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Molina Healthcare, Inc. (MOH)

Q3 2016 Earnings Call

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MANAGEMENT DISCUSSION SECTION

Operator: Ladies and gentlemen, thank you for standing by, and welcome to the Molina Healthcare Third Quarter 2016 Earnings Conference Call. During the presentation, all participants will be in a listen-only mode. Afterwards, we will conduct a question-and-answer session. [Operator Instructions] As a reminder, this call is being recorded Thursday, October 27, 2016.

I would now like to turn the call over to Juan José Orellana, Senior Vice President of Investors Relations. Please go ahead.

Juan José Orellana
Senior Vice President of Investor Relations & Marketing, Molina Healthcare, Inc.

Thank you, Ash. Hello, everyone, and thank you for joining us. The purpose of this call is to discuss Molina Healthcare's financial results for the third quarter ended September 30, 2016. The company's earnings release reporting its results was issued today after the market closed, and it is now posted for viewing on our company website.

On the call with me today are Dr. Mario Molina, our CEO; John Molina, our CFO; Terry Bayer, our COO; and Joseph White, our Chief Accounting Officer. After the completion of our prepared remarks, we will open the call to take your questions. If you have multiple questions, we ask that you get back in the queue so that others can have an opportunity to ask their questions.

Our comments today will contain forward-looking statements under the Safe Harbor Provisions of the Private Securities Litigation Reform Act. All of our forward-looking statements are based on our current expectations and assumptions, which are subject to numerous risk factors that could cause our actual results to differ materially.

A description of such risk factors can be found in our earnings release, and in our reports filed with the Securities and Exchange Commission, including our Form 10-K Annual Report, our Form 10-Q quarterly reports, and our Form 8-K current reports. These reports can be accessed under the Investor Relations tab at our company's website or on the SEC's website. All forward-looking statements made during today's call represent our judgment as of October 27, 2016, and we disclaim any obligation to update such statements, except as required by securities laws.

This call is being recorded and a 30-day replay of the conference call will be available at our company's website, molinahealthcare.com.

I would now like to turn the call over to Dr. Mario Molina.

Joseph Mario Molina

Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.

Thank you, Juan José, and thanks, everyone, for joining us on the call today. We are pleased with the results we reported today. Revenue and enrollment growth remained strong and medical margins across the majority of our products are improving.

Today's results provide insights into the operational improvements we have made, as well as some of the challenges that we confront. While we have shared our strategies for addressing some of these challenges in the past, it is helpful to reexamine them by separating them into two categories: those that are specific to Molina and those that are environmental.

As we communicated early this year, the internal challenges the company faced included weaker than anticipated operational performance at our Puerto Rico, Ohio and Texas health plans. We're making progress in Puerto Rico. But as we have said in the past, the turnaround there will take some time, given our recent entry into the market and the time needed to benefit from new provider agreements and from our care model. In contrast, our interventions at our more established Ohio and Texas health plans have yielded significant operational improvements, enabling us to overcome the challenges we discussed earlier this year.

In addition to the improvements that we have made at specific health plans, we continue to upgrade our technology. During the third quarter, we upgraded the newer version of our existing enterprise core administration platform across 12 health plans. The upgrade allows us to continue to accommodate growth and increase administrative efficiency, while adapting to changing compliance and other business requirements.

The second category of challenges includes environmental or external matters. The most significant of these challenges involve the Affordable Care Act's insurance marketplaces. Before I discuss these challenges further, we should not lose sight of the fact that the Affordable Care Act has been successful in providing health insurance coverage to 20 million people.

We have always believed that participation in the health insurance marketplace is directly aligned with the Molina mission to provide healthcare to people receiving government assistance. The fact that we've enrolled over 550,000 marketplace members today confirms that many Americans value the combination of affordable and quality healthcare that Molina offers.

Notwithstanding all of its benefits, however, the health insurance marketplace has suffered from its share of growing pains. I want to emphasize that no undertaking of this complexity and size is ever implemented perfectly. My remarks today are not meant to condemn a valuable and much-needed program. The marketplaces are generally performing well. They only require modification and adjustment, not wholesale change.

We believe that risk transfer is one aspect of the marketplaces that requires immediate attention. Because this is the first iteration of the risk transfer process, we should not be surprised that it needs fine-tuning. Specifically, the marketplaces must modify their risk-transfer methodology so that low-cost and low-premium insurers are not penalized. The goal of the risk-transfer program is to encourage health plans to compete based on the value and efficiency of their services rather than by attracting healthier enrollees.

This is a laudable and necessary goal, which we at Molina support. But we must be sure that the risk-transfer methodology used does not interfere with the equally laudable and necessary goal of affordable quality healthcare.

As outlined by the U.S. Department of Health and Human Services in the Federal Register, the intent of the Affordable Care Act's use of risk adjustment was to reflect health risk, not other cost differences. The key weakness of the current marketplace risk-transfer methodology is that it redistributes dollars among health plans based on total premiums, not health risk.

To understand this, we need to briefly describe the mechanics behind marketplace risk transfer. Risk scores are determined for each health plan, based upon the documented health status of that specific plan's membership. Risk transfer is accomplished when health plans with risk scores below 1 transfer money to help plans with risk scores above 1.

Payments are calculated by multiplying each individual health plan's relative risk score by the state-wide average premium. But since premiums include medical and administrative costs, any transfer payment is based in part on non-medical costs captured in the state-wide average premium. This is in conflict with the U.S. Department of Health and Human Services' stated intent.

Using premiums in the calculation rather than medical costs creates two distortions. First, the application of risk scores to premiums inappropriately transfers funds based in part on costs that are not medical in nature. Second, the use of a state-wide average premium also discourages health plans from lowering premiums.

In order to offset risk-transfer payment in the future, plans have an incentive to increase premiums. In other words, if a health plan was to cut its premium, its risk profile remained the same and the average state-wide premium increased, it would owe more in risk-transfer payments in the following year.

Fortunately, a risk-transfer fix can be implemented by simply modifying the transfer formula so that premium is adjusted based on 80% of the premium rather than 100% of the premium. This 20% reduction to the premium base would correlate with the statutory minimum medical loss ratio of 80%, as required by the Affordable Care Act.

On October 6, we documented our concerns in a comment letter to CMS. Remember, the financial impact of spiraling premium increases will be borne not only by the insured, but also by the federal government and taxpayers because of associated higher premium subsidies.

Currently, about 25% of Molina's marketplace premiums flow back to the government and then on to our competitors as part of the risk-transfer process. For the 2015 benefit year, our risk-transfer payments were approximately $254 million. And so far this year, we have accrued $372 million for the 2016 benefit year.

As a result of this flawed risk-transfer methodology, we may be forced to curtail our marketing in certain marketplace states. I used the word curtail rather than terminate, because we remain committed to working with the government to create a competitive, stable and sustainable environment for the marketplaces.

In addition to marketplace, another developing story is that of our proposed acquisition of the assets being divested from Aetna and Humana as a result of their proposed merger. This is a great opportunity for Molina to add scale to our Medicare Advantage offering. However, due to its ongoing nature, we cannot comment further. It is important to note that Molina has more than 10 years of experience in serving the most difficult of Medicare members, the dual eligibles.

We are pleased that our Medicare plan in New Mexico has achieved a four-star rating. In addition, our Florida health plan improved to three-and-a-half stars and achieved a commendable rating from NCQA. This improvement to our star scores is no small feat. CMS and the publication Health Affairs have reported that social determinants of health impact star scores. I want to congratulate our health plans on their success on improving measurable quality. Great job.

As a reminder, we closed on the Total Care acquisition in New York and began reporting on that business during the third quarter. We feel good about the prospects for this New York business as well as its long-term strategic value in one of the top-five markets for government programs in the country.

Finally, I wanted to congratulate Molina Medicaid Solutions on two recent accomplishments. First, on October 6, our MMIS system in West Virginia was certified by CMS. West Virginia is the first state to fully participate in a new rigorous certification protocol. CMS cited West Virginia for successfully implementing an MMIS system on schedule and on budget. I would like to congratulate the West Virginia Department of Health and Human Resources as well as our team for accomplishing this significant achievement.

Second, the State of Louisiana has extended our MMIS contract for another year, and we welcome the opportunity to continue to work with the state in 2017.

That concludes my remarks. With that, I will turn the call over to John for a look at our financial performance in greater detail.

John C. Molina, JD

Chief Financial Officer & Director, Molina Healthcare, Inc.

Thank you, Mario. Good afternoon, everyone. Today we reported net income per diluted share of $0.76 in the third quarter, compared to $0.58 in the second quarter of 2016. On an adjusted basis, which we believe to be a more meaningful measure of our earnings, we reported $0.85 this quarter, up from $0.67 during the previous quarter.

Revenue increased to $4.5 billion for the quarter and to nearly $13.5 billion for the first nine months of this year. As Mario discussed earlier, we have worked diligently on the issues we outlined during the first quarter, and we have overcome many of those challenges.

Compared to the first and second quarters of this year, the results we reported today are relatively free of out-of-period adjustments. This makes the discussion of the results we reported today relatively straightforward. Put very simply, our Medicaid and Medicare businesses are doing better, but marketplace has lagged.

I think the key points to draw from in the results that we issued today are the following: First, our business is headed in the right direction. Utilization of medical care services is trending downwards, and the issues we experienced earlier this year in Ohio and Texas are substantially behind us. And results in Puerto Rico, while still not where we want them to be, are improving.

If we remove out-of-period revenue adjustments for Puerto Rico and Texas from our second quarter results, we see that our medical care ratio for all of our businesses combined, excluding marketplace, decreased by 70 basis points from the second quarter of this year.

Second, we continued to benefit from greater administrative cost efficiency. Our general and administrative expense ratio dropped 50 basis points during the third quarter to 7.6%. This decline is partially the result of lowering advertising and broker expenses, and we will see higher G&A expense in the fourth quarter as open enrollment and advertising ramp up. Nevertheless, we are on track to finish 2016 with a full-year G&A ratio well below 8%.

Third, the benefits of geographic and product diversification are real. If you study the health plan and product information in our earnings release, you will see that different states and different products often support earnings when other states and products experience financial challenges. This is why geographic and product diversification, for example our New York acquisition and our proposed Medicare transaction, are so important. This is why we stay the course in markets like Puerto Rico when other health plans might consider leaving.

The ACA marketplaces provide us with a long-term opportunity for continued diversification that is consistent with the Molina mission. 20 million Americans have health insurance today as a result of the Affordable Care Act. Today, we provide affordable and quality health care to over 550,000 marketplace members, making us one of the top-10 largest marketplace providers.

It is important to present the financial challenges we face in the marketplace into the proper perspective. By excluding adjustments made in 2016 that relate to dates of service in 2015, we can get a better sense for what the pure period performance is for the marketplace. Following this approach, the medical care ratio for the marketplace program increased to 89% in the third quarter from 80% in the second quarter.

On our last call, we told you that we expected marketplace performance to deteriorate during the second half of this year. We expected lower financial performance as a result of normal membership attrition, the addition of higher-cost members through the special enrollment process, higher costs as members reach the limits of cost-sharing provisions of their coverage, and increasing utilization as members become more engaged with our care networks.

All of those things happened, but they do not tell the whole story. We also recorded higher-than-expected risk-transfer liabilities in the quarter, which further reduced our premiums and our margins. As Mario said, we believe that the methodology used to calculate marketplace risk-transfer payments penalizes efficient and affordable health plans like Molina. And, as a result, those purchasing affordable marketplace policies ultimately pay higher premiums. Currently, about 25% of Molina's marketplace premiums flow back to the government and then on to our competitors as part of the risk-transfer process.

For the 2015 benefit year, risk transfer payments paid by Molina were approximately $254 million. And so far this year, we have accrued $372 million for the 2016 benefit year due. If the risk-transfer formula were modified so that the state-wide average premium is reduced by 20% to reflect the minimal medical cost floor of the ACA, only 20% of our marketplace premiums would be transferred to competitors, and our liability at September 30 would have been reduced by $75 million.

Nevertheless, we believe that marketplace performance for the full-year 2016 will be approximately breakeven, that is for 2016 dates of service. We continue to be cautiously optimistic that our marketplace business will generate after-tax margins consistent with the rest of our business for 2017. As Mario discussed, we remain actively engaged in improving the risk-transfer payments and the risk-sharing methodology.

Turning to our balance sheet. As of September 30, 2016, the company had cash and investments of more than $4.6 billion, including almost $390 million at the parent company. Days and claims payable came down 1 day sequentially to 47 days.

As a reminder, we do not provide quarterly guidance. As we have said repeatedly during past calls, we adjust guidance only when we believe there is a material change to the business from what we have previously communicated. There have been no material changes to our business since we issued revised guidance in April, and therefore, we are not making any adjustments to our 2016 guidance at this time.

We have decided to wait until February of 2017 to host our next Investor Day. We strive to provide investors with relevant and quality information. However, we felt that the timing of this late fall potential conference combined with a lack of visibility into key events, such as the U.S. presidential election, a decision on the Aetna-Humana merger and greater clarity on marketplace risk transfer made it more prudent to wait.

This concludes our prepared remarks. Ash, we are now ready to take questions.

QUESTION AND ANSWER SECTION

Operator: Thank you. [Operator Instructions] And our first question comes from the line of A. J. Rice with UBS. You may proceed with your question.

A. J. Rice
Analyst, UBS Securities LLC

Q

Thanks. Hello, everybody. I understand not wanting to speculate on what's happening at Humana and Aetna. But just from Molina's thinking about being ready to take on this if the deal were to be approved, it sounds like it would all happen very quickly in January.

Do you have to make any spending investment? Is there something we should think about in terms of contingency that you're likely to need to invest either late this year or early next year as you start to consider that until you get a decision?

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.

A

As we've previously said, we're not going to discuss the transaction.

A. J. Rice
Analyst, UBS Securities LLC

Q

Okay. But even if the transaction doesn't go through, do you have to do any spending that we should think about for the fourth quarter or anything?

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.

A

Well, this is Mario. We mentioned that we will see an uptick in costs related to the open enrollment period around marketing, advertising, broker commissions.

A. J. Rice
Analyst, UBS Securities LLC

Q

Okay. All right. And then, maybe just for my follow-up then. On the commentary around the exchanges, we appreciate that. I'm just trying to understand if your hope is to get to a target margin for next year, is that based on rate increases that you can foresee in your assumptions about where enrollment would be? Or is it contingent upon getting some changes in the risk adjusters?

John C. Molina, JD
Chief Financial Officer & Director, Molina Healthcare, Inc.

A

This is John, A.J. No. We didn't price any changes to the risk-adjustment methodology into 2017. It's a combination of price increases and better medical management.

A. J. Rice
Analyst, UBS Securities LLC

Q

Okay. All right. Thanks a lot.

Operator: Our next question comes from the line of Matthew Borsch with Goldman Sachs. You may proceed with your question.

Christopher Benassi
Analyst, Goldman Sachs & Co.

Q

Congrats on the quarter. This is Chris Benassi on for Matthew Borsch. Could you elaborate on where you're seeing pressure in the marketplace? And is this consistent with prior-year trends such as member churn and the SEPs? Or is this a more accelerated development? Thank you.

John C. Molina, JD
Chief Financial Officer & Director, Molina Healthcare, Inc.

A

It really is along the lines of the four items that I've pointed out, which is attrition, higher cost for the SEP, people running out of their risk sharing and their out-of-pocket costs, and then increasing utilization as people become more familiar with our networks and seek care.

It's not widespread. We are in the marketplace in a number of states and we have very good results in a number of those states. And for this quarter, we were hit with an adjustment to our risk adjustment liability of about $30 million that came from a catch-up, so to speak, as we get more information in from the outside actuaries. But I would say that we have a couple of markets that aren't doing well and we have a number of markets that are doing better.

Christopher Benassi
Analyst, Goldman Sachs & Co.

Q

Thanks. And just kind of one quick follow-up to that. Are you seeing less churn? Or have you seen any incremental improvement from the SEP measures that were implemented? Just trying to kind of dig a little deeper there. Thanks.

John C. Molina, JD
Chief Financial Officer & Director, Molina Healthcare, Inc.

A

No. We're not seeing anything significant in terms of changes between 2015 and 2016 in the SEP.

Christopher Benassi
Analyst, Goldman Sachs & Co.

Q

Perfect. Thank you.

Operator: Our next question comes from the line of Dave Windley with Jefferies. You may proceed with your question.

David Howard Windley
Analyst, Jefferies LLC

Q

Hi. Good afternoon. Appreciate you taking the questions. So, in light of your comments about the marketplace, how do you view your expansion of territory, expansion of offerings and coverage in the marketplace for 2017

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.
A

Hi. This is Mario. We are expanding in a number of counties but staying within our existing states. So we're expanding in Washington, we're expanding in Florida, and we're expanding in California.

David Howard Windley
Analyst, Jefferies LLC
Q

And do those states overlap with the limited areas where you're seeing some challenges that John just alluded to?

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.
A

No, I wouldn't say that.

David Howard Windley
Analyst, Jefferies LLC
Q

Okay.

John C. Molina, JD
Chief Financial Officer & Director, Molina Healthcare, Inc.
A

I wouldn't either, Dave. This is John.

David Howard Windley
Analyst, Jefferies LLC
Q

Okay. And then I guess, on Florida, you had listed in the press release a decent price or a decent rate increase there. MLR ticked up pretty significantly. I guess I was intuiting that that might have been marketplace-driven, but it sounds like from that answer that's not the case. So, maybe what is driving Florida cost performance up?

Joseph W. White
Chief Accounting Officer, Molina Healthcare, Inc.
A

It's Joe speaking, Dave. No, I think what's happening in Florida is tied to the marketplace, but I would associate it more with risk adjustment than I would factors that we were anticipating that played out that John listed.

David Howard Windley
Analyst, Jefferies LLC
Q

Okay. Okay. Thank you for that. I'll drop out. Thank you.

Operator: Our next question comes from the line of Chris Rigg with Susquehanna Financial Group. You may proceed with your question.

Chris Rigg
Analyst, Susquehanna Financial Group LLLP
Q

Thanks. Just wanted to clarify a comment you made a minute ago, John, on the out-of-period risk adjustments of $30 million. Is that related to service dates in 2015 or is it all in-year?

John C. Molina, JD
Chief Financial Officer & Director, Molina Healthcare, Inc.
A

It's all in-year, Chris, but out of quarter.

Chris Rigg
Analyst, Susquehanna Financial Group LLLP
Q

Okay. Okay. And then I guess I'm just trying to – it's still not 100% clear to me whether you're saying that sort of the morbidity of your marketplace membership is trending worse than you thought, or it's simply a function of the risk-adjustment methodology that's – and that is the primary source of the problem right now.

John C. Molina, JD
Chief Financial Officer & Director, Molina Healthcare, Inc.
A

That is correct. It is primarily the risk-adjustment methodology. About 20% of that relates to non-medical costs. So you exclude that, and the marketplace for us is great. It's pretty good now, but it gets great at that point. But it's not the morbidity is worse than we thought.

Chris Rigg
Analyst, Susquehanna Financial Group LLLP
Q

Okay. And then last thing, I'm not sure what you're going to be able to say about this, but obviously the EPS range for the fourth quarter is $0.45 wide. Is there any color you can give us around that?

John C. Molina, JD
Chief Financial Officer & Director, Molina Healthcare, Inc.
A

You're right, we can't say anything about that.

Chris Rigg
Analyst, Susquehanna Financial Group LLLP
Q

Figured. All right. Thanks a lot.

Operator: Our next question comes from the line of Ana Gupte with Leerink. You may proceed with your question.

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.
A

Ana?

Ana A. Gupte
Analyst, Leerink Partners LLC
Q

Hi. Can you hear me?

John C. Molina, JD
Chief Financial Officer & Director, Molina Healthcare, Inc.
A

We can hear you now.

Ana A. Gupte
Analyst, Leerink Partners LLC

Q

Okay. Great.

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.

A

Yes. We hear you.

Ana A. Gupte
Analyst, Leerink Partners LLC

Q

Yes. I wanted to – is it better?

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.

A

Yes. Go ahead, Ana.

Ana A. Gupte
Analyst, Leerink Partners LLC

Q

Yeah. All right. Okay. So, on the risk adjusters, the first question I had was you talk about this cost versus non-medical cost issue. Is this something that is specific to the managed Medicaid MCOs? And as a sub-lobby, if you will, have you all compared notes and are you seeing similar issues on the risk adjusters at all?

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.

A

So this is Mario. This really we believe is the flaw in the methodology. It's not consistent with the stated intention of risk adjustment, as published in the Federal Register. I'm not sure what the other plans are seeing, but I think that this is a generalized phenomenon regardless of the plans. And we made our comments to CMS in a comment letter that was submitted October 6.

Ana A. Gupte
Analyst, Leerink Partners LLC

Q

And is this got anything to do with the level of quoting one plan is doing relative to the others? I've heard that anecdotally, in the marketplace, there are certain plans that have had to write large checks with big balance sheet coffered names like Empire and Anthem and all kind of think that it's a coding issue.

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.

A

No. We think this is a flaw in the methodology.

Ana A. Gupte
Analyst, Leerink Partners LLC

Q

Okay. Then, finally, the same question on the risk methodology, you had put out a press release, and this was right after CMS talked about the prescription drugs being included in the risk adjuster and a more, I guess, fair or something of that nature spread on the risk adjusters across various plans. So what prompted you to put that

press release out? And were you viewing this as a positive thing? Or just any change is better than status quo, or something else?

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.
A

This is Mario. No. We believe that was a positive change. Again, getting back to our comments today, the risk adjustment should be a reflection of the health status of the members. And we think that including pharmacy data is definitely a step in the right direction. Nevertheless, we think the underlying methodology is still flawed and needs to be corrected. This needs to really reflect health risk assessment and not total premium cost.

Ana A. Gupte
Analyst, Leerink Partners LLC
Q

Okay. I'll queue up again. I had other questions. Thanks.

John C. Molina, JD
Chief Financial Officer & Director, Molina Healthcare, Inc.
A

Thank you, Ana.

Operator: [Operator Instructions] And our next question comes from the line of Kevin Fischbeck with Bank of America Merrill Lynch. You may proceed with your question.

Kevin Mark Fischbeck
Analyst, Bank of America Merrill Lynch
Q

Great. Thanks. Just I'd ask a question, I guess, kind of about the Humana deal but I think it's to me you can't answer it because it's more about strategy. Because I guess when other Medicaid companies have said that they didn't really bid on the Humana assets because they wanted to maintain a target to the low-income population.

And since you've had a lot of success on the exchanges because you stuck to that low-income threshold, how do you think about targeting Medicare Advantage in the higher income brackets? Is that something that you think is portable? Or is it really still the low-income side that you really want to be targeting?

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.
A

Hi. This is Mario. I think that if you look at Medicare and managed care, it is where Medicaid was a number of years ago. And we think the experience that we've had with Medicaid and with marketplace and with growing our brand and building out our networks will help us compete for Medicare Advantage patients and to grow our Medicare business.

Kevin Mark Fischbeck
Analyst, Bank of America Merrill Lynch
Q

Okay. So it's not necessarily a low-income target. So, I guess, if for whatever reason Aetna-Humana falls apart, we should expect you to continue to be investing money in the Medicare business. That's a business that you want to grow kind of whether or not this deal happens.

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.
A

That's correct.

Kevin Mark Fischbeck
Analyst, Bank of America Merrill Lynch

Q

Okay. All right. Thanks.

Operator: Our last question comes as a follow-up from the line of Ana Gupte with Leerink. You may proceed with your question.

Ana A. Gupte
Analyst, Leerink Partners LLC

Q

Okay. So, on the Ohio and Texas again, what should we think about as the normalized loss ratio for 2017? And in Texas, I thought you had a sequential deterioration. Is that fair? I don't know whether I saw that correctly since the release came pretty recently.

Joseph W. White
Chief Accounting Officer, Molina Healthcare, Inc.

A

Hey, Ana. It's Joe speaking. Yes, there was a deterioration in Texas sequentially, but remember we had that big out-of-period quality pickup revenue...

Ana A. Gupte
Analyst, Leerink Partners LLC

Q

Okay.

Joseph W. White
Chief Accounting Officer, Molina Healthcare, Inc.

A

...last quarter. So, that's a little bit – more than a little bit distorted. Again, as John said, we feel real good about Texas and Ohio. We feel real good about a lot of our health plans right now. But I think the Texas and Ohio numbers for the third quarter of this year are pretty representative.

Ana A. Gupte
Analyst, Leerink Partners LLC

Q

Okay. That's helpful. Thanks, Joe.

Operator: Apologies. We do have another question from the line of Dave Windley with Jefferies. You may proceed with your question.

David Howard Windley
Analyst, Jefferies LLC

Q

Thanks for taking the follow-up. So your release talks about the institution of an MLR floor in South Carolina. Your first – and I think effective date of July 1, your first half is below that level. The third quarter jumped significantly above that level. I wondered if the third quarter performance was simply kind of a true-up of that MLR floor? Or if there was deterioration in kind of underlying performance there and how might that floor affect you going forward? Thanks.

Joseph W. White
Chief Accounting Officer, Molina Healthcare, Inc.

A

It's Joe speaking. There's a little bit more disclosure about South Carolina in our 10-Q, but I'll save you the trouble of looking that up. South Carolina has had some pretty hefty rate increases over the last 12 months, but there have been benefit expansions that went to that. So we expected to see some tightening of margins in South Carolina that would probably take us above the MLR floor of 86% under normal circumstances. And that's okay. That health plan ran at a very low MCR for quite a while and it was running at MCRs that we don't expect to maintain long-term. But, in summary, it's more of a benefit premium issue than it is an MLR floor issue.

David Howard Windley
Analyst, Jefferies LLC

Q

Okay. Thank you.

Operator: here are no further questions at this time. I will now turn the call back to Dr. Molina.

Joseph Mario Molina
Chairman, President & Chief Executive Officer, Molina Healthcare, Inc.

Well, thank you, everyone, for joining us. We look forward to talking to you in 2017.

Operator: Ladies and gentlemen, that does conclude the call for today. We thank you for your participation and ask that you please disconnect your lines.