Report of Independent Auditors and
Financial Statements

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)

June 30, 2023 and 2022

MOSSADAMS

Table of Contents

Management's Discussion and Analysis

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Management's Discussion and Analysis
June 30, 2023, 2022, and 2021

INTRODUCTION:

In accordance with the Governmental Accounting Standards Board Codification Section 2200, *Annual Comprehensive Financial Report*, the management of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) ("Health Authority") has prepared this discussion and analysis to provide readers and interested parties with an overview of the organizations' financial activities for the fiscal years ended June 30, 2023, 2022, and 2021. This discussion should be reviewed in conjunction with the Health Authority's financial statements and accompanying notes to enhance the reader's understanding of the Health Authority's financial performance.

ORGANIZATION:

Santa Clara County Health Authority is a licensed health maintenance organization ("HMO") that operates in Santa Clara County (the "County"). The County's Board of Supervisors established Santa Clara County Health Authority in August 1995, in accordance with the State of California Welfare and Institutions Code (the "Code") Section 14087.38. During 1996, the Health Authority obtained licensure under the Knox-Keene Health Care Services Plan Act of 1975 and commenced operations.

The Health Authority operates two lines of business. In fiscal year 2022, the Health Authority operated Medi-Cal and Cal Medi-Connect, a dual demonstration pilot program. In fiscal year 2023, the Health Authority operated Medi-Cal and DualConnect, a Medicare dual-eligible special needs plan ("D-SNP"), to which Cal Medi-Connect members transitioned effective January 1, 2023.

OVERVIEW OF FINANCIAL STATEMENTS:

The Health Authority's annual financial report consists of three statements–Statements of Net Position; Statements of Revenues, Expenses, and Changes in Net Position; and Statements of Cash Flows and accompanying notes. The statements report the following financial information:

- The Statements of Net Position present the Health Authority's assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position.

- The Statements of Revenues, Expenses, and Changes in Net Position present the results of operations during the fiscal years and the resulting changes in net position.

- The Statements of Cash Flows identify sources and uses of cash from operating activities, capital and financing activities, and investing activities.

The following discussion and analysis address the Health Authority's overall program activities.

FINANCIAL HIGHLIGHTS:

- Total enrollment increased by 9.9% to 336,775 unique members at June 30, 2023, from 306,351 members at June 30, 2022. Total enrollment increased by 8.4% to 306,351 unique members at June 30, 2022, from 282,670 unique members at June 30, 2021.

- Net position increased by $69,379,254 to $359,422,175 for the fiscal year ended June 30, 2023, from $290,042,921 for the fiscal year ended June 30, 2022, due to operating income of $47,876,881 and nonoperating income of $21,502,373. Net position increased by $35,192,319 to $290,042,921 for the fiscal year ended June 30, 2022, from $254,850,602 for the fiscal year ended June 30, 2021, due to operating income of $33,061,836 and nonoperating income of $2,130,483.

- Total assets and deferred outflows of resources increased to $1,377,340,887 as of June 30, 2023, from $1,309,319,193 as of June 30, June 30, 2022. Total assets and deferred outflows of resources increased to $1,309,319,193 as of June 30, 2022, from $965,668,156 as of June 30, 2021.

- Total liabilities and deferred inflows of resources decreased to $1,017,918,712 at June 30, 2023, from $1,019,276,272 at June 30, 2022. Total liabilities and deferred inflows of resources increased to $1,019,276,272 at June 30, 2022, from $710,817,554 at June 30, 2021.

- The current ratio (current assets divided by current liabilities) of 1.32 as of June 30, 2023, reflected an increase from 1.24 as of June 30, 2022. The current ratio (current assets divided by current liabilities) of 1.24 as of June 30, 2022, reflected a decrease from 1.31 as of June 30, 2021. The Department of Managed Health Care ("DMHC") requires a minimum current ratio of 1.00.

CONDENSED STATEMENTS OF NET POSITION:

	June 30			2023 to 2022 Change		2022 to 2021 Change	
	2023	2022 (As Restated)	2021 (As Restated)	Amount	% Change	Amount	% Change
Assets:							
Current assets	$ 1,337,453,709	$ 1,254,520,523	$ 926,897,526	$ 82,933,186	6.6%	$ 327,622,997	35.3%
Capital assets	22,472,541	24,361,878	27,056,663	(1,889,337)	-7.8%	(2,694,785)	-10.0%
Other assets	3,513,835	17,258,113	4,300,610	(13,744,278)	-79.6%	12,957,503	301.3%
Total assets	1,363,440,085	1,296,140,514	958,254,799	67,299,571	5.2%	337,885,715	35.3%
Deferred outflows of resources	13,900,802	13,178,679	7,413,357	722,123	5.5%	5,765,322	77.8%
Total assets and deferred outflows of resources	$ 1,377,340,887	$ 1,309,319,193	$ 965,668,156	$ 68,021,694	5.2%	$ 343,651,037	35.6%
Liabilities:							
Current liabilities	$ 1,011,091,103	$ 1,011,140,249	$ 706,660,855	$ (49,146)	0.0%	$ 304,479,394	43.1%
Noncurrent liabilities	3,236,333	990,012	1,013,567	2,246,321	226.9%	(23,555)	-2.3%
Total liabilities	1,014,327,436	1,012,130,261	707,674,422	2,197,175	0.2%	304,455,839	43.0%
Deferred inflow of resources	3,591,276	7,146,011	3,143,132	(3,554,735)	-49.7%	4,002,879	127.4%
Net position:							
Net investment in capital assets	22,472,541	24,361,878	27,056,663	(1,889,337)	-7.8%	(2,694,785)	-10.0%
Restricted	325,000	325,000	325,000	-	0.0%	-	0.0%
Unrestricted:							
Designated by Governing Board	34,311,801	15,587,414	17,067,275	18,724,387	120.1%	(1,479,861)	-8.7%
Unrestricted	302,312,833	249,768,629	210,401,664	52,544,204	21.0%	39,366,965	18.7%
Total net position	359,422,175	290,042,921	254,850,602	69,379,254	23.9%	35,192,319	13.8%
Total liabilities, deferred inflows of resources, and net position	$ 1,377,340,887	$ 1,309,319,193	$ 965,668,156	$ 68,021,694	5.2%	$ 343,651,037	35.6%

Assets and Deferred Outflows of Resources

For the fiscal year ended June 30, 2023, assets increased by $67,299,571 or 5.2% due primarily to timing of premiums receivable attributable to the timing of anticipated hospital directed payments and intergovernmental transfers. During the same period, deferred outflows of resources increased by $722,123 or 5.5% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2022, assets increased by $337,885,715 or 35.3% due primarily to increased premiums receivable attributable to the timing of anticipated hospital directed payments (as noted in the footnotes to the financial statements), coupled with increased cash and investment balances. During the same period, deferred outflows of resources increased by $5,765,322 or 77.8% due to the timing of amounts attributable to employee retirement plans.

Liabilities and Deferred Inflows of Resources

For the fiscal year ended June 30, 2023, liabilities increased by $2,197,175 or 0.2% due primarily to timing of various payables and deferred revenues. During the same period, deferred inflows of resources decreased by $3,554,735 or 49.7% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2022, liabilities increased by $304,455,839 or 43.0% due primarily to increased liabilities for hospital directed payments (as noted in the footnotes to the financial statements). During the same period, deferred inflows of resources increased by $4,002,879 or 127.4% due to the timing of amounts attributable to employee retirement plans and recording deferred inflow of resources related to the adoption of Government Accounting Standards Board Statement No. 87 – *Leases* ("GASB 87").

Tangible Net Equity

The Health Authority is required to maintain a minimum level of tangible net equity ("TNE") per its contract with the California Department of Health Care Services ("DHCS"). TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets, if any. The Health Authority's TNE was $359,422,175, $290,042,921, and $254,850,602 at June 30, 2023, 2022, and 2021, respectively. The Health Authority exceeded the minimum required TNE levels at all times during the three fiscal years.

CONDENSED RESULTS OF OPERATIONS:

	Fiscal Year			2023 to 2022 Change		2022 to 2021 Change	
	2023	2022 (As Restated)	2021 (As Restated)	Amount	% Change	Amount	% Change
Year end membership:							
Medi-Cal	326,143	296,019	272,590	30,124	10.2%	23,429	8.6%
Cal Medi-Connect	-	10,332	10,080	(10,332)	-100.0%	252	2.5%
Dual Connect	10,632	-	-	10,632	100.0%	-	0.0%
Total year end membership	336,775	306,351	282,670	30,424	9.9%	23,681	8.4%
Annual member months:							
Medi-Cal	3,773,941	3,390,356	3,137,271	383,585	11.3%	253,085	8.1%
Cal Medi-Connect	63,842	123,700	116,365	(59,858)	-48.4%	7,335	6.3%
Dual Connect	62,719	-	-	62,719	100.0%	-	0.0%
Total annual member months	3,900,502	3,514,056	3,253,636	386,446	11.0%	260,420	8.0%
Operating revenues:							
Capitation and premium revenue	$ 1,969,561,234	$ 1,833,328,501	$ 1,380,375,797	$ 136,232,733	7.4%	$ 452,952,704	32.8%
Total operating revenues	1,969,561,234	1,833,328,501	1,380,375,797	136,232,733	7.4%	452,952,704	32.8%
Operating expenses:							
Medical expenses	1,773,775,049	1,597,879,729	1,162,912,637	175,895,320	11.0%	434,967,092	37.4%
General and administrative expenses	72,304,269	68,339,809	60,783,541	3,964,460	5.8%	7,556,268	12.4%
Depreciation and amortization	4,229,099	5,212,140	3,937,385	(983,041)	-18.9%	1,274,755	32.4%
Premium tax	71,375,936	128,834,987	109,384,692	(57,459,051)	-44.6%	19,450,295	17.8%
Total operating expenses	1,921,684,353	1,800,266,665	1,337,018,255	121,417,688	6.7%	463,248,410	34.6%
Operating income	47,876,881	33,061,836	43,357,542	14,815,045	44.8%	(10,295,706)	-23.7%
Nonoperating revenues:							
Interest and other income	21,502,373	2,130,483	2,852,274	19,371,890	909.3%	(721,791)	-25.3%
Changes in net position	69,379,254	35,192,319	46,209,816	34,186,935	97.1%	(11,017,497)	-23.8%
Net position, beginning of year	290,042,921	254,850,602	208,640,786	35,192,319	13.8%	46,209,816	22.1%
Net position, end of year	$ 359,422,175	$ 290,042,921	$ 254,850,602	$ 69,379,254	23.9%	$ 35,192,319	13.8%

The Cal Medi-Connect program ended December 31, 2022, and was replaced by DualConnect, a dual-eligible special needs plan.

Membership and Enrollment

During the fiscal year ended June 30, 2023, the Health Authority experienced an increase in enrollment of 9.9% predominately due to the County's suspension of Medi-Cal disenrollment during the continued COVID-19 public health emergency through June 30, 2023. Medi-Cal redeterminations resumed effective July 1, 2023.

During the fiscal year ended June 30, 2022, the Health Authority experienced an increase in enrollment of 8.4% predominately due to the County's suspension of Medi-Cal disenrollment during the continued COVID-19 public health emergency.

Operating Revenue

During the fiscal year ended June 30, 2023, operating revenues increased by $136,232,733 or 7.4% to $1,969,561,234 versus the prior year operating revenue of $1,833,328,501. Much of the increase was attributable to increased enrollment, changes in capitation rates and member mix, new California Advancing and Innovative Medi-Cal ("CalAIM") incentive programs, and fluctuations in hospital directed payment accruals.

During the fiscal year ended June 30, 2022, operating revenues increased by $452,952,704 or 32.8% to $1,833,328,501 versus the prior year operating revenue of $1,380,375,797. Much of the increase was attributable to a new DHCS requirement to record hospital directed payments on the statement of net position, coupled with increased enrollment.

Medical Expenses

During the fiscal year ended June 30, 2023, medical expenses increased by $175,895,320 or 11.0% to $1,773,775,049 versus the prior year medical expense of $1,597,879,729. Much of the increase was attributable to increased enrollment, changes in capitation rates and mix payable, new CalAIM incentive programs and fluctuations in hospital directed payment accruals.

During the fiscal year ended June 30, 2022, medical expenses increased by $434,967,092 or 37.4% to $1,597,879,729 versus the prior year medical expense of $1,162,912,637. Much of the increase was attributable to a new DHCS requirement to record hospital directed payments on the statement of net position, coupled with increased enrollment.

The Health Authority's medical loss ratio ("MLR"), or medical expenses as a percentage of capitation and premium revenue (less contra-revenue premium tax), was 93.4%, 93.7%, and 91.5% for the fiscal years ended June 30, 2023, 2022, and 2021, respectively.

Premium Deficiency Reserve

During the fiscal years ended June 30, 2023 and 2022, management maintained its estimated premium deficiency reserve ("PDR") on the DualConnect contract and Cal Medi-Connect ("CMC") contract, respectively, at $8,294,025 for fiscal year 2023 and 2022, due to continued uncertainties and past reconciliations.

General and Administrative Expenses

During the fiscal year ended June 30, 2023, general and administrative expenses increased by $3,964,460 or 5.8% to $72,304,269 versus the prior year expense of $68,339,809 due to increased headcount required by expanding scope of responsibilities.

During the fiscal year ended June 30, 2022, general and administrative expenses increased by $7,556,268 or 12.4% to $68,339,809 versus the prior year expense of $60,783,541 due to increased headcount required by expanding scope of responsibilities under the various CalAIM programs.

The Health Authority's administrative loss ratio ("ALR"), or general and administrative (including depreciation and amortization expense) as a percentage of capitation and premium revenue (including contra-revenue premium tax), was 4.0%, 4.3%, and 5.1% for the fiscal years ended June 30, 2023, 2022, and 2021, respectively.

Nonoperating Revenues

During the fiscal year ended June 30, 2023, nonoperating revenues increased by $19,371,890 or 909.3% to $21,502,373 versus the prior year nonoperating revenue of $2,130,483 due to increased investment income.

During the fiscal year ended June 30, 2022, nonoperating revenues decreased by $721,791 or 25.3% to $2,130,483 versus the prior year nonoperating revenue of $2,852,274 due to fluctuations in invested balances.

CONDENSED CASH-FLOW INFORMATION:

The table below summarizes the major sources and uses of cash and cash equivalents for the fiscal years ended June 30, 2023, 2022, and 2021:

	Fiscal Year			2023 to 2022 Change		2022 to 2021 Change	
	2023	2022 (As Restated)	2021 (As Restated)	Amount	% Change	Amount	% Change
Cash flows from operating activities	$ 124,062,631	$ 142,760,574	$ 75,657,913	$ (18,697,943)	-13.1%	$ 67,102,661	88.7%
Cash flows from capital and financing activities	(1,702,545)	(2,609,118)	(4,197,579)	906,573	-34.7%	1,588,461	-37.8%
Cash flows from investing activities	(148,613,120)	(77,915,004)	(12,569,800)	(70,698,116)	90.7%	(65,345,204)	519.9%
Net change in cash and cash equivalents	(26,253,034)	62,236,452	58,890,534	(88,489,486)	-142.2%	3,345,918	5.7%
Cash and cash equivalents, beginning of year	254,897,750	192,661,298	299,117,154	62,236,452	32.3%	(106,455,856)	-35.6%
Cash and cash equivalents, end of year	$ 228,644,716	$ 254,897,750	$ 358,007,688	$ (26,253,034)	-10.3%	$ (103,109,938)	-28.8%

The Health Authority considers all highly liquid instruments with a maturity of three months or less to be cash and cash equivalents. The Health Authority invests excess cash in the Santa Clara County Investment Pool and City National Bank Managed Investment Account, both of which can be withdrawn on demand.

CONDENSED CAPITAL ASSET INFORMATION:

The table below summarizes the major changes in capital assets for the fiscal years ended June 30, 2023, 2022, and 2021. Capital assets largely included furniture and fixtures, computer hardware and software, and leasehold improvements:

	Fiscal Year Ended June 30,			2023 to 2022 Change		2022 to 2021 Change	
	2023	2022 (As Restated)	2021 (As Restated)	Amount	% Change	Amount	% Change
Beginning balance, net	$ 24,361,878	$ 27,056,663	$ 26,649,088	$ (2,694,785)	-10.0%	$ 407,575	1.5%
Additions	1,087,735	2,182,144	4,583,540	(1,094,409)	-50.2%	(2,401,396)	-52.4%
Reductions/adjustments	(12,069,776)	(749,294)	(446,556)	(11,320,482)	1510.8%	(302,738)	67.8%
Depreciation and amortization expense	9,092,704	(4,127,635)	(3,729,409)	13,220,339	-320.3%	(398,226)	10.7%
Ending balance, net	$ 22,472,541	$ 24,361,878	$ 27,056,663	$ (1,889,337)	-7.8%	$ (2,694,785)	-10.0%

GENERAL ECONOMIC FACTORS:

Effective July 1, 2023, post-pandemic Medi-Cal eligibility redeterminations resumed, and the Health Authority expects its enrollment to decline over the next fiscal year. The State of California is expanding Medi-Cal eligibility to undocumented adults effective January 1, 2024. With these changes in enrollment, the Health Authority's costs may move with potential changes in member acuity and utilization patterns. Changes in the general economic and employment conditions may also impact the Health Authority. Additionally, the broader economy faces additional challenges such as inflation, supply chain concerns and continued changes to monetary policy, which may add cost pressures to the healthcare delivery system. The Health Authority will continue to carefully navigate the vast landscape of unknowns to ensure it remains in a stable financial position.

FISCAL YEAR BUDGETS:

Fiscal Year 2023 Key Budget Impacts:

- *Population Changes* – The resumption of Medi-Cal redeterminations and the addition to undocumented adults. The acuity of the remaining member population is unclear.

- *Changes to the Medi-Cal Rate Setting Process* – The DHCS and its actuaries continue to make adjustments to the rate-setting process including subdividing by immigration status.

- *CalAIM* – The State of California launched a multi-year initiative entitled California Advancing and Innovative Medi-Cal to improve health outcomes for the Medi-Cal population by implementing a multi-year program of broad reforms to the delivery systems, programs, and payment reforms. The initial components of CalAIM launched January 1, 2022. CalAIM is expected to provide new funding to the Health Authority and increased expenses, the magnitude of which are unknown at this time.

Fiscal Year 2024 Budget Summary:

In June 2023, the Health Authority's Governing Board formally approved operating and capital budgets for the fiscal year ending June 30, 2024. Key assumptions included:

- Enrollment decline of 18.6% due to the resumption of Medi-Cal eligibility redeterminations following the end of the public health emergency. Revenue and medical expenses to decline similarly with acuity mix unknown.

- Departure of all remaining Kaiser members effective January 1, 2024.

- Modest growth in G&A expenses.

REQUESTS FOR INFORMATION

This financial report is designed to provide a general overview of the Health Authority's finances for interested parties. Questions concerning any of the information provided in this report or requests for additional information should be addressed to Santa Clara Family Health Plan, Attention: Controller, 6201 San Ignacio Avenue, San Jose, California 95119 or call (408) 376-2000.

MOSSADAMS

Report of Independent Auditors

The Governing Board
Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan), which comprise the statements of net position as of June 30, 2023 and 2022, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) as of June 30, 2023 and 2022, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America ("GAAS"). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Santa Clara County Health Authority (dba Santa Clara Family Health Plan)'s ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Santa Clara County Health Authority (dba Santa Clara Family Health Plan)'s internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Santa Clara County Health Authority (dba Santa Clara Family Health Plan)'s ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Emphasis of Matter – New Accounting Standard

As discussed in Note 1 to the financial statements, Santa Clara County Health Authority (dba Santa Clara Family Health Plan) adopted Government Accounting Standards Board No. 96, *Subscription-Based Information Technology Arrangements*, as of July 1, 2022, applied retrospectively. Our opinion is not modified with respect to this matter.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 1 through 8, supplementary schedule of proportionate share of the net pension asset/liability, supplementary schedule of pension contributions, supplementary schedules of changes in net other post-employment benefit asset/liability, and supplementary schedule of other post-employment benefit contributions on pages 49 through 52 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Moss Adams LLP

San Francisco, California
October 27, 2023

Financial Statements

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Net Position
June 30, 2023 and 2022

	2023	2022 (As Restated)
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets		
Cash and cash equivalents	$ 228,644,716	$ 254,897,750
Investments	466,315,233	296,007,423
Premiums receivable	633,235,398	698,665,326
Lease receivable, current portion	198,553	349,459
Prepaids and other assets	9,059,809	4,600,565
Total current assets	1,337,453,709	1,254,520,523
Lease receivable, net of current portion	34,586	233,139
Capital assets, net		
Nondepreciable	3,509,128	3,509,128
Depreciable, net of accumulated depreciation and amortization	18,963,413	20,852,750
Total capital assets, net	22,472,541	24,361,878
Assets restricted as to use	325,000	325,000
Net pension asset	-	8,138,023
Other post-employment benefits asset	1,432,456	6,557,302
Lease assets, net	448,068	727,014
Subscription assets, net	1,273,725	1,277,635
Total assets	1,363,440,085	1,296,140,514
Deferred outflows of resources	13,900,802	13,178,679
Total deferred outflows of resources	13,900,802	13,178,679
Total assets and deferred outflows of resources	$1,377,340,887	$1,309,319,193

See accompanying notes.

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Net Position (Continued)
June 30, 2023 and 2022

	2023	2022 (As Restated)
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
Current liabilities		
Accounts payable and accrued liabilities	$ 38,478,928	$ 32,123,572
Deferred revenues	17,265,307	-
Amounts due to the State of California	127,127,832	132,578,880
In-home supportive services payable	388,061,519	419,990,933
Due to providers	322,165,381	311,710,640
Medical incurred but not reported claims and medical claims payable	106,014,529	103,977,932
Provider incentives and other medical liabilities	2,648,667	1,499,998
Premium deficiency reserves	8,294,025	8,294,025
Lease liabilities, current portion	297,289	292,605
Subscription liabilities, current portion	737,626	671,664
Total current liabilities	1,011,091,103	1,011,140,249
Noncurrent liabilities		
Net pension liability	2,618,673	-
Lease liabilities, net of current portion	224,019	521,308
Subscription liabilities, net of current portion	393,641	468,704
Total liabilities	1,014,327,436	1,012,130,261
Deferred inflows of resources	3,591,276	7,146,011
Total deferred inflows of resources	3,591,276	7,146,011
Net position		
Net investment in capital assets	22,472,541	24,361,878
Restricted	325,000	325,000
Unrestricted:		
Designated by Governing Board	34,311,801	15,587,414
Unrestricted	302,312,833	249,768,629
Total net position	359,422,175	290,042,921
Total liabilities, deferred inflows of resources, and net position	$1,377,340,887	$1,309,319,193

See accompanying notes.

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2023 and 2022

	2023	2022 (As Restated)
Operating revenues		
Capitation and premium revenue	$ 1,969,561,234	$ 1,833,328,501
Total operating revenues	1,969,561,234	1,833,328,501
Operating expenses		
Medical expenses	1,773,775,049	1,597,879,729
Premium tax	71,375,936	128,834,987
General and administrative expenses	72,304,269	68,339,809
Depreciation and amortization	4,229,099	5,212,140
Total operating expenses	1,921,684,353	1,800,266,665
Operating income	47,876,881	33,061,836
Nonoperating revenues		
Interest and other income	21,502,373	2,130,483
Change in net position	69,379,254	35,192,319
Net position, beginning of year	290,042,921	254,850,602
Net position, end of year	$ 359,422,175	$ 290,042,921

See accompanying notes.

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Cash Flows
Years Ended June 30, 2023 and 2022

	2023	2022 (As Restated)
Cash flows from operating activities		
Capitation and premiums received	$ 2,052,256,469	$ 1,646,882,701
Medical expenses paid	(1,868,891,440)	(1,443,126,332)
Marketing, general, and administrative expenses paid	(59,302,398)	(60,995,795)
Net cash provided by operating activities	124,062,631	142,760,574
Cash flows from capital and financing activities		
Purchases of capital assets	(1,087,735)	(1,898,211)
Payments on lease liabilities	(292,605)	(266,826)
Payments on subscription liabilities	(671,664)	(762,870)
Proceeds from lease receivable	349,459	318,789
Net cash used in capital and financing activities	(1,702,545)	(2,609,118)
Cash flows from investing activities		
Purchase of investments	(2,113,232,717)	(1,801,354,060)
Sale of investments	1,943,117,224	1,721,308,573
Interest collection on investments	21,502,373	2,130,483
Net cash used in investing activities	(148,613,120)	(77,915,004)
Net change in cash and cash equivalents	(26,253,034)	62,236,452
Cash and cash equivalents, beginning of year	254,897,750	192,661,298
Cash and cash equivalents, end of year	$ 228,644,716	$ 254,897,750

See accompanying notes.

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Cash Flows (Continued)
Years Ended June 30, 2023 and 2022

	2023	2022 (As Restated)
Reconciliation of operating income to net cash provided by operating activities		
Operating income	$ 47,876,881	$ 33,061,836
Adjustments to reconcile operating income to net cash provided by operating activities		
Depreciation and amortization	4,229,099	5,212,140
Net unrealized gain on investments	(192,317)	(876,169)
Changes in operating assets and liabilities:		
Premiums receivable	65,429,928	(186,445,800)
Prepaids and other assets	(4,459,244)	2,011,580
Subscription assets/liabilities	(372,750)	(179,955)
Net pension asset/liability	10,756,696	(8,337,677)
Other post-employment benefits asset	5,124,846	(4,170,250)
Deferred outflows of resources	(722,123)	(5,765,322)
Accounts payable and accrued liabilities	6,421,498	20,658,928
Amounts due to the State of California	(5,451,048)	42,093,611
In-home supportive services payable	(31,929,414)	-
Due to providers	10,454,741	243,604,167
Medical incurred but not reported claims and medical claims payable	2,036,597	3,890,608
Provider incentives and other medical liabilities	1,148,669	(6,000,002)
Deferred revenues	17,265,307	-
Deferred inflows of resources	(3,554,735)	4,002,879
Net cash provided by operating activities	$ 124,062,631	$ 142,760,574
Supplemental cash-flow disclosure		
Cash paid during the year for premium tax	$ 71,400,384	$ 118,500,088
Supplemental disclosure of noncash item		
Payables for capital asset purchases	$ -	$ 283,933
Subscription assets as a result of implementation of *GASB 96*	$ 101,637	$ 1,981,556
Subscription liabilities as a result of implementation of *GASB 96*	$ 662,563	$ 1,903,237

See accompanying notes.

Note 1 – Organization and Summary of Significant Accounting Policies

History and organization – The Santa Clara County Health Authority (dba Santa Clara Family Health Plan) ("Health Authority") was established on August 1, 1995, by the Santa Clara County Board of Supervisors pursuant to Section 14087.38 of the State of California Welfare and Institutions Code (the "Code"). The Health Authority was created for the purpose of developing the Local Initiative Plan (the "Plan") for the expansion of Medi-Cal Managed Care, as presently regulated by the California Department of Managed Health Care ("DMHC"). The Medi-Cal Managed Care Program offers no-cost health coverage to children from birth through age 18, pregnant women, and other low-income populations in Santa Clara County (the "County").

The Health Authority has contracted with the California Department of Health Care Services ("DHCS") to receive funding to provide healthcare services to the Medi-Cal eligible County residents who are enrolled as members of the Health Authority ("DHCS contract"). The DHCS contract specifies capitation rates, which may be adjusted annually. DHCS revenue is paid monthly and is based upon contracted rates and actual Medi-Cal enrollment. The Health Authority, in turn, has contracted with hospitals and physicians whereby capitation payments (agreed-upon monthly payments per member) and fee-for-service payments are made in return for contracted healthcare services for its members. Provider contracts are typically evergreen and contain annual rate change provisions, termination clauses, and risk-sharing provisions.

The Health Authority contracts with the Centers for Medicare & Medicaid Services ("CMS") and the DHCS, effective January 1, 2015, to participate in Cal Medi-Connect ("CMC"), a demonstration project to integrate care for dual-eligible beneficiaries. Cal Medi-Connect is part of California's larger demonstration plan known as the Coordinated Care Initiative ("CCI"), which transforms the delivery of healthcare for seniors and people with disabilities. It integrates dual-eligible beneficiaries' care across all their entitlement benefits from Medicare, Medi-Cal, and other supportive services. The Cal Medi-Connect program ended on December 31, 2022, and was replaced with DualConnect, a dual-eligible special needs plan ("D-SNP"), effective January 1, 2023.

On March 1, 2016, SB X2-2 established a Managed Care Organization ("MCO") provider tax for July 1, 2016, through June 30, 2019, and administered by the DHCS. The tax is assessed by the DHCS on licensed health plans contracted to provide Medi-Cal services. The legislation established taxing tiers and per-enrollee amounts for the fiscal years ended June 30, 2017, 2018, and 2019. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized the DHCS to implement a modified MCO tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services on April 3, 2020. The effective date range for this approval is January 1, 2020, through December 31, 2022. On June 29, 2023, Assembly Bill 119 (Chapter 13, Statues of 2023) reimposed the MCO premium tax effective April 1, 2023, through December 31, 2026, and it had not been approved by the Centers for Medicare & Medicaid Services as of June 30, 2023. The Health Authority paid $71,400,384 and $118,500,088 in MCO premium taxes during fiscal years 2023 and 2022, respectively. At June 30, 2023 and 2022, the Health Authority had payables due in the amount of $14,956,227 and $42,311,132, respectively, included in amounts due to the State of California.

Beginning January 1, 2022, the DHCS began implementing California Advancing and Innovating Medi-Cal ("CalAIM") to modernize the state of California's Medi-Cal Program. CalAIM will require managed care plans to implement a whole-system, person-centered strategy that focuses on wellness and prevention, including assessments of each enrollee's health risks and health-related social needs, and provide care management and care transitions across delivery systems and settings. CalAIM is expected to provide additional new funding to the Health Authority and increase expenses, the total magnitude of which are not all known at this time.

Basis of accounting – The Health Authority is a governmental health insuring organization and, accordingly, follows principles, as prescribed by the Governmental Accounting Standards Board ("GASB"), the provisions of the American Institute of Certified Public Accountants Audit and Accounting Guide ("AICPA"), *Health Care Organizations*, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines. The Health Authority utilizes the proprietary fund method of accounting under which the financial statements are prepared on the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when incurred.

Pursuant to GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Health Authority's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989.

Use of estimates – The preparation of the financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Medical incurred but not reported ("IBNR") claims and medical claims payable, premiums receivable, fair market value of investments, net pension asset/liability, other post-employment benefits asset, premium deficiency reserves, and useful lives of capital assets represent significant estimates. Actual results could differ from those estimates.

Cash and cash equivalents – The Health Authority considers all highly liquid instruments with a maturity of three months or less at the time of purchase to be cash equivalents. Cash and cash equivalents are carried at cost, which approximates fair value. At June 30, 2023 and 2022, the Health Authority's cash deposits and investment pool had carrying amounts of $228,644,716 and $254,897,750, respectively. The Health Authority's bank and investment pool balances at June 30, 2023 and 2022, including interests in an investment pool, were $240,779,296 and $260,066,086, respectively. Of the bank and investment pool balances at June 30, 2023 and 2022, $240,013,445 and $259,267,576, respectively, were not covered by federal depository insurance.

Amounts invested in the County Treasurer's investment pool (the "Investment Pool") are considered cash and cash equivalents, as funds can be withdrawn by the Health Authority on demand. The County's Investment Oversight Committee Board has oversight responsibility for the Investment Pool. The Investment Pool is not U.S. Securities and Exchange Commission registered, and based on the California statutes and the County's investment policy primarily invests in obligations of U.S. Treasury, certain federal agencies, bankers' acceptances, commercial papers, certificates of deposit, repurchase agreements, and California State Treasurer's Local Agency Investment Fund. The amounts invested in the Investment Pool are considered investments in an external investment pool and earn interest based on the blended rate of return earned by the entire portfolio in the pool. Fair value is the amount at which a financial instrument could be exchanged in a current transaction between willing parties, other than in forced liquidation. The fair value of the Investment Pool is generally based on published market prices and quotations from major investment firms. As the Health Authority does not own identifiable investment securities of the pool but participates as a shareholder of the pool, these cash and cash equivalents are not individually identifiable and were not required to be categorized under GASB Codification Section C20, *Cash Deposits with Financial Institutions*, Section 150, *Investments*, and Section 155, *Investments – Reverse Repurchase Agreements*. The fair value of the Health Authority's share in the pool approximated the fair value of the position in the pool at June 30, 2023 and 2022.

Investments – The Health Authority adopted GASB Statement No. 72, *Fair Value Measurement and Application* ("GASB 72"), effective July 1, 2019. GASB 72 requires the Health Authority to use valuation techniques that are appropriate under the circumstances and are consistent with the market approach, the cost approach, or the income approach. GASB 72 establishes a hierarchy of inputs used to measure fair value consisting of three levels. Level 1 inputs are quoted prices in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. Level 3 inputs are unobservable inputs.

Capital assets – Purchased capital assets are stated at cost. Depreciation and amortization are provided using the straight-line method over the estimated useful lives of the respective assets, generally three to five years. Leasehold improvements are amortized over the shorter of the remaining term of the lease or the useful life. The Health Authority capitalizes capital expenditures over $1,000, which will have a useful life of three or more years.

The Health Authority evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Assets restricted as to use – The Health Authority is required by DMHC to restrict cash having a fair value of at least $300,000 for payment of member claims in the event of insolvency. The amount recorded was $325,000 at June 30, 2023 and 2022.

Amounts due to the State of California – When the Health Authority is made aware of changes to the DHCS rate structure, such as rate changes, risk corridors, or program reconciliations, that significantly impacts the financial outlook, an accrual for the estimated change is recorded.

In-Home Supportive Services ("IHSS") payable – The DHCS paid IHSS payments directly to Santa Clara County's Department of Social Services. As part of CCI, the Health Authority assumed full risk for IHSS provider payments. These amounts are included in both premium revenue and medical expenses and equivalent amounts are recorded as premiums receivable and IHSS payable, respectively, in the Health Authority's financials statements. Additionally, the Health Authority paid the MCO tax on the IHSS revenue and recorded it as premium tax. Effective January 1, 2018, IHSS was phased-out of CCI.

Due to providers – Due to providers consists predominately of payables related to managed care hospital directed payments, Proposition 56 funds, and Ground Emergency Medical Transportation ("GEMT") funds.

Effective July 1, 2017, the DHCS implemented three Medi-Cal managed care hospital directed payments: (1) Private Hospital Directed Payment ("PHDP"), (2) Designated Public Hospital Enhanced Payment Program ("EPP"), and (3) Designated Public Hospital Quality Incentive Pool ("QIP").

- For PHDP, the Department has directed Managed Care Plans ("MCP") to reimburse private hospitals as defined in Section 14169.51 of the Code, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient care.

- For EPP, which consists of fee-for-service and capitated pools, the Department has directed MCPs to reimburse California's designated public hospitals ("DPH") for contracted services based on actual utilization of contracted services.

- For QIP, the Department has directed MCPs to make additional payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization.

Proposition 56 is a supplemental payment for certain professional medical services to Medi-Cal beneficiaries funded by the California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56) as defined by the DHCS in the All Plan Letter ("APL") 19-006.

GEMT is a supplemental payment that provides additional funding to eligible providers of GEMT services to Medi-Cal beneficiaries as defined by the DHCS in APL 19-007.

Medical incurred but not reported claims and medical claims payable – The Health Authority contracts with various providers, including physicians and hospitals, to provide certain healthcare products and services to enrolled beneficiaries. The cost of the healthcare products and services provided or contracted for is accrued in the period in which it is provided to a member, based in part on actuarial estimates, including an accrual for medical services incurred but not yet reported to the Health Authority. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

Provider incentives and other medical liabilities – The Health Authority has various incentive agreements with certain providers whereby the providers are reimbursed for efficient and quality services provided to certain enrolled beneficiaries. Under the incentive agreements, healthcare costs (which include all fee-for-service claims and estimated medical incurred but not reported claims and medical claims payable) are allocated on a per member per month basis. Based on the terms of certain incentive agreements, a final reconciliation of surpluses is completed annually and paid within six months of the end of the Health Authority's fiscal year. Incentive payments are recorded as medical expenses in the accompanying financial statements.

Net pension asset/liability – The Health Authority recognizes a net pension asset/liability, which represents the proportionate share of the difference of the total pension asset/liability over the fiduciary net position of the pension reflected in the actuarial report provided by the California Public Employees' Retirement System ("CalPERS"). The net pension asset/liability is measured as of the Health Authority's prior fiscal year-end. Changes in the net pension asset/liability are recorded in the period incurred as pension expense and as deferred inflows of resources or deferred outflows of resources depending on the nature of the change. The changes in net pension asset/liability that are recorded as deferred inflows of resources or deferred outflows of resources are recognized in pension expense systematically over time.

For purposes of measuring the net pension asset/liability, deferred outflows and inflows of resources related to pensions, pension expense, information about the fiduciary net position, and additions to and deductions from the fiduciary net position have been determined on the same basis as they are reported by the CalPERS Financial Office. For this purpose, benefit payments (including refunds of employee contributions) are recognized when currently due and payable in accordance with the benefit terms. Investments are reported at fair value.

Other post-employment benefits asset – The Health Authority recognizes a net other post-employment benefits ("OPEB") asset, which represents the difference of the total OPEB liability over the fiduciary net position of the Health Authority's OPEB plan, which is administered by CalPERS. The net OPEB asset is measured as of the Health Authority's prior fiscal year-end. Changes in the net OPEB asset are recorded in the period incurred as OPEB expense and as deferred inflows of resources or deferred outflows of resources depending on the nature of the change. The changes in net OPEB asset that are recorded as deferred inflows of resources or deferred outflows of resources are recognized in OPEB expense systematically over time.

For purposes of measuring the net OPEB asset, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position, and additions to and deductions from the fiduciary net position have been determined on the same basis as they are reported by the CalPERS Financial Office. For this purpose, benefit payments (including refunds of employee contributions) are recognized when currently due and payable in accordance with the benefit terms. Investments are reported at fair value, except for money market investments and participating interest-earning investment contracts that have a maturity at the time of purchase of one year or less, which are reported at cost.

Lease assets and lease liabilities – The Health Authority has recorded lease assets and lease liabilities as a result of implementing GASB 87, *Leases* ("GASB 87"). The lease assets are initially measured at an amount equal to the initial measurement of the related lease liability plus any lease payments made prior to the lease term, less lease incentives, and plus ancillary charges necessary to place the lease into service. The lease assets are amortized on a straight-line basis over the life of the related lease.

The Health Authority recognizes lease contracts or equivalents that have a term exceeding one year that meet the definition of an other than short-term lease. The Health Authority uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the Health Authority's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments are expensed when incurred.

Lease receivable and deferred inflow of resources – Pursuant to GASB 87, the Health Authority, as a lessor, recognized a lease receivable and a deferred inflow of resources in the statements of net position. A lease receivable represents the present value of future lease payments expected to be received by the Health Authority during the lease term. A deferred inflow of resources is recognized corresponding to the lease receivable amount and is defined as an acquisition of net position by the Health Authority that is applicable to future reporting periods. Amortization of the deferred inflow of resources is based on the straight-line method over the terms of the leases.

The Health Authority recognizes lease contracts or equivalents that have a term exceeding one year that meet the definition of an other than short-term lease. The Health Authority uses the same interest rate it charges to the lessee as the discount rate or that is implicit in the contract to the lessee. Short-term lease receipts and variable lease receipts not included in the measurement of the lease receivable are recognized as income when earned.

Subscription assets and liabilities – The Health Authority has recorded subscription assets as a result of implementing GASB Statement No. 96, *Subscription-Based Information Technology Arrangements* ("GASB 96"). The subscription assets are initially measured at an amount equal to the initial measurement of the related subscription liability plus any contract payments made to the subscription-based information technology arrangement ("SBITA") vendor at the commencement of the subscription term, capitalizable initial implementation cost, less any incentive payments received from the SBITA vendor at the commencement of the subscription term. The subscription assets are amortized on a straight-line basis over the shorter of the subscription term or the useful life of the underlying assets.

The Health Authority recognizes contracts or equivalents that have a term exceeding one year with cumulative future payments on the contract exceeding $50,000 per year that meet the definition of an other than short-term lease. The Health Authority uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the Health Authority's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments are expensed when incurred.

Net position – Net position is classified as net investment in capital assets, restricted net position, and unrestricted net position, which includes board-designated funds. Net investment in capital assets represents capital assets, net of accumulated depreciation and amortization. Restricted net position is noncapital net position that must be used for a particular purpose, as specified by the state regulatory agency, grantors, or contributors external to the Health Authority. Unrestricted net position consists of net position that does not meet the definition of restricted or net investment in capital assets and board-designated funds. In December 2019, the Health Authority's Governing Board designated $16,000,000 for an Innovation fund and increased its previous designation for a Community-Based Organization fund to $4,000,000. As of June 30, 2023 and 2022, $34,311,801 and $15,587,414 was unexpended, respectively.

Capitation and premium revenue – The Health Authority has agreements with the Medi-Cal Program in the State of California to provide certain healthcare products and services to enrolled Medi-Cal beneficiaries. Eligibility of beneficiaries is determined by Santa Clara County Social Services Agency and validated by the State of California. The State of California provides the Health Authority the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month. The Health Authority receives monthly premium payments from the DHCS based on the number of enrolled Medi-Cal beneficiaries, regardless of services actually performed. Premiums are due from the DHCS monthly and are recognized as revenue during the period in which the Health Authority is obligated to provide services to members. A portion of revenues received from the DHCS is subject to possible retroactive adjustments. Provisions have been made for estimated retroactive adjustments. For the years ended June 30, 2023 and 2022, premium revenues recorded from the DHCS under the Medi-Cal program totaled $1,750,297,665 and $1,605,283,554, respectively.

The Health Authority entered into a three-way contract with CMS and the DHCS effective January 1, 2015, to participate in the CMC program. For the years ended June 30, 2023 and 2022, premium revenues totaled $23,374,739 and $195,888,830, and $42,996,569 and $45,682,524 for the Medi-Cal and Medicare components of the DualConnect and CMC programs (period ended June 30, 2023) and CMC program (period ended June 30, 2022), respectively. According to Chapter 33, Statutes of 2013 (SB 78, Committee on Budget and Fiscal Review), premium tax is imposed on only the revenues received by MCOs through their Medi-Cal and Healthy Kids managed care plans; consequently, Medicare revenues are not subject to premium tax.

Premium deficiency reserves – The Health Authority performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. The Health Authority entered into a three-way contract with CMS and the DHCS effective January 1, 2015, to participate in a demonstration project to integrate care for dual-eligible beneficiaries. The contract shall be renewed in one-year terms through December 31, 2023. The Health Authority is in the process of renewing the current contract with the DHCS. The Health Authority has the option to cancel this agreement prior to the end of each term. Management has estimated that it may incur losses on the contract. Accordingly, a premium deficiency reserve in the amount of $8,294,025 has been recorded at June 30, 2023 and 2022. The Health Authority may receive future revenue adjustments in the form of shared risk corridor payments and CMS hierarchical condition category risk adjustment true ups; however, these adjustments cannot currently be estimated. Management has determined that no other premium deficiency reserves were needed at June 30, 2023 and 2022. The Cal Medi-Connect program ended on December 31, 2022, and was replaced with DualConnect, a Medicare dual-eligible special needs plan ("D-SNP"), effective January 1, 2023.

Concentration of credit risk – A majority of the Health Authority's revenues are derived from contracts with the DHCS and CMS. Loss of the contracts due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of the Health Authority. As of June 30, 2023, the Health Authority had premiums receivable of $589,231,644, $4,578,328, and $39,425,426 due from Medi-Cal program, CMC program, and Medicare, respectively. As of June 30, 2022, the Health Authority had premiums receivable of $654,743,403, $10,468,902, and $33,453,021 due from Medi-Cal program, CMC program, and Medicare, respectively.

Medical expenses – Hospital, physician, and other service costs are based on actual paid claims plus an estimate for accrued incurred but not reported claims. Claims are paid primarily on a fee-for-service basis. Many physicians belonging to medical groups and certain hospitals are compensated primarily on a capitation basis with provisions for additional incentive payments in certain circumstances.

Operating revenues and expenses – The Health Authority's primary operating revenue is derived from capitation. As defined by GASB Codification Section P80, *Proprietary Fund Accounting and Financial Reporting,* all operating revenues are considered program revenues since they are charges for services provided and program-specific operating grants. The primary operating expense is medical care cost. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from nonexchange transactions or net investment income and changes in the fair value of investments.

Income taxes – The Health Authority is a public entity and falls under the purview of Internal Revenue Code, Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to federal income or state franchise taxes.

New accounting pronouncements – GASB 96 provides guidance on the accounting and financial reporting for SBITAs for government end users (governments). GASB 96 (1) defines a SBITA; (2) establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability; (3) provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA; and (4) requires note disclosures regarding a SBITA.

The Health Authority adopted GASB 96 as of July 1, 2022, applied retrospectively. The Health Authority calculated and recognized subscription assets, net, of $1,277,635 and subscription liabilities of $1,140,368 as of June 30, 2022. There was no material impact to beginning net position from the adoption of GASB 96.

In June 2022, the GASB issued Statement No. 100, *Accounting Changes and Error Corrections - an amendment of GASB Statement No. 62*. This Statement enhances accounting and financial reporting requirements for accounting changes and error corrections. It defines accounting changes as changes in accounting principles, changes in accounting estimates, and changes to or within the financial reporting entity. This statement requires that (1) changes in accounting principles and error corrections be reported retroactively by restating prior periods, (2) changes to or within the financial reporting entity be reported by adjusting beginning balances of the current period, and (3) changes in accounting estimates be reported prospectively by recognizing the change in the current period. The statement is effective for fiscal years beginning after June 15, 2023. The Health Authority is currently evaluating the impact of the adoption of this standard on its financial statements.

In June 2022, the GASB issued Statement No. 101, *Compensated Absences*. The statement updates the recognition and measurement guidance for compensated absences. This statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used, and (2) leave that has been used but not yet paid, provided the services have occurred, the leave accumulates, and the leave is more likely than not to be used for time off or otherwise paid in cash or noncash means. In estimating the leave that is more likely than not to be used or otherwise paid or settled, a government entity should consider relevant factors such as employment policies related to compensated absences and historical information about the use or payment of compensated absences. The statement amends the existing requirements to disclose only the net change in the liability instead of the gross additions and deductions to the liability. This statement is effective for fiscal years beginning after December 15, 2023. The Health Authority is currently evaluating the impact of the adoption of this standard on its financial statements.

Reclassifications – Certain reclassifications of prior years' balances have been made to conform with the current year presentations. Such reclassifications did not affect the total increase in net position or total current or noncurrent assets or liabilities.

Note 2 – Investments

At June 30, 2023 and 2022, the Health Authority's investments consisted of commercial paper, U.S. government agency bonds, corporate bonds, foreign bonds, municipal bonds, U.S. treasury securities, and money market funds.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. The Health Authority manages risk of market value fluctuations due to overall changes in the general level of interest rates by complying with California Government Code Section 53600.5. As of June 30, 2023 and 2022, the Health Authority's investments all have maturities of less than one year.

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a nationally recognized statistical rating organization. The following are the credit ratings for each investment type at June 30, 2023:

Description	Fair Value	Not Rated	AAA	AA+	AA	AA-	A+	A	A-
Investments in:									
U.S. government agency bonds	$ 211,246,255	$ 211,246,255	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	59,435,174	-	-	-	-	-	19,395,488	-	40,039,686
Foreign bonds	41,724,169	-	-	-	-	-	-	-	41,724,169
Municipal bonds	6,094,464	-	-	6,094,464	-	-	-	-	-
Commercial paper	122,873,549	122,873,549	-	-	-	-	-	-	-
Money market funds	24,941,622	-	24,941,622	-	-	-	-	-	-
Total investments	$ 466,315,233	$ 334,119,804	$ 24,941,622	$ 6,094,464	$ -	$ -	$ 19,395,488	$ -	$ 81,763,855

The following are the credit ratings for each investment type at June 30, 2022:

Description	Fair Value	Not Rated	AAA	AA+	AA	AA-	A+	A	A-
Investments in:									
U.S. government agency bonds	$ 1,988,320	$ 1,988,320	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	53,440,085	-	1,010,623	-	-	4,000,163	6,816,745	4,375,795	37,236,759
Foreign bonds	22,983,662	-	-	-	-	14,935,397	-	-	8,048,265
Municipal bonds	24,295,915	-	11,783,975	1,830,183	1,850,023	999,568	7,832,166	-	-
Commercial paper	108,906,959	108,906,959	-	-	-	-	-	-	-
U.S. Treasury securities	49,987,500	49,987,500	-	-	-	-	-	-	-
Money market funds	34,404,982	-	34,404,982	-	-	-	-	-	-
Total investments	$ 296,007,423	$ 160,882,779	$ 47,199,580	$ 1,830,183	$ 1,850,023	$ 19,935,128	$ 14,648,911	$ 4,375,795	$ 45,285,024

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer. The Health Authority's investments as a percentage of its portfolio at June 30, 2023, are as follows:

Investment	Issuer	Percentage of Portfolio
U.S. government agency bonds	Various	45.0 %
Corporate bonds	Various	13.0
Foreign bonds	Various	9.0
Municipal bonds	Various	1.0
Commercial paper	Various	27.0
Money market funds	Various	5.0
		100.00 %

The Health Authority's investments as a percentage of its portfolio at June 30, 2022, are as follows:

Investment	Issuer	Percentage of Portfolio
U.S. government agency bonds	Various	1.0 %
Corporate bonds	Various	18.0
Foreign bonds	Various	8.0
Municipal bonds	Various	8.0
Commercial paper	Various	36.0
U.S. Treasury securities	Various	17.0
Money market funds	Various	12.0
		100.00 %

Note 3 – Fair Value

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The following table presents fair value measurements of assets recognized in the accompanying financial statements measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at June 30:

Description	Level 1	Level 2	Level 3	2023
Investments in:				
U.S. government agency bonds	$ -	$ 211,246,255	$ -	$ 211,246,255
Corporate bonds	-	59,435,174	-	59,435,174
Foreign bonds	-	41,724,169	-	41,724,169
Municipal bonds	-	6,094,464	-	6,094,464
Total investments subject to fair value hierarchy	$ -	$ 318,500,062	$ -	318,500,062
Investments and restricted cash not subject to fair value hierarchy				
Commercial paper				122,873,549
Money market funds				24,941,622
Certificates of deposits				325,000
Total investments and restricted cash				$ 466,640,233

Description	Level 1	Level 2	Level 3	2022
Investments in:				
U.S. government agency bonds	$ -	$ 1,988,320	$ -	$ 1,988,320
Corporate bonds	-	53,440,085	-	53,440,085
Foreign bonds	-	22,983,662	-	22,983,662
Municipal bonds	-	24,295,915	-	24,295,915
Total investments subject to fair value hierarchy	$ -	$ 102,707,982	$ -	102,707,982
Investments and restricted cash not subject to fair value hierarchy				
Commercial paper				108,906,959
U.S. Treasury securities				49,987,500
Money market funds				34,404,982
Certificates of deposits				325,000
Total investments and restricted cash				$ 296,332,423

Note 4 – Capital Assets

Capital asset activity for the fiscal years ended June 30, 2023 and 2022, are as follows:

	2023				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ 3,509,128	$ -	$ -	$ -	$ 3,509,128
Furniture and equipment	13,815,664	584,209	(10,708,544)	-	3,691,329
Building and building improvements	23,113,375	109,046	-	-	23,222,421
Software	12,488,236	394,480	(1,361,232)	-	11,521,484
Vehicles	29,248	-	-	-	29,248
Total capital assets	52,955,651	1,087,735	(12,069,776)	-	41,973,610
Less accumulated depreciation and amortization for:					
Furniture and equipment	12,255,671	811,515	(10,642,402)	-	2,424,784
Building and building improvements	4,498,989	1,619,275	-	-	6,118,264
Software	11,817,584	475,265	(1,361,232)	-	10,931,617
Vehicles	21,529	4,875	-	-	26,404
Total accumulated depreciation and amortization	28,593,773	2,910,930	(12,003,634)	-	19,501,069
Capital assets, net	$ 24,361,878	$ (1,823,195)	$ (66,142)	$ -	$ 22,472,541

	2022				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ 3,509,128	$ -	$ -	$ -	$ 3,509,128
Furniture and equipment	13,236,492	930,513	(351,341)	-	13,815,664
Building and building improvements	22,913,963	307,959	(108,547)	-	23,113,375
Software	11,833,970	943,672	(289,406)	-	12,488,236
Vehicles	29,248	-	-	-	29,248
Total capital assets	51,522,801	2,182,144	(749,294)	-	52,955,651
Less accumulated depreciation and amortization for:					
Furniture and equipment	11,474,319	794,725	(13,373)	-	12,255,671
Building and building improvements	2,885,035	1,613,970	(16)	-	4,498,989
Software	10,090,129	1,736,079	(8,624)	-	11,817,584
Vehicles	16,655	4,874	-	-	21,529
Total accumulated depreciation and amortization	24,466,138	4,149,648	(22,013)	-	28,593,773
Capital assets, net	$ 27,056,663	$ (1,967,504)	$ (727,281)	$ -	$ 24,361,878

Depreciation and amortization expense totaled $2,910,930 and $4,127,635 at June 30, 2023 and 2022, respectively.

Note 5 – Medical Incurred But Not Reported Claims and Medical Claims Payable

The Health Authority estimates IBNR claims, and medical claims payable based on historical claims payment and other relevant information. Estimates are monitored and reviewed and, as settlements are made or estimates are adjusted, differences are reflected in current operations. Such estimates are subject to impact of changes in the regulatory environment. Activity for medical IBNR and medical claims payable for the years ended June 30, 2023 and 2022, is summarized as follows:

	2023	2022
Beginning balance	$ 103,977,932	$ 100,087,324
Incurred related to:		
Current year	630,134,250	661,732,668
Prior year	(13,958,832)	(28,652,411)
Total incurred	616,175,418	633,080,257
Paid related to:		
Current year	523,343,359	555,604,717
Prior year	90,795,462	73,584,932
Total paid	614,138,821	629,189,649
Ending balance	$ 106,014,529	$ 103,977,932

As presented in the table above, $616,175,418 and $633,080,257 in medical claims were incurred for the years ended June 30, 2023 and 2022, respectively, which are reflected in medical services in the statements of revenues, expenses, and changes in net position.

IBNR liability increased by $2,036,597 in comparison to the previous year as a result of changes between actual payments for medical services and estimated amounts in previous years. Management believes the increase in estimated prior year's claims experience is largely a result of higher-than-anticipated adverse healthcare claims experience.

Note 6 – Designated Net Position

Designated funds remain under the control of the Governing Board, which may, at its discretion, later use the funds for other purposes. For the fiscal years ended June 30, 2023 and 2022, board-designated funds of $34,311,801 and $15,587,414, respectively, were made.

Note 7 – Leases

The Health Authority is a lessee for noncancelable leases of office space and equipment with lease terms through 2026. In fiscal year 2023 and 2022, the total lease payments were $292,605 and $266,826, respectively. There are no residual value guarantees included in the measurement of the Health Authority's lease liability nor recognized as an expense for the years ended June 30, 2023 and 2022. The Health Authority does not have any commitments that were incurred at the commencement of the leases. The Health Authority is not subject to variable payments. No termination penalties were incurred for the years ended June 30, 2023 and 2022.

The Health Authority has the following lease right-of-use activities as of June 30:

	2023			
	Beginning Balance	Increase	Decrease	Ending Balance
Lease assets				
Office space	$ 876,823	$ -	$ -	$ 876,823
Equipment	337,114	-	-	337,114
Total lease assets	1,213,937	-	-	1,213,937
Less accumulated amortization				
Office space	344,980	172,490	-	517,470
Equipment	141,943	106,456	-	248,399
Total accumulated amortization	486,923	278,946	-	765,869
Lease assets, net	$ 727,014	$ (278,946)	$ -	$ 448,068

	2022			
	Beginning Balance	Increase	Decrease	Ending Balance
Lease assets				
Office space	$ 876,823	$ -	$ -	$ 876,823
Equipment	337,114	-	-	337,114
Total lease assets	1,213,937	-	-	1,213,937
Less accumulated amortization				
Office space	172,490	172,490	-	344,980
Equipment	35,486	106,457	-	141,943
Total accumulated amortization	207,976	278,947	-	486,923
Lease assets, net	$ 1,005,961	$ (278,947)	$ -	$ 727,014

For the years ended June 30, 2023 and 2022, the Health Authority recognized $278,946 and $278,947, respectively, in amortization expense.

The Health Authority has the following lease liabilities activities for the years ended June 30, 2023 and 2022:

	2023				
	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
Lease liabilities					
Office space	$ 588,669	$ -	$ 174,780	$ 413,889	$ 189,870
Equipment	225,244	-	117,825	107,419	107,419
	$ 813,913	$ -	$ 292,605	$ 521,308	$ 297,289

	2022				
	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
Lease liabilities					
Office space	$ 749,265	$ -	$ 160,596	$ 588,669	$ 174,780
Equipment	331,474	-	106,230	225,244	117,825
	$ 1,080,739	$ -	$ 266,826	$ 813,913	$ 292,605

The future principal and interest lease payments as of June 30, 2023, were as follows:

Year Ending June 30,	Principal	Interest	Total
2024	$ 297,289	$ 18,899	$ 316,188
2025	205,938	6,546	212,484
2026	18,081	75	18,156
	$ 521,308	$ 25,520	$ 546,828

The Health Authority evaluated the lease assets for impairment and determined there was no impairment for the years ended June 30, 2023 and 2022.

The Health Authority is a lessor for noncancelable lease of office space with lease terms through fiscal year 2026. For the years ending June 30, 2023 and 2022, the Health Authority recognized $329,632 in lease revenue released from deferred inflows of resources related to the office space lease. The Health Authority recognized interest revenue of $19,800 and $36,616 for the years ended June 30, 2023 and 2022, respectively. No variable payments were charged to the lessees. No inflows of resources were recognized in the year related to termination penalties or residual value guarantees during the year.

Note 8 – Subscription-Based Information Technology Arrangements

The Health Authority entered into various agreements for information technology ("IT") subscriptions. These agreements range in terms up to year 2025. In fiscal years 2023 and 2022, the total subscription payments were $671,664 and $762,870, respectively. Variable payments based upon the use of the underlying IT asset are not fixed in substance — therefore, these payments are not included in subscription assets or subscription liabilities. There were no variable subscription expenses and payments in fiscal years ended June 30, 2023 or 2022. The Health Authority is in the process of entering into additional subscription agreements that have yet to commence as of June 30, 2023.

The Health Authority has the following subscription assets activities for the years ended June 30, 2023 and 2022:

	2023			
	Beginning Balance	Increase	Decrease	Ending Balance
Subscription assets	$ 2,032,621	$ 1,035,313	$ -	$ 3,067,934
Less accumulated amortization	754,986	1,039,223	-	1,794,209
Subscription assets, net	$ 1,277,635	$ (3,910)	$ -	$ 1,273,725

	2022			
	Beginning Balance	Increase	Decrease	Ending Balance
Subscription assets	$ 1,981,556	$ 101,637	$ 50,572	$ 2,032,621
Less accumulated amortization	-	805,558	50,572	754,986
Subscription assets, net	$ 1,981,556	$ (703,921)	$ -	$ 1,277,635

For the years ended June 30, 2023 and 2022, the Health Authority recognized $1,039,223 and $805,558, respectively, in amortization expense.

	2023				
	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
Subscription liabilities	$ 1,140,368	$ 662,563	$ 671,664	$ 1,131,267	$ 737,626

	2022				
	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
Subscription liabilities	$ 1,852,936	$ 50,301	$ 762,869	$ 1,140,368	$ 671,664

The future principal and interest subscription payments as of June 30, 2023, were as follows:

Year Ending June 30,	Principal	Interest	Total
2024	$ 737,626	$ 45,927	$ 783,553
2025	291,765	20,139	311,904
2026	101,876	5,212	107,088
	$ 1,131,267	$ 71,278	$ 1,202,545

The Health Authority evaluated the subscription assets for impairment and determined there was no impairment for the years ended June 30, 2023 and 2022.

Note 9 – Employee Benefit Plans

Internal Revenue Code 401(a) Plan – The Health Authority has a defined contribution plan under Section 401(a) of the Internal Revenue Code. Nonsenior staff employees may make an irrevocable election by their first day of employment to contribute 6% of their gross compensation and the Health Authority must contribute 3% of the participant's gross compensation. For senior staff employees, the Health Authority contributes greater than 3% of gross compensation and senior staff employees contribute less than 6% of their gross compensation. Contributions by the Health Authority totaled $1,076,431 and $907,115 for the years ended June 30, 2023 and 2022, respectively.

The 401(a) plan is administered through a third-party administrator and is available to all employee groups. The Heath Authority does not perform the investment function and has no fiduciary accountability for the plan. Thus, plan assets and any related liability to plan participants have been excluded from the Health Authority's financial statements.

Internal Revenue Code 457 Plan – The Health Authority has a deferred compensation plan under Section 457 of the Internal Revenue Code. Participants may contribute up to the maximum allowed under Section 457. The Health Authority makes matching contributions only to 457 plan participants who are not participating in the 401(a) plan. For those employees, the Health Authority matches 50% of employee contributions, up to a maximum of 3% of compensation. Matching contributions are made to the 401(a) plan.

The 457 plan is administered through a third-party administrator and is available to all employee groups. The Heath Authority does not perform the investment function and has no fiduciary accountability for the plan. Thus, plan assets and any related liability to plan participants have been excluded from the Health Authority's financial statements.

California Public Employees' Retirement System

Plan description – The Health Authority participates in CalPERS, a cost-sharing multiple-employer defined benefit pension plan. CalPERS acts as a common investment and administrative agent for various local and state governmental agencies within the State of California. CalPERS provides retirement, disability, and death benefits based on the employee's years of service, age, and final compensation. CalPERS provides retirement benefits payable beginning at age 55 that are equal to 2% of the employee's final 3-year average compensation multiplied by the employee's years of service. The State passed the California Employees' Pension Reform Act of 2013 ("PEPRA"), which became effective on January 1, 2013. PEPRA changes include the classification of active employees into two distinct classifications: classic members and new members. Classic members represent active members hired before January 1, 2013, and retain the pension plan benefits in effect. This plan was closed to entrants on January 1, 2013, or after. New members are active members hired on or after January 1, 2013, and are subject to PEPRA. PEPRA offers a reduced benefit formula and increased retirement ages to new public employees, who first became PERS members on or after January 1, 2013. CalPERS provides retirement benefits payable beginning at age 62 that are equal to 2% of the employee's final 3-year average compensation times the employee's years of service. The provisions and all other requirements are established by state statute. CalPERS issues a stand-alone report that is available upon request at the following address: CalPERS Actuarial & Employer Service Division; P.O. Box 942709; Sacramento, California 94229-2709.

Funding policy – The contribution requirements of the plan members and the Health Authority are established and may be amended by CalPERS. With the election to participate in CalPERS, participation in Social Security is discontinued, and contributions to CalPERS are in lieu of contributions to Social Security. The Health Authority is required to contribute an actuarially determined rate. The employer contribution rate for classic members was 10.32% and 10.34% of annual covered payroll for the years ended June 30, 2023 and 2022, respectively. The employer contribution rate for PEPRA members was 7.47% and 7.59% for the years ended June 30, 2023 and 2022, respectively. All eligible participating classic employees are required to contribute 7.00% of their monthly salaries to CalPERS for years ended June 30, 2023 and 2022. All eligible participating PEPRA employees are required to contribute 6.75% for years ended June 30, 2023 and 2022. The Health Authority deducts the contributions from employees' wages and remits to CalPERS on their behalf and for their account. Contributions to the pension plans from the Health Authority were $2,762,165 and $2,519,660 for the years ended June 30, 2023 and 2022, respectively.

Pension liability/asset, pension expense, and deferred outflows of resources and deferred inflows of resources related to pension – The net pension liability at June 30, 2023, is measured as of June 30, 2022, using an annual actuarial valuation as of June 30, 2021, rolled forward to June 30, 2022, using standard update procedures. The total pension liability in the June 30, 2021, actuarial valuation was based on the following actuarial methods and assumptions:

Actuarial cost method:	Entry Age Normal in accordance with the requirements of GASB Statement No. 68
Actuarial assumptions:	
Discount rate	6.90%
Inflation	2.30%
Salary increases	Varies by Entry Age and Service
Mortality rate table	Derived using CaIPERS' Membership Data for all Funds
Postretirement benefit increase:	Contract COLA up to 2.30% until Purchasing Power Protection Allowance Floor on Purchasing Power applies

The net pension asset at June 30, 2022, is measured as of June 30, 2021, using an annual actuarial valuation as of June 30, 2020, rolled forward to June 30, 2021, using standard update procedures. The total pension asset in the June 30, 2020, actuarial valuation was based on the following actuarial methods and assumptions:

Actuarial cost method:	Entry Age Normal in accordance with the requirements of GASB Statement No. 68
Actuarial assumptions:	
Discount rate	7.15%
Inflation	2.50%
Salary increases	Varies by Entry Age and Service
Mortality rate table	Derived using CaIPERS' Membership Data for all Funds
Postretirement benefit increase:	Contract COLA up to 2.50% until Purchasing Power Protection Allowance Floor on Purchasing Power applies

All other actuarial assumptions used in the June 30, 2021, valuation were based on the results of an actuarial experience study for the fiscal years 2001 to 2019, including updates to salary increase, mortality, and retirement rates. All other actuarial assumptions used in the June 30, 2020, valuation were based on the results of an actuarial experience study for the fiscal years 1997 to 2015, including updates to salary increase, mortality, and retirement rates. The experience study report can be obtained at the CalPERS' website under Forms and Publications.

Change of assumptions – The inflation rate decreased from 2.50% to 2.30% for the June 30, 2022, measurement date. The inflation rate remained unchanged at 2.50% for the June 30, 2021, measurement date.

Discount rate – The discount rate used to measure the total pension asset at June 30, 2023 and 2022, measurement date was 6.90% and 7.15%, respectively. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress-tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. The test revealed the assets would not run out. Therefore, the current 6.90% discount rate is appropriate, and the use of the municipal bond rate calculation is not deemed necessary. The long-term expected discount rate of 6.90% is applied to all plans in the Public Employees Retirement Fund. The cash flows used in the testing were developed assuming that both members and employers will make their required contributions on time and as scheduled in all future years. The stress test results are presented in a detailed report called “GASB Crossover Testing Report” that can be obtained from the CalPERS website.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make the required contributions as scheduled in all future years. Using historical returns of all the funds’ asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11-60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one-quarter of one percent.

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation.

Asset Class	Assumed Asset Allocation	Real Return Years 1-10 [a,b]
Global equity - cap-weighted	30.0%	4.45%
Global equity non-cap-weighted	12.0%	3.84%
Private equity	13.0%	7.28%
Treasury	5.0%	0.27%
Mortgage-backed securities	5.0%	0.50%
Investment grade corporates	10.0%	1.56%
High yield	5.0%	2.27%
Emerging market debt	5.0%	2.48%
Private debt	5.0%	3.57%
Real assets	15.0%	3.21%
Leverage	-5.0%	-0.59%

[a] An expected inflation rate of 2.30% was used for this period.
[b] Figures are based on the 2021-22 Asset Liability Management study.

Sensitivity of the employer's proportionate share of the net pension asset/liability to changes in the discount rate – The following presents the Health Authority's net pension asset/liability as of June 30, 2023 and 2022, as well as what the net pension asset/liability would be if it were calculated using a discount rate that is 1% point lower or 1% point higher than the current rate:

	June 30, 2023		
	1% Decrease (5.90%)	Current Discount Rate (6.90%)	1% Increase (7.90%)
Health Authority's net pension liability (asset)	$ 12,265,852	$ 2,618,673	$ (5,318,562)
	June 30, 2022		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Health Authority's net pension (asset)	$ (116,848)	$ (8,138,023)	$ (14,769,014)

The Health Authority's proportion for the miscellaneous plan was 0.02267% and -0.15047% at June 30, 2023 and 2022, respectively.

For the years ended June 30, 2023 and 2022, the Health Authority recognized pension expense of $14,898,436 and pension income of $13,019,517, respectively. Pension income/expense represents the change in the net pension asset/liability during the measurement period, adjusted for actual contributions and the deferred recognition of changes in investment gain/loss, actuarial gain/loss, actuarial assumptions or method, and plan benefits.

As of June 30, 2023, the Health Authority had $10,768,109 of deferred outflows of resources and $839,720 of deferred inflows of resources related to pensions from the following sources:

	2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 6,996,196	$ -
Difference in experience	52,588	(35,221)
Differences between employer's actual contributions and its proportionate share of total employer contributions	-	(804,499)
Net differences between projected and actual earnings on pension plan investments	479,671	-
Changes in assumptions	268,338	-
Pension contributions made subsequent to measurement date	2,971,316	-
	$ 10,768,109	$ (839,720)

As of June 30, 2022, the Health Authority had $12,516,133 of deferred outflows of resources and $1,417,320 of deferred inflows of resources related to pensions from the following sources:

	2022	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 2,660,042	$ -
Difference in experience	-	(912,592)
Differences between employer's actual contributions and its proportionate share of total employer contributions	-	(504,728)
Net differences between projected and actual earnings on pension plan investments	7,104,064	-
Changes in assumptions	-	-
Pension contributions made subsequent to measurement date	2,752,027	-
	$ 12,516,133	$ (1,417,320)

Deferred outflows of resources and deferred inflows of resources above represent the unamortized portion of changes to net pension asset/liability to be recognized in future periods in a systematic manner.

Deferred outflows of resources of $2,971,316 and $2,752,027 resulting from contributions subsequent to the measurement date will be recognized as an increase/reduction of the net pension asset/liability in the years ending June 30, 2024 and 2023, respectively.

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

Year Ended June 30,	
2024	$ 2,823,140
2025	$ 2,454,668
2026	$ 1,385,882
2027	$ 293,383

Note 10 – Post-Employment Health Benefits

Plan description – The Health Authority participates in the California Employers' Retiree Benefit Trust ("CERBT"), a single-employer agent plan as administered by CalPERS to prefund its post-employment healthcare benefits. The Health Authority's OPEB plan provides healthcare benefits to eligible employees and certain dependents. Retired employees who retire directly from the health plan are eligible to receive contributions from the Health Authority toward their monthly Public Employees' Medical and Hospital Care Act (health plans offered by CalPERS) if they meet certain age and service eligibility requirements as outlined in the plan document and as approved by the Health Authority's Governing Board.

Employees hired prior to May 1, 2018, who attain age 50, with a minimum of 5 years of CalPERS service, and are employed by the Health Authority at the time of retirement, are eligible for coverage. Employees hired on or after May 1, 2018, who attain age 50, with a minimum of 12 continuous years at the Health Authority and are employed by the Health Authority at the time of retirement, are eligible for coverage.

Copies of CERBT's annual financial report may be obtained from the executive office at 400 Q Street, Sacramento, California 95811. A separate report for the Health Authority's participation in the CERBT trust is not available.

Funding policy – For employees hired prior to May 1, 2018, and service with CalPERS of 5 years, the Health Authority pays for 90% of the cost of retiree medical plan premiums, including the cost for spouse and dependent coverage. Retirees are required to pay the other 10% of the cost of coverage. The Health Authority's contribution is capped at 90% of the monthly premium cost of the second most expensive HMO plan available from CalPERS (basic and supplemental rates for non-Medicare and Medicare retirees, respectively) for retirees who elect PERS Care or out-of-state coverage. Upon the death of the retiree, the Health Authority will continue contributions described above for the surviving spouse or until surviving minor dependents reach age 26.

For employees hired on or after May 1, 2018, and 12 years of employment with the Health Authority, the Health Authority pays for 90% of the cost of retiree-only medical plan premiums. Retirees are required to pay the other 10% of the cost of coverage. The Health Authority's contribution is capped at 90% of the employee-only premium cost of the second most expensive HMO plan available from CalPERS (basic and supplemental rates for non-Medicare and retirees, respectively) for retirees who elect PERS Care or out-of-state coverage.

Employees covered – At June 30, 2023 and 2022, the following number of employees were covered by the plan:

	2023	2022
Active	351	331
Retirees	73	65
Total participants	424	396

Contributions – The Health Authority must contribute the minimum required amount of $5,000 or the actuarially determined contribution, whichever is lower. The contribution requirements of the Health Authority are established and may be amended by the CERBT.

Net OPEB asset – The Health Authority's net OPEB asset at June 30, 2023 and 2022, was measured as of June 30, 2022 and 2021, respectively, and the total OPEB asset used to calculate the net OPEB asset was determined by an actuarial valuation as of June 30, 2022 and 2021, respectively.

The total OPEB asset in the June 30, 2023, actuarial valuation was determined using the following actuarial assumptions:

Actuarial cost method:	Individual Entry Age Normal Level Percent of Pay
Actuarial assumptions:	
Discount rate	6.25%
Inflation	2.50%
Investment rate of return	6.25%
Healthcare cost trend rates:	8.50 % for 2024 – Non-Medicare, decreasing to 3.45% in 2076, 7.50% for 2024 – Medicare (Non-Kaiser), decreasing to 3.45% in 2076, 6.25% for 2024 – Medicare (Kaiser), decreasing to 3.45% in 2076

Mortality rates are based on statistics taken from the CalPERS 2000-2019 Experience Study Report. Mortality projected fully generational with Scale MP-2021.

The total OPEB liability in the June 30, 2022, actuarial valuation was determined using the following actuarial assumptions:

Actuarial cost method:	Individual Entry Age Normal Level Percent of Pay
Actuarial assumptions:	
Discount rate	6.25%
Inflation	2.50%
Investment rate of return	6.75%
Healthcare cost trend rates:	6.50 % for 2023 – Non-Medicare, decreasing to 3.75% in 2076, 5.65% for 2023 – Medicare (Non-Kaiser), decreasing to 3.75% in 2076, 4.6% for 2023 – Medicare (Kaiser), decreasing to 3.75% in 2076

Mortality rates are based on statistics taken from the CalPERS 2000-2019 Experience Study Report. Mortality projected fully generational with Scale MP-2021.

Discount rate – The discount rate used to measure the total OPEB asset was 6.25% at June 30, 2022 and 2021 measurement dates. The projection of cash flows used to determine the discount rate assumed that Health Authority contributions will be made at rates equal to the actuarially determined contribution rates. Based on those assumptions, the OPEB plan's fiduciary net position was projected to be available to make all projected OPEB payments for current active and inactive employees. Therefore, the long-term expected rate of return on OPEB plan investments was applied to all periods of projected benefit payments to determine the total OPEB asset.

The Health Authority's retiree health plan assets are invested in the California Employers' Retirement Benefit Trust Fund Strategy 1 ("Strategy"). The table below reflects the Strategy's asset allocation.

Asset Class	Asset Allocation	Expected Real Rate of Return
Global equity	49.00%	4.56%
Fixed income	23.00%	1.56%
Treasury inflation-protected securities	5.00%	-0.08%
Commodities	3.00%	1.22%
Real estate investment trusts	20.00%	4.06%
Assumed long-term rate of inflation		2.50%
Expected long-term net rate of return		6.25%

Changes in the net OPEB asset – The changes in the net OPEB asset for the years June 30, 2023, were as follows:

	June 30, 2023		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB (Asset)
Balance at June 30, 2022	$ 13,780,500	$ 20,337,802	$ (6,557,302)
Changes during the year:			
Service cost	1,133,723	-	1,133,723
Interest on the total OPEB asset	913,306	-	913,306
Actual vs. expected experience	(98,525)	-	(98,525)
Assumption changes	1,051,988	-	1,051,988
Contributions from employer	-	604,048	(604,048)
Net investment income	-	(2,721,847)	2,721,847
Benefit payments	(602,644)	(602,644)	-
Administrative expense	-	(6,555)	6,555
Net change	2,397,848	(2,726,998)	5,124,846
Balance at June 30, 2023	$ 16,178,348	$ 17,610,804	$ (1,432,456)

	June 30, 2022		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB (Asset)
Balance at June 30, 2021	$ 13,485,032	$ 15,872,084	$ (2,387,052)
Changes during the year:			
Service cost	1,231,856	-	1,231,856
Interest on the total OPEB asset	977,230	-	977,230
Actual vs. expected experience	(1,267,092)	-	(1,267,092)
Assumption changes	(167,716)	-	(167,716)
Contributions from employer	-	588,065	(588,065)
Net investment income	-	4,362,468	(4,362,468)
Benefit payments	(478,810)	(478,810)	-
Administrative expense	-	(6,005)	6,005
Net change	295,468	4,465,718	(4,170,250)
Balance at June 30, 2022	$ 13,780,500	$ 20,337,802	$ (6,557,302)

Sensitivity of the net OPEB asset to changes in the discount rate – The following presents the net OPEB asset of the Health Authority as of June 30, 2023 and 2022, as well as what the Health Authority's net OPEB asset would be if it were calculated using a discount rate that is one percentage point lower or one percentage point higher than the current discount rate:

	June 30, 2023		
	1% Decrease (5.25%)	Current Discount Rate (6.25%)	1% Increase (7.25%)
Health Authority's net OPEB liability (asset)	$ 752,645	$ (1,432,456)	$ (3,240,860)

	June 30, 2022		
	1% Decrease (5.25%)	Current Discount Rate (6.25%)	1% Increase (7.25%)
Health Authority's net OPEB (asset)	$ (4,641,149)	$ (6,557,302)	$ (8,138,562)

Sensitivity of the net OPEB asset to changes in the healthcare cost trend rates – The following presents the net OPEB asset of the Health Authority, as well as what the Health Authority's net OPEB asset would be if it were calculated using healthcare cost trend rates that is one percentage point lower or one percentage point higher than the current healthcare cost trend rates:

	June 30, 2023		
	1% Decrease in Healthcare Costs Trend Rate	Current Healthcare Costs Trend Rate	1% Increase in Healthcare Costs Trend Rate
Health Authority's net OPEB (asset)	$ (3,588,016)	$ (1,432,456)	$ 1,264,050

	June 30, 2022		
	1% Decrease in Healthcare Costs Trend Rate	Current Healthcare Costs Trend Rate	1% Increase in Healthcare Costs Trend Rate
Health Authority's net OPEB (asset)	$ (8,451,652)	$ (6,557,302)	$ (4,179,007)

OPEB expense and deferred outflows of resources and deferred inflows of resources related to OPEB – For the year ended June 30, 2023, the Health Authority recognized OPEB expense of $746,552. At June 30, 2023, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Difference in experience	$ -	$ (2,354,845)
Net differences between projected and actual earnings on pension plan investments	1,397,664	-
Changes in assumptions	995,673	(189,448)
OPEB contributions made subsequent to measurement date	739,356	-
	$ 3,132,693	$ (2,544,293)

For the year ended June 30, 2022, the Health Authority recognized OPEB expense of $178,226. At June 30, 2022, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2022	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Difference in experience	$ -	$ (2,598,897)
Net differences between projected and actual earnings on pension plan investments	-	(2,378,173)
Changes in assumptions	58,498	(214,726)
OPEB contributions made subsequent to measurement date	604,048	-
	$ 662,546	$ (5,191,796)

The Health Authority reported $739,356 and $604,048 as deferred outflows of resources related to contributions made subsequent to the measurement date for the years ended June 30, 2023 and 2022, respectively. This amount will be recognized as an increase of net OPEB asset in the years ended June 30, 2024 and 2023, respectively.

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB expense as follows:

Year Ended June 30,	
2024	$ (31,291)
2025	$ (15,987)
2026	$ (112,744)
2027	$ 532,526
2028	$ (266,033)
Thereafter	$ (257,427)

Payable to the OPEB plan – At June 30, 2023 and 2022, the Health Authority had no outstanding amount of contributions to the OPEB plan required for the years ended June 30, 2023 and 2022.

Note 11 – Medical Stop-Loss Insurance

The Health Authority has entered into certain stop-loss agreements with third parties in order to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse the Health Authority certain proportions of the cost of each member's annual hospital services excluding those that are capitated, in excess of specified deductibles, up to a maximum of $10,000,000 per member per contract year. Insurance premiums are recorded as medical expenses and recoveries are recorded as a reduction of these expenses. Premiums exceeded stop-loss recoveries by $704,851 and $896,925 in 2023 and 2022, respectively.

Note 12 – Tangible Net Equity

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975, the Health Authority is required to maintain a minimum level of tangible net equity. The required tangible net equity level was $50,203,720 and $43,667,905 at June 30, 2023 and 2022, respectively. The Health Authority's tangible net equity was $359,422,175 and $290,042,921 at June 30, 2023 and 2022, respectively.

Note 13 – Risk Management

The Health Authority is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Health Authority carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Health Authority's commercial coverage.

Note 14 – Commitments and Contingencies

In the ordinary course of business, the Health Authority is a party to claims and legal actions by enrollees, providers, and governmental and regulatory agencies. The Health Authority's policy is to accrue for amounts related to these claims and legal actions if it is probable that a liability has been incurred and the amount of the liability can be reasonably estimated. After consulting with legal counsel, Health Authority management is of the opinion that any liability that may ultimately result from claims or legal actions will not have a material effect on the financial position or results of operations of the Health Authority.

Note 15 – Healthcare Reform

There are various proposals at the federal and state levels that could, among other things, significantly change member eligibility, payment rates, or benefits. The ultimate outcome of these proposals, including the potential effects of or changes to healthcare reform that will be enacted cannot presently be determined.

Supplementary Information

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Schedule of Proportionate Share of the Net Pension Asset/Liability

	2023	2022	2021	2020	2019	2018	2017	2016	2015
Measurement period	2021-2022	2020-2021	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Proportion of the net pension liability	0.02267%	-0.15047%	0.00183%	-0.00992%	-0.02053%	0.01840%	0.07925%	0.07311%	0.07849%
Proportionate share of the net pension liability	$ 2,618,673	$ (8,138,023)	$ 199,654	$ (1,017,002)	$ (1,978,644)	$ 1,824,796	$ 6,857,370	$ 5,018,386	$ 4,883,971
Covered-employee payroll*	$ 32,455,141	$ 29,826,808	$ 26,732,488	$ 23,706,126	$ 19,966,458	$ 16,512,291	$ 11,010,647	$ 7,427,745	$ 9,121,825
Proportionate share of the net pension liability as a percentage of covered-employee payroll	8.07%	-27.28%	0.75%	-4.29%	-9.91%	11.05%	62.28%	67.56%	53.54%
Plan's fiduciary net position as a percentage of the plan's total pension liability	76.68%	88.29%	75.10%	75.26%	75.26%	73.31%	74.06%	78.40%	80.43%

*For the year ending on the measurement date

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Schedule of Pension Contributions

	2023	2022	2021	2020	2019	2018	2017	2016	2015
Measurement period	2021-2022	2020-2021	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Actuarially determined contribution	$ 2,971,316	$ 2,752,027	$ 2,365,673	$ 2,058,408	$ 1,669,920	$ 1,198,065	$ 1,287,320	$ 910,906	$ 886,335
Contributions in relation to the actuarially determined contribution	2,971,316	2,752,027	2,365,673	2,058,408	1,669,920	4,426,715	7,188,179	910,906	886,335
Contribution (excess)	$ -	$ -	$ -	$ -	$ -	$ (3,228,650)	$ (5,900,859)	$ -	$ -
Covered-employee payroll*	$ 36,690,195	$ 32,455,141	$ 29,826,808	$ 26,732,488	$ 23,706,126	$ 19,966,458	$ 16,512,291	$ 11,010,647	$ 7,427,745
Contributions as a percentage of covered-employee payroll	8.10%	8.48%	7.93%	7.70%	7.04%	22.17%	43.53%	8.27%	11.93%

*For the fiscal year ending on the date shown

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Schedule of Changes in Net Other Post-Employment Benefit Asset/Liability

	2023	2022	2021	2020	2019	2018	2017
Measurement period	2021-2022	2020-2021	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016
Total OPEB liability							
Service cost	$ 1,133,723	$ 1,231,856	$ 1,222,378	$ 1,089,286	$ 1,119,648	$ 756,248	$ 736,008
Interest on the total OPEB liability	913,306	977,230	867,980	901,963	805,036	708,213	648,807
Actual vs. expected experience	(98,525)	(1,267,092)	-	(2,076,281)	-	(14,700)	-
Assumption changes	1,051,988	(167,716)	-	(90,590)	-	131,618	-
Benefit payments	(602,644)	(478,810)	(483,793)	(438,081)	(478,669)	(542,029)	(499,704)
Net change in total OPEB liability	2,397,848	295,468	1,606,565	(613,703)	1,446,015	1,039,350	885,111
Total OPEB liability, beginning of year	13,780,500	13,485,032	11,878,467	12,492,170	11,046,155	10,006,805	9,121,694
Total OPEB liability, end of year	$ 16,178,348	$ 13,780,500	$ 13,485,032	$ 11,878,467	$ 12,492,170	$ 11,046,155	$ 10,006,805
Plan fiduciary net position							
Contributions from employer	$ 604,048	$ 588,065	$ 3,018,143	$ 2,601,369	$ 3,588,109	$ 1,142,027	$ 954,155
Net investment income	(2,721,847)	4,362,468	435,252	795,021	518,470	551,777	283,871
Benefit payments	(602,644)	(478,810)	(483,793)	(438,081)	(478,669)	(542,029)	(499,704)
Administrative expense	(6,555)	(6,005)	(6,630)	(2,277)	(12,267)	(2,784)	(2,239)
Net change in plan fiduciary net position	(2,726,998)	4,465,718	2,962,972	2,956,032	3,615,643	1,148,991	736,083
Plan fiduciary net position, beginning of year	20,337,802	15,872,084	12,909,112	9,953,080	6,337,437	5,188,446	4,452,363
Plan fiduciary net position, end of year	$ 17,610,804	$ 20,337,802	$ 15,872,084	$ 12,909,112	$ 9,953,080	$ 6,337,437	$ 5,188,446
Health Authority's net OPEB (asset) liability	$ (1,432,456)	$ (6,557,302)	$ (2,387,052)	$ (1,030,645)	$ 2,539,090	$ 4,708,718	$ 4,818,359
Plan fiduciary net position as a percentage of the total OPEB liability	108.85%	147.58%	117.70%	108.68%	79.67%	57.37%	51.85%
Covered-employee payroll*	$ 34,511,813	$ 28,680,020	$ 26,732,488	$ 24,360,228	$ 20,046,373	$ 17,216,515	$ 17,195,643
Health Authority's net OPEB (asset) liability as a percentage of covered-employee payroll	-4.15%	-22.86%	-8.93%	-4.23%	12.67%	27.35%	28.02%

*For the year ending on the measurement date

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Schedule of Other Post-Employment Benefit Contributions

	2023	2022	2021	2020	2019	2018	2017
Measurement period	2021-2022	2020-2021	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016
Actuarially determined contribution	$ 625,015	$ 639,939	$ 624,728	$ 1,062,967	$ 1,269,369	$ 1,427,237	$ 1,217,313
Contributions in relation to the actuarially determined contribution	739,356	604,048	2,844,693	3,018,143	2,601,369	3,588,109	1,217,313
Contribution (excess) deficiency	$ (114,341)	$ 35,891	$ (2,219,965)	$ (1,955,176)	$ (1,332,000)	$ (2,160,872)	$ -
Covered-employee payroll*	$ 39,497,742	$ 34,511,813	$ 28,680,020	$ 26,732,488	$ 24,360,228	$ 20,046,373	$ 17,216,515
Contributions as a percentage of covered-employee payroll	1.87%	1.75%	9.92%	11.29%	10.68%	17.90%	7.07%

*For the fiscal year ending on the date shown


MOSSADAMS