Date of Hearing: April 21, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2327 (Lowenthal) – As Introduced February 19, 2026

SUBJECT: Medi-Cal: subcontractors: rates.

SUMMARY: Requires specified subcontractors of a Medi-Cal managed care plan to be paid actuarially sound rates and makes failure to pay such rates an unfair business practice and subject to Department of Health Care Services (DHCS) dispute resolution. Specifically, **this bill**:

1) Establishes legislative intent that fully delegated subcontractor and partially delegated subcontractor managed care plans (subcontracting plan) arranging for or providing Medi-Cal services be paid in an actuarially sound manner.

2) Requires, as of January 1, 2027, DHCS to require a subcontracting Medi-Cal managed care plan to be paid actuarially sound rates developed in accordance with generally accepted actuarial rate development principles and practices.

3) Makes failure to pay a subcontracting plan consistent with 2) above an unlawful and unfair business practice pursuant to existing state law.

4) Allows, notwithstanding any contractual rights that the subcontracting plan has, the subcontracting plan to be afforded the opportunity to enforce the requirements in 2) by filing a notice of dispute with DHCS.

5) Allows DHCS to implement the provisions of this bill using non-regulatory authority.

6) Defines the applicable subcontracting plans as follows:

   a) "Downstream fully delegated subcontractor" as a downstream subcontractor of a Medi-Cal managed care plan that is contracted with DHCS and that contractually assumes all duties and obligations of the Medi-Cal managed care plan contracted with DHCS, except for those contractual duties and obligations where delegation is legally prohibited; and,

   b) "Downstream partially delegated subcontractor" as a downstream subcontractor of a Medi-Cal managed care plan that is contracted with DHCS and that contractually assumes some, but not all, duties and obligations of the Medi-Cal managed care plan contracted with DHCS.

EXISTING FEDERAL LAW:

1) Prohibits capitated managed care contracts in Medicaid unless they meet certain requirements, including actuarial soundness of rates. [Title 42, United States Code (42 U.S.C.), § 1396b (m)(2)(A)]

2) Establishes actuarial soundness standards for Medicaid managed care. Defines "actuarially sound capitation rates" as those that are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the

contract, and such capitation rates are developed in accordance with and generally accepted actuarial principles and practices. [Title 42, Code of Federal Regulations (CFR), § 438.4]

3) Prohibits payments from any rate cell (capitation rates for a particular group of enrollees in a particular region) from cross-subsidizing or being cross-subsidized by payments for any other rate cell. [42 CFR § 438.4(b)]

4) Allows states to develop and certify a range of capitation rates per rate cell as actuarially sound, under specified conditions. [42 CFR § 438.4(c)]

5) Establishes a step-by-step process and requirements for setting actuarially sound capitation rates. [42 CFR § 438.5(b)]

6) Requires risk adjustment (a methodology to account for variation in risk levels among contracted plans that is derived from experience of the plan) to be developed in a manner that is budget-neutral, consistent with generally accepted actuarial principles and practices. [42 CFR § 438.5(g)]

EXISTING STATE LAW:

1) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [Welfare and Institutions Code (WIC) § 14000, *et seq.*]

2) Authorizes the DHCS Director to contract, on a bid or non-bid basis, with any qualified individual, organization, or entity to provide services to, arrange for, or case manage the care of Medi-Cal beneficiaries and establishes managed care models that DHCS contracts within each county. [WIC §§ 14087.3, 14089, 14087.98, 14087.967, and 14087.5]

3) Requires DHCS, except as otherwise authorized, to enter into contracts, on an exclusive or nonexclusive basis, with managed care plans licensed by the Department of Managed Health Care for the provision of medical benefits to all people eligible to receive medical benefits under publicly supported programs. [WIC § 14093.05]

4) Requires DHCS, prior to issuing a new request for proposal or entering into new Medi-Cal managed care contracts, to provide an opportunity for interested stakeholders to provide input to inform the development of contract provisions. [*Ibid*.]

5) Defines a Medi-Cal plan as any individual, organization, or entity that enters into a comprehensive risk contract with the DHCS to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries. [WIC § 14184.101]

6) Establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative effective from January 1, 2022 until December 31, 2026. Establishes the goals of CalAIM: to identify and manage the risk and needs of Medi-Cal beneficiaries through whole-person-care approaches and addressing social determinants of health; transition and transform the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility; and improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform. [WIC § 14184.100]

7) Requires DHCS to determine, by actuarial methods, prospective per capita rates of payment for services provided for Medi-Cal beneficiaries enrolled in a Medi-Cal managed care plan. [WIC § 14301(a)]

8) Requires a contract between DHCS and a Medi-Cal managed care plan to provide the specific per capita rates, to be determined by sound actuarial methods on the basis of age, sex, and aid categories, which the state must pay the plan each month for each beneficiary enrolled in the plan; a detailed description of the specific actuarial method or methods and assumptions used in determining per capita rates; and a summary of the data base, including costs and inflation assumptions and utilization rates used to determine per capita rates. Requires DHCS to engage and rely upon the services of an actuary or consulting actuary in determining prospective per capita rates. [*Ibid*.]

9) Prohibits the actuarial rate development pursuant to 8) above from being construed as removing from a Medi-Cal managed care plan the risk of beneficial or adverse effects, including inflation, which normally result from contracting to furnish health services. [WIC § 14301(e)]

10) Defines unfair competition to mean and include any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising and any act prohibited by specified laws. [Business and Professions Code § 17200]

11) Authorizes a court of competent jurisdiction to enjoin any person (defined to include natural persons, corporations, and other organizations) who engages, has engaged, or proposes to engage in unfair competition. Allows a court to make such orders or judgments, including the appointment of a receiver, as may be necessary to prevent the use or employment by any person of any practice which constitutes unfair competition, or as may be necessary to restore to any person in interest any money or property, real or personal, which may have been acquired by means of such unfair competition. [*Ibid*.]

12) Creates, notwithstanding any other provision of law, whenever DHCS is authorized or required by statute, regulation, due process, or a contract, to conduct an adjudicative hearing leading to a final decision of the director or the department, standards for conducting such a hearing. [Health and Safety Code § 100171]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, existing state and federal law require that state Medicaid agencies pay rates that meet certain standards of actuarial soundness, to ensure that they are sufficient to cover costs. In many counties, the Medi-Cal managed care plan that holds the primary contract with the state will subcontract with one or more health plans to serve Medi-Cal recipients. The author explains that while the rates paid by the state to the primary health plan contractor are required to be actuarially sound, there is a policy gap in addressing the rates paid to subcontracted health plans. As a result, the subcontract health plan rates may be insufficient to support patient care, program innovation, and quality improvement. This bill is intended to correct a gap in current policy by requiring that the rates paid to subcontracted Medi-Cal managed care plans be actuarially sound, meeting the same standards as the rates paid to primary plans. The author asserts that in the wake of

federal H.R.1 that cuts Medicaid, and with California facing long-term Medi-Cal funding challenges, we should ensure that our investments in safety net programs are being administered appropriately.

2) BACKGROUND.

a) Medi-Cal Managed Care. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), a federal advisory body to the United Stated Congress, managed care is the primary Medicaid delivery system in more than half of states. States have incorporated managed care into their Medicaid programs for several reasons, including greater control and predictability over future costs; greater accountability for outcomes, quality improvement, and access; and improved care management and care coordination.

According to DHCS, managed care plans are a cost-effective use of health care resources that provides care through established networks of organized systems of care, which emphasize preventive and primary care. In 2026, there are 22 distinct Medi-Cal managed care plans operating in California, each with their own regional footprint. Today, over 95%, or 13.7 million of the 14.4 million people enrolled in Medi-Cal receive care though a managed care plan for general health services, including counties offering solely commercial plans, counties with public county organized health systems (COHS) that cover all enrollees in the county, and other models.

The alternative delivery system to Medi-Cal managed care that provides care to less than 5% of Medi-Cal enrollees is Medi-Cal fee-for-service, in which providers contracted directly with the state bill the state Medi-Cal program for each service provided. Some services are "carved out" of (i.e., not provided by) managed care, including pharmacy services that are delivered through the statewide Medi-Cal Rx program, dental services, and specialty mental health and substance use disorder services that are delivered by county-administered plans.

b) CalAIM. CalAIM is a collection of major initiatives spearheaded by the DHCS to transform Medi-Cal, including addressing social drivers of health, reducing program complexity and increasing flexibility, and modernizing payment structures to promote better outcomes. Most CalAIM program initiatives have been advanced through managed care plans, including delivery of new benefits to address social drivers of health and coordinate care, Memoranda of Understanding and partnership with local government agencies and other community partners, and population health management. Under CalAIM, Medi-Cal managed care plans are becoming an ever more complex and critical part of the Medi-Cal landscape in California.

c) Capitation Rates and Actuarial Soundness. DHCS pays Medi-Cal managed care plans to cover a defined benefits package for an enrolled population through fixed monthly payments called capitation payments. Per MACPAC, capitation payment rates are typically established prospectively and remain in effect for the duration of the 12-month rating period, regardless of changes in health care costs or service use.

Per federal law and regulation, the capitation rates DHCS pays to contracting plans must be actuarially sound, and a certified actuary must attest that the rates meet this standard. Under federal regulations, actuarial soundness means the rates are "projected to provide

for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract." It also requires capitation rates to be developed in accordance with and generally accepted actuarial principles and practices.

DHCS contracts with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rates using federally required process steps, including collecting base data from plans, developing "rate cells" (capitation rates for a particular group of enrollees in a particular region) and adjusting for various trends and plan-specific factors. Data used by Mercer include plan membership, medical utilization, and medical cost data, including plan-reported encounter data, data from subcontracting plans, and other ad hoc claims data reported by DHCS and the plans. This data is collected separately for each rating region in which each plan operates. Medi-Cal-specific financial reports are also considered in the rate range development process. Rates are adjusted by a number of factors, including any observed changes in the population case mix and underlying risk of the plan from the base data period. Mercer also considers administration and "underwriting gain loading" (excess of premiums over claims, which compensates plans for risk). Mercer indicates each plan has the opportunity and responsibility to independently review the rates offered by DHCS and to determine whether the rates are acceptable based on their individual financial requirements.

d) Plan Delegation (Subcontracting) Arrangements. Plans contract with network providers like physicians and hospitals to provide health care, but also commonly delegate certain functions to contractors, such as delegating a set of medical benefits to a physician group or contracting with a behavioral health service provider for behavioral health services. Some plans subcontract with other plans to delegate essentially the full responsibility for provision of services to another plan. For instance, in Los Angeles (L.A.) County, L.A. Care, the locally administered public plan, subcontracts with Anthem Blue Cross and Blue Shield of California to provide their members access to these other plans' established doctor networks while maintaining L.A. Care's local focus and community services. When this occurs, the primary plan (L.A. Care in this case), still retains responsibility for ensuring the delivery of care to members and all other responsibilities under their contract with DHCS.

e) DHCS Requirements with Respect to Subcontractors. DHCS's model Medi-Cal managed care contract describes the obligations of contracting plans, and spells out a number of requirements related to plans' use of delegation (subcontractors). These requirements include:

i) Plans must disclose delegation arrangements and include justification for the use of delegated entities to ensure that the Medi-Cal member's experience and outcomes are centered;

ii) Plans are to implement financial arrangements that link payments to value in the form of higher quality of care, better health care outcomes, and lower cost of care;

iii) Plans must ensure that all subcontractors comply with all contract requirements related to the delegated functions undertaken by each subcontractor;

iv) Plans remain fully responsible for the performance of all duties and obligations it delegates to subcontractors;

v) Plans must provide to DHCS a Delegation Reporting and Compliance Plan using a specific template. This plan includes all contractual relationships with subcontractors, the managed care plans' oversight responsibilities for delegated obligations, and how the plan intends to oversee all delegated activities, among other things;

vi) Plans must maintain policies and procedures approved by DHCS to ensure that network providers and subcontractors fully comply with all applicable terms and conditions of the DHCS-plan contract and all duties delegated to subcontractors;

vii) Plans must oversee and remain responsible and accountable for any services or functions undertaken by a network provider or subcontractor; and,

viii) Plans must maintain a system to evaluate and monitor the financial viability of all network providers and subcontractors that accept financial risk for the provision of covered services including, but not limited to, Medi-Cal managed care plans, independent physician/provider associations, medical groups, hospitals, and risk-bearing organizations.

However, DHCS does not dictate rates or assess anything related to adequacy of rates paid by the primary plan to network providers or subcontractors. There are no federal or state laws or regulations requiring rates, other than rates paid to the primary plan, to be actuarially sound. DHCS has produced nonbinding rate guidance on some new services provided pursuant to CalAIM, and fee-for-service Medi-Cal rates are often used as a benchmark for plan-provider rate negotiations. But outside specific state-directed payments, as explained below, DHCS is (and is federally required to be) "hands-off" on what rates are paid to network providers and subcontractors of primary plans. Rate discussions are generally seen as a negotiation between entities in the health care marketplace.

f) **State-Directed Payments**. Per federal regulations, states are generally not permitted to direct the expenditures of a Medicaid managed care plan under the contract between the state and the plan. According to MACPAC, in 2016, the Centers for Medicare & Medicaid Services (CMS) updated the regulations for Medicaid managed care to eliminate "pass-through payments" from states to providers, and created a new option for states, allowing them to direct Medi-Cal managed care plans to pay providers according to specific rates or methods. These "state directed payment" arrangements, however, are narrowly prescribed. They can be used to establish minimum or maximum fee schedules for certain types of providers, to require participation in value-based payment arrangements or other delivery system reform initiatives, or to make uniform payment rate increases. Although plans generally have the flexibility to negotiate payments with providers, the directed payment option provides states with more control over the rates and methods used by plans to pay network providers and can direct plans to use methods that advance specific state goals. In 2024, CMS released a managed care rule that improved the oversight and transparency of directed payments and 2025 federal legislation, H.R. 1, further restricted states' ability to make state-directed payments.

CMS may consider actuarial certification at the subcontractor level, as this bill proposes, an impermissible state-directed payment, as it would set a rate floor for payments to a subcontractor, and it does not obviously fall into one of the allowable exceptions to the general rule that states cannot direct the expenditures of their contracted plans.

g) **CalAIM and 2024 Reprocurement**. A centerpiece of CalAIM was a revised model managed care contract the state would use with a 2024 reprocurement of commercial plans in certain counties, including L.A. County. The contract contained many provisions to increase accountability, quality, local engagement, and access; reduce health disparities; increase value-based services; and address other DHCS goals. On August 25, 2022, DHCS announced the outcome of its competitive "request for proposal" process, stating its intent to award contracts to Molina Healthcare (Molina), Anthem Blue Cross Partnership Plan, and Health Net. Plans that were not awarded quickly appealed DHCS's decision, including Blue Shield of California, Aetna, Community Health Group, and Health Net (for certain counties for which Health Net was not awarded a contract, including L.A. County). One of the biggest "upsets" among these new planned contract awards was that Molina was to serve as the new primary commercial plan in L.A. County, where Health Net was the existing primary commercial plan. The fall of 2022 saw Public Records Act requests about the scoring process, methodology, and communications related to the planned contract awards; bitter public recriminations; and lawsuits against DHCS.

   On December 30, 2022, DHCS announced an agreement with five commercial plans that effectively ended the appeals and lawsuits, allowing the 2024 contracts to move forward. Anthem, Blue Shield of California, Community Health Group, Health Net and Molina issued a joint statement that pursuant to the settlement agreement, these plans would serve Medi-Cal managed care members in 21 counties across the state starting in January 2024. In the statement, DHCS said "to bring certainty for members, providers and plans, the state used its authority to work directly with the plans to re-chart our partnership and move with confidence and speed toward the implementation of the changes we want to see. An agreement has been reached so that together we can begin our collective work of delivering a person-centered, equity-focused, and data-driven Medi-Cal program."

   The most novel and significant aspect of this agreement was that Health Net retained the contract with DHCS in L.A. County but was required to subcontract with Molina for 50% of its membership in L.A. County. Molina receives the same rates as Health Net, but Health Net retains an administrative percentage that is intended to support its oversight responsibilities and other responsibilities it maintains as the primary plan.

3) **SUPPORT.** Molina supports this bill, stating that actuarially sound payment rates are essential to maintaining stable provider networks and safeguarding access to care for Medi-Cal beneficiaries. When subcontracted health plans are reimbursed appropriately, Molina explains, those plans are better positioned to recruit and retain providers, invest in care coordination, and meet quality and access standards—particularly for medically complex and underserved populations. Molina asserts this bill promotes transparency, accountability, and fairness in Medi-Cal rate-setting while aligning with long-standing federal Medicaid principles. They note the bill does not mandate specific rate increases; rather, it reinforces sound actuarial methodology and contractual compliance, supporting program integrity and sustainability. Disabled Resources Center writes in support that when rates to subcontractors

are inadequate, funding gaps translate into real and harmful consequences to the disability community. Disabled Resources Center writes that by extending actuarial soundness requirements to subcontracted plans, this bill helps ensure that Medi-Cal dollars are used as intended, to support direct care and improve outcomes for beneficiaries.

4) **OPPOSITION.** Local Health Plans of California opposes this bill, noting it sets a risky policy precedent and expands the state role in private contracts. LHPC contends this bill establishes a significant departure from longstanding industry practice by permitting subcontractors to file disputes directly with DHCS. Today, LHPC explains, plan–subcontractor agreements include established mechanisms to resolve disputes, and DHCS has not historically intervened in these private contractual relationships. LHPC states that requiring DHCS to adjudicate these disputes would place the state in the position of arbitrating private contract disagreements, creating unintended consequences and undermining efficient, locally managed network operations. LHPC notes it could also impose substantial administrative burden on plans, which may be required to replicate complex state rate-setting methodologies in their subcontractor arrangements, significantly increasing compliance costs and operational complexity. LHPC is concerned this bill could lead to plans needing to renegotiate complex delegated contracts without corresponding adjustments to state-certified rates, creating significant operational and compliance risk. Finally, LHPC raises the potential for this bill to increase system-wide costs, reduce flexibility for value-based care models, and place additional pressure on the Medi-Cal program and state budget. Health Net also opposes this bill, stating that while they appreciate the intent of the bill to address concerns raised by subcontractors within the Medi-Cal managed care delivery system, it would create significant administrative burdens for the state, disrupt a system that has long been proven effective, set a troubling precedent for intervention in private contractual relationships and impact the quality of care for Medi-Cal beneficiaries.

5) **PREVIOUS LEGISLATION.** AB 614 (Wood), Chapter 266, Statutes of 2023, requires DHCS, except as otherwise authorized, to enter into contracts with managed care plans licensed by the Department of Managed Health Care and requires DHCS, prior to issuing a new request for proposal or entering into new Medi-Cal managed care contracts, to provide an opportunity for interested stakeholders to provide input to inform the development of contract provisions.

6) **AMENDMENTS**. Because of the unique and proprietary nature of the Health Net-Molina contract, which was agreed to pursuant to an unusual six-way settlement agreement; because of these private companies' status as competitors; and because it is unclear how aspects of the settlement agreement are enforced; it is difficult to adjudicate the issues at play through the legislative process. However, the state maintains a moral responsibility to ensure fair treatment and adherence to the terms of the agreement it brokered, particularly given the unusual nature of the "arranged marriage" of Health Net and Molina in L.A. County. The author and committee have committed to amending this bill to address concerns of the committee, including the overbroad nature of the proposed solution to a problem that appears to be quite narrow, the significant administrative complexity and effort such a broad actuarial soundness requirement would entail, and potential unintended consequences of instituting such a requirement.

REGISTERED SUPPORT / OPPOSITION:

Support

Disabled Resources Center, Inc.
Molina Healthcare, Inc.

Opposition

Health Net
Local Health Plans of California

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