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

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Table of Contents

		Page Number
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.	Conclusion	25

Tables

Table 1	Enrollment in Local Initiatives September 2014 - September 2015	5
Table 2	Per Member Per Month Medical Expense and Premium Revenue - LI	9
Table 3	LI Net Income by Quarter	12
Table 4	Enrollment in County Organized Health Systems September 2014 - September 2015	17
Table 5	Per Member Per Month Medical Expenses and Premium Revenue - COHS	21
Table 6	COHS Net Income by Quarter	23

Charts

Chart 1	Medi-Cal Enrollment – All LI Plans 2012-2015	6
Chart 2	Medi-Cal Enrollment by LI Plan 2012-2015	7
Chart 3	Total Medical Expenses - All LI Plans 2012-2015	8
Chart 4	PMPM Medical Expense vs PMPM Premium Revenue - LI	11
Chart 5	Percentage TNE - LI September 2014 - September 2015	13
Chart 6	Medi-Cal Enrollment in COHS Plans 2012-2015	18
Chart 7	Medi-Cal Enrollment by COHS Plan 2012-2015	19
Chart 8	Total Medical Expenses - COHS 2012-2015	20
Chart 9	PMPM Medical Expenses vs PMPM Premium Revenue - COHS	22
Chart 10	Percentage TNE - COHS September 2014 - September 2015	24

I. Overview

Medi-Cal, California's Medicaid program, has experienced significantly increased enrollment in the last two years due to the transition of children from the Healthy Families Program (HFP) to Medi-Cal and the expansion of Medi-Cal eligibility to low-income individuals under the Patient Protection and Affordable Care Act (ACA).

There are two main Medi-Cal systems administered by the Department of Health Care Services (DHCS) for the delivery of medical services to Medi-Cal beneficiaries : fee-for-service Medi-Cal and Medi-Cal managed care (MCMC). Over two-thirds of Medi-Cal beneficiaries are enrolled in a MCMC plan. Locally-sponsored plans known as Local Initiatives (LIs) participate as MCMC plans under the Two-Plan Model, while County Organized Health Systems (COHS) plans serve Medi-Cal enrollees under the COHS Model.[*] Both LI and COHS plans are local agencies established by county boards of supervisors to contract with the Medi-Cal program. Approximately 6.4 million Medi-Cal beneficiaries are enrolled in LI and COHS plans under the Two-Plan and COHS Models.

This report details the significant increases in 2015 enrollment for LIs and COHS and demonstrates how Medi-Cal revenue and expenses are affecting these plans' profitability and tangible net equity (TNE). The report includes enrollment and financial information reported by LI and COHS plans as of the quarter ending September 30, 2015. Because LI and COHS plans serve primarily Medi-Cal enrollees, Medi-Cal enrollment increases and the rates provided by DHCS are driving factors for the financial performance of these plans.[†]

[*] Counties with the two-plan model offer both a LI and a commercial Medi-Cal managed care plan. In counties using the COHS model, the COHS is the only Medi-Cal managed care plan available. This report looks at the financial performance only of LI and COHS plans, not the commercial plans participating in MCMC.

[†] Additionally, medical expenses for these plans increased due to legislation that expanded outpatient mental health benefits available to beneficiaries with mild to moderate impairment of mental, emotional or behavioral functioning resulting from any mental health condition defined by the DSM-IV, and clarified that the Early and Periodic Screening, Diagnostic and Treatment benefit includes the provision of Behavioral Health Treatment to all Medi-Cal children and adolescent beneficiaries 0 to 21 years of age that are diagnosed with Autism Spectrum Disorder.

II. Summary of Findings

Key findings from this report include:

- LI and COHS plans continued to experience significant growth in 2015.
- Almost all LI and COHS plans reported enrollment increases of at least 14% from September 2014 to September 2015. This is a moderate increase compared to 2014 when enrollment increased by at least 35%.
- Increased enrollment contributed to increased medical expenses for both LI and COHS plans.
- Per Member Per Month (PMPM) premium revenue exceeded PMPM medical expense for every LI and COHS plan for September 2015.
- The LI plans reported higher net income than COHS, and COHS reported higher TNE reserves than LIs. However, both the LI and COHS plans continue to report positive net income and healthy TNE reserves.

III. Local Initiative Health Plans (LI)

A. Highlights

- At present, 14 counties participate in the Two-Plan model of Medi-Cal managed care. In 13 of these counties, the DHCS contracts with both an LI plan and a commercial plan; in Tulare County, the DHCS contracts with two commercial plans – Anthem Blue Cross and Health Net. LIs must be licensed under the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act), for their Medi-Cal lines of business.

- Beneficiaries in the Two-Plan Model have a choice between the two plans, and those beneficiaries who do not make a selection are automatically assigned to a plan. The DHCS uses an algorithm based on quality and use of safety net providers to distribute the assignments. Overall, there are nearly three times as many Medi-Cal beneficiaries enrolled in LI plans as in commercial plans in Two-Plan Model counties.[‡]

- Medi-Cal providers who wish to provide services to managed care enrollees must participate in the managed care plan's provider network.

- The LIs and the counties in which they provide services are as follows:
    - Alameda Alliance For Health ("Alameda Alliance") – Alameda
    - Contra Costa County Medical Services ("Contra Costa") – Contra Costa
    - Fresno-Kings-Madera Regional Health Authority ("Fresno-Kings-Madera") – Fresno, Kings, and Madera
    - Health Plan of San Joaquin ("San Joaquin") – San Joaquin and Stanislaus
    - Inland Empire Health Plan ("Inland Empire") – Riverside and San Bernardino
    - Kern Health Systems ("Kern") - Kern
    - Local Initiative Health Authority for L.A County ("L.A. Care") – Los Angeles
    - San Francisco Community Health Authority ("San Francisco") – San Francisco
    - Santa Clara County Health Authority ("Santa Clara County") – Santa Clara

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

- LI plans reported combined enrollment of 4.7 million individuals as of September 30, 2015. Over 4.5 million (97%) of the total LI enrollment were Medi-Cal beneficiaries. The remaining 3% of non-Medi-Cal LI enrollment included other lines of business such as In-Home Supportive Services (IHSS), Healthy Kids or the Access for Infants and Mothers Program (AIM).

- Total LI plan enrollment increased by 19% from September 2014 to September 2015.

- Per member per month medical expenses and premium revenue stabilized at September 2015 as a result of Medi-Cal Coverage Expansion (MCE) rate adjustments for the 2014/2015 fiscal year. LI plans' PMPM premium revenue outpaced expenses for September 2015.

- LI plans reported $247 million in net income in September 2015, which was significantly greater than the $62.8 million net income reported in September 2014.

- The LIs reported TNE that ranged from 243% to 965% of required TNE.

- The LIs reported $338 million in cash flow from operations, which was significantly lower than the $1.1 billion reported in September 2014.

B. Enrollment Trends - LI

The LI plans serve 4.6 million enrollees in 13 counties in California. The table below lists LI total enrollment and the percentage of total LI enrollment accounted for by Medi-Cal lives. The table also shows the increase in enrollment from September 2014 to September 2015. In 2015, nearly all LIs reported an increase in total enrollment of over 15%. Inland Empire Health Plan and L.A. Care reported the largest increase in enrollment with the addition of over 200,000 members.

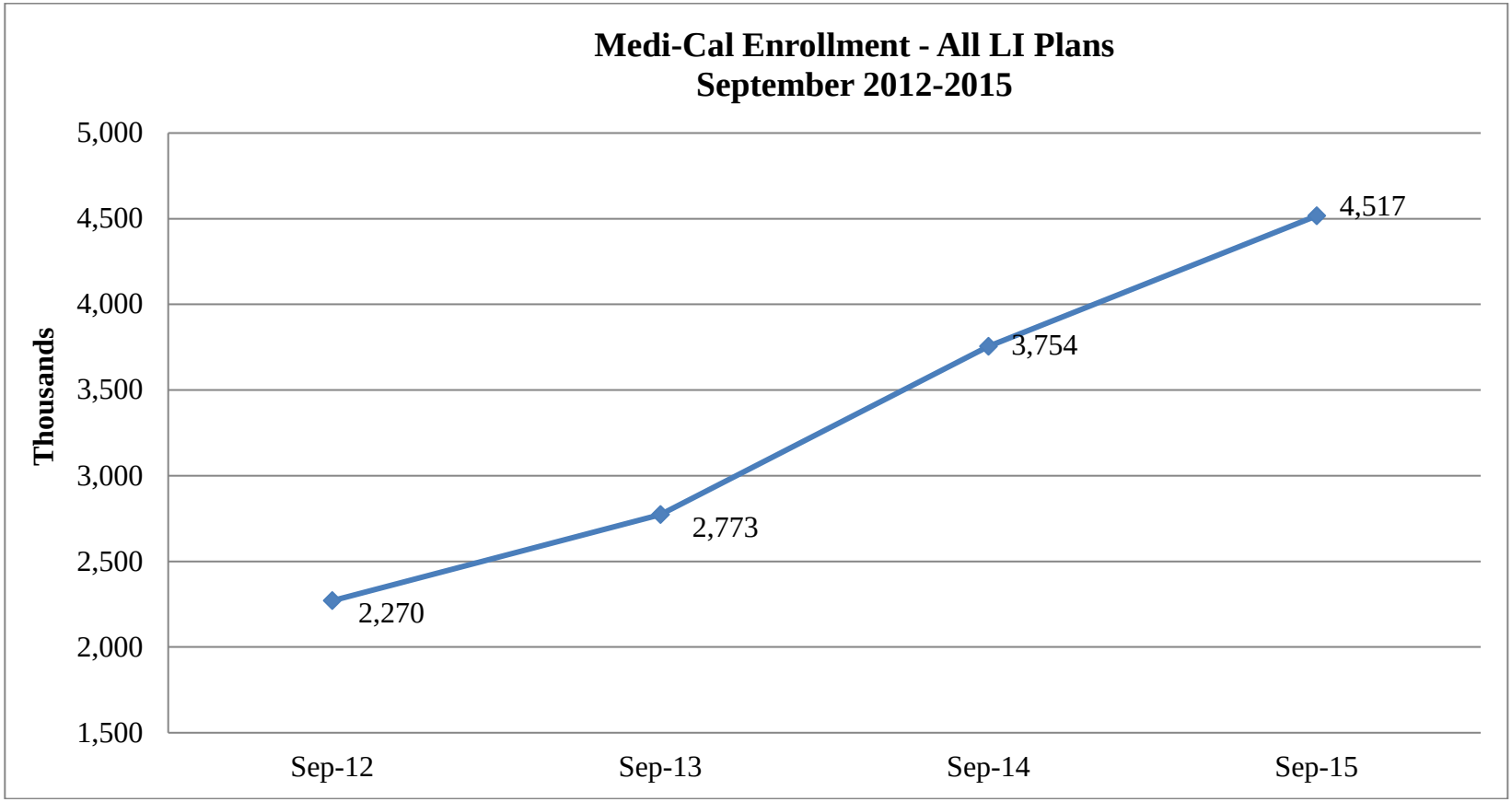
Table 1
Enrollment in Local Initiatives
September 2014 – September 2015

Local Initiative	Total Medi-Cal Enrollment September 2015	Percentage of Medi-Cal Enrollment September 2015	Total Enrollment September 2015*	Total Enrollment September 2014	Enrollment Increase	Percentage Enrollment Increase
Alameda Alliance For Health	248,869	98%	254,295	223,204	31,091	14%
Contra Costa County Medical Services	167,553	93%	179,423	152,060	27,363	18%
Fresno-Kings-Madera Regional Health Authority	326,765	100%	326,765	283,562	43,203	15%
Inland Empire Health Plan	1,099,065	98%	1,123,253	909,225	214,028	24%
Kern Health Systems	212,733	100%	212,733	175,296	37,437	21%
Local Initiative Health Authority for L.A County	1,768,858	96%	1,841,788	1,565,170	276,618	18%
San Francisco Community Health Authority	127,312	90%	141,055	122,995	18,060	15%
Health Plan of San Joaquin	319,471	99%	323,549	271,903	51,646	19%
Santa Clara County Health Authority	246,049	95%	258,249	207,204	51,045	25%
Total	4,516,675	97%	4,661,110	3,910,619	750,491	19%

* The total enrollment consists of Large Group Commercial, Medicare Risk, Medicare Supplement, Medi-Cal Risk, ASO, Healthy Kids, IHSS, and contracted from other plans. Note that Healthy Kids is a separate program from the Healthy Families Program.

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

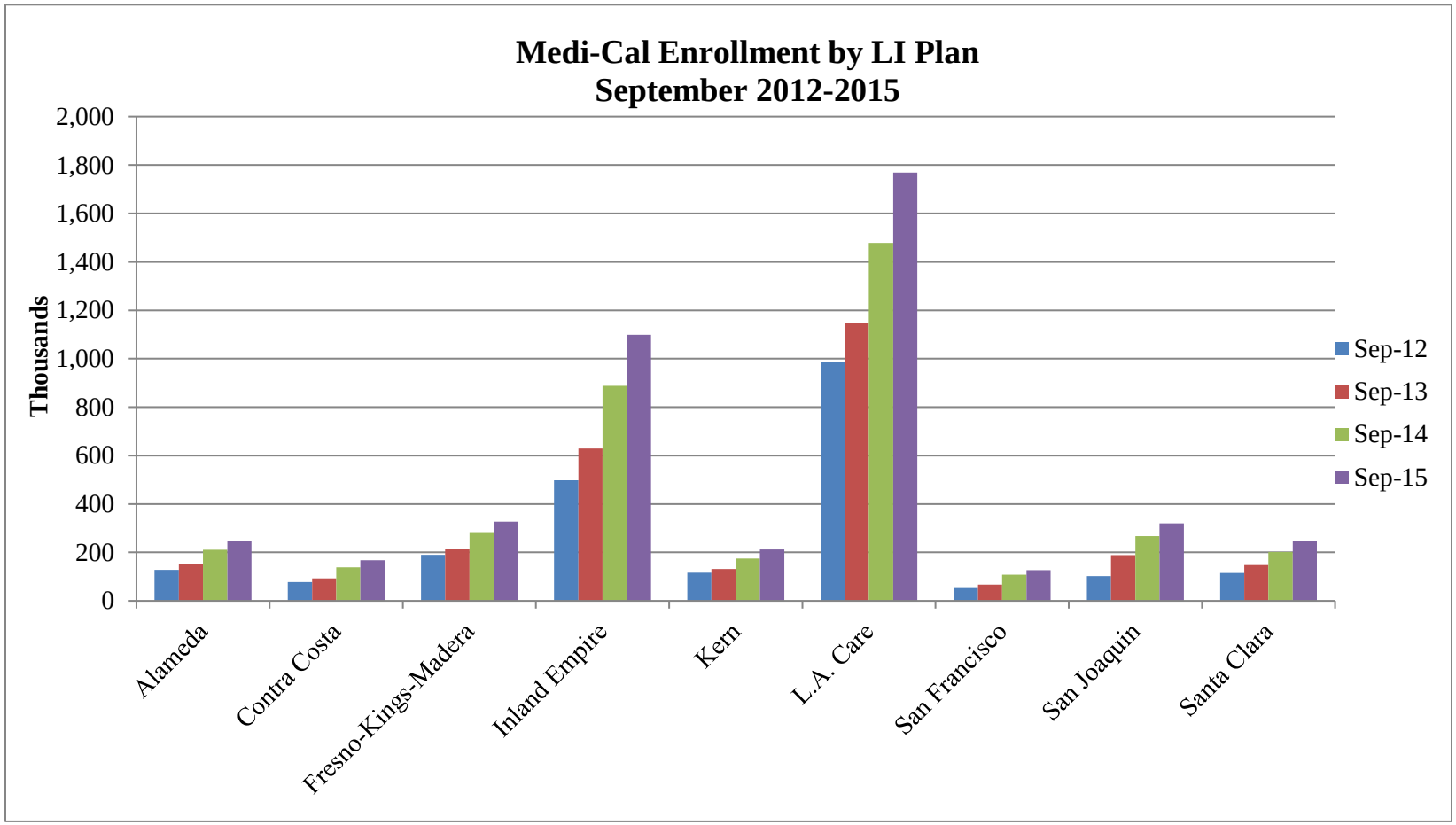
Chart 1



Medi-Cal enrollment in LIs continues to increase. Two Southern California LIs, L.A. Care and Inland Empire Health Plan, reported the highest number of enrollees and make up the majority of the enrollment increase. L.A. Care and Inland Empire reported Medi-Cal enrollment of 1.8 million and 1.1 million, respectively.

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

Chart 2



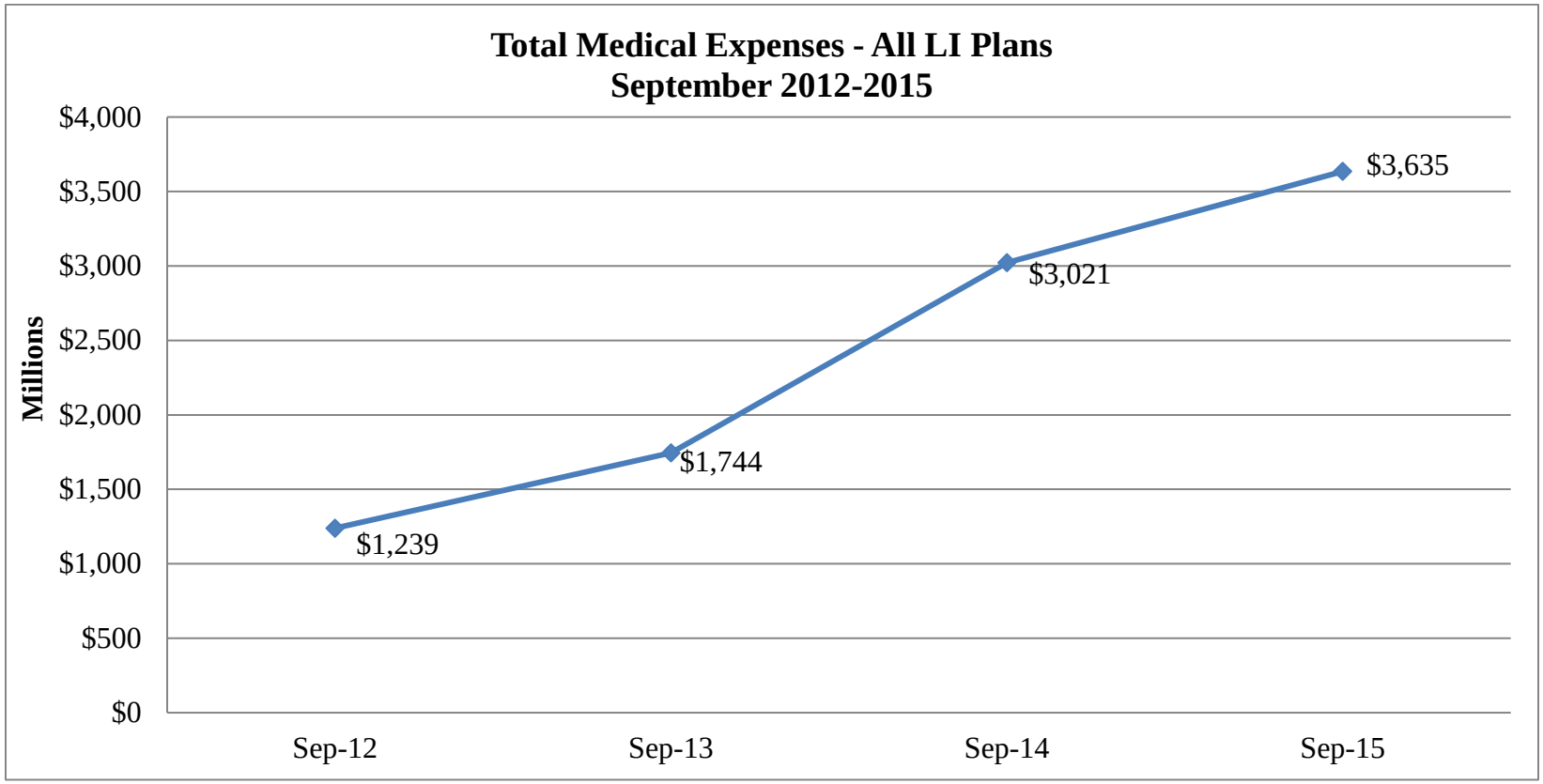
All nine LIs have experienced increases in enrollment. The majority of the increases were from their Medi-Cal lines of business. From September 2014 to September 2015, L.A. Care and Inland Empire experienced 18% and 24% increases in enrollment, respectively.

C. Financial Trends - LI

Medical Expenses

Chart 3 illustrates total medical expenses for the LIs compared to the same quarter in the last three year. There was an increase in total medical expenses in the quarter ending September 2015 compared to the quarter ending in September 2014. The increase in medical expenses is correlated to the increase in the LIs' enrollment and expanded Medi-Cal benefits. Total medical expense changes as enrollment increases or decreases and as the enrollee mix (healthy or unhealthy, high or low utilizers) changes.

Chart 3



Per Member Per Month Medical Expenses and Premium Revenue - LI

Table 2 shows the PMPM medical expenses and premium revenue of the LIs for the quarter ending in September for the past four years, as well as the difference in PMPM medical expenses and premium revenue for September 2015.

L.A. Care and Santa Clara reported the highest PMPM medical expenses and premium revenue. All LIs had higher PMPM premium revenue than medical expenses at September 2015.

Table 2
Per Member Per Month Medical Expenses and Premium Revenue – LI
2012-2015

Local Initiative	Sep-12		Sep-13		Sep-14		Sep-15		
	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	Net[§]
Alameda Alliance For Health	$219	$228	$226	$232	$310	$329	$205	$251	$46
Contra Costa County Medical Services	236	198	248	231	307	312	274	287	$13
Fresno-Kings-Madera Regional Health Authority	155	170	159	180	223	247	262	275	$12
Inland Empire Health Plan	154	166	172	173	265	299	264	293	$29
Kern Health Systems	181	151	246	141	202	224	209	233	$24
Local Initiative Health Authority For L.A. County	151	160	222	238	276	288	268	308	$40
San Francisco Community Health Authority	224	261	227	250	304	334	285	293	$8
Health Plan of San Joaquin	147	153	153	164	224	242	219	230	$11
Santa Clara County Health Authority	146	155	156	166	226	270	277	298	$22

[§] Difference between September 2015 PMPM Medical Expenses and PMPM Premium Revenue.

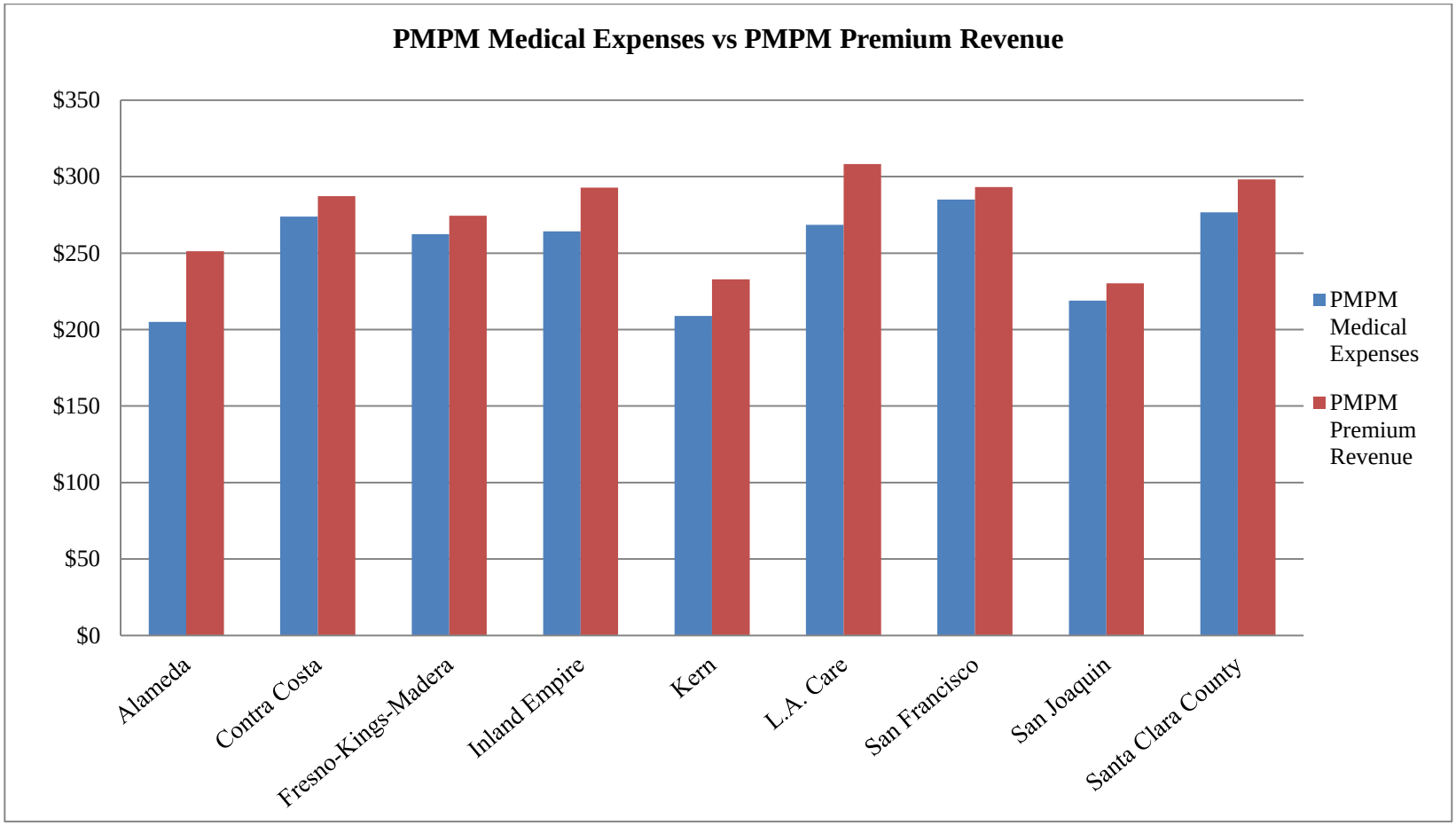
Fluctuations in PMPM medical expenses and premium revenue can be due to a number of factors including utilization of medical services by enrollees, the timing of pass-through revenues and expenses, and premium rate adjustments. Although pass-through revenues and expenses have zero net effect on a health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

Currently, MCMC plans include pass-through expenses under medical expenses and premium revenue. This inclusion may be a reason why PMPM medical expenses and premium revenue have continued to fluctuate. The Department was able to gather information from the LI and COHS plans regarding the pass-through income and expenses reported under medical expenses and premium revenue for September 2015. Additionally, the Department is in the process of implementing a financial statement redesign that will add an additional schedule which would list the pass-through expenses and revenue reported under medical expenses and premium revenue.

PMPM Medical Expense vs. PMPM Premium Revenue - LI

Chart 4 illustrates the LIs' PMPM medical expense vs PMPM premium revenue for September 2015. 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 LIs over the past six quarters. For the quarter ending September 2015, all LI plans reported positive net income. Net income or loss is directly related to premium revenue and medical expenses.

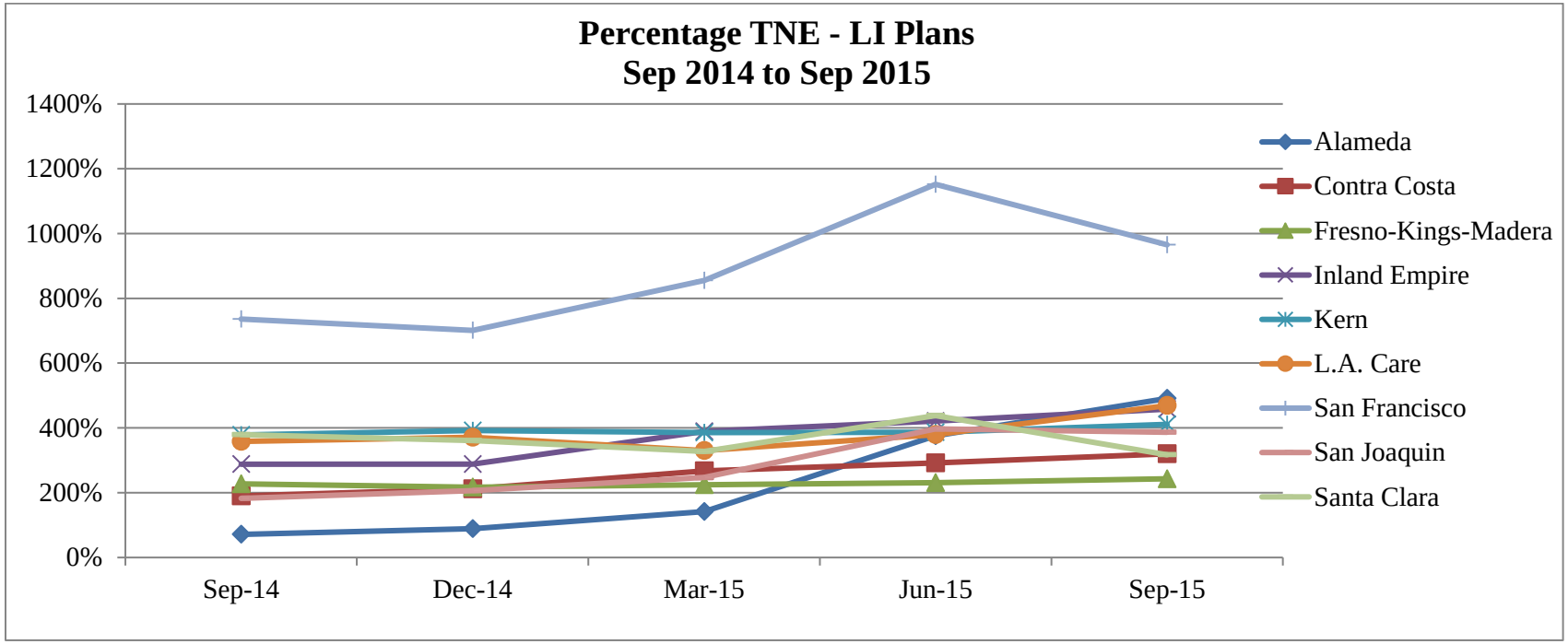
Table 3
LI Net Income by Quarter (in thousands)

Local Initiative	QE Jun-14	QE Sep-14	QE Dec-14	QE Mar-15	QE Jun-15	QE Sep-15
Alameda Alliance For Health	$401	$1,189	$7,677	$16,936	$44,715	$20,581
Contra Costa County Medical Services	6,053	1,138	4,842	7,726	5,950	4,526
Fresno-Kings-Madera Regional Health Authority	1,276	2,048	2,496	2,933	5,812	3,057
Inland Empire Health Plan	45,371	38,200	46,787	140,915	91,446	63,093
Kern Health Systems	(723)	(3,099)	7,148	3,915	6,875	10,300
Local Initiative Health Authority for L.A County	30,129	(205)	52,923	11,418	80,447	129,777
San Francisco Community Health Authority	5,661	5,640	7,489	6,867	18,176	10,344
Health Plan of San Joaquin	(7,253)	7,596	13,116	18,932	35,964	2,346
Santa Clara County Health Authority	6,968	10,246	3,105	1,550	28,693	3,319
Total LI Net Income	**$87,883**	**$62,753**	**$145,583**	**$211,193**	**$318,082**	**$247,343**

Tangible Net Equity - LI

TNE is a reserve requirement described in section 1300.76 of the Knox-Keene regulations[††] and a measure of the financial health of plans. TNE is defined as a health plan's total assets minus total liabilities reduced by the value of intangible assets (i.e., goodwill[‡‡], organizational or start-up costs, etc.) and unsecured obligations of officers, directors, owners, or affiliates outside the normal course of business. Any debt that is properly subordinated[§§] may be added to the TNE calculation, which serves to increase the plan's TNE.

Chart 5



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

[‡‡] Goodwill is an intangible asset that arises as a result of the acquisition of one company by another for a premium value.
[§§] Subordinated debt - A loan that ranks below other loans with regard to claims on assets or earnings. In the case of default, creditors with subordinated debt would not get paid out until after the other creditors were paid in full.

The Department's minimum requirement for TNE reserves is 100% of required TNE. If the Plan's TNE falls below 130%, the health plan must file monthly financial statements with the Department. If 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 2014 and the trend continued in the first three quarters of 2015. For September 2015, reported TNE ranged from 243% to 965% 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.

LI plans reported positive cash flow from operations in September 2015. The cash flow from operations totaled $338 million in September 2015 compared to $1.1 billion in September 2014. 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 2014/2015 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. 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 September 30, 2015, L.A. Care failed to process 95% of its claims within 45 working days and submitted a corrective action plan with the Department outlining measures taken to comply with the regulations.

IV. County Organized Health Systems (COHS)

A. Highlights

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

- Beneficiaries in COHS counties have only one MCMC option.

- While California law exempts COHS plans from Knox-Keene licensure for Medi-Cal, COHS plans must have a Knox-Keene license for other lines of business. Only San Mateo has voluntarily included its Medi-Cal enrollment under its Knox-Keene license, but CalOptima, CenCal Health, Central California Alliance for Health and Partnership HealthPlan have Knox-Keene licenses for other lines of business such as Healthy Kids, IHSS, AIM and Medicare Advantage. Gold Coast Health Plan has no Knox-Keene license since it has only a Medi-Cal line of business; therefore, this report does not include information for Gold Coast.

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

- COHS plans enrollment increased 12% from September 2014 to September 2015. Per member per month expenses and premium revenue rose for COHS plans in conjunction with increased enrollment and expanded Medi-Cal benefits. COHS plans' PMPM premium revenue outpaced expenses for September 2015.

- COHS plans reported $124 million in net income in September 2015, a slight decrease compared to net income of $129 million reported in September 2014.
- Tangible net equity for COHS plans ranged from 442% to 1,341% of required TNE. Four of the five reporting COHS plans reported progressively higher TNE from September 2014 to September 2015.
- COHS plans reported $1.26 billion in cash flows from operations in September 2015 compared to $1.13 billion at September 2014.

B. Enrollment Trends - COHS

Like LI plans, COHS plans have reported consistent increases in enrollment since 2012. CalOptima and Partnership HealthPlan reported the highest enrollment numbers. Health Plan of San Mateo's total enrollment declined by 1% from September 2014 to September 2015, which can be attributed to the decline in the Plan's reported Medicare enrollment.

Table 4
Enrollment in County Organized Health Systems
Mar 2014 – Mar 2015

COHS	September 2015 Total Medi-Cal Enrollment	September 2015 Percentage of Medi-Cal Enrollment	September 2015 Total Enrollment	September 2014 Total Enrollment	Enrollment Change from September 2014 to September 2015	Percentage Enrollment Change from September 2014 to September 2015
CalOptima	752,695	98%	767,108	679,441	87,667	13%
CenCal Health	165,442	99%	166,370	145,326	21,044	14%
Central California Alliance for Health	333,679	100%	334,983	291,679	43,304	15%
Partnership HealthPlan	546,530	100%	547,021	489,918	57,103	12%
Health Plan of San Mateo	120,342	89%	135,205	136,593	(1,388)	(1%)
Total	1,918,688	98%	1,950,687	1,742,957	207,730	12%

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

Chart 6

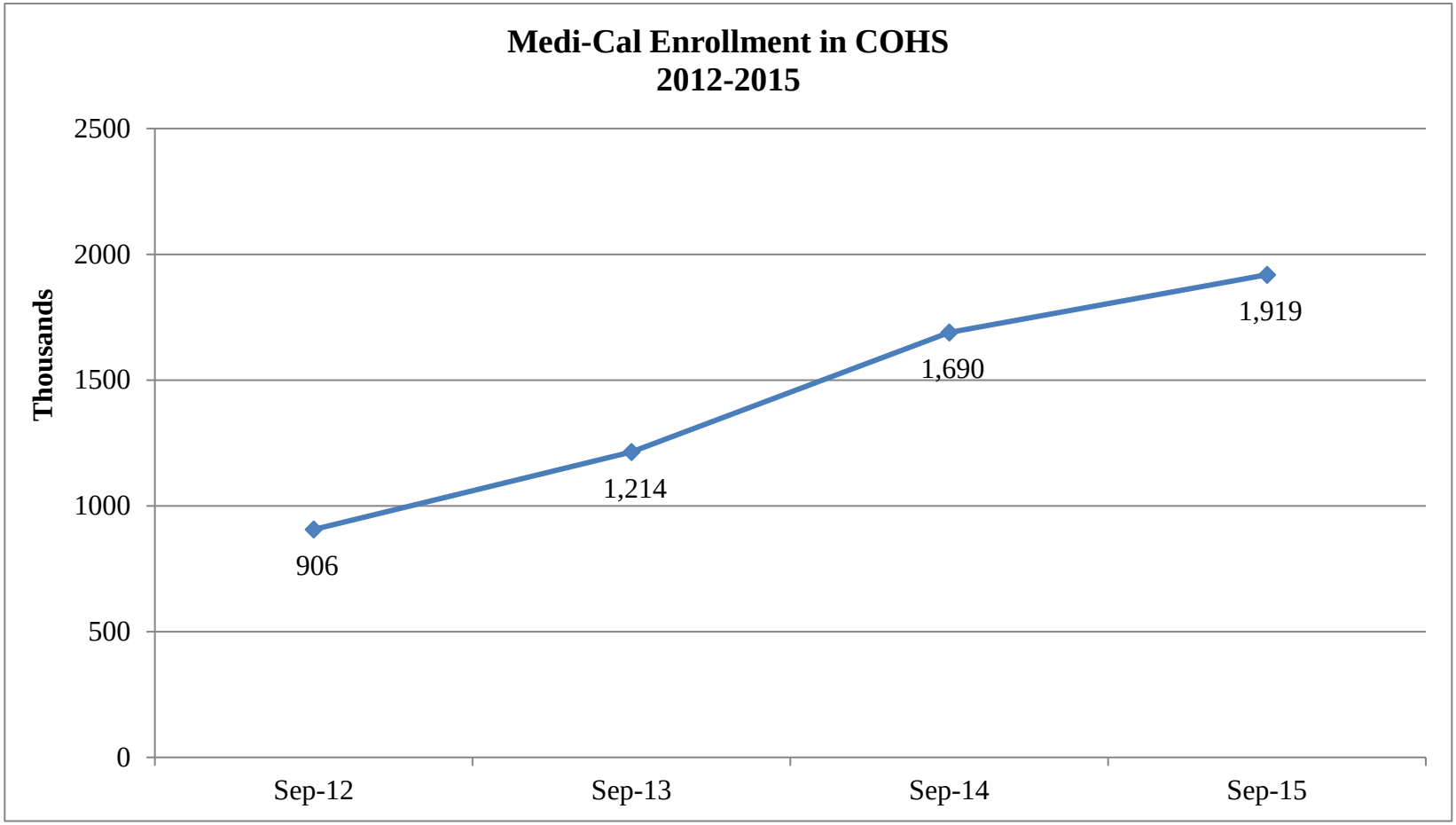
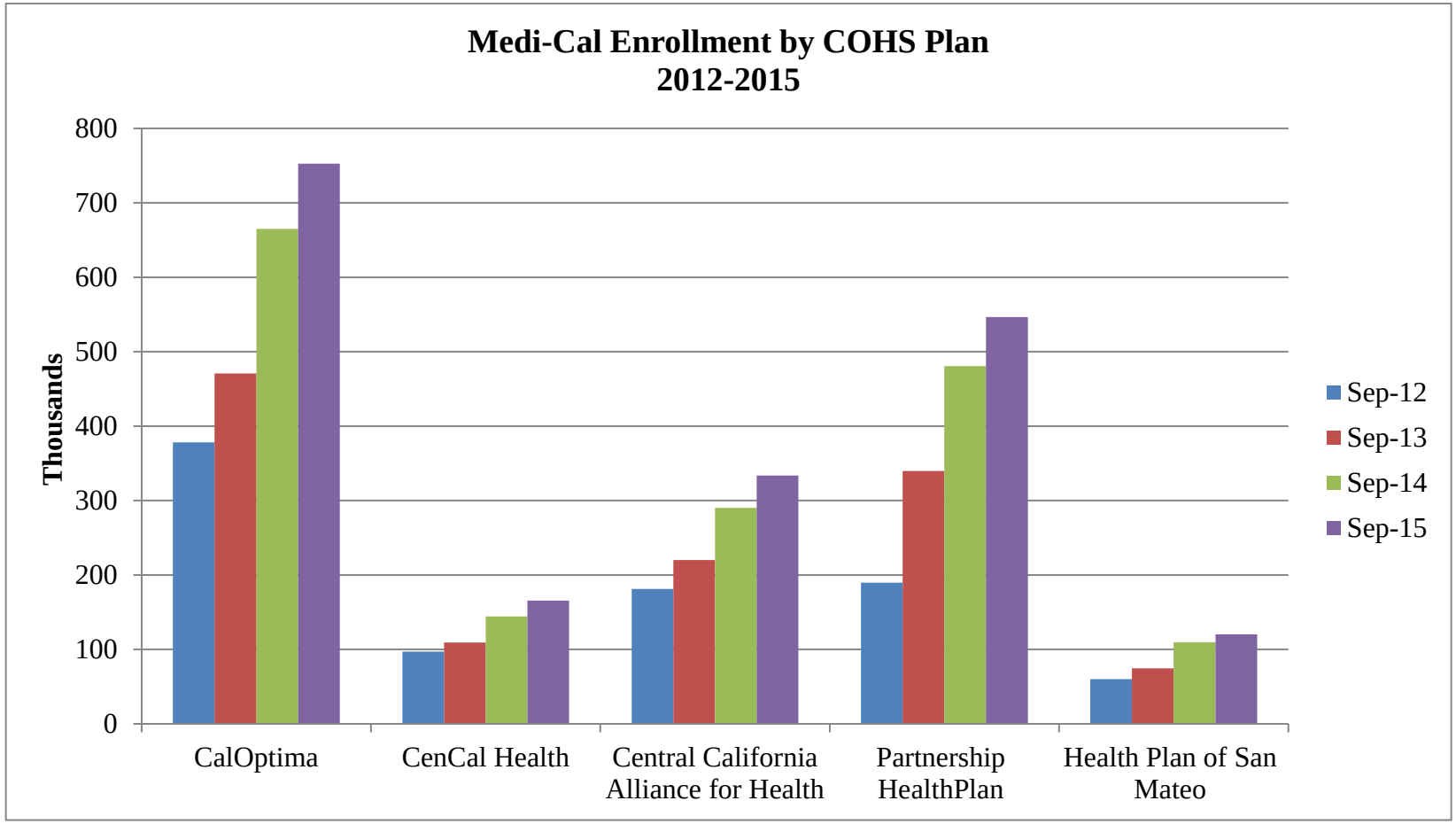


Chart 7 shows the enrollment growth for each COHS plan over the past four years.

Chart 7

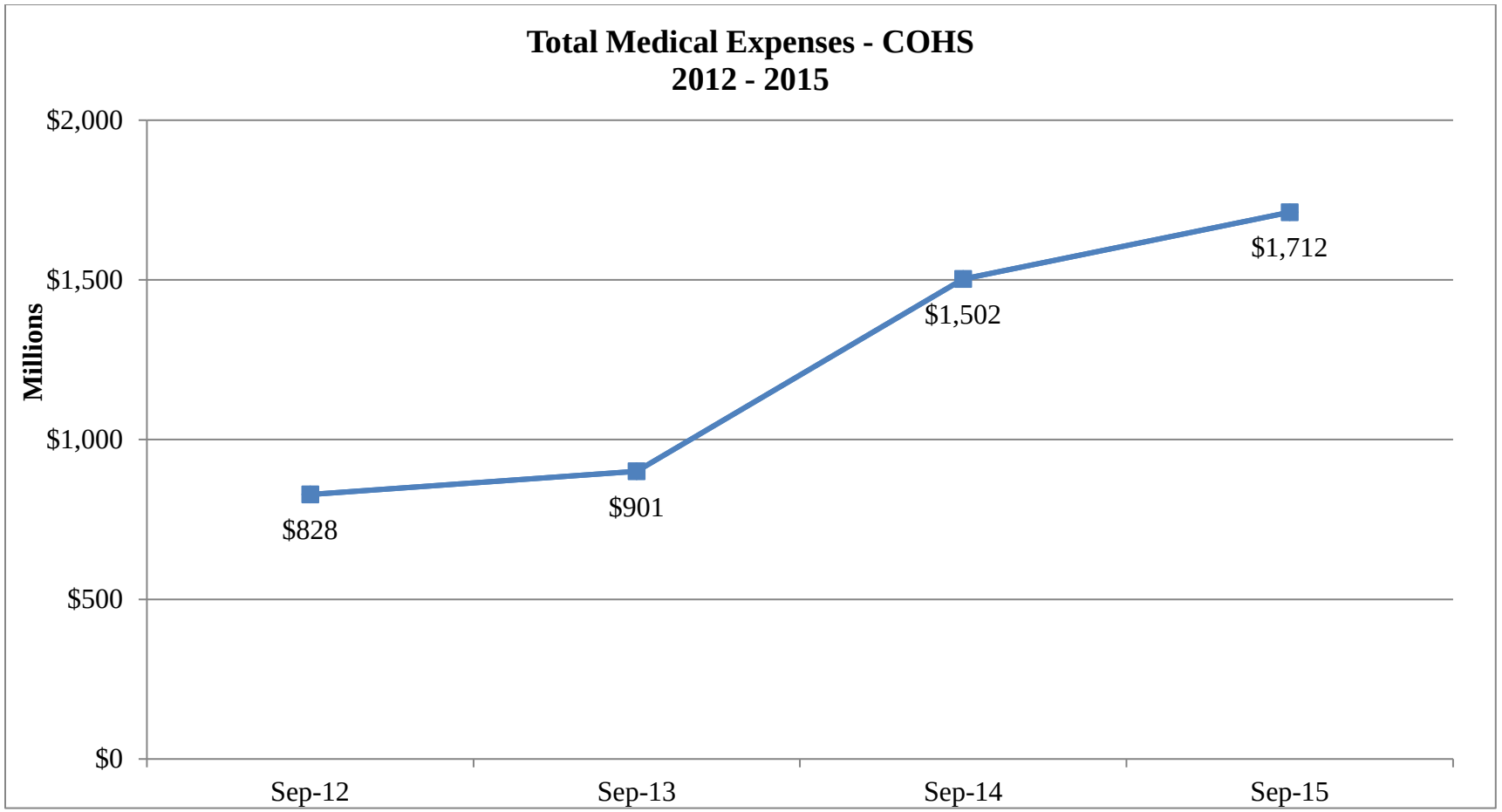


All COHS plans, with the exception of Health Plan of San Mateo, reported enrollment increases of 12% or more from September 2014 to September 2015. Health Plan of San Mateo's Medi-Cal enrollment increased by 10%; however, its total enrollment declined by 1% as a result of decreased Medicare enrollment.

Financial Trends - COHS

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

Chart 8



Per Member Per Month Medical Expenses and Premium Revenue - COHS

Table 5 shows the PMPM medical expenses and premium revenue of the COHS plans for the quarter ending in September for the past four years, as well as the percentage change in the PMPM medical expenses and premium revenue between September 2014 and September 2015.

All COHS plans had higher PMPM premium revenue than medical expenses at September 2015. Health Plan of San Mateo reported the highest PMPM medical expenses ($433) and premium revenue ($531).

Table 5
Per Member Per Month Medical Expenses and Premium Revenue – COHS
2012-2015

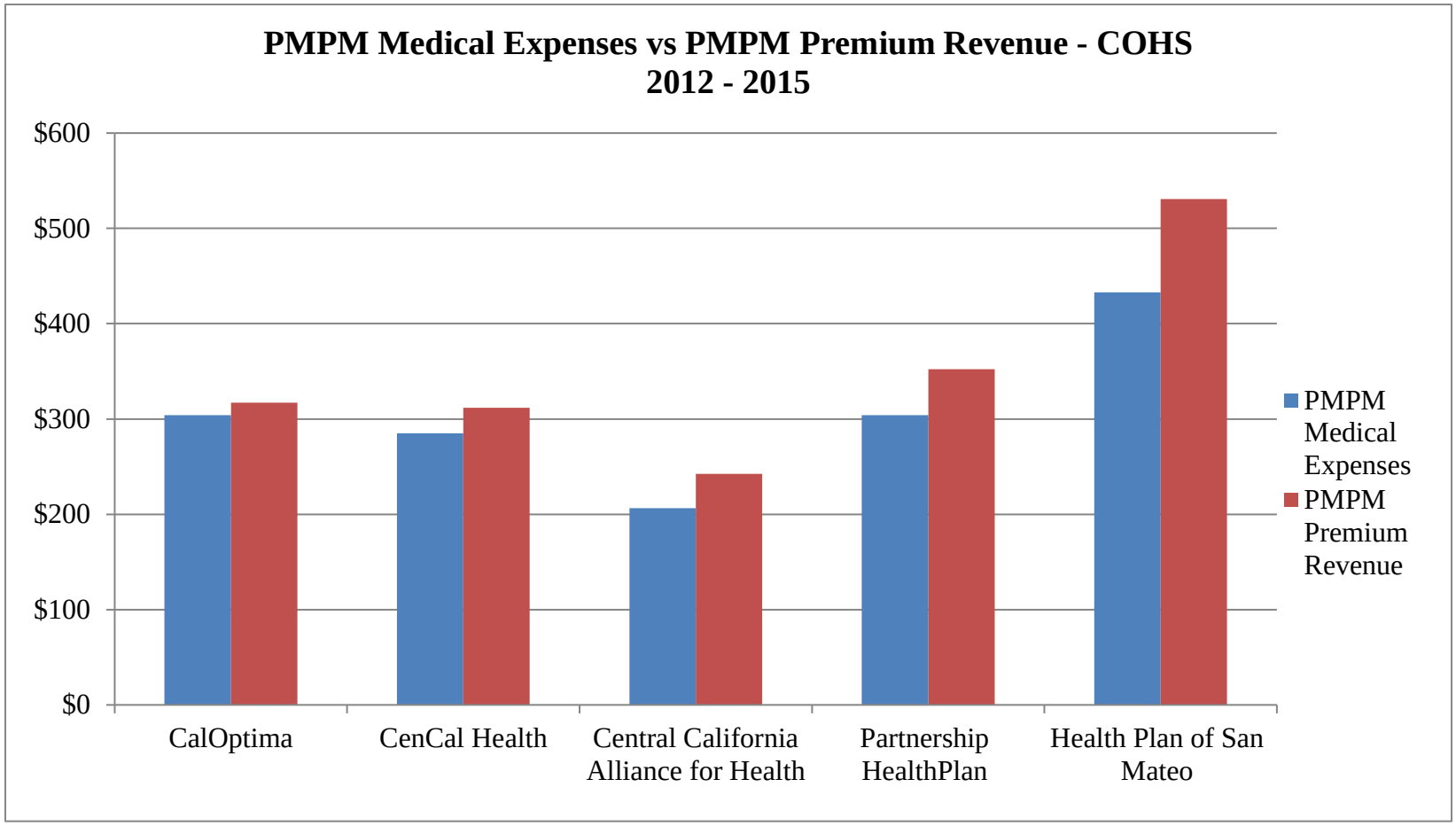
	Sep-12		Sep-13		Sep-14		Sep-15***		
	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	PMPM Medical Expenses	PMPM Premium Revenue	Net†††
CalOptima	$254	$268	$243	$265	$319	$371	$304	$317	$13
CenCal Health	248	261	239	278	262	290	285	312	$27
Central California Alliance for Health	201	240	187	250	194	227	207	242	$36
Partnership HealthPlan	328	359	312	377	313	371	304	352	$48
Health Plan of San Mateo	142	152	379	457	404	529	433	531	$98

*** September 2015 PMPM Medical Expenses and PMPM Premium Revenue information excludes pass-through income and expense items
††† Difference between September 2015 PMPM Medical Expenses and PMPM Premium Revenue.

PMPM Medical Expense vs PMPM Premium Revenue

Chart 9 illustrates the COHS plans' PMPM medical expense vs PMPM premium revenue for September 2015. 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 all COHS plans. All COHS plans reported positive net income for the last five quarters.

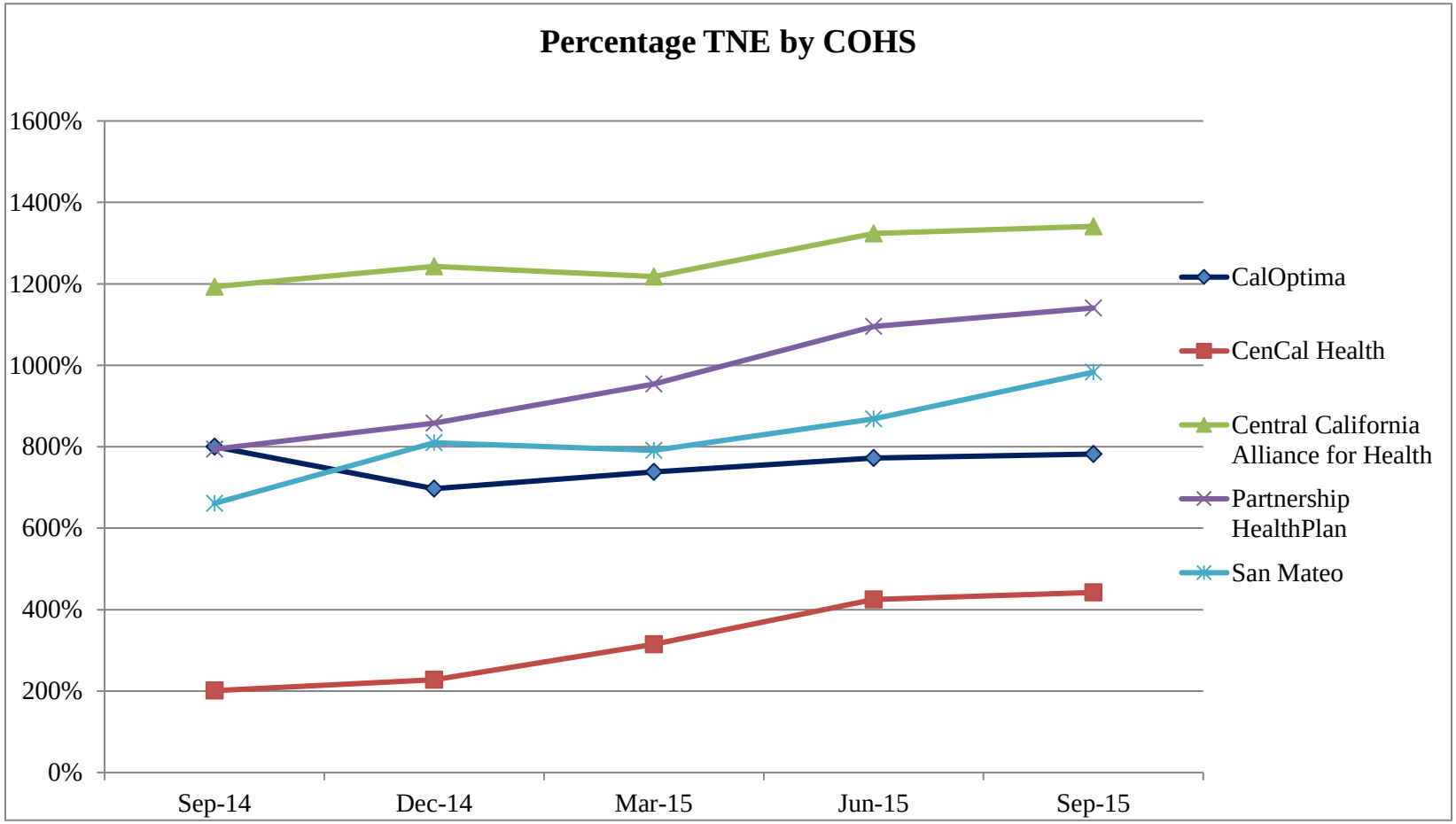
Table 6
COHS Net Income by Quarter (in thousands)

COHS	QE Jun-14	QE Sep-14	QE Dec-14	QE Mar-15	QE Jun-15	QE Sep-15
CalOptima	75,607	53,407	53,672	57,600	61,289	9,338
CenCal Health	(1,695)	1,876	8,206	15,690	33,178	8,664
Central California Alliance for Health	16,975	13,756	40,480	28,188	32,229	24,434
Partnership HealthPlan	40,665	42,897	71,141	68,147	97,270	52,384
Health Plan of San Mateo	6,888	17,858	37,804	14,497	15,315	28,861
Total COHS Net Income	**$138,440**	**$129,794**	**$211,303**	**$184,122**	**$239,281**	**$123,681**

Tangible Net Equity - COHS

All COHS plans reported over 400% of required TNE for September 2015. TNE to Required TNE ranged from 442% to 1,341%. CenCal's reported TNE increased to 442% at September 2015. All other COHS plans report 600% or more of required TNE for the past five quarters.

Chart 10



Cash Flow from Operations

COHS plans reported $1.26 billion in cash flow from operations in September 2015. Similar to the LIs, COHS plans' increase in cash inflow from operations is primarily attributed to the Medi-Cal premium revenue paid by DHCS.

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 September 2015.

V. Conclusion

The Department anticipates continued enrollment increases for both LI and COHS plans in 2015. However, after the initial surge in enrollment brought on by the ACA in 2014, the rate of increase should slow down for the later part of 2015 and beyond. Expenses and revenue will continue to rise as enrollment increases. As anticipated, Medi-Cal capitation rates for plans were reduced by the DHCS based on the 2014/2015 medical loss ratio information. The DMHC will continue to monitor the enrollment trends and financial solvency of all LI and COHS plans reporting to the Department.