Report of Independent Auditors and
Combined Financial Statements

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

June 30, 2018 and 2017

MOSSADAMS

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Management's Discussion and Analysis

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan) and
Santa Clara Community Health Authority
Management's Discussion and Analysis
June 30, 2018, 2017, and 2016

INTRODUCTION:

In accordance with the Governmental Accounting Standards Board Codification Section 2200, Comprehensive Annual Financial Report, the management of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority, (the "JPA") (collectively, the "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, 2018, 2017, and 2016. This discussion should be reviewed in conjunction with the Health Authority's combined 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 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. During 2006, the JPA obtained licensure under the Knox-Keene Health Care Services Plan Act of 1975 and commenced operations.

OVERVIEW OF FINANCIAL STATEMENTS:

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

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

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

FINANCIAL HIGHLIGHTS:

- Total enrollment decreased 6.0% to 259,475 members at June 30, 2018 from 276,028 members at June 30, 2017. Total enrollment increased 1.2% to 276,028 members at June 30, 2017 from 272,667 members at June 30, 2016.

- Net position increased by $19,635,304 to $178,015,865 for the fiscal year ended June 30, 2018 from $158,380,561 for the fiscal year ended June 30, 2017 due to operating income of $15,867,109 and nonoperating income of $3,768,195. Net position increased by $58,087,106 to $158,380,561 for the fiscal year ended June 30, 2017 from $100,293,455 for the fiscal year ended June 30, 2016 due to operating income of $56,821,494 and nonoperating income of $1,265,612.

- Total assets and deferred outflows of resources decreased to $763,293,226 as of June 30, 2018 from $866,340,704 as of June 30, 2017. Total assets and deferred outflows of resources increased to $866,340,704 as of June 30, 2017 from $576,527,455 as of June 30, 2016.

- Total liabilities and deferred inflows of resources decreased to $585,277,361 at June 30, 2018 from $707,960,143 at June 30, 2017. Total liabilities and deferred inflows of resources increased to $707,960,143 at June 30, 2017 from $476,234,000 at June 30, 2016.

- The current ratio (current assets divided by current liabilities) of 1.26 as of June 30, 2018 reflected an increase from 1.22 at June 30, 2017. The current ratio (current assets divided by current liabilities) of 1.22 as of June 30, 2017 reflected a decrease from 1.23 at June 30, 2016.

CONDENSED COMBINED STATEMENTS OF NET POSITION:

	June 30			2018 to 2017 Change		2017 to 2016 Change	
	2018	2017	2016	Amount	% Change	Amount	% Change
Assets:							
Current assets	$ 724,183,257	$ 846,240,713	$ 569,709,852	$ (122,057,456)	-14.4%	$ 276,530,861	48.5%
Capital assets	24,269,369	10,507,128	4,941,914	13,762,241	131.0%	5,565,214	112.6%
Other assets	305,350	305,350	305,350	-	0.0%	-	0.0%
Total assets	748,757,976	857,053,191	574,957,116	(108,295,215)	-12.6%	282,096,075	49.1%
Deferred outflows of resources	14,535,250	9,287,513	1,570,339	5,247,737	56.5%	7,717,174	491.4%
Total assets and deferred outflows of resources	$ 763,293,226	$ 866,340,704	$ 576,527,455	$ (103,047,478)	-11.9%	$ 289,813,249	50.3%
Liabilities:							
Current liabilities	$ 574,535,150	$ 695,799,085	$ 462,966,493	$ (121,263,935)	-17.4%	$ 232,832,592	50.3%
Noncurrent liabilities	6,533,514	11,675,729	10,937,886	(5,142,215)	-44.0%	737,843	6.7%
Total liabilities	581,068,664	707,474,814	473,904,379	(126,406,150)	-17.9%	233,570,435	49.3%
Deferred inflow of resources	4,208,697	485,329	2,329,621	3,723,368	767.2%	(1,844,292)	-79.2%
Net position:							
Net investment in capital assets	24,269,369	10,507,128	4,941,914	13,762,241	131.0%	5,565,214	112.6%
Restricted	305,350	305,350	305,350	-	0.0%	-	0.0%
Unrestricted	153,441,146	147,568,083	95,046,191	5,873,063	4.0%	52,521,892	55.3%
Total net position	178,015,865	158,380,561	100,293,455	19,635,304	12.4%	58,087,106	57.9%
Total liabilities, deferred inflows of resources, and net position	$ 763,293,226	$ 866,340,704	$ 576,527,455	$ (103,047,478)	-11.9%	$ 289,813,249	50.3%

Assets and Deferred Outflows of Resources

For the fiscal year ended June 30, 2018, assets decreased $108,295,215 or 12.6% due primarily to repayment to the Department of Health Care Services ("DHCS") of prior years' Med-Cal Expansion ("MCE") rate overpayments. During the same period, deferred outflows of resources increased $5,247,737 or 56.5% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2017, assets increased $282,096,075 or 49.1% due primarily to increases in cash and premiums receivable due largely from the State of California. During the same period, deferred outflows of resources increased $7,717,174 or 491.4% due to the timing of amounts attributable to employee retirement plans.

Liabilities and Deferred Inflows of Resources

For the fiscal year ended June 30, 2018, liabilities decreased $126,406,150 or 17.9% due primarily to repayment to DHCS of prior years' MCE rate overpayments. During the same period, deferred inflows of resources increased $3,723,368 or 767.2% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2017, liabilities increased $233,570,435 or 49.3% due primarily to amounts due to the State of California and increases in medical cost reserves. During the same period, deferred inflows of resources decreased $1,844,292 or 79.2% 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 $178,015,865, $158,380,561, and $100,293,455 at June 30, 2018, 2017, and 2016, respectively. The Health Authority exceeded the minimum required TNE levels at all times during the three fiscal years.

CONDENSED COMBINED RESULTS OF OPERATIONS:

	Fiscal Year			2018 to 2017 Change		2017 to 2016 Change	
	2018	2017	2016	Amount	% Change	Amount	% Change
Year end membership:							
Medi-Cal	248,776	265,753	260,029	(16,977)	-6.4%	5,724	2.2%
Medicare	7,503	7,543	8,203	(40)	-0.5%	(660)	-8.0%
Healthy Kids	3,196	2,732	4,435	464	17.0%	(1,703)	-38.4%
Total year end membership	259,475	276,028	272,667	(16,553)	-6.0%	3,361	1.2%
Annual member months:							
Medi-Cal	3,417,650	3,568,375	3,039,258	(150,725)	-4.2%	529,117	17.4%
Medicare	88,970	92,374	101,943	(3,404)	-3.7%	(9,569)	-9.4%
Healthy Kids	34,294	35,667	52,025	(1,373)	-3.8%	(16,358)	-31.4%
Total annual member months	3,540,914	3,696,416	3,193,226	(155,502)	-4.2%	503,190	15.8%
Operating revenues:							
Capitation and premium revenue	$ 1,329,112,179	$ 1,373,491,475	$ 1,213,865,945	$ (44,379,296)	-3.2%	$ 159,625,530	13.2%
Total operating revenues	1,329,112,179	1,373,491,475	1,213,865,945	(44,379,296)	-3.2%	159,625,530	13.2%
Operating expenses:							
Medical expenses	1,162,181,837	1,167,862,922	1,114,554,803	(5,681,085)	-0.5%	53,308,119	4.8%
Marketing, general, and administrative expenses	45,893,851	45,357,972	35,646,645	535,879	1.2%	9,711,327	27.2%
Depreciation	3,548,003	1,985,807	1,412,014	1,562,196	78.7%	573,793	40.6%
Premium tax	101,621,379	101,463,280	44,809,237	158,099	0.2%	56,654,043	126.4%
Premium deficiency	-	-	(9,705,975)	-	0.0%	9,705,975	-100.0%
Total operating expenses	1,313,245,070	1,316,669,981	1,186,716,724	(3,424,911)	-0.3%	129,953,257	11.0%
Operating income	15,867,109	56,821,494	27,149,221	(40,954,385)	-72.1%	29,672,273	109.3%
Nonoperating revenues:							
Interest income	3,768,195	1,265,612	513,280	2,502,583	197.7%	752,332	146.6%
Changes in net position	19,635,304	58,087,106	27,662,501	(38,451,802)	-66.2%	30,424,605	110.0%
Net position, beginning of year	158,380,561	100,293,455	72,630,954	58,087,106	57.9%	27,662,501	38.1%
Net position, end of year	$ 178,015,865	$ 158,380,561	$ 100,293,455	$ 19,635,304	12.4%	$ 58,087,106	57.9%

Membership and Enrollment

During the fiscal year ended June 30, 2018, the Health Authority experienced a decrease in enrollment of 6.0% predominately in the Medi-Cal program.

During the fiscal year ended June 30, 2017, the Health Authority experienced an enrollment increase in the Medi-Cal line of business, largely due to growth in the Medi-Cal program.

Operating Revenue

During the fiscal year ended June 30, 2018, operating revenues decreased by $44,379,296 or 3.2% to $1,329,112,179 versus the prior year operating revenue of $1,373,491,475. Much of the decrease was attributable to the phase-out of In-Home Supportive Services ("IHSS") from the Cal MediConnect ("CMC") and Coordinated Care Initiative ("CCI") programs effective January 1, 2018.

During the fiscal year ended June 30, 2017, operating revenues increased by $159,625,530 or 13.2% to $1,373,491,475 versus the prior year operating revenue of $1,213,865,945. Much of the increase was attributable to growth in the Med-Cal program coupled with certain CCI capitation rate increases.

Medical Expenses

During the fiscal year ended June 30, 2018, medical expenses decreased by $5,681,085 or 0.5% to $1,162,181,837 versus the prior year of $1,167,862,922. Much of the decrease was attributable to the phase-out of IHSS from the Cal MediConnect program effective January 1, 2018, offset by an increase in healthcare costs.

During the fiscal year ended June 30, 2017, medical expenses increased by $53,308,119 or 4.8% to $1,167,862,922 versus the prior year of $1,114,554,803. Much of the increase was attributable to substantial growth in the Medi-Cal program.

The Health Authority's medical loss ratio ("MLR"), or medical expenses as a percentage of premiums revenue, was 87.4%, 85.0%, and 91.8% for the fiscal years ended June 30, 2018, 2017, and 2016, respectively.

Premium Deficiency Reserve

During the fiscal year ended June 30, 2018, management maintained its estimated premium deficiency reserve ("PDR") on the CMC contract at $8,294,025 for fiscal year 2019 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.

During the fiscal year ended June 30, 2017, management maintained its estimated PDR on the CMC contract at $8,294,025 for fiscal year 2018 due to continuing uncertainties about final rate recasts for multiple fiscal years, shared risk corridor payments and 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, 2018, administrative expenses increased by $535,879 or 1.2% to $45,893,851 versus the prior year expense of $45,357,972 due to general cost increases.

During the fiscal year ended June 30, 2017, administrative expenses increased by $9,711,327 or 27.2% to $45,357,972 versus the prior year expense of $35,646,645. Much of the increase was attributable to personnel costs, including temporary staff and consultants used to supplement full-time staff.

The Health Authority's administrative loss ratio ("ALR"), or marketing, general, and administrative expenses as a percentage of capitation and premium revenue (including depreciation and amortization expense), was 3.7%, 3.4%, and 3.1% for the fiscal years ended June 30, 2018, 2017, and 2016, respectively.

CONDENSED COMBINED CASH FLOW INFORMATION:

The table below summarizes the major sources and uses of cash and cash equivalents for the fiscal years ended June 30, 2018, 2017, and 2016:

	As of June 30			2018 to 2017 Change		2017 to 2016 Change	
	2018	2017	2016	Amount	% Change	Amount	% Change
Cash flows from operating activities	$ (130,630,635)	$ 224,795,253	$ 36,812,249	$ (355,425,888)	-158.1%	$ 187,983,004	510.7%
Cash flows from capital and financing activities	(13,590,598)	(7,533,687)	(1,764,386)	(6,056,911)	80.4%	(5,769,301)	327.0%
Cash flows from investing activities	3,768,195	1,265,612	513,280	2,502,583	197.7%	752,332	146.6%
Net change in cash and cash equivalents	(140,453,038)	218,527,178	35,561,143	(358,980,216)	-164.3%	182,966,035	514.5%
Cash and cash equivalents, beginning of year	364,303,897	145,776,719	110,215,576	218,527,178	149.9%	35,561,143	32.3%
Cash and cash equivalents, end of year	$ 223,850,859	$ 364,303,897	$ 145,776,719	$ (140,453,038)	-38.6%	$ 218,527,178	149.9%

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, 2018, 2017 and 2016. Capital assets largely included furniture and fixtures, computer hardware and software, and leasehold improvements:

	Fiscal Year Ended June 30,			2018 to 2017 Change		2017 to 2016 Change	
	2018	2017	2016	Amount	% Change	Amount	% Change
Beginning balance, net	$ 10,507,128	$ 4,941,914	$ 4,515,303	$ 5,565,214	112.6%	$ 426,611	9.4%
Additions	17,365,176	7,795,195	2,067,654	9,569,981	122.8%	5,727,541	277.0%
Reductions/adjustments	(54,932)	(244,174)	(229,029)	189,242	-77.5%	(15,145)	6.6%
Depreciation expense	(3,548,003)	(1,985,807)	(1,412,014)	(1,562,196)	78.7%	(573,793)	40.6%
Ending balance, net	$ 24,269,369	$ 10,507,128	$ 4,941,914	$ 13,762,241	131.0%	$ 5,565,214	112.6%

KEY FACTORS INFLUENCING THE FISCAL YEAR 2018-2019 BUDGET:

In June 2018, the Health Authority's Governing Board formally approved operating and capital budgets for the fiscal year ending June 30, 2019. The operating budget anticipates a 5.5% reduction in enrollment, an overall 3.1% decrease in Medi-Cal capitation rates received from DHCS, and modest growth in expenses, net of the effect of the phase-out of IHSS from the CMC and CCI programs effective January 1, 2018. The 2019 capital budget includes approximately $4.3 million for investments in information systems and facilities.

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, 6201 San Ignacio Avenue, San Jose, CA 95119 or call (408) 376-2000.

MOSSADAMS

Report of Independent Auditors

To the Board of Directors
Santa Clara County Health Authority
(dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority

Report on the Financial Statements

We have audited the accompanying combined financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority (collectively, the "Health Authority"), a discrete component unit of the County of Santa Clara, California, which comprise the combined statements of net position as of June 30, 2018 and 2017, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined 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 combined 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 combined 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 combined financial statements are free from material misstatements.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined 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 combined 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 combined 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 combined financial statements referred to above present fairly, in all material respects, the combined net position of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority as of June 30, 2018 and 2017, and the results in its operations and its cash flows for the year 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 liability, supplementary schedule of contributions, supplementary schedules of changes in net other post-employment benefit liability, and supplementary schedule of other post-employment benefit contributions on pages 37 through 40 are not a required part of the combined 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 combined 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 combined financial statements, and other knowledge we obtained during our audits of the combined 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 25, 2018

Combined Financial Statements

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan) and
Santa Clara Community Health Authority
Combined Statements of Net Position
June 30, 2018 and 2017

	2018	2017
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets		
Cash and cash equivalents	$ 223,850,859	$ 364,303,897
Premiums receivable	493,307,426	474,866,197
Prepaids and other assets	7,024,972	7,070,619
Total current assets	724,183,257	846,240,713
Capital assets, net		
Nondepreciable	10,057,379	6,402,859
Depreciable, net of accumulated depreciation and amortization	14,211,990	4,104,269
Total capital assets, net	24,269,369	10,507,128
Assets restricted as to use	305,350	305,350
Total assets	748,757,976	857,053,191
Deferred outflows of resources	14,535,250	9,287,513
Total deferred outflows of resources	14,535,250	9,287,513
Total assets and deferred outflows of resources	$ 763,293,226	$ 866,340,704
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
Current liabilities		
Accounts payable and accrued liabilities	$ 29,099,112	$ 45,881,366
Amounts due to the State of California	24,429,978	241,524,325
In-home supportive services payable	413,549,551	300,220,266
Due to Santa Clara County Valley Health Plan and Kaiser	6,691,980	9,456,453
Medical incurred but not reported claims and medical claims payable	78,089,647	76,537,431
Provider incentives and other medical liabilities	14,380,857	13,885,219
Premium deficiency reserves	8,294,025	8,294,025
Total current liabilities	574,535,150	695,799,085
Noncurrent liabilities		
Net pension liability	1,824,796	6,857,370
Other post-employment benefits liability	4,708,718	4,818,359
Total liabilities	581,068,664	707,474,814
Deferred inflows of resources	4,208,697	485,329
Total deferred inflows of resources	4,208,697	485,329
Net position		
Net investment in capital assets	24,269,369	10,507,128
Restricted	305,350	305,350
Unrestricted	153,441,146	147,568,083
Total net position	178,015,865	158,380,561
Total liabilities, deferred inflows of resources, and net position	$ 763,293,226	$ 866,340,704

See accompanying notes to financial statements.

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan) and
Santa Clara Community Health Authority
Combined Statements of Revenues, Expenses, and Changes in Net Position
For the Years Ended June 30, 2018 and 2017

	2018	2017
Operating revenues		
Capitation and premium revenue	$ 1,329,112,179	$ 1,373,491,475
Total operating revenues	1,329,112,179	1,373,491,475
Operating expenses		
Medical expenses	1,162,181,837	1,167,862,922
Premium tax	101,621,379	101,463,280
Marketing, general, and administrative expenses	45,893,851	45,357,972
Depreciation and amortization	3,548,003	1,985,807
Total operating expenses	1,313,245,070	1,316,669,981
Operating income	15,867,109	56,821,494
Nonoperating revenues		
Interest income	3,768,195	1,265,612
Change in net position	19,635,304	58,087,106
Net position, beginning of year	158,380,561	100,293,455
Net position, end of year	$ 178,015,865	$ 158,380,561

See accompanying notes to financial statements.

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan) and
Santa Clara Community Health Authority
Combined Statements of Cash Flows
For the Years Ended June 30, 2018 and 2017

	2018	2017
Cash flows from operating activities		
Capitation and premiums received	$ 1,310,670,950	$ 1,315,792,248
Medical expenses paid	(1,368,780,535)	(1,084,894,148)
Marketing, general, and administrative expenses paid	(72,521,050)	(6,102,847)
Net cash (used in) provided by operating activities	(130,630,635)	224,795,253
Cash flows from capital and financing activities		
Purchases of capital assets	(13,590,598)	(7,533,687)
Net cash used in capital and financing activities	(13,590,598)	(7,533,687)
Cash flows from investing activities		
Interest collection on investments	3,768,195	1,265,612
Net cash provided by investing activities	3,768,195	1,265,612
Net change in cash and cash equivalents	(140,453,038)	218,527,178
Cash and cash equivalents, beginning of year	364,303,897	145,776,719
Cash and cash equivalents, end of year	$ 223,850,859	$ 364,303,897
Reconciliation of operating income to net cash provided by operating activities		
Operating income	$ 15,867,109	$ 56,821,494
Adjustments to reconcile operating income to net cash (used in) provided by operating activities		
Depreciation and amortization	3,548,003	1,985,807
Changes in operating assets and liabilities		
Premiums receivable	(18,441,229)	(57,699,227)
Prepaids and other assets	45,647	(304,456)
Accounts payable and accrued liabilities	(20,501,900)	32,391,387
Amounts due to the State of California	(217,094,347)	123,514,662
In-home supportive services payable	113,329,285	61,833,125
Due to Santa Clara County Valley Health Plan and Kaiser	(2,764,473)	2,851,981
Net pension liability	(4,167,907)	(6,580,492)
Net other post-employment benefits liability	(2,498,677)	3,676,369
Medical incurred but not reported claims and medical claims payable	1,552,216	(3,767,714)
Provider incentives and other medical liabilities	495,638	10,072,317
Net cash (used in) provided by operating activities	$ (130,630,635)	$ 224,795,253
Supplemental cash flow disclosure		
Cash paid during the year for premium tax	$ 140,124,201	$ 79,506,126
Supplemental disclosure of noncash item		
Payables for capital asset purchases	$ 3,774,578	$ 261,508

See accompanying notes to financial statements.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

History and organization – The accompanying combined financial statements include the Santa Clara County Health Authority and the Santa Clara Community Health Authority Joint Powers Authority ("JPA") (collectively, the "Health Authority"). The combined financial statements are included in the County of Santa Clara's basic financial statements as a discretely presented component unit.

The Santa Clara County Health Authority (dba Santa Clara Family Health Plan ("SCFHP")) was established 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 State 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 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 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 current DHCS contract is effective through December 31, 2020. 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. The CMC contract is for five one-year terms expiring on December 31, 2019. The Health Authority has the option to cancel this agreement prior to the end of each term. 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. This program has been assigned to the JPA.

In September 2009, DHCS implemented Assembly Bill No. 1422 ("AB 1422") or Managed Care Organization ("MCO") premium tax. This program imposed an assessment on the Health Authority's capitation and premium revenue. DHCS used this assessment to obtain matching federal funds, which was used to sustain enrollment in the former Healthy Families program. This provision was effective retroactive to January 1, 2009 and continued through June 30, 2013. In June 2013, Senate Bill No. 78 ("SB 78") reauthorized the MCO premium tax. For July 1, 2013 through June 30, 2016, the tax rate was equal to the state sales and use tax rate of 3.9375%. On March 1, 2016, SB X2-2 established a new MCO provider tax, to be administered by DHCS, effective July 1, 2016 through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. The Health Authority paid $140,124,201 and $79,506,126 in MCO premium taxes during fiscal years 2018 and 2017, respectively. At June 30, 2018 and 2017, the Health Authority had payables due in the amount of $0 and $33,865,555, 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 combined 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.

Basis of combination – The accompanying financial statements include the Santa Clara County Health Authority and the Santa Clara Community Health Authority, as both entities are under common management and control.

Use of estimates – The preparation of the combined 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 combined financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Medical incurred but not reported claims and medical claims payable, premiums receivable, net pension liability, other post-employment benefits liability, 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, 2018 and 2017, the Health Authority's cash deposits had carrying amounts of $223,850,859 and $364,303,897, respectively. The Health Authority's bank balances at June 30, 2018 and 2017, including interests in an investment pool, were $245,879,254 and $362,227,706, respectively. Of the bank and investment pool balances at June 30, 2018 and 2017, $245,129,254 and $361,477,706, respectively, were not covered by federal depository insurance.

Amounts invested in the County Treasurer's investment pool (the "Investment Pool") are considered as 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, 2018 and 2017.

Capital assets – Purchased capital assets are stated at cost. Depreciation 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 $305,350 at June 30, 2018 and 2017.

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 – The Department of Health Care Services pays IHSS payments directly to the Santa Clara County's Department of Social Services. As part of CCI, the Health Authority assumes 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 combined financials statements. Additionally, the Health Authority pays the MCO tax on the IHSS revenue and records it as premium tax.

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 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 teams of certain incentive agreements, a final reconciliation of surpluses are completed annually and paid within six months of the Health Authority's fiscal year. Incentive payments are recorded in medical expenses in the accompanying combined financial statements.

Net pension liability – The Health Authority recognizes a net pension liability, which represents the proportionate share of the excess of the total pension 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 is measured as of the Health Authority's prior fiscal year-end. Changes in the net pension liability are recorded in the period incurred as pension expense and as deferred inflows of resources or deferred outflows of resources depending on the nature of the change. The changes in net pension liability that are recorded as deferred inflows of resources or deferred outflows of resources are recognized in pension expense systematically over time.

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

Other post-employment benefit liability – The Health Authority recognizes a net other post-employment benefit ("OPEB") liability, which represents the excess 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 liability is measured as of the Health Authority's prior fiscal year-end. Changes in the net OPEB liability 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 liability 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 liability, 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, or unrestricted net position. Net investment in capital assets represents capital assets, net of accumulated depreciation and amortization, reduced by outstanding balances of bonds, mortgages, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets. 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.

Premium revenue – The Health Authority has agreements with the Medi-Cal Program in the state to provide certain health care products and services to enrolled Medi-Cal beneficiaries. 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, 2018 and 2017, premium revenues recorded from DHCS under the Medi-Cal Program totaled $1,177,273,921 and $1,230,737,038, 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, 2018 and 2017, premium revenues totaled $36,143,056 and $29,547,395, and $112,123,902 and $109,742,832 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 grants for the Healthy Kids Program totaled $3,571,300 and $3,464,210 for the years ended June 2018 and 2017, and were funded by the following organization: County of Santa Clara $2,994,854 and $2,791,440, respectively, and monthly family premiums of $546,971 and $672,770, respectively.

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 is for five one-year terms expiring on December 31, 2019. The Health Authority has the option to cancel this agreement prior to the end of each term. Management has estimated that it will incur losses on the contract. The premium deficiency reserves have been calculated to December 31, 2018 as this is the next date management could terminate the contract. Accordingly, a premium deficiency reserve in the amount of $8,294,025 has been recorded at June 30, 2018 and 2017. 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, 2018 and 2017.

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, 2018, the Health Authority had premiums receivable of $483,612,087, $3,425,599, $5,579,432, and $690,308 due from Medi-Cal Program, CMC program, Medicare and Healthy Kids Program, respectively. As of June 30, 2017, the Health Authority had premiums receivable of $464,854,123, $2,621,034, $6,744,941, and $646,099 due from the 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 March 2016, the GASB issued GASB Statement No. 82, *Pension Issues – An Amendment of GASB Statements No. 67, No. 68, and No. 73* ("GASB 82"), which is effective for financial statements for periods beginning after June 15, 2017. GASB 82 improves financial reporting by enhancing consistency in the application of financial reporting requirements to certain pension issues. The Health Authority has adopted GASB 82 as of July 1, 2017. There was no material impact on the adoption of GASB 82.

In March 2017, the GASB issued GASB Statement No. 85, *Omnibus 2017* ("GASB 85"), which is effective for financial statements for periods beginning after June 15, 2017. GASB 85 addresses practice issues that have been identified during implementation and application of certain GASB statements, including issues related to blending component units, goodwill, fair value measurement and application, and post-employment benefits (pensions and other post-employment benefits). The Health Authority has adopted GASB 85 as of July 1, 2017. There was no material impact on the adoption of GASB 85.

In June 2017, the GASB issued GASB Statement No. 87, *Leases* ("GASB 87"), which is effective for financial statements for periods beginning after December 15, 2019. 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. The Health Authority is reviewing the impact of the adoption of GASB 87 for the fiscal year ending 2021.

Reclassifications – Certain amounts in the 2017 combined financial statements have been reclassified to conform to the 2018 presentation. These reclassifications have no effect on the 2017 operating income or net position.

NOTE 2 – CAPITAL ASSETS

Capital asset activity for the fiscal years ended June 30, 2018 and 2017 are as follows:

	2018				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ -	$ 3,507,578	$ -	$ -	$ 3,507,578
Furniture and equipment	10,290,008	754,131	(204,670)	-	10,839,469
Leasehold improvements	759,482	-	-	-	759,482
Building and building improvements	-	6,235,856	-	-	6,235,856
Software	3,816,470	438,300	-	6,402,859	10,657,629
Vehicles	-	29,248	-	-	29,248
Software work in progress	6,402,859	347,526	-	(6,402,859)	347,526
Building improvements work in progress	-	6,052,537	149,738	-	6,202,275
Total capital assets	21,268,819	17,365,176	(54,932)	-	38,579,063
Less accumulated depreciation and amortization for:					
Furniture and equipment	8,261,463	1,136,188	-	-	9,397,651
Leasehold improvements	592,058	154,544	-	-	746,602
Building and building improvements	-	159,894	-	-	159,894
Software	1,908,170	2,095,346	-	-	4,003,516
Vehicles	-	2,031	-	-	2,031
Total accumulated depreciation and amortization	10,761,691	3,548,003	-	-	14,309,694
Capital assets, net	$ 10,507,128	$ 13,817,173	$ (54,932)	$ -	$ 24,269,369

	2017				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Furniture and equipment	$ 9,237,170	$ 1,297,012	$ (244,174)	$ -	$ 10,290,008
Leasehold improvements	664,158	95,324	-	-	759,482
Software	3,816,470	-	-	-	3,816,470
Software work in progress	-	6,402,859	-	-	6,402,859
Total capital assets	13,717,798	7,795,195	(244,174)	-	21,268,819
Less accumulated depreciation and amortization for:					
Furniture and equipment	7,167,477	1,093,986	-	-	8,261,463
Leasehold improvements	463,531	128,527	-	-	592,058
Software	1,144,876	763,294	-	-	1,908,170
Total accumulated depreciation and amortization	8,775,884	1,985,807	-	-	10,761,691
Capital assets, net	$ 4,941,914	$ 5,809,388	$ (244,174)	$ -	$ 10,507,128

Depreciation and amortization expense totaled $3,548,003 and $1,985,807, at June 30, 2018 and 2017, respectively.

NOTE 3 – MEDICAL INCURRED BUT NOT REPORTED CLAIMS AND MEDICAL CLAIMS PAYABLE

The Health Authority estimates medical incurred but not reported ("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, 2018 and 2017 is summarized as follows:

	2018	2017
Beginning balance	$ 76,537,431	$ 80,305,145
Incurred related to:		
Current year	547,935,606	480,444,699
Prior year	(9,848,544)	(2,205,033)
Total incurred	538,087,062	478,239,666
Paid related to:		
Current year	471,250,062	410,499,344
Prior year	65,284,784	71,508,036
Total paid	536,534,846	482,007,380
Ending balance	$ 78,089,647	$ 76,537,431

NOTE 4 – DESIGNATED NET POSITION

Designated funds remain under the control of the Board of Directors, which may, at its discretion, later use the funds for other purposes. For the fiscal years ended June 30, 2018 and 2017, no designation of unrestricted net position was made.

NOTE 5 – OPERATING LEASE OBLIGATIONS

The Health Authority leases facilities under an operating lease that expired in August 2018. The Health Authority also has various equipment operating leases expiring in various years through September 2023.

Future minimum lease payments as of June 30, 2018 consist of the following:

Years ending June 30,	Building	Equipment	Total
2019	$ 164,919	$ 50,650	$ 215,569
2020	-	47,416	47,416
2021	-	47,416	47,416
2022	-	47,416	47,416
2023	-	47,416	47,416
Thereafter	-	11,854	11,854
Total minimum lease payments	$ 164,919	$ 252,168	$ 417,087

Rent expense, included in marketing, general, and administrative expenses in the combined statements of revenues, expenses, and changes in net position, for the years ended June 30, 2018 and 2017 was $1,407,585 and $1,239,074, respectively.

NOTE 6 – 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 $535,167 and $433,402 for the years ended June 30, 2018 and 2017, 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 have no fiduciary accountability for the plan. Thus, plan assets and any related liability to plan participants have been excluded from the Health Authority's combined 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, 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 have no fiduciary accountability for the plan. Thus, plan assets and any related liability to plan participants have been excluded from the Health Authority's combined 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 times 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 offer 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, 2018 and 2017. 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 $4,426,715 and $5,900,859 for the years ended June 30, 2018 and 2017, respectively.

Pension liabilities, pension expense, and deferred outflows of resources and deferred inflows of resources related to pension – The net pension liability at June 30, 2018 is measured as of June 30, 2017, using an annual actuarial valuation as of June 30, 2016, rolled forward to June 30, 2017, using standard update procedures. The total pension liabilities in the June 30, 2016 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	2.75%
Salary increases	Varies by Entry Age and Service
Mortality rate table	Derived using CaIPERS' Membership Data for all Funds
Post retirement benefit increase:	Contract COLA up to 2.75% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.75% thereafter

The net pension liability at June 30, 2017 is measured as of June 30, 2016, using an annual actuarial valuation as of June 30, 2015, rolled forward to June 30, 2016, using standard update procedures. The total pension liabilities in the June 30, 2015 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	7.65%
Inflation	2.75%
Salary increases	Varies by Entry Age and Service
Mortality rate table	Derived using CaIPERS' Membership Data for all Funds
Post retirement benefit increase:	Contract COLA up to 2.75% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.75% thereafter

All other actuarial assumptions used in the June 30, 2016 and 2015 valuation were based on the results of an actuarial experience study for the fiscal years 1997 to 2011, including updates to salary increase, mortality, and retirement rates. The Experience Study report can be obtained at CalPERS' website under Forms and Publications.

Change of assumptions – The discount rate decreased from 7.65% to 7.15% for the June 30, 2017 measurement date. The discount rate of 7.65% used for the June 30, 2016 measurement date is without reduction of pension plan administrative expense.

Discount rate – The discount rate used to measure the total pension liability at June 30, 2017 and 2016 measurement date was 7.15% and 7.65%, respectively. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. The test revealed the assets would not run out. Therefore, the current 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 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	47.0%	4.90%	5.38%
Global fixed income	19.0%	0.80%	2.27%
Inflation sensitive	6.0%	0.60%	1.39%
Private equity	12.0%	6.60%	6.63%
Real estate	11.0%	2.80%	5.21%
Infrastructure and forestland	3.0%	3.90%	5.36%
Liquidity	2.0%	-0.40%	-0.90%

(a) An expected inflation rate of 2.5% was used for this period.
(b) An expected inflation rate of 3.0% was used for this period.

Sensitivity of the employer's proportionate share of the net pension liability to changes in the discount rate – The following presents the Health Authority's net pension liability as of June 30, 2018 and 2017, as well as what the net pension liability would be if it were calculated using a discount rate that is 1% point lower or 1% point higher than the current rate:

	June 30, 2018		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Health Authority's net pension liability (asset)	$ 7,138,936	$ 1,824,796	$ (2,576,471)

	June 30, 2017		
	1% Decrease (6.65%)	Current Discount Rate (7.65%)	1% Increase (8.65%)
Health Authority's net pension liability	$ 11,296,151	$ 6,857,370	$ 3,188,937

Health Authority's proportion for the miscellaneous plan was 0.0184% and 0.0793% at June 30, 2018 and 2017, respectively.

For the years ended June 30, 2018 and 2017, the Health Authority recognized pension expense of $1,546,128 and ($679,633), respectively. Pension expense represents the change in the net pension liability during the measurement period, adjusted for actual contributions and the deferred recognition of changes in investment gain/loss, actuarial gain/loss, actuarial assumptions or method, and plan benefits.

For the year ended June 30, 2018, the Health Authority had $10,830,147 of deferred outflows of resources and $4,034,620 of deferred inflows of resources related to pensions from the following sources:

	2018	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 138,370	$ (3,697,278)
Experience	12,993	(186,153)
Differences between employer's actual contributions and its proportionate share of total employer contributions	4,275,305	(28,260)
Net differences between projected and actual earnings on pension plan investments	364,604	-
Assumptions	1,612,160	(122,929)
Pension contributions made subsequent to measurement date	4,426,715	-
	$ 10,830,147	$ (4,034,620)

For the year ended June 30, 2017, the Health Authority had $8,145,523 of deferred outflows of resources and $485,329 of deferred inflows of resources related to pensions from the following sources:

	2017	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 263,624	$ (67,815)
Experience	30,362	-
Differences between employer's actual contributions and its proportionate share of total employer contributions	11,256	(44,883)
Net differences between projected and actual earnings on pension plan investments	1,939,422	-
Assumptions	-	(372,631)
Pension contributions made subsequent to measurement date	5,900,859	-
	$ 8,145,523	$ (485,329)

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

Deferred outflows of resources of $4,426,715 and $5,900,859 resulting from contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the years ending June 30, 2019 and 2018, 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,	
2019	$ 692,687
2020	1,163,852
2021	728,746
2022	(216,473)
	$ 2,368,812

NOTE 7 – 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 their 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, 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, 2018 and 2017, the following employees were covered by the plan:

	2018	2017
Active	216	155
Retirees	55	51
Total participants	271	206

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 liability – The Health Authority's net OPEB liability at June 30, 2018 and 2017 was measured as of June 30, 2017 and 2016, respectively, and the total OPEB liability used to calculate the net OPEB liability was determined by an actuarial valuation as of June 30, 2017 and 2016, respectively.

The total OPEB liability in the June 30, 2017 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, decreasing to 4.00% for year 2017 for ages pre-65 and 6.5% for 2019, decreasing to 4.00% in 2075 for ages post-65

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

The total OPEB liability in the June 30, 2016 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	2.50%
Investment rate of return	6.71%
Healthcare cost trend rates:	7.50% for 2018, graded to 4.25% for year 2088 and beyond for ages pre-65 and 7.50% for 2018, graded to 4.50% for year 2075 and beyond for ages post-65

Mortality rates are based on statistics taken from the CalPERS Experience Study Report adopted in 2014. The rates include a projection to 2028 using Scale BB to account for anticipated future mortality improvement.

Discount rate – The discount rate used to measure the total OPEB liability was 6.75% at both June 30, 2017 and 2016 measurement date. 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 liability.

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	Expected Real Rate of Return	Asset Allocation
Global equity	4.82%	57.00%
U.S. fixed income	1.47%	27.00%
Treasury inflation-protected securities	1.29%	5.00%
Commodities	0.84%	3.00%
Real estate investment trusts	3.76%	8.00%
Assumed long-term rate of inflation		2.75%
Expected long-term net rate of return		6.75%

Changes in the net OPEB liability – The changes in the net OPEB liability for the years ended June 30, 2018 and 2017 were as follows:

	June 30, 2018		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability
Balance at June 30, 2017	$ 10,006,805	$ 5,188,446	$ 4,818,359
Changes during the year:			
Service cost	756,248	-	756,248
Interest on the total OPEB liability	708,213	-	708,213
Actual vs. expected experience	(14,700)	-	(14,700)
Assumption changes	131,618	-	131,618
Contributions from employer	-	1,142,027	(1,142,027)
Net investment income	-	551,777	(551,777)
Benefit payments	(542,029)	(542,029)	-
Administrative expense	-	(2,784)	2,784
Net change in total OPEB liability	1,039,350	1,148,991	(109,641)
Balance at June 30, 2018	$ 11,046,155	$ 6,337,437	$ 4,708,718

	June 30, 2017		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability
Balance at June 30, 2016	$ 9,121,694	$ 4,452,363	$ 4,669,331
Changes during the year:			
Service cost	736,008	-	736,008
Interest on the total OPEB liability	648,807	-	648,807
Contributions from employer	-	954,155	(954,155)
Net investment income	-	283,871	(283,871)
Benefit payments	(499,704)	(499,704)	-
Administrative expense	-	(2,239)	2,239
Net change in total OPEB liability	885,111	736,083	149,028
Balance at June 30, 2017	$ 10,006,805	$ 5,188,446	$ 4,818,359

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability of the Health Authority as of June 30, 2018 and 2017, as well as what the Health Authority's net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current discount rate:

	June 30, 2018		
	1% Decrease (5.75%)	Current Discount Rate (6.75%)	1% Increase (7.75%)
Health Authority's net OPEB liability	$ 6,249,142	$ 4,708,718	$ 3,440,656

	June 30, 2017		
	1% Decrease (5.75%)	Current Discount Rate (6.75%)	1% Increase (7.75%)
Health Authority's net OPEB liability	$ 6,230,367	$ 4,818,359	$ 3,659,432

Sensitivity of the net OPEB liability to changes in the healthcare cost trend rates – The following presents the net OPEB liability of the Health Authority, as well as what the Health Authority's net OPEB liability would be if it were calculated using healthcare cost trend rates that is 1 percentage point lower or 1 percentage point higher than the current healthcare cost trend rates:

	June 30, 2018		
	1% Decrease in Healthcare Costs Trend Rate	Current Healthcare Costs Trend Rate	1% Increase in Healthcare Costs Trend Rate
Health Authority's net OPEB liability	$ 3,318,333	$ 4,708,718	$ 6,353,250

	June 30, 2017		
	1% Decrease in Healthcare Costs Trend Rate	Current Healthcare Costs Trend Rate	1% Increase in Healthcare Costs Trend Rate
Health Authority's net OPEB liability	$ 3,493,781	$ 4,818,359	$ 6,710,550

OPEB expense and deferred outflows of resources and deferred inflows of resources related to OPEB – For the year ended June 2018, the Health Authority recognized OPEB expense of $1,089,469. At June 30, 2018, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2018	
	Deferred outflows of resources	Deferred inflows of resources
Experience	$ -	$ (13,067)
Net differences between projected and actual earnings on pension plan investments	-	(161,010)
Assumptions	116,994	-
OPEB contributions made subsequent to measurement date	3,588,109	-
	$ 3,705,103	$ (174,077)

For the year ended June 2017, the Health Authority recognized OPEB expense of $1,103,183. At June 30, 2017, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2017	
	Deferred outflows of resources	Deferred inflows of resources
OPEB contributions made subsequent to measurement date	$ 1,141,990	$ -
	$ 1,141,990	$ -

The Health Authority reported $3,588,109 and $1,141,990 as deferred outflows of resources related to contributions made subsequent to the measurement date for the year ended June 30, 2018 and 2017. This amount will be recognized as a reduction of net OPEB liability in the year ended June 30, 2019 and 2018, 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,	
2019	$ (27,261)
2020	(27,261)
2021	(27,261)
2022	(27,263)
2023	12,991
Thereafter	38,972
	$ (57,083)

Payable to the OPEB plan – At June 30, 2018 and 2017, the Health Authority had no outstanding amount of contributions to the OPEB plan required for the years ended June 30, 2018 and 2017.

NOTE 8 – 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 exceed stop-loss recoveries by $819,793 in 2018. Stop-loss recoveries exceeded premiums by $2,331,441 in 2017.

NOTE 9 – TANGIBLE NET EQUITY

As a limited license plan under 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 $36,037,000 and $35,685,000 at June 30, 2018 and 2017, respectively. The Health Authority's tangible net equity was $178,015,865 and $158,380,561 at June 30, 2018 and 2017, respectively.

NOTE 10 – 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 11 – COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, the Health Authority is a party to claims and legal actions by enrollees, providers, and others. 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 combined financial position or combined results of operations of the Health Authority.

NOTE 12 – HEALTH CARE REFORM

The Patient Protection and Affordable Care Act (“PPACA”) allowed for the expansion of Medical members in the State of California. Any further changes in federal or state funding could have an impact on the Health Authority. The future of the PPACA and the impact of future changes in Medicaid to the Health Authority is uncertain at this time.

Supplementary Information

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

	2018	2017	2016	2015
Measurement period	2016-2017	2015-2016	2014-2015	2013-2014
Proportion of the net pension liability	0.01840%	0.07925%	0.07311%	0.07849%
Proportionate share of the net pension liability	$ 1,824,796	$ 6,857,370	$ 5,018,386	$ 4,883,971
Covered-employee payroll*	$ 16,512,291	$ 11,010,647	$ 7,427,745	$ 9,121,825
Proportionate share of the net pension liability as a percentage of covered-employee payroll	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	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) and Santa Clara Community Health Authority
Schedule of Pension Contributions

	2018	2017	2016	2015
Measurement period	2016-2017	2015-2016	2014-2015	2013-2014
Actuarially determined contribution	$ 1,198,065	$ 1,287,320	$ 910,906	$ 886,335
Contributions in relation to the actuarially determined contribution	4,426,715	7,188,179	910,906	886,335
Contribution excess	$ (3,228,650)	$ (5,900,859)	$ -	$ -
Covered-employee payroll*	$ 19,966,458	$ 16,512,291	$ 11,010,647	$ 7,427,745
Contributions as a percentage of covered-employee payroll	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) and
Santa Clara Community Health Authority
Schedule of Changes in Net Other Post-Employment Benefit Liability

	2018	2017
Measurement period	2016-2017	2015-2016
Total OPEB liability		
Service cost	$ 756,248	$ 736,008
Interest on the total OPEB liability	708,213	648,807
Actual vs. expected experience	(14,700)	-
Assumption changes	131,618	-
Benefit payments	(542,029)	(499,704)
Net change in total OPEB liability	1,039,350	885,111
Total OPEB liability, beginning of year	10,006,805	9,121,694
Total OPEB liability, end of year	$ 11,046,155	$ 10,006,805
Plan fiduciary net position		
Contributions from employer	$ 1,142,027	$ 954,155
Net investment income	551,777	283,871
Benefit payments	(542,029)	(499,704)
Administrative expense	(2,784)	(2,239)
Net change in plan fiduciary net position	1,148,991	736,083
Plan fiduciary net position, beginning of year	5,188,446	4,452,363
Plan fiduciary net position, end of year	$ 6,337,437	$ 5,188,446
Health Authority's net OPEB liability	$ 4,708,718	$ 4,818,359
Plan fiduciary net position as a percentage of the total OPEB liability	57.37%	51.85%
Covered-employee payroll*	$ 17,216,515	$ 17,195,643
Health Authority's net OPEB liability as a percentage of covered-employee payroll	27.35%	28.02%

*For the year ending on the measurement date.

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

	2018	2017
Measurement period	2016-2017	2015-2016
Actuarially determined contribution	$ 1,427,237	$ 1,217,313
Contributions in relation to the actuarially determined contribution	3,588,109	1,217,313
Contribution deficiency (excess)	$ (2,160,872)	$ -
Covered-employee payroll*	$ 20,046,373	$ 17,195,643
Contributions as a percentage of covered-employee payroll	17.90%	7.08%

*For the fiscal year ending on the date shown.


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