Report of Independent Auditors and Financial Statements

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

June 30, 2021 and 2020

MOSSADAMS

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Management's Discussion and Analysis

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Management's Discussion and Analysis
June 30, 2021, 2020, and 2019

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, 2021, 2020, and 2019. 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 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 Santa Clara Community Health Authority Joint Powers Authority ("JPA") is a licensed health maintenance organization that operated in the County. The County's Board of Supervisors established the JPA in October 2005, in accordance with the Code Section 14087.54. During 2006, the JPA obtained licensure under the Knox-Keene Health Care Services Plan Act of 1975 and commenced operations. The Health Authority has advised the California Department of Managed HealthCare ("DMHC") of its intent to surrender the JPA's license as of December 31, 2019, and the JPA ceased to exist on December 31, 2019.

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 addresses the Health Authority's overall program activities.

FINANCIAL HIGHLIGHTS:

- Total enrollment increased 11.3% to 282,670 members at June 30, 2021, from 253,875 members at June 30, 2020. Total enrollment increased 1.9% to 253,875 members at June 30, 2020, from 249,206 members at June 30, 2019.

- Net position increased by $46,209,816 to $254,850,602 for the fiscal year ended June 30, 2021, from $208,640,786 for the fiscal year ended June 30, 2020, due to operating income of $43,357,542 and nonoperating income of $2,852,274. Net position increased by $6,515,031 to $208,640,786 for the fiscal year ended June 30, 2020, from $202,125,755 for the fiscal year ended June 30, 2019, due to operating income of $38,958 and nonoperating income of $6,476,073.

- Total assets and deferred outflows of resources decreased to $963,677,770 as of June 30, 2021, from $1,189,881,233 as of June 30, 2020. Total assets and deferred outflows of resources increased to $1,189,881,233 as of June 30, 2020, from $1,009,258,566 as of June 30, 2019.

- Total liabilities and deferred inflows of resources decreased to $708,827,168 at June 30, 2021, from $981,240,447 at June 30, 2020. Total liabilities and deferred inflows of resources increased to $981,240,447 at June 30, 2020, from $897,132,811 at June 30, 2019.

- The current ratio (current assets divided by current liabilities) of 1.31 as of June 30, 2021, reflected an increase from 1.18 as of June 30, 2020. The current ratio (current assets divided by current liabilities) of 1.18 as of June 30, 2020, reflected a decrease from 1.19 at June 30, 2019.

CONDENSED STATEMENTS OF NET POSITION:

	June 30			2021 to 2020 Change		2020 to 2019 Change	
	2021	2020	2019	Amount	% Change	Amount	% Change
Assets:							
Current assets	$ 926,495,698	$ 1,152,476,888	$ 1,060,344,723	$ (225,981,190)	-19.6%	$ 92,132,165	8.7%
Capital assets	27,056,663	26,649,088	27,392,240	407,575	1.5%	(743,152)	-2.7%
Other assets	2,712,052	2,352,997	2,283,994	359,055	15.3%	69,003	3.0%
Total assets	956,264,413	1,181,478,973	1,090,020,957	(225,214,560)	-19.1%	91,458,016	8.4%
Deferred outflows of resources	7,413,357	8,402,260	9,237,609	(988,903)	-11.8%	(835,349)	-9.0%
Total assets and deferred outflows of resources	$ 963,677,770	$ 1,189,881,233	$ 1,099,258,566	$ (226,203,463)	-19.0%	$ 90,622,667	8.2%
Liabilities:							
Current liabilities	$ 706,350,909	$ 977,464,723	$ 891,447,827	$ (271,113,814)	-27.7%	$ 86,016,896	9.6%
Noncurrent liabilities	199,654	-	2,539,090	199,654	100.0%	(2,539,090)	-100.0%
Total liabilities	706,550,563	977,464,723	893,986,917	(270,914,160)	-27.7%	83,477,806	9.3%
Deferred inflow of resources	2,276,605	3,775,724	3,145,894	(1,499,119)	-39.7%	629,830	20.0%
Net position:							
Net investment in capital assets	27,056,663	26,649,088	27,392,240	407,575	1.5%	(743,152)	-2.7%
Restricted	325,000	305,350	305,350	19,650.0	6.4%	-	0.0%
Unrestricted:							
Designated by Governing Board	17,067,275	17,339,275	2,200,000	(272,000)	-1.6%	15,139,275	100.0%
Unrestricted	210,401,664	164,347,073	172,228,165	46,054,591	28.0%	(7,881,092)	-4.6%
Total net position	254,850,602	208,640,786	202,125,755	46,209,816	22.1%	6,515,031	3.2%
Total liabilities, deferred inflows of resources, and net position	$ 963,677,770	$ 1,189,881,233	$ 1,099,258,566	$ (226,203,463)	-19.0%	$ 90,622,667	8.2%

Assets and Deferred Outflows of Resources

For the fiscal year ended June 30, 2021, assets decreased $225,214,560 or -19.1% due primarily to decreases in hospital pass-through receivables. During the same period, deferred outflows of resources decreased $988,903 or -11.8% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2020, assets increased $91,458,016 or 8.4% due primarily to increases in receivables from the California Department of Health Care Services (“DHCS”). During the same period, deferred outflows of resources decreased $835,349 or -9.0% due to the timing of amounts attributable to employee retirement plans.

Liabilities and Deferred Inflows of Resources

For the fiscal year ended June 30, 2021, liabilities decreased $270,914,160 or -27.7% due primarily to decreases in hospital pass-through payables. During the same period, deferred inflows of resources decreased $1,499,119 or -39.7% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2020, liabilities increased $83,477,806 or 9.3% due primarily to increases in timing of payables to DHCS and certain providers. During the same period, deferred inflows of resources increased $629,830 or 20.0% due to the timing of amounts attributable to employee retirement plans.

Tangible Net Equity

The Health Authority is required to maintain a minimum level of tangible net equity ("TNE") per its contract with 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 $254,850,602, $208,640,786, and $202,125,755 at June 30, 2021, 2020, and 2019, respectively. The Health Authority exceeded the minimum required TNE levels at all times during the three fiscal years.

CONDENSED RESULTS OF OPERATIONS:

	Fiscal Year			2020 to 2019 Change		2019 to 2018 Change	
	2021	2020	2019	Amount	% Change	Amount	% Change
Year end membership:							
Medi-Cal	272,590	244,888	237,698	27,702	11.3%	7,190	3.0%
Cal Medi-Connect	10,080	8,987	8,022	1,093	12.2%	965	12.0%
Healthy Kids	-	-	3,486	-	0.0%	(3,486)	-100.0%
Total year end membership	282,670	253,875	249,206	28,795	11.3%	4,669	1.9%
Annual member months:							
Medi-Cal	3,137,271	2,829,690	2,904,840	307,581	10.9%	(75,150)	-2.6%
Cal Medi-Connect	116,365	101,391	92,838	14,974	14.8%	8,553	9.2%
Healthy Kids	-	10,528	40,083	(10,528)	-100.0%	(29,555)	-73.7%
Total annual member months	3,253,636	2,941,609	3,037,761	312,027	10.6%	(96,152)	-3.2%
Operating revenues:							
Capitation and premium revenue	$ 1,380,375,797	$ 1,147,826,608	$ 1,161,897,093	$ 232,549,189	20.3%	$ (14,070,485)	-1.2%
Total operating revenues	1,380,375,797	1,147,826,608	1,161,897,093	232,549,189	20.3%	(14,070,485)	-1.2%
Operating expenses:							
Medical expenses	1,162,912,637	1,036,714,518	979,947,150	126,198,119	12.2%	56,767,368	5.8%
General and administrative expenses	60,991,517	57,442,133	54,419,879	3,549,384	6.2%	3,022,254	5.6%
Depreciation and amortization	3,729,409	3,370,268	3,816,251	359,141	10.7%	(445,983)	-11.7%
Premium tax	109,384,692	50,260,731	105,415,550	59,123,961	117.6%	(55,154,819)	-52.3%
Total operating expenses	1,337,018,255	1,147,787,650	1,143,598,830	189,230,605	16.5%	4,188,820	0.4%
Operating income	43,357,542	38,958	18,298,263	43,318,584	111193.0%	(18,259,305)	-99.8%
Nonoperating revenues:							
Interest and other income	2,852,274	6,476,073	5,811,627	(3,623,799)	-56.0%	664,446	11.4%
Changes in net position	46,209,816	6,515,031	24,109,890	39,694,785	609.3%	(17,594,859)	-73.0%
Net position, beginning of year	208,640,786	202,125,755	178,015,865	6,515,031	3.2%	24,109,890	13.5%
Net position, end of year	$ 254,850,602	$ 208,640,786	$ 202,125,755	$ 46,209,816	22.1%	$ 6,515,031	3.2%

Membership and Enrollment

During the fiscal year ended June 30, 2021, the Health Authority experienced an increase in enrollment of 11.3% predominately due to the County's suspension of Medi-Cal disenrollment during the COVID-19 public health emergency.

During the fiscal year ended June 30, 2020, the Health Authority experienced an increase in enrollment of 1.9% predominately due to the County's suspension of Medi-Cal disenrollment during the COVID-19 public health emergency.

Operating Revenue

During the fiscal year ended June 30, 2021, operating revenues increased by $232,549,189 or 20.3% to $1,380,375,797 versus the prior year operating revenue of $1,147,826,608. Much of the increase was attributable to changes in enrollment and capitation rates.

During the fiscal year ended June 30, 2020, operating revenues decreased by $14,070,485 or -1.2% to $1,147,826,608 versus the prior year operating revenue of $1,161,897,093. Much of the decrease was attributable to changes in enrollment and capitation rates.

Medical Expenses

During the fiscal year ended June 30, 2021, medical expenses increased by $126,198,119 or 12.2% to $1,162,912,637 versus the prior year of $1,036,714,518. Much of the increase was attributable to increases in certain capitation and fee-for-service expenses.

During the fiscal year ended June 30, 2020, medical expenses increased by $56,767,368 or 5.8% to $1,036,714,518 versus the prior year of $979,947,150. Much of the increase was attributable to certain increases in capitation and fee-for-service expenses.

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 91.4%, 94.5%, and 92.8% for the fiscal years ended June 30, 2021, 2020, and 2019, respectively.

Premium Deficiency Reserve

During the fiscal year ended June 30, 2021, management maintained its estimated premium deficiency reserve ("PDR") on the CMC contract at $8,294,025 for fiscal year 2022 due to continued uncertainties and past reconciliations.

During the fiscal year ended June 30, 2020, management maintained its estimated premium deficiency reserve ("PDR") on the CMC contract at $8,294,025 for fiscal year 2021 due to continuing uncertainties about final rate recasts for multiple fiscal years, shared risk corridor payments and hierarchical condition category ("HCC") risk adjustments, for which management cannot fully quantify the likelihood of these impacts.

General and Administrative Expenses

During the fiscal year ended June 30, 2021, general and administrative expenses increased by $3,549,384 or 6.2% to $60,991,517 versus the prior year expense of $57,442,133 due to increased employee headcount and associated benefit costs.

During the fiscal year ended June 30, 2020, general and administrative expenses increased by $3,022,254 or 5.6% to $57,442,133 versus the prior year expense of $54,419,879 due to increased staffing and increases in other expenses.

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 5.1%, 5.5%, and 5.5% for the fiscal years ended June 30, 2021, 2020, and 2019, respectively.

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, 2021, 2020, and 2019:

	Fiscal Year			2021 to 2020 Change		2020 to 2019 Change	
	2021	2020	2019	Amount	% Change	Amount	% Change
Cash flows from operating activities	$ 75,810,997	$ 30,675,986	$ 75,870,490	$ 45,135,011	147.1%	$ (45,194,504)	-59.6%
Cash flows from capital and financing activities	(4,350,663)	(2,826,838)	(6,415,822)	(1,523,825)	53.9%	3,588,984	-55.9%
Cash flows from investing activities	(12,569,800)	(193,195,538)	5,811,627	180,625,738	-93.5%	(199,007,165)	-3424.3%
Net change in cash and cash equivalents	58,890,534	(165,346,390)	75,266,295	224,236,924	-135.6%	(240,612,685)	-319.7%
Cash and cash equivalents, beginning of year	133,770,764	299,117,154	223,850,859	(165,346,390)	-55.3%	75,266,295	33.6%
Cash and cash equivalents, end of year	$ 192,661,298	$ 133,770,764	$ 299,117,154	$ 58,890,534	44.0%	$ (165,346,390)	-55.3%

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, 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, 2021, 2020, and 2019. Capital assets largely included furniture and fixtures, computer hardware and software, and leasehold improvements:

	Fiscal Year Ended June 30,			2021 to 2020 Change		2020 to 2019 Change	
	2021	2020	2019	Amount	% Change	Amount	% Change
Beginning balance, net	$ 26,649,088	$ 27,392,240	$ 24,269,369	$ (743,152)	-2.7%	$ 3,122,871	12.9%
Additions	4,583,540	2,826,838	6,941,405	1,756,702	62.1%	(4,114,567)	-59.3%
Reductions/adjustments	(446,556)	(199,722)	(2,283)	(246,834)	123.6%	(197,439)	8648.2%
Depreciation and amortization expense	(3,729,409)	(3,370,268)	(3,816,251)	(359,141)	10.7%	445,983	-11.7%
Ending balance, net	$ 27,056,663	$ 26,649,088	$ 27,392,240	$ 407,575	1.5%	$ (743,152)	-2.7%

KEY FACTORS INFLUENCING THE FISCAL YEAR 2021-2022 BUDGET:

- COVID-19 Impact – The declaration of a Public Health Emergency by the State of California paused the normal Medi-Cal disenrollment process. The Plan saw a significant increase in enrollment for the fiscal years ended June 30, 2021 and June 30, 2020. Following the conclusion of the public health emergency, the Plan anticipates that Medi-Cal disenrollment process resumes.

- CalAIM – The State of California launched a multi-year initiative entitled California Advancing and Innovative Medi-Cal ("CalAIM") 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 are scheduled to launch January 1, 2022. CalAIM is expected to provide new funding to the Plan and increased expenses, the magnitude of which are unknown at this time.

In June 2021, the Health Authority's Governing Board formally approved operating and capital budgets for the fiscal year ending June 30, 2022. The fiscal year 2022 operating budget anticipates enrollment growth of 11.3%, carve-out of pharmacy from Medi-Cal for the second half of the fiscal year, introduction of Enhanced Care Management ("ECM") in January 2022, modest changes in capitation rates, and modest growth in operating 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, Attn: Controller, 6201 San Ignacio Avenue, San Jose, California 95119 or call (408) 376-2000.

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Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) ("Health Authority"), which comprise the statements of net position as of June 30, 2021 and 2020, 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.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes 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.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatements.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements 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 the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the net position of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) as of June 30, 2021 and 2020, and the results in its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 7, 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 liability, and supplementary schedule of other post-employment benefit contributions on pages 40 through 43 are not a required part of the financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of the Health Authority's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the financial statements, and other knowledge we obtained during our audits of the financial statements. We do not express an opinion or provide an assurance on the supplementary information because limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Moss Adams LLP

San Francisco, California
October 28, 2021

Financial Statements

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Net Position
June 30, 2021 and 2020

	2021	2020
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets		
Cash and cash equivalents	$ 192,661,298	$ 133,770,764
Investments	215,085,767	199,883,355
Premiums receivable	512,219,526	811,006,716
Prepaids and other assets	6,529,107	7,816,053
Total current assets	926,495,698	1,152,476,888
Capital assets, net		
Nondepreciable	3,509,128	4,074,349
Depreciable, net of accumulated depreciation and amortization	23,547,535	22,574,739
Total capital assets, net	27,056,663	26,649,088
Assets restricted as to use	325,000	305,350
Net pension asset	-	1,017,002
Other post-employment benefits asset	2,387,052	1,030,645
Total assets	956,264,413	1,181,478,973
Deferred outflows of resources	7,413,357	8,402,260
Total deferred outflows of resources	7,413,357	8,402,260
Total assets and deferred outflows of resources	$ 963,677,770	$ 1,189,881,233
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
Current liabilities		
Accounts payable and accrued liabilities	$ 11,886,885	$ 13,010,770
Amounts due to the State of California	90,485,269	104,429,798
In-home supportive services payable	419,990,933	419,268,582
Due to providers	68,106,473	345,356,397
Medical incurred but not reported claims and medical claims payable	100,087,324	84,105,151
Provider incentives and other medical liabilities	7,500,000	3,000,000
Premium deficiency reserves	8,294,025	8,294,025
Total current liabilities	706,350,909	977,464,723
Noncurrent liabilities		
Net pension liability	199,654	-
Total liabilities	706,550,563	977,464,723
Deferred inflows of resources	2,276,605	3,775,724
Total deferred inflows of resources	2,276,605	3,775,724
Net position		
Net investment in capital assets	27,056,663	26,649,088
Restricted	325,000	305,350
Unrestricted:		
Designated by Governing Board	17,067,275	17,339,275
Unrestricted	210,401,664	164,347,073
Total net position	254,850,602	208,640,786
Total liabilities, deferred inflows of resources, and net position	$ 963,677,770	$ 1,189,881,233

See accompanying notes to financial statements.

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Revenues, Expenses, and Changes in Net Position
For the Years Ended June 30, 2021 and 2020

	2021	2020
Operating revenues		
Capitation and premium revenue	$ 1,380,375,797	$ 1,147,826,608
Total operating revenues	1,380,375,797	1,147,826,608
Operating expenses		
Medical expenses	1,162,912,637	1,036,714,518
Premium tax	109,384,692	50,260,731
General and administrative expenses	60,991,517	57,442,133
Depreciation and amortization	3,729,409	3,370,268
Total operating expenses	1,337,018,255	1,147,787,650
Operating income	43,357,542	38,958
Nonoperating revenues		
Interest and other income	2,852,274	6,476,073
Change in net position	46,209,816	6,515,031
Net position, beginning of year	208,640,786	202,125,755
Net position, end of year	$ 254,850,602	$ 208,640,786

See accompanying notes to financial statements.

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Cash Flows
For the Years Ended June 30, 2021 and 2020

	2021	2020
Cash flows from operating activities		
Capitation and premiums received	$ 1,679,162,987	$ 1,087,886,018
Medical expenses paid	(1,542,306,908)	(1,004,597,624)
Marketing, general, and administrative expenses paid	(61,045,082)	(52,612,408)
Net cash provided by operating activities	75,810,997	30,675,986
Cash flows from capital and financing activities		
Purchases of capital assets	(4,350,663)	(2,826,838)
Net cash used in capital and financing activities	(4,350,663)	(2,826,838)
Cash flows from investing activities		
Purchase of investments	(693,316,965)	(311,427,165)
Sale of investments	677,894,891	111,755,554
Interest collection on investments	2,852,274	6,476,073
Net cash used in investing activities	(12,569,800)	(193,195,538)
Net change in cash and cash equivalents	58,890,534	(165,346,390)
Cash and cash equivalents, beginning of year	133,770,764	299,117,154
Cash and cash equivalents, end of year	$ 192,661,298	$ 133,770,764
Reconciliation of operating income to net cash provided by operating activities		
Operating income	$ 43,357,542	$ 38,958
Adjustments to reconcile operating income to net cash provided by operating activities		
Depreciation and amortization	3,729,409	3,370,268
Net unrealized loss (gain) on investments	219,662	(211,744)
Changes in operating assets and liabilities:		
Premiums receivable	298,787,190	(59,940,590)
Prepaids and other assets	1,267,296	2,345,390
Net pension asset/liability	1,216,656	961,642
Other post-employment benefits asset	(1,356,407)	(3,569,735)
Deferred outflows of resources	988,903	835,349
Accounts payable and accrued liabilities	(910,206)	3,838,993
Amounts due to the State of California	(13,944,529)	51,286,710
In-home supportive services payable	722,351	3,176,056
Due to providers	(277,249,924)	28,664,725
Medical incurred but not reported claims and medical claims payable	15,982,173	1,750,134
Provider incentives and other medical liabilities	4,500,000	(2,500,000)
Deferred inflows of resources	(1,499,119)	629,830
Net cash provided by operating activities	$ 75,810,997	$ 30,675,986
Supplemental cash-flow disclosure		
Cash paid during the year for premium tax	$ 82,038,521	$ 26,353,887
Supplemental disclosure of noncash item		
Payables for capital asset purchases	$ 232,877	$ 257,855

See accompanying notes to financial statements.

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"). SCFHP 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, birth through age 18, pregnant women, and other low-income adults in Santa Clara County (the "County"). During 1996, SCFHP obtained licensure under the Knox-Keene Health Care Service Plan Act of 1975 and commenced operations. The financial statements are included in the County of Santa Clara's basic financial statements as a discretely presented component unit.

The Santa Clara Community Health Authority Joint Powers Authority ("JPA") is a licensed health maintenance organization that operates in the County. The County's Board of Supervisors established the JPA in October 2005, in accordance with the Code Section 14087.54. The JPA received its Knox-Keene license on May 11, 2006, and commenced operations on June 1, 2006. The Health Authority advised the DMHC of its intent to surrender the JPA's license as of December 31, 2019, and the JPA ceased to exist on December 31, 2019.

The following table presents certain combined financial statement captions as previously reported which combines the JPA with the Health Authority, and compares them to the current presentation which does not combine the JPA with the Health Authority as of and for the year ended June 30, 2020:

	Health Authority with JPA	Health Authority without JPA	Difference
Total operating revenues	$ 1,147,826,608	$ 1,147,826,608	$ -
Total operating expenses	$ 1,147,787,650	$ 1,147,787,650	$ -
Change in net position	$ 6,515,031	$ 6,515,031	$ -

The Health Authority has contracted with the California Department of Health Care Services ("DHCS") to receive funding to provide health care 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 health care 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 MediConnect ("CMC"), a demonstration project to integrate care for dual-eligible beneficiaries. Cal MediConnect is part of California's larger demonstration plan known as the Coordinated Care Initiative ("CCI"), which transforms the delivery of health care for seniors and people with disabilities. It integrates dual eligibles' care across all their entitlement benefits from Medicare, Medi-Cal, and other supportive services.

The Health Authority operates a Healthy Kids program to provide medical coverage to children of parents not otherwise eligible for the Medi-Cal program. All Health Kids members transitioned to Medi-Cal by December 31, 2019.

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 DHCS. The tax is assessed on by 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 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. The Health Authority paid $82,038,521 and $0 in MCO premium taxes during fiscal years 2021 and 2020, respectively. At June 30, 2021 and 2020, the Health Authority had payables due in the amount of $31,975,622 and $48,615,420, respectively, included in amounts due to the State of California.

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, 2021 and 2020, the Health Authority's cash deposits and investment pool had carrying amounts of $192,661,298 and $133,770,764, respectively. The Health Authority's bank and investment pool balances at June 30, 2021 and 2020, including interests in an investment pool, were $223,433,288 and $344,500,631, respectively. Of the bank and investment pool balances at June 30, 2021 and 2020, $222,563,094 and $343,653,375, 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, 2021 and 2020.

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 which 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 is 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 and $305,350 at June 30, 2021 and 2020, respectively.

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

In-Home Supportive Services ("IHSS") payable – DHCS paid IHSS payments directly to the 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, 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 WIC 14169.51, 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 Tobacco Tax (California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56) as defined by DHCS in 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 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 health care products and services to enrolled beneficiaries. The cost of the health care 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, health care 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 liability/asset – The Health Authority recognizes a net pension liability/asset, 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 liability/asset is measured as of the Health Authority's prior fiscal year-end. Changes in the net pension liability/asset 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 liability/asset 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 liability/asset, 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.

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, 2021 and 2020, $17,067,275 and $17,339,275 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 health care 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 DHCS based on the number of enrolled Medi-Cal beneficiaries, regardless of services actually performed. Premiums are due from 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 DHCS is subject to possible retroactive adjustments. Provisions have been made for estimated retroactive adjustments. For the years ended June 30, 2021 and 2020, premium revenues recorded from DHCS under the Medi-Cal Program totaled $1,169,271,641 and $970,210,089, 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, 2021 and 2020, premium revenues totaled $45,682,524 and $34,839,647, and $165,421,632 and $141,653,083 for the Medi-Cal and Medicare components of the CMC program, 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.

The Health Authority has an agreement with the County of Santa Clara to provide health care services to enrolled Healthy Kids beneficiaries. The Health Authority issues monthly invoices to the funding organization for its respective portion of premium costs for all Healthy Kids enrollees. Premiums are due monthly and are recognized as revenue in the period the Health Authority is obligated to provide medical services. A nominal monthly premium is invoiced directly to the family of the Healthy Kids enrolled child and recognized as revenue in the service month. Annual premium revenue for the Healthy Kids Program totaled $1,123,789 for the year ended June 30, 2020, and was funded by County of Santa Clara. All Health Kids members transitioned to Medi-Cal by December 31, 2019.

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, 2022. 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, 2021 and 2020. 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 are needed at June 30, 2021 and 2020.

Concentration of credit risk – A majority of the Health Authority's revenues are derived from contracts with 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, 2021, the Health Authority had premiums receivable of $490,415,912, $9,002,439, and $12,801,175 due from Medi-Cal Program, CMC program, and Medicare, respectively. As of June 30, 2020, the Health Authority had premiums receivable of $785,628,061, $7,405,424, $17,972,777, and $454 due from Medi-Cal Program, CMC program, Medicare, and Healthy Kids Program, 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 – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities* (“GASB 84”). GASB 84 provides improved guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. The statement also provides for recognition of a liability to the beneficiaries in a fiduciary fund when an event has occurred that compels the government to disburse fiduciary resources. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 84 to reporting periods beginning after December 15, 2019. The Health Authority adopted GASB 84 in the current fiscal year. The Health Authority adopted GASB 84 in the current fiscal year. The adoption of this standard did not have significant impact to the financial statements.

In June 2017, the GASB issued GASB Statement No. 87, *Leases ("GASB 87")*. GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 87 to fiscal years beginning after June 15, 2021. The Health Authority is reviewing the impact of the adoption of GASB 87 for the fiscal year ending 2022.

In June 2020, the GASB issued Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans – an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32* ("GASB 97"). GASB 97 amends the criteria for reporting governmental fiduciary component units – separate legal entities included in a government's financial statements. GASB 97 clarifies rules related to reporting of fiduciary activities under Statements No. 14 and No. 84 for defined contribution plans and to enhance the relevance, consistency, and comparability of the accounting and financial reporting of IRC Code section 457 plans that meet the definition of a pension plan. The Health Authority adopted GASB 97 in the current fiscal year. The adoption of this standard did not have significant impact to the financial statements.

Reclassifications – Certain amounts in the 2020 financial statements have been reclassified to conform to the 2021 presentation. These reclassifications have no effect on the 2020 operating income or net position.

NOTE 2 – INVESTMENTS

At June 30, 2021 and 2020, the Health Authority's investments consisted of money market funds, commercial paper, U.S. government agency bonds, corporate bonds, municipal bonds, asset back securities, commercial paper, and U.S. treasury securities.

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, 2021 and 2020, 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, 2021:

Description	Fair value	AAA	AA+	AA	AA-	A+	A	A-	A-1+	A-1
Investments in:										
U.S. government agency bonds	$ 91,032,849	$ 25,549,604	$ -	$ 5,074,397	$ -	$ -	$ -	$ -	$ 60,408,848	$ -
Corporate bonds	62,445,780	-	3,019,216	-	9,520,715	16,644,503	20,140,173	13,121,173	-	-
Municipal bonds	13,108,692	1,925,611	499,868	6,596,581	4,086,632	-	-	-	-	-
Commercial paper	40,257,340	-	-	-	-	-	-	-	24,658,032	15,599,308
U.S. treasury securities	8,241,106	2,541,134	-	-	-	-	-	-	5,699,972	-
Total investments	$ 215,085,767	$ 30,016,349	$ 3,519,084	$ 11,670,978	$ 13,607,347	$ 16,644,503	$ 20,140,173	$ 13,121,173	$ 90,766,852	$ 15,599,308

The following are the credit ratings for each investment type at June 30, 2020:

Description	Fair value	AAA	AA+	AA	AA-	A+	A	A-	A-1+
Investments in:									
U.S. government agency bonds	$ 101,825,363	$ 2,026,549	$ -	$ -	$ -	$ -	$ -	$ -	$ 99,798,814
Corporate bonds	34,790,027	2,047,076	-	-	2,015,254	22,744,968	7,982,729	-	-
Municipal bonds	9,018,771	-	1,681,741	2,560,532	-	761,476	-	-	4,015,022
Asset-backed securities	1,203,170	1,203,170	-	-	-	-	-	-	-
Commercial paper	10,995,235	-	-	-	-	-	-	-	10,995,235
U.S. treasury securities	42,050,789	18,358,657	-	-	-	-	-	-	23,692,132
Total investments	$ 199,883,355	$ 23,635,452	$ 1,681,741	$ 2,560,532	$ 2,015,254	$ 23,506,444	$ 7,982,729	$ -	$ 138,501,203

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, 2021 were as follows:

Investment	Issuer	Percentage of portfolio
U.S. government agency bonds	Various	42.0 %
Corporate bonds	Various	29.0
Municipal bonds	Various	6.0
Commercial paper	Various	19.0
U.S. treasury securities	Various	4.0
		100.00 %

The Health Authority's investments as a percentage of its portfolio at June 30, 2020 were as follows:

Investment	Issuer	Percentage of portfolio
U.S. government agency bonds	Various	50.0 %
Corporate bonds	Various	17.0
Municipal bonds	Various	5.0
Asset-backed securities	Various	1.0
Commercial paper	Various	6.0
U.S. treasury securities	Various	21.0
		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 present 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	2021
Investments in:				
U.S. government agency bonds	$ -	$ 91,032,849	$ -	$ 91,032,849
Corporate bonds	-	62,445,780	-	62,445,780
Municipal bonds	-	13,108,692	-	13,108,692
Total investments subject to fair value hierarchy	$ -	$ 166,587,321	$ -	166,587,321
Investments and restricted cash not subject to fair value hierarchy				
Commercial paper				40,257,340
U.S. treasury securities				8,241,106
Certificate of deposits				325,000
Total investments and restricted cash				$ 215,410,767

Description	Level 1	Level 2	Level 3	2020
Investments in:				
U.S. government agency bonds	$ -	$ 101,825,363	$ -	$ 101,825,363
Corporate bonds	-	34,790,027	-	34,790,027
Municipal bonds	-	9,018,771	-	9,018,771
Asset-backed securities	-	1,203,170	-	1,203,170
Total investments subject to fair value hierarchy	$ -	$ 146,837,331	$ -	146,837,331
Investments and restricted cash not subject to fair value hierarchy				
Commercial paper				10,995,235
U.S. treasury securities				42,050,789
Certificate of deposits				305,350
Total investments and restricted cash				$ 200,188,705

NOTE 4 – CAPITAL ASSETS

Capital asset activity for the fiscal years ended June 30, 2021 and 2020, are as follows:

	2021				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ 3,507,578	$ 1,550	$ -	$ -	$ 3,509,128
Furniture and equipment	12,642,255	594,237	-	-	13,236,492
Building and building improvements	19,008,213	3,767,238	(214,889)	353,401	22,913,963
Software	11,631,752	220,515	(18,297)	-	11,833,970
Vehicles	29,248	-	-	-	29,248
Building improvements work in progress	566,771	-	(213,370)	(353,401)	-
Total capital assets	47,385,817	4,583,540	(446,556)	-	51,522,801
Less accumulated depreciation and amortization for:					
Furniture and equipment	10,860,863	613,456	-	-	11,474,319
Building and building improvements	1,557,918	1,327,117	-	-	2,885,035
Software	8,306,167	1,783,962	-	-	10,090,129
Vehicles	11,781	4,874	-	-	16,655
Total accumulated depreciation and amortization	20,736,729	3,729,409	-	-	24,466,138
Capital assets, net	$ 26,649,088	$ 854,131	$ (446,556)	$ -	$ 27,056,663

	2020				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ 3,507,578	$ -	$ -	$ -	$ 3,507,578
Furniture and equipment	11,983,493	849,663	(6,290)	(184,611)	12,642,255
Leasehold improvements	-	-	-	-	-
Building and building improvements	17,267,569	1,568,598	(12,565)	184,611	19,008,213
Software	11,342,155	408,577	(150,207)	31,227	11,631,752
Vehicles	29,248	-	-	-	29,248
Software work in progress	61,887	-	(30,660)	(31,227)	-
Building improvements work in progress	566,771	-	-	-	566,771
Total capital assets	44,758,701	2,826,838	(199,722)	-	47,385,817
Less accumulated depreciation and amortization for:					
Furniture and equipment	9,647,338	621,469	592,056	-	10,860,863
Leasehold improvements	592,056	-	(592,056)	-	-
Building and building improvements	755,003	802,915	-	-	1,557,918
Software	6,365,158	1,941,009	-	-	8,306,167
Vehicles	6,906	4,875	-	-	11,781
Total accumulated depreciation and amortization	17,366,461	3,370,268	-	-	20,736,729
Capital assets, net	$ 27,392,240	$ (543,430)	$ (199,722)	$ -	$ 26,649,088

Depreciation and amortization expense totaled $3,729,409 and $3,370,268 at June 30, 2021 and 2020, 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, 2021 and 2020, is summarized as follows:

	2021	2020
Beginning balance	$ 84,105,151	$ 82,355,017
Incurred related to:		
Current year	677,315,048	609,184,841
Prior year	(13,082,432)	(12,867,896)
Total incurred	664,232,616	596,316,945
Paid related to:		
Current year	578,912,062	529,237,516
Prior year	69,338,381	65,329,295
Total paid	648,250,443	594,566,811
Ending balance	$ 100,087,324	$ 84,105,151

As presented in the table above, $664,232,616 and $596,316,945 in medical claims were incurred for the years ended June 30, 2021 and 2020, respectively, which are reflected in medical services in the statements of revenues, expenses, and changes in net position.

IBNR liability increased by $15,982,173 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 health care 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, 2021 and 2020, board-designated funds of $17,067,275 and $17,339,275, respectively, were made.

NOTE 7 – OPERATING LEASE OBLIGATIONS

The Health Authority leases the Blanca Alvarado Community Resource Center and various equipment leases expiring in various years.

Future minimum lease payments as of June 30, 2021, consist of the following:

Years Ending June 30,	
2022	$ 314,857
2023	326,711
2024	316,187
2025	212,484
2026	18,157
Total minimum lease payments	$ 1,188,396

Rent expense, included in general and administrative expenses in the statements of revenues, expenses, and changes in net position, for the years ended June 30, 2021 and 2020, was $189,949 and $23,923, respectively.

NOTE 8 – 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. For employees hired prior to January 1, 2013, participants must contribute 6% of their gross compensation and the Health Authority must contribute 3% of the participant's gross compensation. For employees hired on or after January 1, 2013, participants must contribute 6.25% of their gross compensation within a specific range and the Health Authority must contribute 6.533% of the participant's gross compensation with the same specific range. 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 $854,462 and $775,731 for the years ended June 30, 2021 and 2020, 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 employees' 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 was 8.00% of annual covered payroll for both the years ended June 30, 2021 and 2020. All eligible participating employees are required to contribute 7.00% of their monthly salaries to CalPERS. 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 $2,361,122 and $2,058,408 for the years ended June 30, 2021 and 2020, 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, 2021, is measured as of June 30, 2020, using an annual actuarial valuation as of June 30, 2019, rolled forward to June 30, 2020, using standard update procedures. The total pension liability in the June 30, 2019, 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 CalPERS' Membership Data for all Funds
Postretirement benefit increase:	Contract COLA up to 2.50% until Purchasing Power Protection Allowance Floor on Purchasing Power applies

The net pension asset at June 30, 2020, is measured as of June 30, 2019, using an annual actuarial valuation as of June 30, 2018, rolled forward to June 30, 2019, using standard update procedures. The total pension asset in the June 30, 2018, 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 CalPERS' Membership Data for all Funds
Postretirement benefit increase:	Contract COLA up to 2.00% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.50% thereafter

All other actuarial assumptions used in the June 30, 2019 and 2018 valuations 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 remained unchanged at 2.50% for the June 30, 2020 and 2019, measurement dates.

Discount rate – The discount rate used to measure the total pension asset at June 30, 2021 and 2020, measurement date was 7.15%. 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 7.15% discount rate is appropriate and the use of the municipal bond rate calculation is not deemed necessary. The long-term expected discount rate of 7.15% 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	Current Target Allocation	Real Return Years 1-10 [(a)]	Real Return Years 11+ [(b)]
Global equity	50.0%	4.80%	5.98%
Fixed income	28.0%	1.00%	2.62%
Inflation assets	0.0%	0.77%	1.81%
Private equity	8.0%	6.30%	7.23%
Real estate	13.0%	3.75%	4.93%
Liquidity	1.0%	0.00%	-0.92%

[(a)] An expected inflation rate of 2.00% was used for this period.
[(b)] An expected inflation rate of 2.92% was used for this period.

Sensitivity of the employer's proportionate share of the net pension liability/asset to changes in the discount rate – The following presents the Health Authority's net pension liability/asset as of June 30, 2021 and 2020, as well as what the net pension liability/asset 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, 2021		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Health Authority's net pension liability (asset)	$ 7,419,584	$ 199,654	$ (5,765,948)

	June 30, 2020		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Health Authority's net pension (asset) liability	$ 5,574,335	$ (1,017,002)	$ (6,457,686)

The Health Authority's proportion for the miscellaneous plan was 0.00183% and -0.00992% at June 30, 2021 and 2020, respectively.

For the years ended June 30, 2021 and 2020, the Health Authority recognized pension expense of $3,551,927 and $2,924,828, respectively. Pension expense represents the change in the net pension liability/asset 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, 2021, the Health Authority had $4,204,264 of deferred outflows of resources and $539,318 of deferred inflows of resources related to pensions from the following sources:

	2021	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 1,248,667	$ (84,236)
Difference in experience	10,290	-
Differences between employer's actual contributions and its proportionate share of total employer contributions	573,703	(453,658)
Net differences between projected and actual earnings on pension plan investments	5,931	-
Changes in assumptions	-	(1,424)
Pension contributions made subsequent to measurement date	2,365,673	-
	$ 4,204,264	$ (539,318)

As of June 30, 2020, the Health Authority had $5,296,371 of deferred outflows of resources and $1,661,827 of deferred inflows of resources related to pensions from the following sources:

	2020	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 686,603	$ (1,245,899)
Difference in experience	5,473	(70,635)
Differences between employer's actual contributions and its proportionate share of total employer contributions	2,510,916	(296,798)
Net differences between projected and actual earnings on pension plan investments	17,780	-
Changes in assumptions	17,191	(48,495)
Pension contributions made subsequent to measurement date	2,058,408	-
	$ 5,296,371	$ (1,661,827)

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

Deferred outflows of resources of $2,365,673 and $2,058,408 resulting from contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability/asset in the years ending June 30, 2022 and 2021, 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,	
2022	$ 825,407
2023	$ 311,187
2024	$ 159,833
2025	$ 2,846

NOTE 9 – 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, 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 retirees hired on or after May 1, 2018, 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, 2021 and 2020, the following employees were covered by the plan:

	2021	2020
Active	300	238
Retirees	58	54
Total participants	358	292

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, 2021 and 2020, was measured as of June 30, 2020 and 2019, respectively, and the total OPEB asset used to calculate the net OPEB asset was determined by an actuarial valuation as of June 30, 2020 and 2019, respectively.

The total OPEB asset in the June 30, 2020, actuarial valuation was determined using the following actuarial assumptions:

Actuarial cost method:	Individual Entry Age Normal Level Percent of Pay
Actuarial assumptions:	
Discount rate	6.75%
Inflation	2.75%
Investment rate of return	6.75%
Healthcare cost trend rates:	7.00% for 2022 – Non-Medicare, decreasing to 4.00% in 2076, 6.10% for 2022 – Medicare, decreasing to 4.00% in 2076

Mortality rates are based on statistics taken from the CalPERS 1997-2015 Experience Study Report. Mortality projected fully generational with Scale MP-19.

The total OPEB liability in the June 30, 2019, actuarial valuation was determined using the following actuarial assumptions:

Actuarial cost method:	Individual Entry Age Normal Level Percent of Pay
Actuarial assumptions:	
Discount rate	6.75%
Inflation	2.75%
Investment rate of return	6.75%
Healthcare cost trend rates:	7.50% for 2019 – Non-Medicare, decreasing to 4.00% in 2076, 6.50% for 2019 – Medicare, decreasing to 4.00% in 2076

Mortality rates are based on statistics taken from the CalPERS 1997-2015 Experience Study Report. Mortality projected fully generational with Scale MP-17.

Discount rate – The discount rate used to measure the total OPEB asset was 6.75% at both June 30, 2020 and 2019, 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	59.00%	4.82%
Fixed income	25.00%	1.47%
Treasury inflation-protected securities	5.00%	1.29%
Commodities	3.00%	0.84%
Real estate investment trusts	8.00%	3.76%
Assumed long-term rate of inflation		2.75%
Expected long-term net rate of return		6.75%

Changes in the net OPEB asset – The changes in the net OPEB asset for the years ended June 30, 2021 and 2020, were as follows:

	June 30, 2021		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB (Asset)
Balance at June 30, 2020	$ 11,878,467	$ 12,909,112	$ (1,030,645)
Changes during the year:			
Service cost	1,222,378	-	1,222,378
Interest on the total OPEB asset	867,980	-	867,980
Actual vs. expected experience	-	-	-
Assumption changes	-	-	-
Contributions from employer	-	3,018,143	(3,018,143)
Net investment income	-	435,252	(435,252)
Benefit payments	(483,793)	(483,793)	-
Administrative expense	-	(6,630)	6,630
Net change	1,606,565	2,962,972	(1,356,407)
Balance at June 30, 2021	$ 13,485,032	$ 15,872,084	$ (2,387,052)

	June 30, 2020		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability (Asset)
Balance at June 30, 2019	$ 12,492,170	$ 9,953,080	$ 2,539,090
Changes during the year:			
Service cost	1,089,286	-	1,089,286
Interest on the total OPEB asset	901,963	-	901,963
Actual vs. expected experience	(2,076,281)	-	(2,076,281)
Assumption changes	(90,590)	-	(90,590)
Contributions from employer	-	2,601,369	(2,601,369)
Net investment income	-	795,021	(795,021)
Benefit payments	(438,081)	(438,081)	-
Administrative expense	-	(2,277)	2,277
Net change	(613,703)	2,956,032	(3,569,735)
Balance at June 30, 2020	$ 11,878,467	$ 12,909,112	$ (1,030,645)

Sensitivity of the net OPEB asset to changes in the discount rate – The following presents the net OPEB liability of the Health Authority as of June 30, 2021 and 2020, as well as what the Health Authority's net OPEB liability 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, 2021		
	1% Decrease (5.75%)	Current Discount Rate (6.75%)	1% Increase (7.75%)
Health Authority's net OPEB (asset)	$ (438,734)	$ (2,387,052)	$ (3,981,312)

	June 30, 2020		
	1% Decrease (5.75%)	Current Discount Rate (6.75%)	1% Increase (7.75%)
Health Authority's net OPEB (asset) liability	$ 676,268	$ (1,030,645)	$ (2,428,373)

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, 2021		
	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) liability	$ (4,396,093)	$ (2,387,052)	$ 161,692

	June 30, 2020		
	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) liability	$ (2,684,513)	$ (1,030,645)	$ 1,053,799

OPEB expense and deferred outflows of resources and deferred inflows of resources related to OPEB – For the year ended June 2021, the Health Authority recognized OPEB expense of $1,008,472. At June 30, 2021, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2021	
	Deferred outflows of resources	Deferred inflows of resources
Difference in experience	$ -	$ (1,664,999)
Net differences between projected and actual earnings on pension plan investments	291,278	-
Changes in assumptions	73,122	(72,288)
OPEB contributions made subsequent to measurement date	2,844,693	-
	$ 3,209,093	$ (1,737,287)

For the year ended June 2020, the Health Authority recognized OPEB expense of $1,008,809. At June 30, 2020, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2020	
	Deferred outflows of resources	Deferred inflows of resources
Difference in experience	$ -	$ (1,876,357)
Net differences between projected and actual earnings on pension plan investments	-	(156,101)
Changes in assumptions	87,746	(81,439)
OPEB contributions made subsequent to measurement date	3,018,143	-
	$ 3,105,889	$ (2,113,897)

The Health Authority reported $2,844,693 and $3,018,143 as deferred outflows of resources related to contributions made subsequent to the measurement date for the years ended June 30, 2021 and 2020, respectively. This amount will be recognized as a reduction of net OPEB asset in the years ended June 30, 2022 and 2021, 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,	
2022	$ (169,478)
2023	$ (129,222)
2024	$ (124,433)
2025	$ (109,129)
2026	$ (205,886)
Thereafter	$ (634,739)

Payable to the OPEB plan – At June 30, 2021 and 2020, the Health Authority had no outstanding amount of contributions to the OPEB plan required for the years ended June 30, 2021 and 2020.

NOTE 10 – 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 $1,500,000 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 $861,145 and $474,183 in 2021 and 2020, respectively.

NOTE 11 – 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 $33,804,554 and $32,471,000 at June 30, 2021 and 2020, respectively. The Health Authority's tangible net equity was $254,850,602 and $208,640,786 at June 30, 2021 and 2020, respectively.

NOTE 12 – 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 13 – 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 14 – HEALTH CARE 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 health care 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 Liability/Asset

	2021	2020	2019	2018	2017	2016	2015
Measurement period	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Proportion of the net pension liability (asset)	0.00183%	-0.00992%	-0.02053%	0.01840%	0.07925%	0.07311%	0.07849%
Proportionate share of the net pension liability (asset)	$ 199,654	$ (1,017,002)	$ (1,978,644)	$ 1,824,796	$ 6,857,370	$ 5,018,386	$ 4,883,971
Covered-employee payroll*	$ 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 (asset) as a percentage of covered-employee payroll	0.75%	-4.29%	-9.91%	11.05%	62.28%	67.56%	53.54%
Proportionate share of plan's fiduciary net position as a percentage of the plan's total pension liability (asset)	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

	2021	2020	2019	2018	2017	2016	2015
Measurement period	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Actuarially determined contribution	$ 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	2,365,673	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*	$ 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	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

	2021	2020	2019	2018	2017
Measurement period	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016
Total OPEB liability					
Service cost	$ 1,222,378	$ 1,089,286	$ 1,119,648	$ 756,248	$ 736,008
Interest on the total OPEB liability	867,980	901,963	805,036	708,213	648,807
Actual vs. expected experience	-	(2,076,281)	-	(14,700)	-
Assumption changes	-	(90,590)	-	131,618	-
Benefit payments	(483,793)	(438,081)	(478,669)	(542,029)	(499,704)
Net change in total OPEB liability	1,606,565	(613,703)	1,446,015	1,039,350	885,111
Total OPEB liability, beginning of year	11,878,467	12,492,170	11,046,155	10,006,805	9,121,694
Total OPEB liability, end of year	$ 13,485,032	$ 11,878,467	$ 12,492,170	$ 11,046,155	$ 10,006,805
Plan fiduciary net position					
Contributions from employer	$ 3,018,143	$ 2,601,369	$ 3,588,109	$ 1,142,027	$ 954,155
Net investment income	435,252	795,021	518,470	551,777	283,871
Benefit payments	(483,793)	(438,081)	(478,669)	(542,029)	(499,704)
Administrative expense	(6,630)	(2,277)	(12,267)	(2,784)	(2,239)
Net change in plan fiduciary net position	2,962,972	2,956,032	3,615,643	1,148,991	736,083
Plan fiduciary net position, beginning of year	12,909,112	9,953,080	6,337,437	5,188,446	4,452,363
Plan fiduciary net position, end of year	$ 15,872,084	$ 12,909,112	$ 9,953,080	$ 6,337,437	$ 5,188,446
Health Authority's net OPEB (asset) liability	$ (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	117.70%	108.68%	79.67%	57.37%	51.85%
Covered-employee payroll*	$ 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	-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

	2021	2020	2019	2018	2017
Measurement period	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016
Actuarially determined contribution	$ 624,728	$ 1,062,967	$ 1,269,369	$ 1,427,237	$ 1,217,313
Contributions in relation to the actuarially determined contribution	2,844,693	3,018,143	2,601,369	3,588,109	1,217,313
Contribution excess	$ (2,219,965)	$ (1,955,176)	$ (1,332,000)	$ (2,160,872)	$ -
Covered-employee payroll*	$ 28,680,020	$ 26,732,488	$ 24,360,228	$ 20,046,373	$ 17,195,643
Contributions as a percentage of covered-employee payroll	9.92%	11.29%	10.68%	17.90%	7.08%

*For the fiscal year ending on the date shown


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