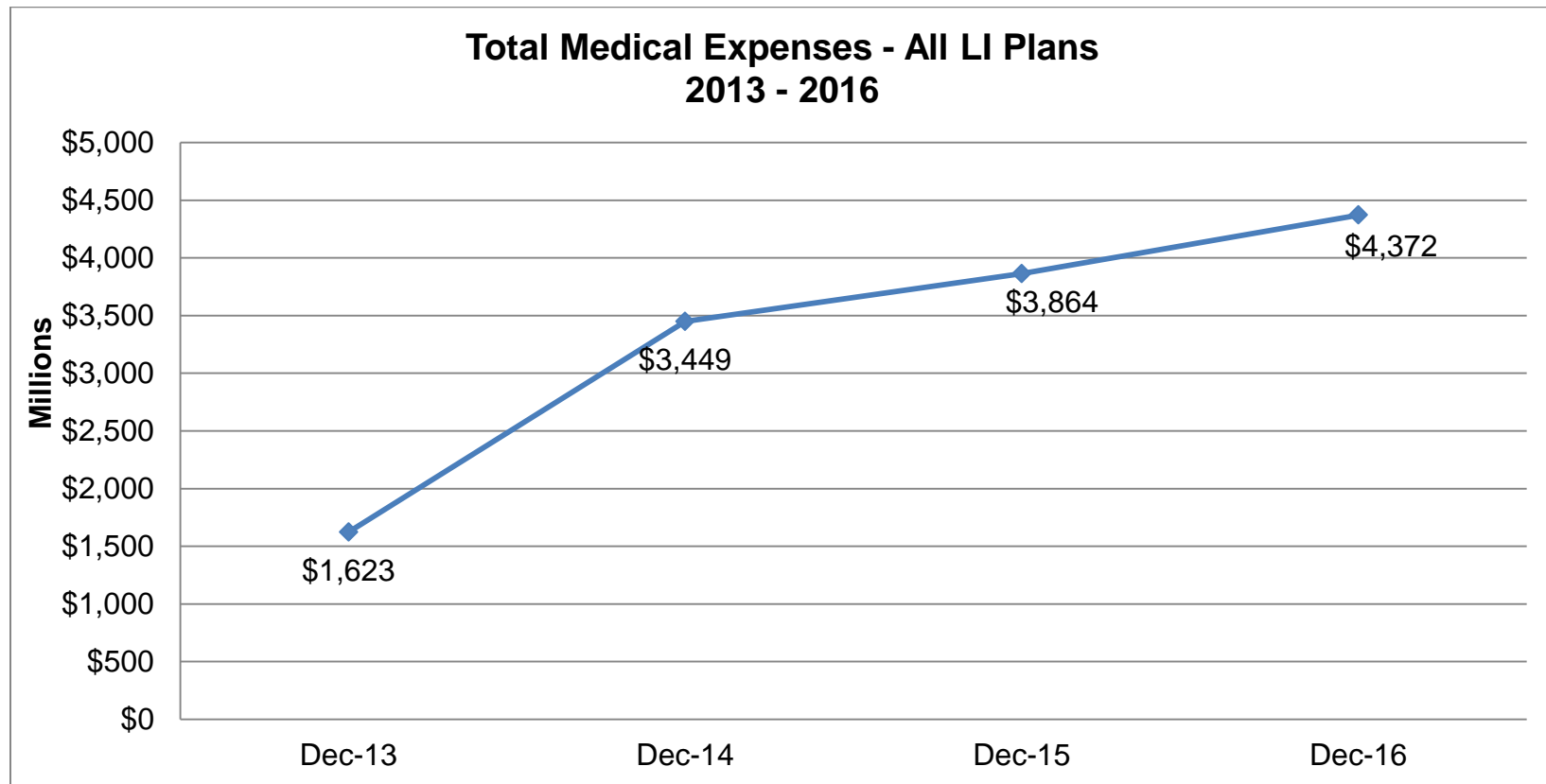
All nine LIs have experienced increases in enrollment. The majority of the increases were from their Medi-Cal lines of business. From December 2015 to December 2016, IEHP and L.A. Care experienced 12% and 9% increases in enrollment, respectively. Total Medi-Cal enrollment for LI plans increased by 82% from 2013 to 2016.

C. Financial Trends - LI

Medical Expenses

Chart 3 illustrates total medical expenses for the LIs compared to the same quarter over the last four years. Total medical expenses continued to increase in the quarter ending December 2016. The change in medical expenses is correlated to the increase in the LIs' enrollment and expanded Medi-Cal benefits. Generally, total medical expenses change as enrollment, enrollee mix (healthy or unhealthy, high or low utilizers) and Medi-Cal benefits change.

Chart 3



Per Member Per Month Medical Expense and Premium Revenue – LI

Table 2 shows the PMPM medical expense and premium revenue of the LIs for the quarter ending in December for the past four years, as well as the difference in PMPM medical expense and premium revenue for December 2016. L.A. Care and San Francisco reported the highest PMPM medical expense and premium revenue. All LIs had higher PMPM premium revenue than medical expenses for December 2016.

**Table 2
Per Member Per Month Medical Expenses and Premium Revenue – LI
2013 – 2016**

Local Initiative	Dec-13		Dec-14		Dec-15		Dec-16 ⁵		
	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	Net ⁶ Revenue
Alameda Alliance	\$239	\$226	\$308	\$335	\$236	\$263	\$229	\$279	\$50
Contra Costa	134	132	285	307	293	306	280	283	\$3
CalViva	163	182	283	295	252	265	266	277	\$11
IEHP	163	172	275	301	270	304	269	301	\$32
Kern	212	172	209	226	207	238	199	229	\$30
L.A. Care	188	196	285	306	277	292	300	316	\$16
San Francisco	231	265	316	349	291	329	296	318	\$22
San Joaquin	171	175	241	267	222	240	201	239	\$38
Santa Clara	155	186	249	268	277	294	280	301	\$21

⁵ December 2015 and December 2016 PMPM Medical Expense and Premium Revenue information excludes pass through income and expense items.

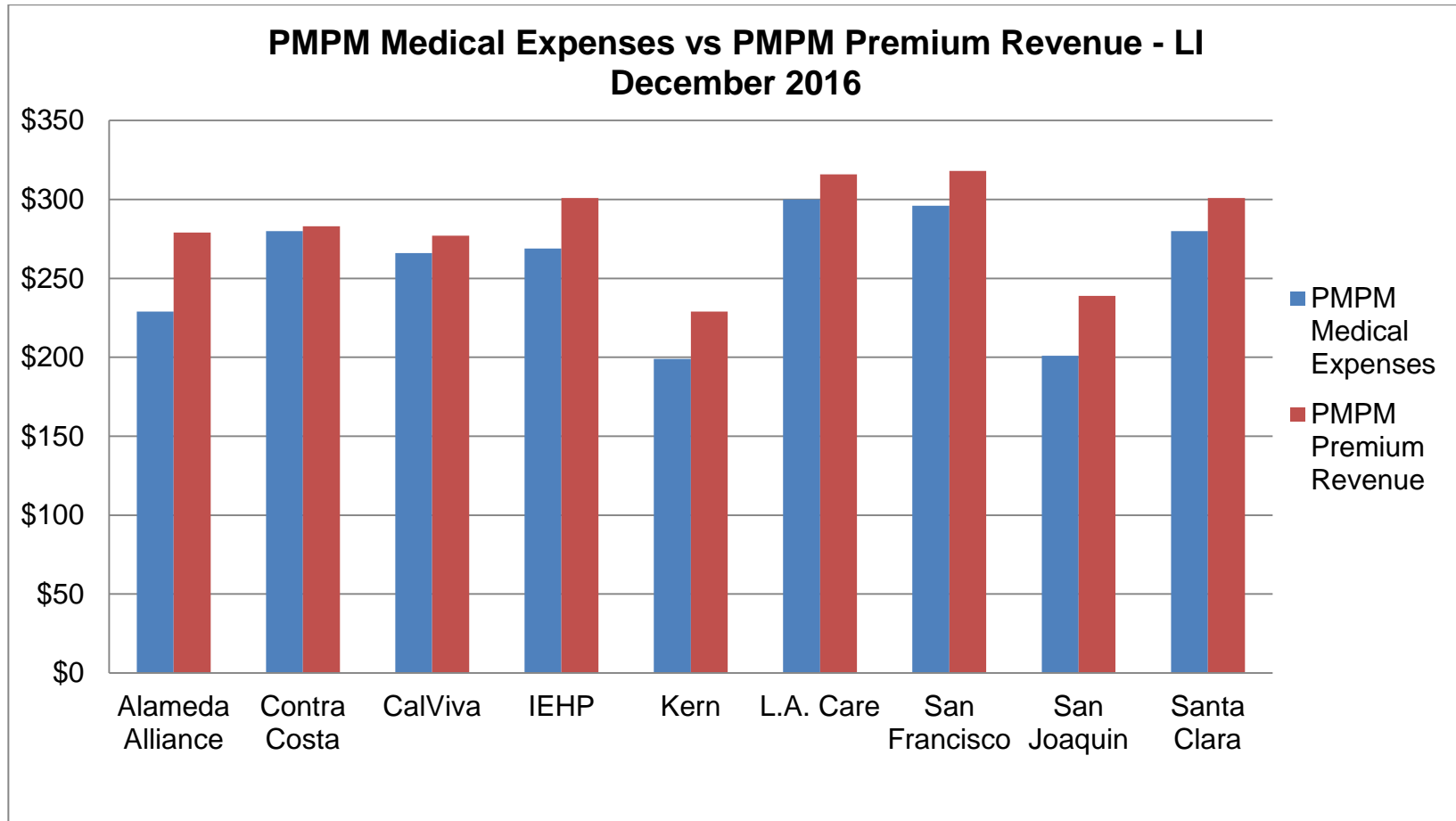
⁶ Difference between December 2016 PMPM Medical Expense and PMPM Premium Revenue.

PMPM medical expense is calculated by dividing the total medical expenses by cumulative member months. PMPM premium revenue is calculated by dividing the premium revenues by cumulative member months. Fluctuations in PMPM medical expense and premium revenue can be due to a number of factors including utilization of medical services by enrollees, and premium rate adjustments.

PMPM Medical Expense vs. PMPM Premium Revenue - LI

Chart 4 illustrates the LI plans' PMPM medical expense vs PMPM premium revenue for December 2016. The PMPM premium revenue received exceeded the PMPM medical expense for each LI.

Chart 4



Net Income - LI

Table 3 shows the Net Income for LI plans over the past six quarters. For the quarter ending (QE) December 2016, all except one LI plan reported positive net income. Net income or loss is directly related to premium revenue and medical expenses.

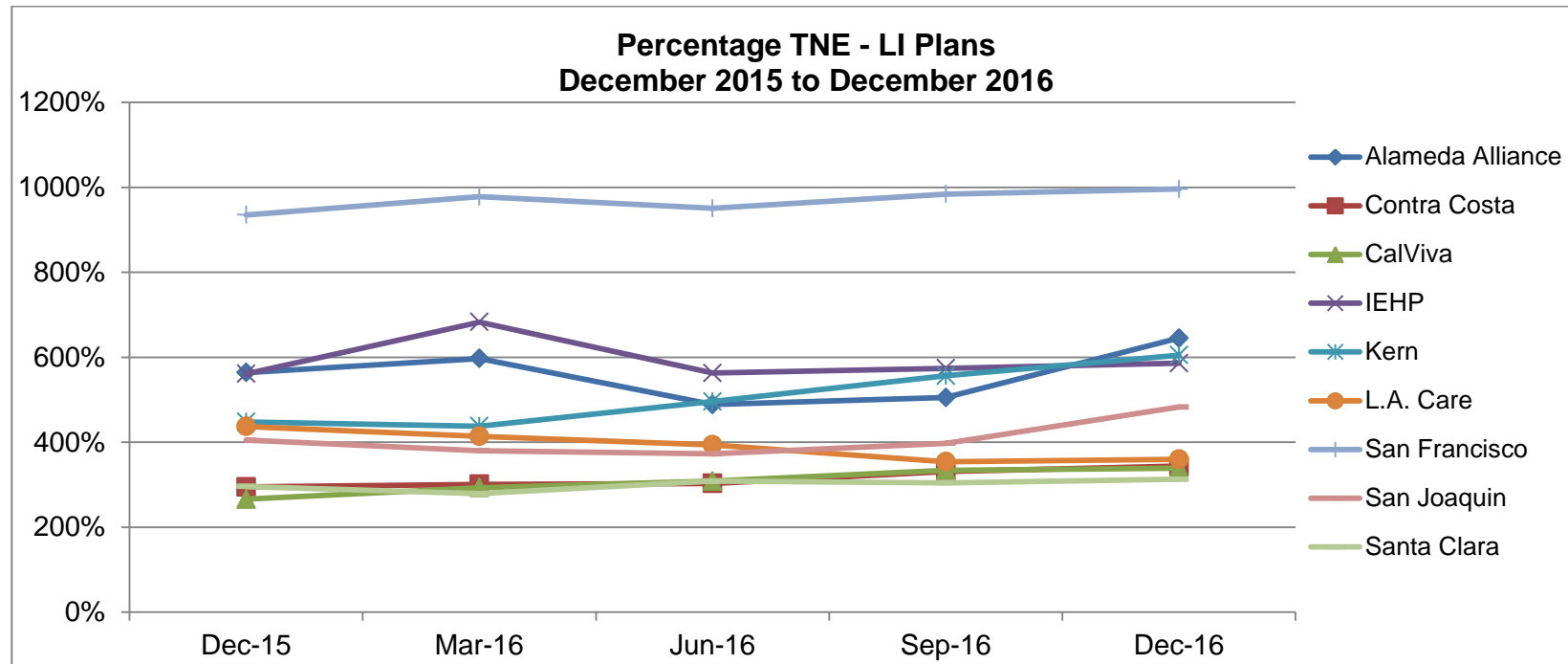
Table 3
LI Net Income by Quarter (in thousands)

Local Initiative	QE Sep-15	QE Dec-15	QE Mar-16	QE Jun-16	QE Sep-16	QE Dec-16
Alameda Alliance	\$20,582	\$7,833	\$6,152	\$13,817	\$11,198	\$27,886
Contra Costa	4,526	4,528	2,166	572	4,290	35
CalViva	3,058	2,942	2,443	3,086	3,320	3,332
IEHP	63,093	77,857	47,696	39,555	46,711	43,844
Kern	10,300	12,882	6,297	18,076	19,447	15,367
L.A. Care	128,078	12,532	21,180	36,535	(39,375)	21,262
San Francisco	10,345	8,661	4,833	6,085	1,165	(185)
San Joaquin	2,346	8,911	(2,911)	18,326	11,307	30,508
Santa Clara	3,319	4,428	3,259	16,656	3,655	7,205
Total LI Net Income	\$245,647	\$140,574	\$91,115	\$152,708	\$61,718	\$149,254

Tangible Net Equity - LI

TNE is a reserve requirement described in section 1300.76 of the Knox-Keene regulations⁷ 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., goodwill⁸, 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 subordinated⁹ may be added to the TNE calculation, which serves to increase the plan’s TNE. All the LIs had TNE that exceeded the regulatory requirements.

Chart 5



⁷ “Knox-Keene regulations” refer to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, as amended, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

⁸ Goodwill is an intangible asset that arises as a result of the acquisition of one company by another for a premium value.

⁹ Subordinated debt 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 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 health plan's TNE falls below 130%, the health plan must file monthly financial statements with the Department. If a health plan reports a TNE deficiency (TNE below 100%), the Department may take enforcement action against the plan.

The average TNE for the LIs overall was stable in 2015 and the trend continued in 2016. For December 2016, the reported TNE ranged from 313% to 996% 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.

Three of the nine LI plans reported negative cash flow from operations in December 2016. The cash flow from operations totaled negative \$14 million in December 2016 compared to \$502 million in December 2015. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and the MCE rate adjustments for the 2016/2017 fiscal year which occurred in July 2016.

Claims

Pursuant to the Knox-Keene Act, full service health plans are required to process 95% of their claims within 45 working days. Health plans are required to submit to the Department, on a quarterly basis, a claims settlement practice report if the Plan fails to process 95% of its claims timely and/or the plan identifies any emerging patterns of claims payment deficiencies. For the quarter ending December 31, 2016, Contra Costa failed to process 95% of their claims within 45 working days. Santa Clara reported emerging claims payment deficiencies. Each Plan submitted a corrective action plan outlining measures they are taking to comply with the regulations.

IV. County Organized Health Systems (COHS)

A. Highlights

- Six COHS plans currently serve 22 counties. The COHS plans and the counties in which they provide services are:
 - Orange County Health Authority (CalOptima) – Orange
 - Partnership HealthPlan of California (Partnership HealthPlan) – Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo
 - Santa Barbara San Luis Obispo Regional Health Authority (CenCal Health) – Santa Barbara and San Luis Obispo
 - Santa Cruz-Monterey-Merced Managed Medical Care Commission (Central California Alliance for Health) – Merced, Monterey, and Santa Cruz
 - San Mateo Health Commission (Health Plan of San Mateo) – San Mateo
 - Gold Coast Health Plan (Gold Coast) – Ventura

- Medi-Cal beneficiaries in COHS counties have only one 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 the Health Plan of San Mateo has voluntarily included its Medi-Cal enrollment under its Knox-Keene license, however, CalOptima, CenCal Health, Central California Alliance for Health and Partnership HealthPlan have Knox-Keene licenses for other lines of business such as Healthy Kids, IHSS, AIM and Medicare Advantage. Gold Coast Health Plan has no Knox-Keene license, and has only one Medi-Cal line of business. Therefore, this report does not include information for Gold Coast.

- Enrolled beneficiaries choose their health care provider from among the COHS plan contracted providers.

- COHS plans' enrollment increased 2% from December 2015 to December 2016. Health Plan of San Mateo's PMPM Medical Expense outpaced its premium revenue for December 2016. Medical expenses at CenCal Health decreased from December 2015.
- COHS plans reported \$58,000 in net loss in December 2016 compared to \$142 million in net income in December 2015 due to significant net loss for the Health Plan of San Mateo.
- Tangible net equity for COHS plans ranged from 700% to 1,478% of required TNE. Two of the five reporting COHS plans reported higher TNE from December 2015 to December 2016.
- COHS plans reported \$571 million in cash flow from operations in December 2016 compared to \$424 million in December 2015. The variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and the MCE rate adjustments for the 2016/2017 fiscal year.

B. Enrollment Trends - COHS

COHS plans have reported consistent increases in enrollment since 2013; however, enrollment has stabilized in the 2016. CalOptima and Partnership HealthPlan reported the highest enrollment numbers. All COHS plans reported increases in total enrollment compared to December 2015, except the Health Plan of San Mateo, who had a slight decrease in total enrollment.

**Table 4
Enrollment in County Organized Health Systems
December 2015 – December 2016**

COHS	December 2016 Total Medi-Cal Enrollment	December 2016 Percentage of Medi-Cal Enrollment	December 2016 Total Enrollment	December 2015 Total Enrollment	Enrollment Change from December 2015 to December 2016	Percentage Enrollment Change from December 2015 to December 2016
CalOptima	781,733	98%	800,001	796,331	3,670	0.5%
CenCal Health	179,122	100%	179,155	172,812	6,343	3.7%
Central California Alliance for Health	351,466	99.8%	352,112	340,028	12,084	3.6%
Partnership HealthPlan	571,581	100.0%	571,581	557,869	13,712	2.5%
Health Plan of San Mateo	124,554	91%	136,248	137,841	(1,593)	-1.2%
Total	2,008,456	98%	2,039,097	2,004,881	34,216	1.7%

Chart 6 illustrates the Medi-Cal managed care enrollment trend in COHS plans. Medi-Cal enrollment in COHS plans has almost doubled over the last four years.

Chart 6

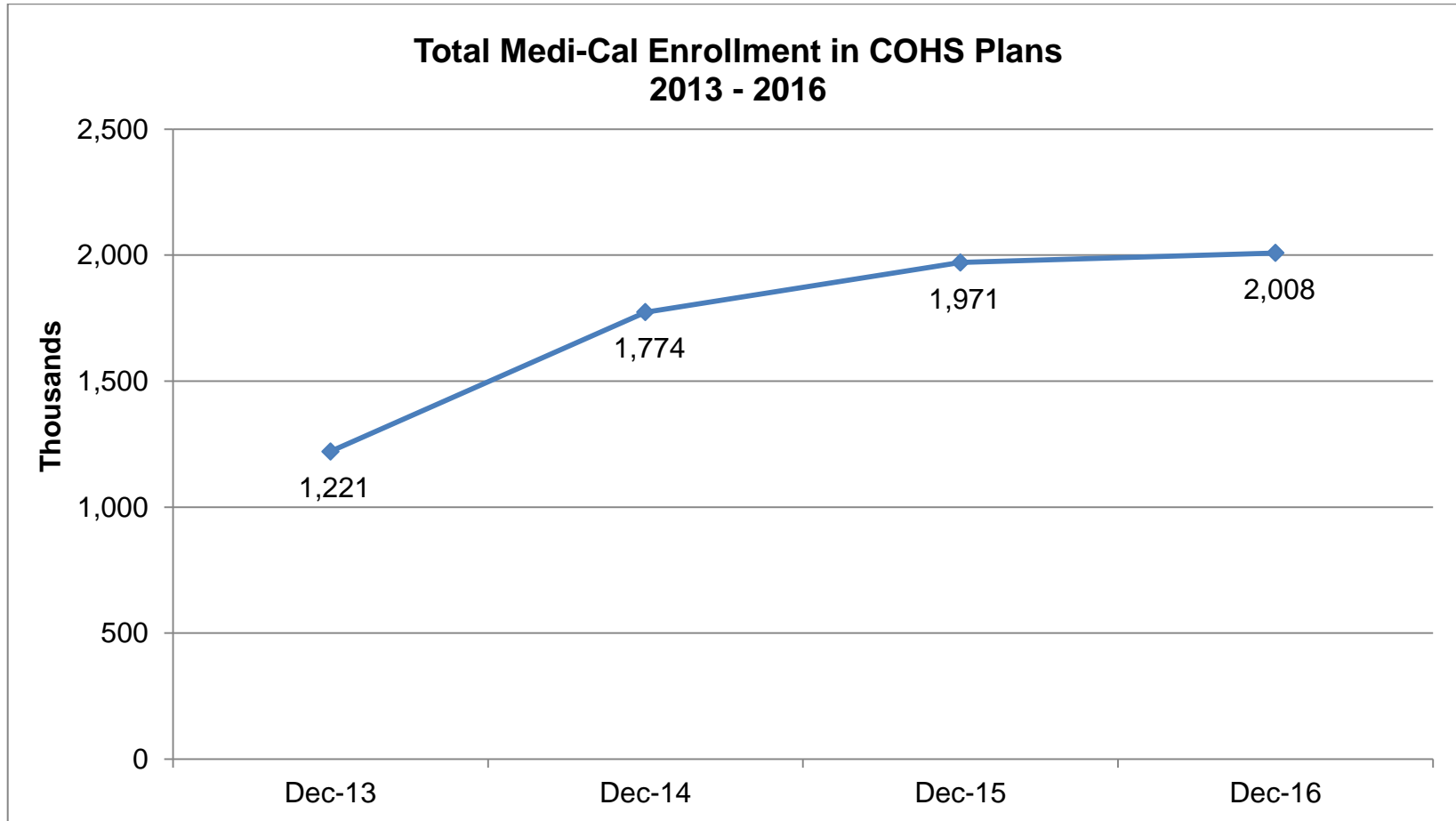
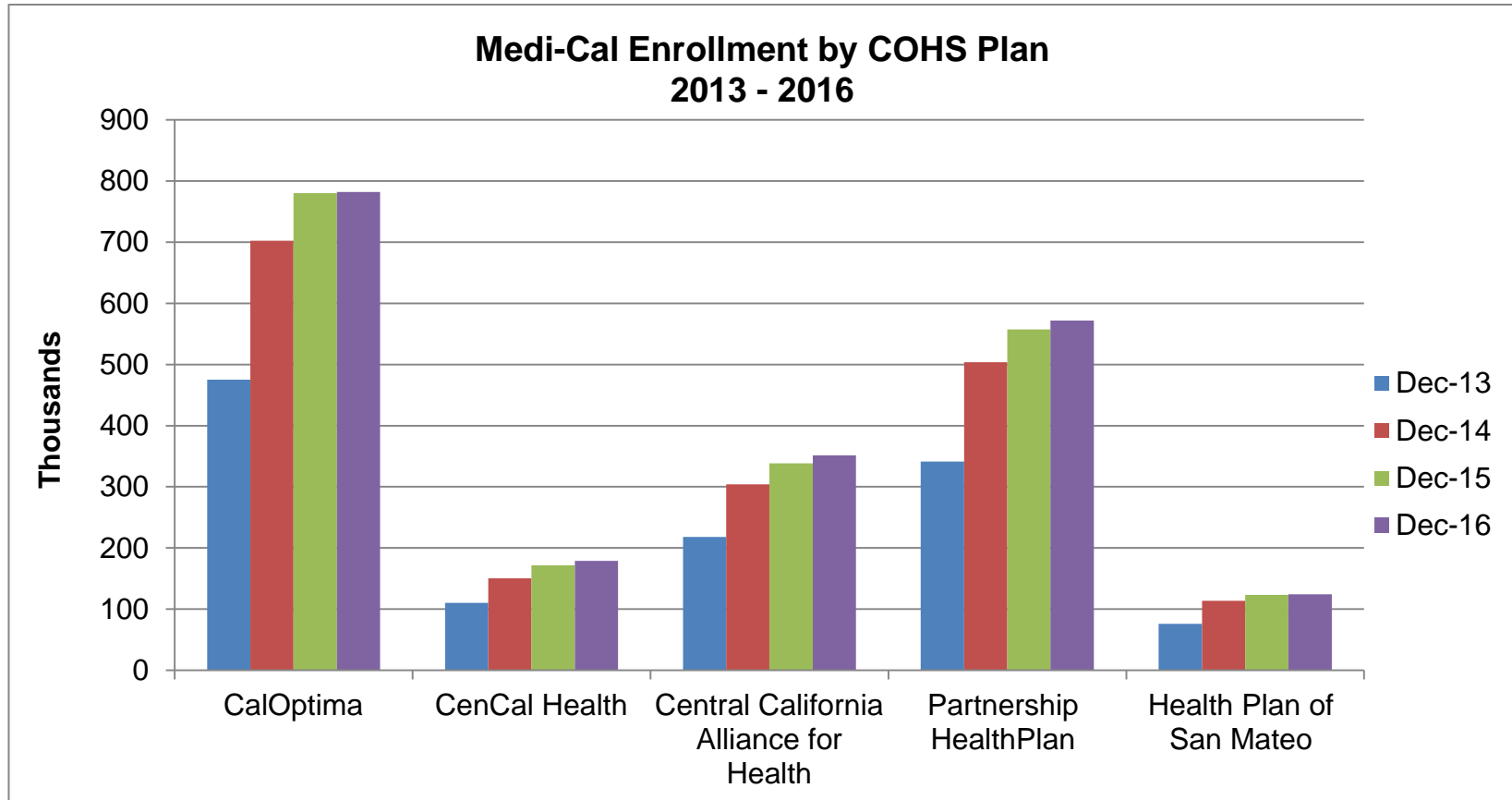


Chart 7 shows the enrollment growth for each COHS plan over the past four years.

Chart 7

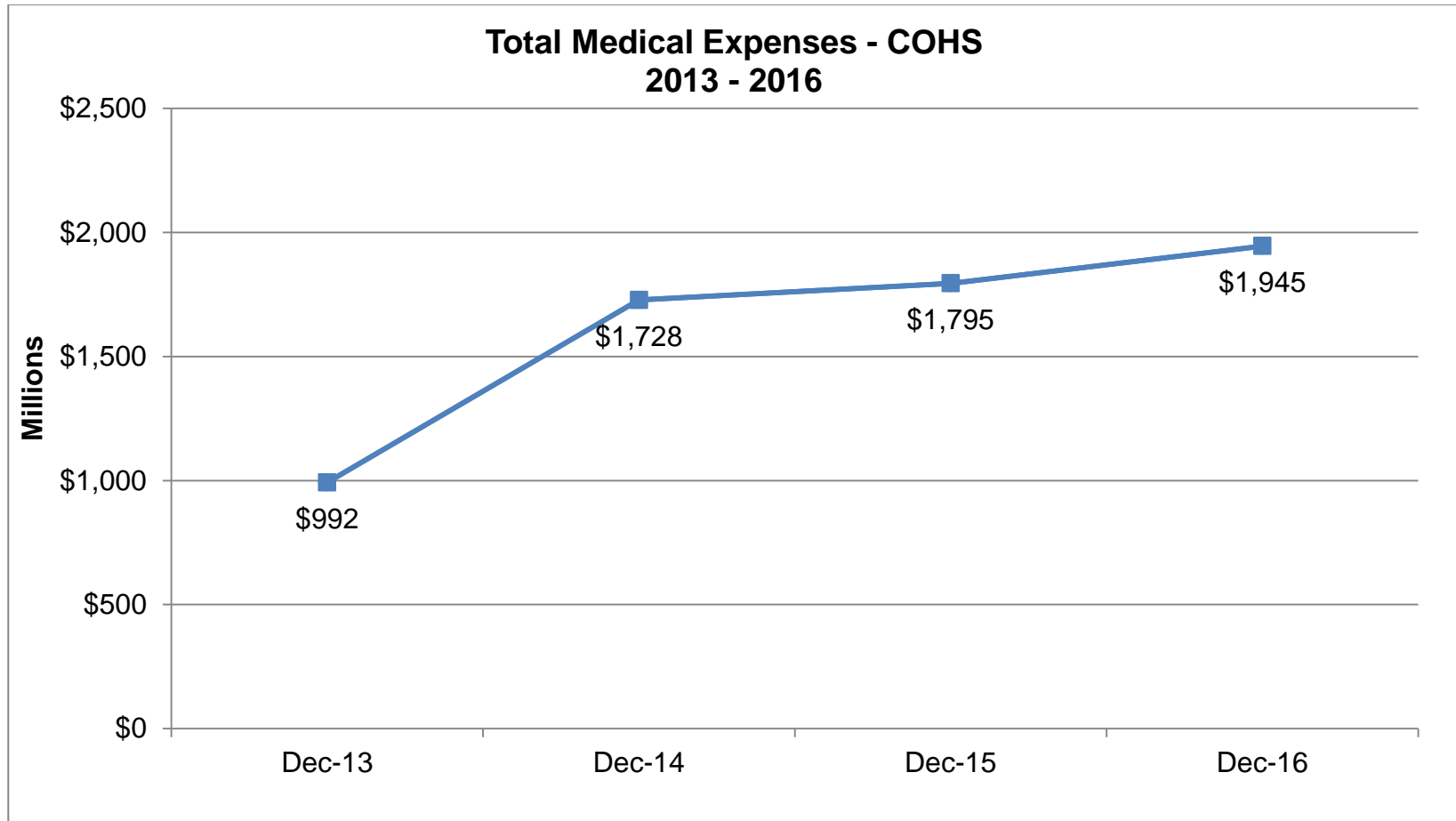


All COHS plans reported increases in their Medi-Cal enrollment from 2013 to 2016. Although Health Plan of San Mateo had a small decrease in total enrollment from December 2015, it reported a slight increase in its Medi-Cal line of business. Total Medi-Cal enrollment for COHS plans increased by 65% from 2013 to 2016.

C. Financial Trends - COHS

Similar to LI plans, Chart 8 shows a continued increase in medical expenses for COHS plans.

Chart 8



Per Member Per Month Medical Expense and Premium Revenue - COHS

Table 5 shows the PMPM medical expense and premium revenue of the COHS plans for the quarter ending in December for the past four years, as well as the difference between the PMPM medical expense and premium revenue for December 2016.

Almost all COHS plans had higher PMPM premium revenue than medical expenses at December 2016. Only the Health Plan of San Mateo reported a higher PMPM medical expense than premium revenue.

**Table 5
Per Member Per Month Medical Expense and Premium Revenue – COHS
2013-2016**

COHS	Dec-13		Dec-14		Dec-15		Dec-16 ¹⁰		
	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	Net Revenue ¹¹
CalOptima	\$240	\$266	\$367	\$402	\$310	\$322	\$341	\$352	\$11
CenCal Health	236	260	266	308	269	340	248	291	\$43
Central California Alliance for Health	202	349	205	262	227	264	232	274	\$42
Partnership HealthPlan	297	343	299	358	304	349	328	347	\$19
Health Plan of San Mateo	420	614	469	613	450	597	466	382	(\$84)

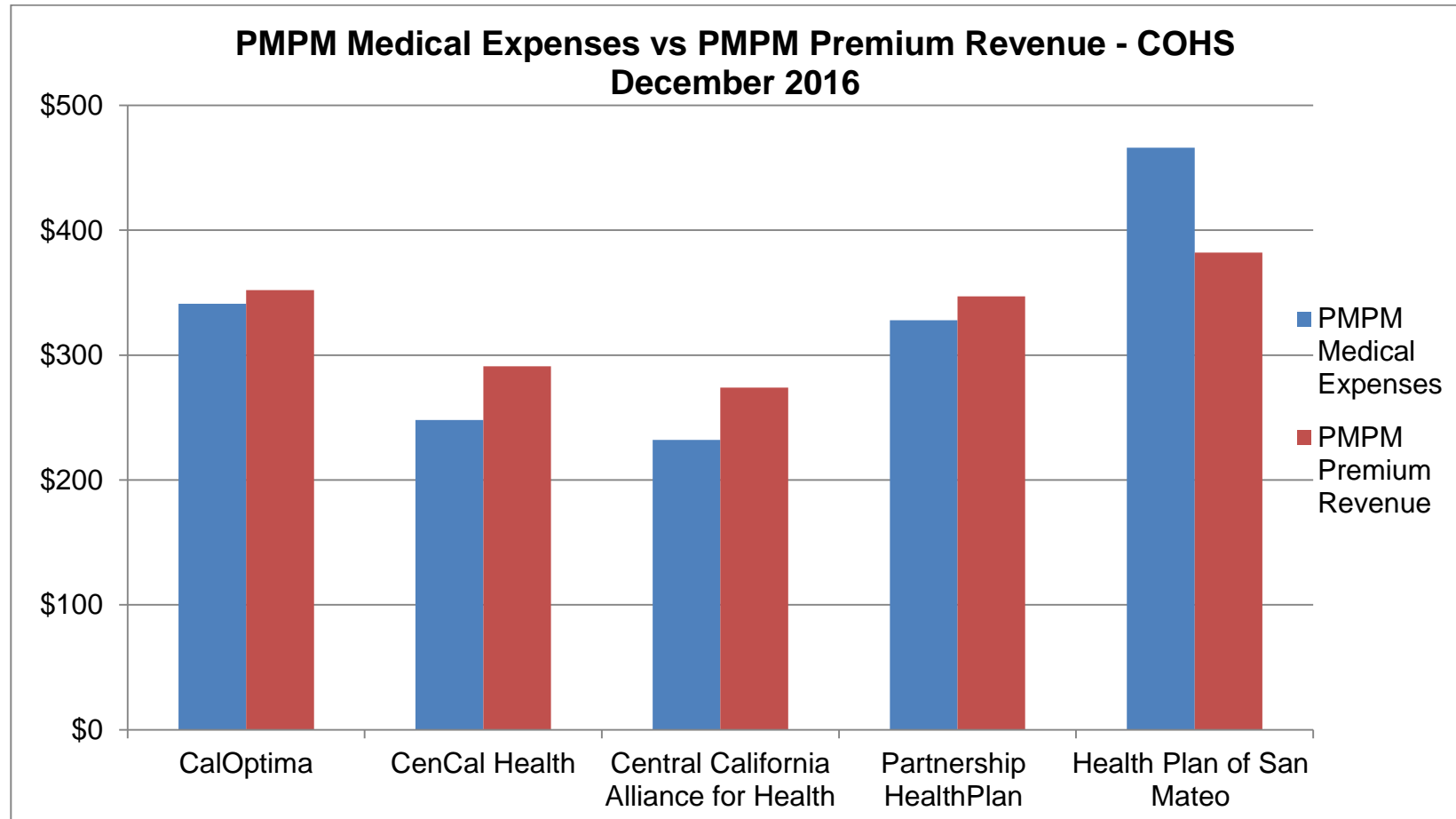
¹⁰ December 2015 and December 2016 PMPM Medical Expense and PMPM Premium Revenue information excludes pass through income and expense items.

¹¹ Difference between December 2016 PMPM Medical Expense and PMPM Premium Revenue.

PMPM Medical Expense vs PMPM Premium Revenue

Chart 9 illustrates the COHS plans' PMPM medical expense vs PMPM premium revenue for December 2016. Almost all plans reported premium revenue that was higher than per member per month expenses.

Chart 9



Net Income - COHS

Favorable PMPM premium revenue ratios translated to positive net income for almost all of the COHS plans. Only the Health Plan of San Mateo reported a negative net income.

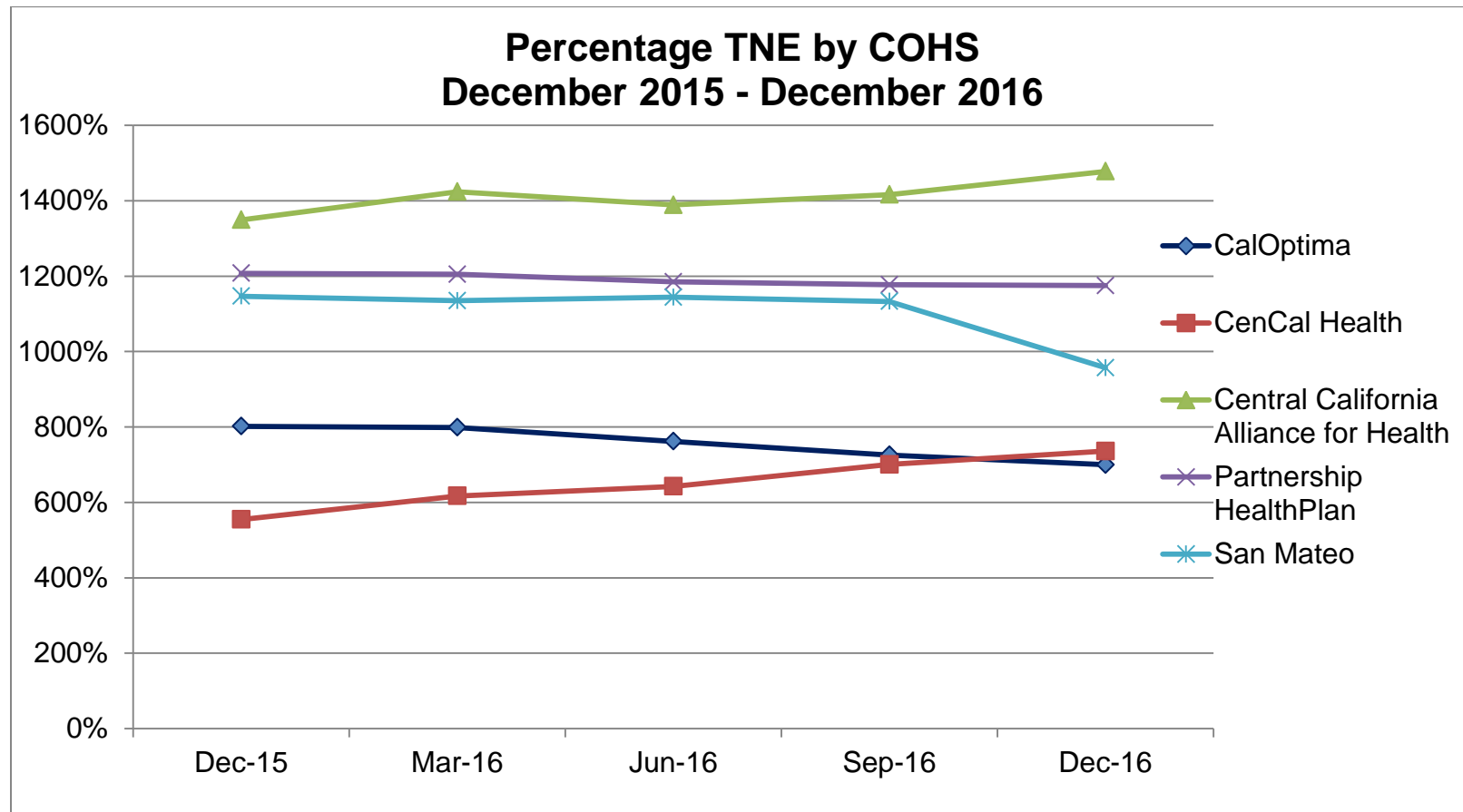
Table 6
COHS Net Income by Quarter (in thousands)

COHS	QE Sep-15	QE Dec-15	QE Mar-16	QE Jun-16	QE Sep-16	QE Dec-16
CalOptima	\$9,338	\$(1,228)	\$15,025	\$9,389	\$2,564	\$501
CenCal Health	8,664	24,117	19,769	8,672	15,802	15,878
Central California Alliance for Health	24,434	23,696	34,169	12,060	10,986	23,381
Partnership HealthPlan	52,384	50,926	34,908	28,817	18,771	6,132
Health Plan of San Mateo	28,861	44,758	11,976	14,013	(376)	(45,950)
Total COHS Net Income	\$123,681	\$142,269	\$115,847	\$72,951	\$47,749	\$(58)

Tangible Net Equity – COHS

All COHS plans reported 700% or more of required TNE for December 2016. TNE to Required TNE ranged from 700% to 1,478%. The Health Plan of San Mateo reported a decrease in TNE from 1133% to 957% from September 2016 to December 2016.

Chart 10



Cash Flow from Operations

COHS plans reported \$571 million in cash flow from operations in December 2016. Similar to the LIs, COHS plans' variation in cash flow from operations is attributed to the timing of Medi-Cal premium revenue paid by DHCS and the MCE rate adjustments for the 2016/2017 fiscal year.

Claims

Pursuant to the Knox-Keene Act, full service health plans are required to process 95% of their claims within 45 working days. COHS plans did not report any claims processing or emerging claims payment deficiencies for December 2016.

V. Non-Governmental Medi-Cal Plans

A. Highlights

- For the purposes of this report, Non-Governmental Medi-Cal (NGM) plans include plans with greater than 50% Medi-Cal enrollment.
- Five NGM plans currently serve approximately 31 counties. The NGM plans and the counties in which they provide services are:
 - California Health and Wellness Plan - Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba.
 - Care 1st Health Plan - Los Angeles and San Diego.
 - Community Health Group - San Diego.
 - Health Net Community Solutions, Inc. (HNCS) - Fresno, Kern, Kings, Los Angeles, Madera, Sacramento, San Diego, San Joaquin, Stanislaus, and Tulare counties. In Kern, Los Angeles, San Joaquin, Stanislaus and Tulare counties, HNCS participates in the two-plan model and competes with the LI plans for enrollment. In Sacramento and San Diego counties, HNCS participates in the GMC model and contracts directly with DHCS.
 - Molina Healthcare of California (Molina Healthcare) - Imperial, Los Angeles, Sacramento, Riverside, San Bernardino, and San Diego. In Sacramento and San Diego counties, Molina Healthcare participates in the GMC model and contracts directly with DHCS.
- The structure among the NGM plans varies in the following ways:
 - California Health and Wellness Plan is a for-profit wholly owned subsidiary of Centene Corporation (Centene), a publicly traded company.
 - Care 1st Health Plan was acquired by California Physicians' Services (Blue Shield) in October 2015 and was converted from a for-profit plan to a not-for-profit plan.

- Community Health Group participates in the GMC model and contracts directly with DHCS. Community Health Group is a not-for-profit health plan.
 - Health Net Community Solutions, Inc. is a for-profit wholly owned subsidiary of Health Net, Inc., which was recently acquired by Centene.
 - Molina Healthcare of California is a for-profit wholly owned subsidiary of Molina Healthcare, Inc., a publicly traded company.
- NGM plans provide and administer health care services to Medi-Cal beneficiaries either as a direct contractor to DHCS, or as subcontractors to other health plans that contract with the DHCS. For example, L.A. Care subcontracts its Medi-Cal enrollment to Care 1st and Molina Healthcare in Los Angeles County.
 - There also are two commercial plans that serve another 1.9 million Medi-Cal enrollees (Blue Cross of California (Blue Cross) – 1,267,094 enrollees and Kaiser Foundation Health Plan (Kaiser) – 647,873 enrollees). Enrollment information for these two plans was included in this report. However, financial solvency indicators are not included since both of these plans report over 50% of other types of enrollment (Commercial, Medicare) and their financial solvency is significantly impacted by these other lines of business. Both Anthem and Kaiser are in solid financial health.
 - NGM plans' enrollment increased 5% from December 2015 to December 2016. Similar to LI and COHS plans, per member per month expenses and premium revenue rose for NGM plans in conjunction with increased enrollment and expanded Medi-Cal benefits. NGM plans' PMPM premium revenue outpaced expenses for December 2016.
 - NGM plans reported \$429 million in net income in December 2016, a significant increase compared to net income of \$295 million reported in December 2015 and \$270 million in September 2016.
 - Tangible net equity for NGM plans ranged from 250% to 1010% of required TNE at December 2016. Four of the five reporting NGM plans reported progressively higher TNE from December 2015 to December 2016.
 - NGM plans reported \$930 million in cash flow from operations in December 2016 compared to \$332 million at December 2015 and \$721 million in September 2016.

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

Like LI and COHS plans, NGM plans have reported consistent increases in enrollment since 2013. Health Net Community Solutions, Inc. and Molina Healthcare reported the highest enrollment numbers. In addition to the NGM plans, two other commercial plans serve 1.9 million Medi-Cal enrollees - Blue Cross of California and Kaiser Foundation Health Plan.

Table 7
Enrollment in Non-Governmental Medi-Cal Plans
December 2015 – December 2016

Non-Governmental Medi-Cal Plans	December 2016 Total Medi-Cal Enrollment	December 2016 Percentage of Medi-Cal Enrollment	December 2016 Total Enrollment	December 2015 Total Enrollment	Enrollment Change from December 2015 to December 2016	Percentage Enrollment Change from December 2015 to December 2016
California Health and Wellness Plan	188,366	100%	188,366	185,272	3,094	2%
Care 1 st Health Plan	409,344	85%	478,897	437,010	41,887	10%
Community Health Group	291,313	100%	291,313	271,232	20,081	7%
Health Net Community Solutions	1,859,525	99%	1,873,457	1,848,395	25,062	1%
Molina Healthcare	617,472	90%	684,342	617,659	66,683	11%
Total Medi-Cal Enrollment in NGMs	3,366,020	96%	3,516,375	3,359,568	156,807	5%
Blue Cross	1,267,094	31%	4,066,964	3,890,326	176,638	5%
Kaiser	647,873	8%	8,113,192	7,818,952	294,240	4%
Grand Total	5,280,987	34%	15,696,531	15,068,846	627,685	4%

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

Chart 11

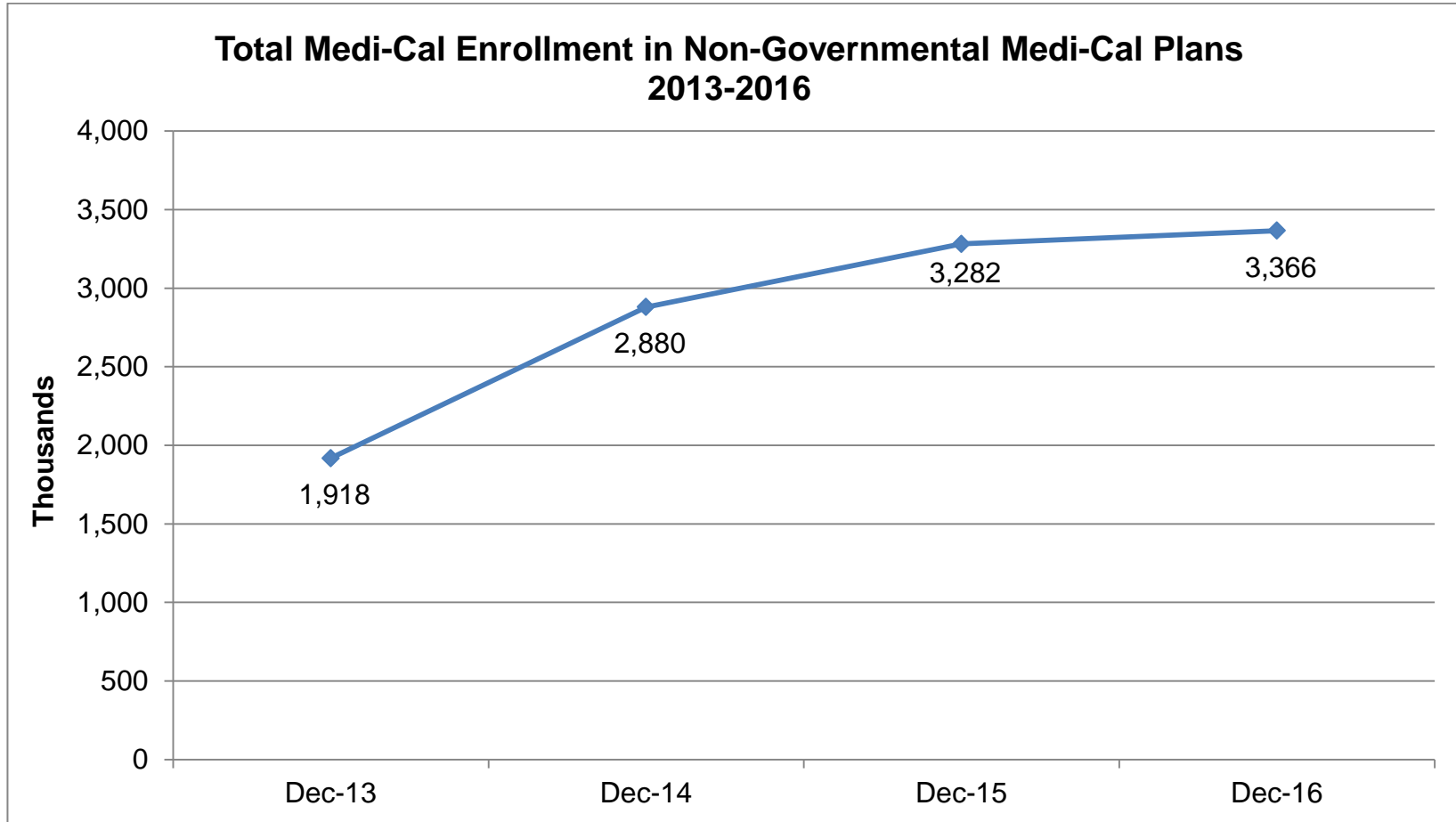
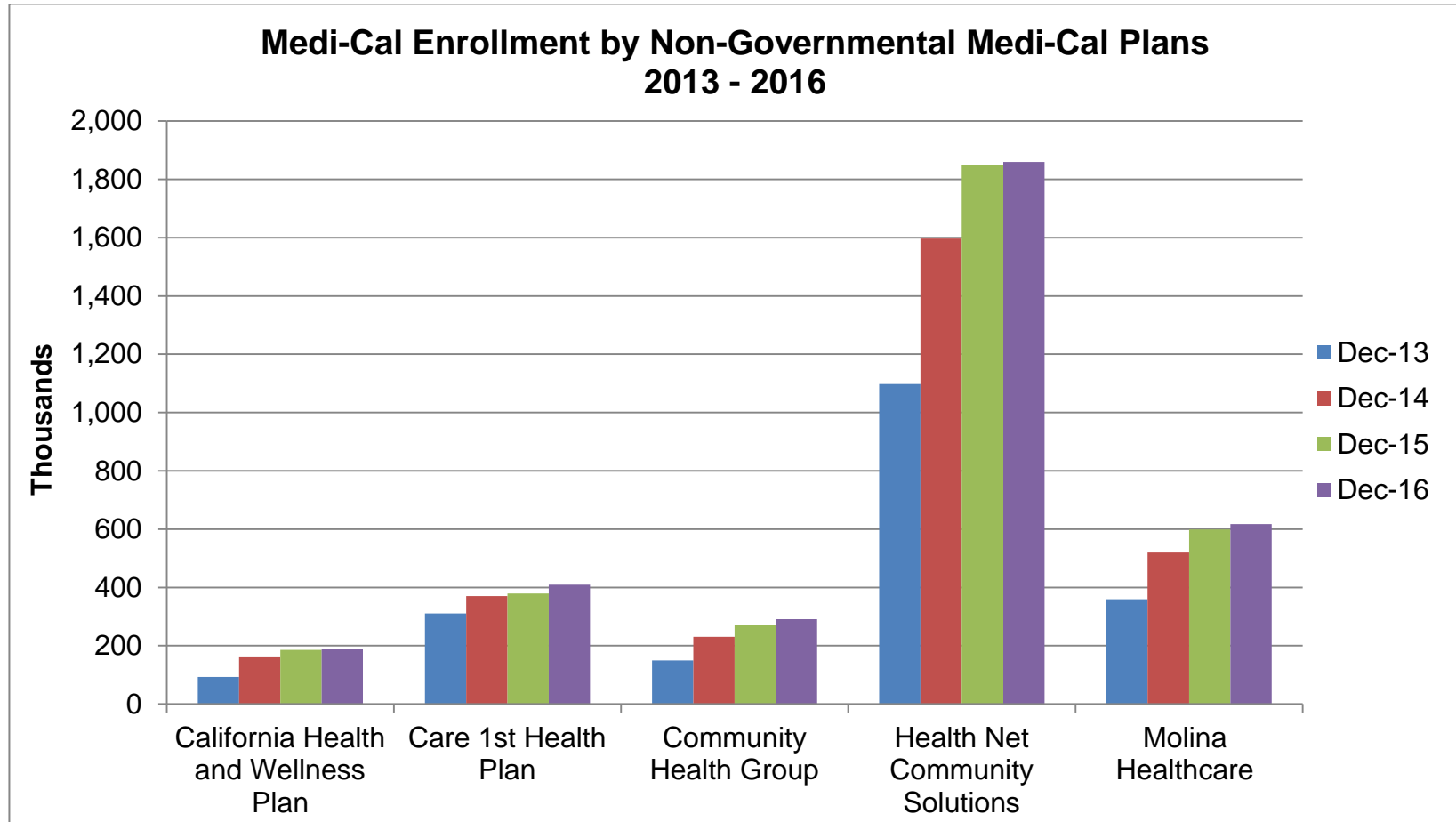


Chart 12 shows the enrollment growth for each NGM plan over the past four years.

Chart 12

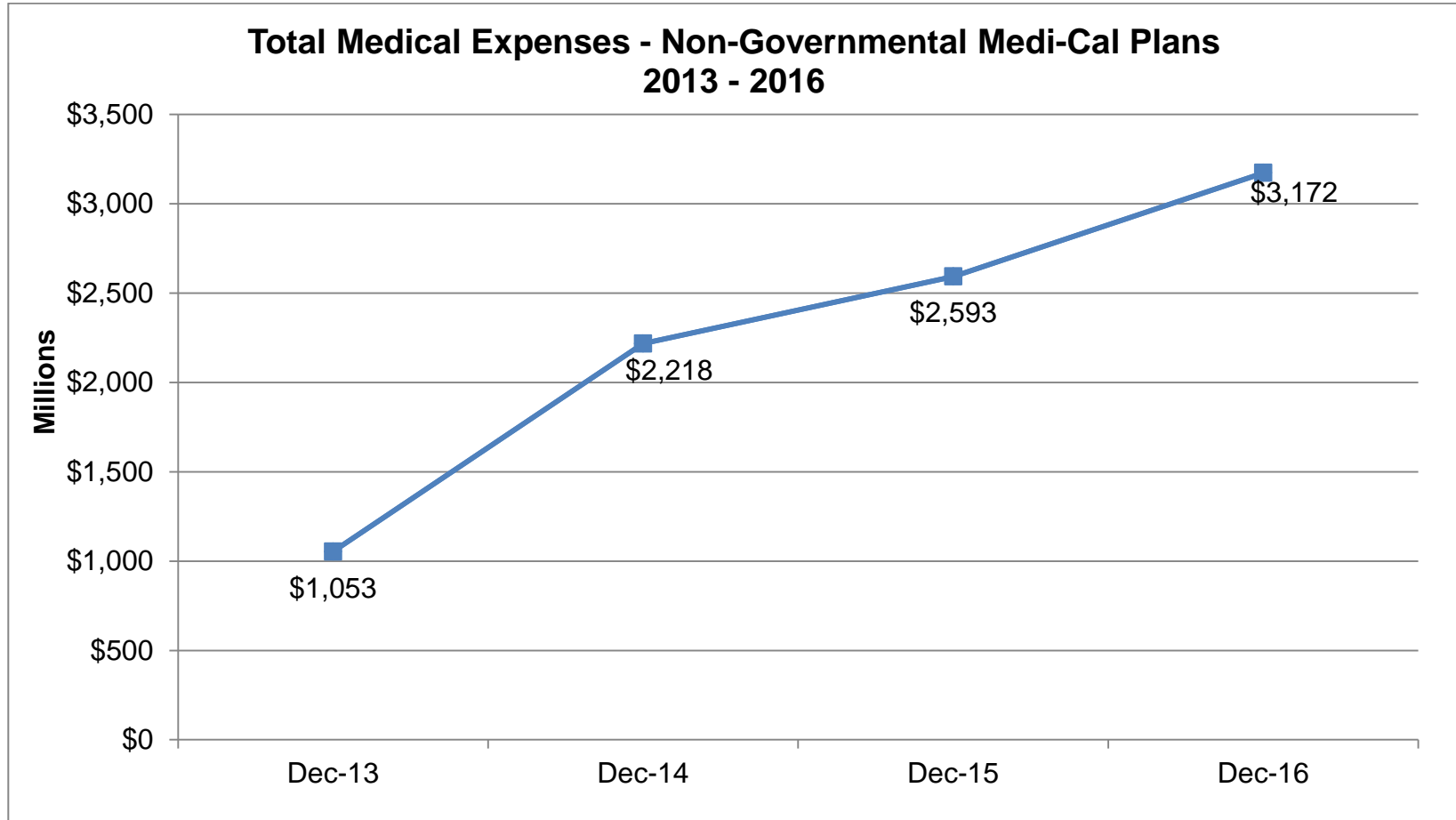


All NGM plans reported increases in their Medi-Cal enrollment from December 2015 to December 2016. Total Medi-Cal enrollment for NGM plans increased by 67% from 2013 to 2016.

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

Similar to LI and COHS plans, Chart 13 shows an increase in medical expenses for NGM plans. This chart does not include the medical expenses reported by Blue Cross and Kaiser.

Chart 13



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

Table 8 shows the PMPM medical expense and premium revenue of the NGM plans for the quarter ending in December for the past four years, as well as the difference in the PMPM medical expense and premium revenue for quarter ending December 2016. All NGM plans had higher PMPM premium revenue than medical expenses at December 2016. Care 1st Health Plan reported the highest PMPM medical expense and premium revenue.

**Table 8
Per Member Per Month Medical Expenses and Premium Revenue – Non-Governmental Medi-Cal Plans
2013-2016**

Non-Governmental Medi-Cal Plans	Dec-13		Dec-14		Dec-15		Dec-16 ¹²		
	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	PMPM Medical Expense	PMPM Premium Revenue	Net ¹³ Revenue
California Health and Wellness Plan	\$149	\$147	\$179	\$238	\$217	\$267	217	284	\$67
Care 1st Health Plan ¹⁴	223	252	283	334	337	367	380	438	\$58
Community Health Group	191	198	298	337	283	360	272	337	\$65
Health Net Community Solutions	146	149	232	219	221	295	289	385	\$96
Molina Healthcare	158	183	243	302	266	319	265	287	\$22

¹² December 2016 PMPM Medical Expense and PMPM Premium Revenue information excludes pass through income and expense items.

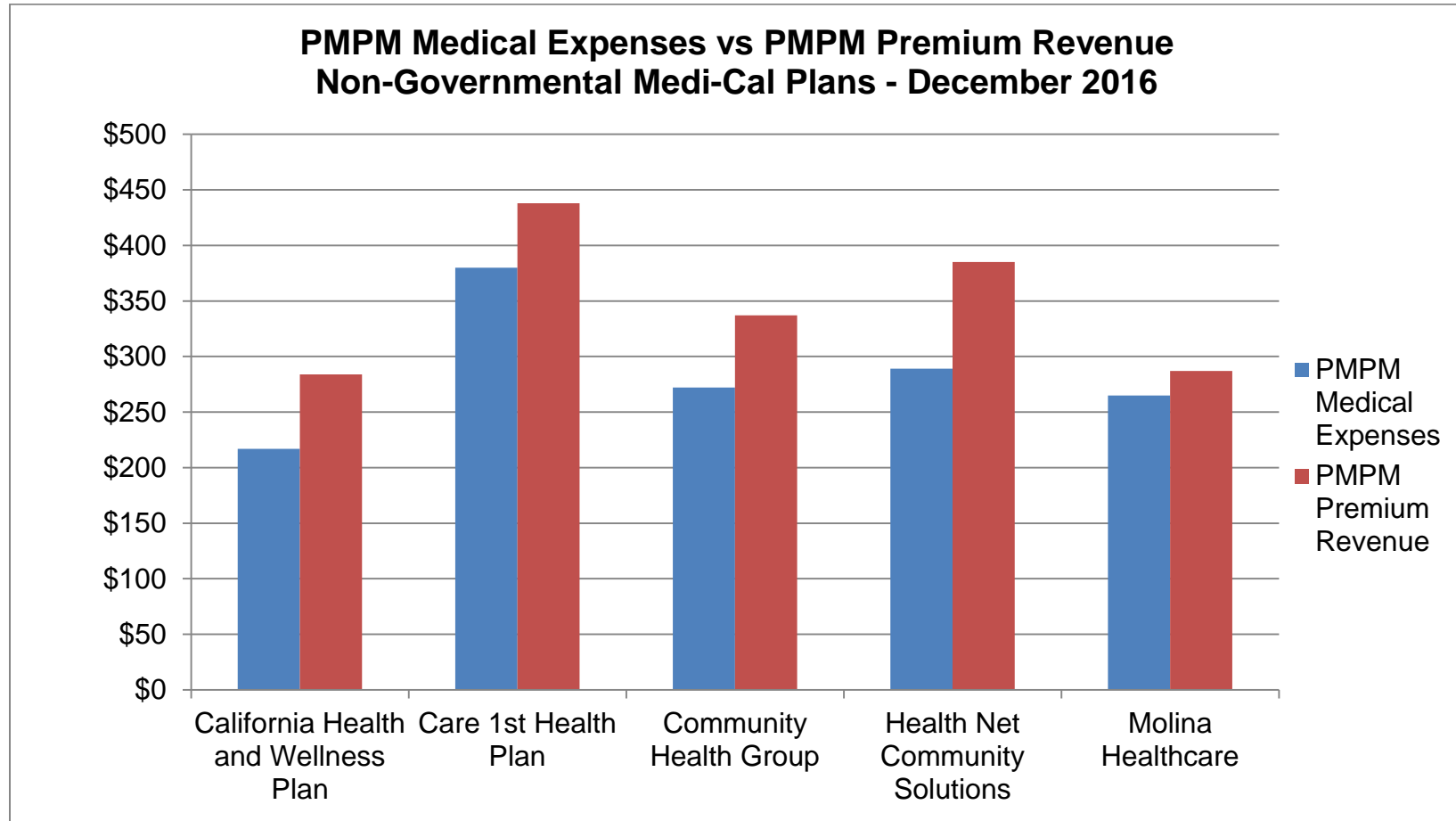
¹³ Difference between December 2016 PMPM Medical Expense and PMPM Premium Revenue.

¹⁴ PMPM information for Care 1st includes commercial and other lines of business for 2013-2016.

PMPM Medical Expense vs PMPM Premium Revenue

Chart 9 illustrates the NGM plans' PMPM medical expense vs PMPM premium revenue for December 2016. All plans reported premium revenue that was higher than per member per month expenses.

Chart 14



Net Income - Non-Governmental Medi-Cal Plans

Favorable PMPM premium revenue ratios translated to positive net income for almost all NGM plans from September 2016 to December 2016. Only Molina Healthcare reported negative net income at December 2016.

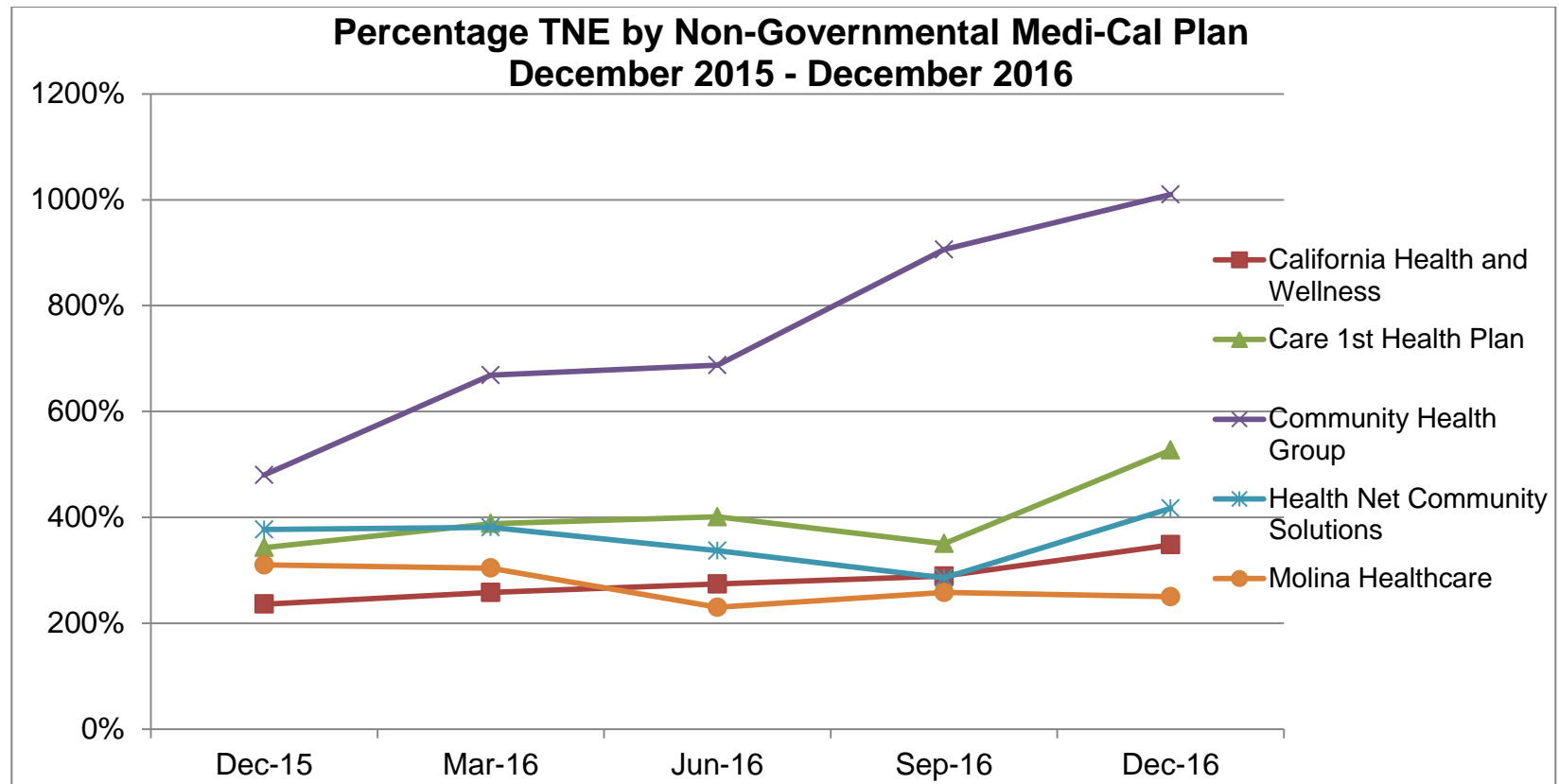
Table 9
Non-Governmental Medi-Cal Plans Net Income by Quarter (in thousands)

Non-Governmental Medi-Cal Plans	QE Sep-15	QE Dec-15	QE Mar-16	QE Jun-16	QE Sep-16	QE Dec-16
California Health and Wellness Plan	\$507	\$6,973	\$3,940	\$3,946	\$4,285	\$15,196
Care 1st Health Plan	15,960	7,201	22,111	19,089	28,400	93,986
Community Health Group	9,296	77,057	78,864	21,851	81,095	47,781
Health Net Community Solutions	149,653	177,541	77,507	67,593	124,738	272,079
Molina Healthcare	24,991	26,879	10,675	5,999	22,329	(300)
Total Net Income	\$200,407	\$295,651	\$193,097	\$118,478	\$260,847	\$428,742

Tangible Net Equity – Non-Governmental Medi-Cal Plans

NGM plans' TNE to Required TNE ranged from 250% to 1010%. TNE reported by most NGM plans is lower than the LI and COHS plans. Many NGM plans pay dividends to parent companies or shareholders thereby reducing the reserve levels. Community Health Group, a not-for-profit, reported TNE comparable to LIs and COHS.

Chart 15



Cash Flow from Operations

NGM plans reported \$930 million in cash flow from operations in December 2016, an increase of 29% from September 2016. NGM plans' cash inflow from operations is primarily attributed to the Medi-Cal premium revenue paid by DHCS and/or capitation revenue from their plan-to-plan arrangements with plans directly contracted with DHCS.

Claims

Pursuant to the Knox-Keene Act, full service health plans are required to process 95% of their claims within 45 working days. NGM plans did not report any claims processing or emerging claims payment deficiencies for December 2016.

Conclusion

After the initial surge in LI and COHS plan's enrollment brought on by the ACA in 2014, the rate of increase in enrollment slowed down for 2016. Most Medi-Cal managed care plans continue to see moderate increases in enrollment. Overall, expenses and premium revenue continue to rise as enrollment increases. The Medi-Cal managed care plans continue to meet or significantly exceed the minimum TNE requirement. The DMHC will continue to monitor the enrollment trends and financial solvency of all LI, COHS and NGM plans reporting to the Department.