Date of Hearing: April 21, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2594 (Lowenthal) – As Introduced February 20, 2026

SUBJECT: Voluntary employees' beneficiary association pilot program.

SUMMARY: Extends, from December 31, 2027 to December 31, 2032, the authority for a pilot program under the Department of Managed Health Care (DMHC) for a voluntary employees' beneficiary association (VEBA) to contract with health care providers using risk-based or global payment arrangements. Requires DMHC, before December 31, 2029, to submit an interim report to the Legislature regarding the costs and clinical patient outcomes of the pilot program through December 31, 2027, compared to fee-for-service payment models.

EXISTING LAW:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act (Knox-Keene Act). [Health and Safety Code (HSC) § 1340, *et seq*.]

2) Permits the DMHC director to exempt from the Knox-Keene Act any class of persons or plan contracts if they find the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under the Knox-Keene Act, and that the regulation of the persons or plan contracts is not essential to the purposes of the Knox-Keene Act. [HSC § 1343]

3) Makes it unlawful for any person to engage in the business as a health plan in California or receive advance or periodic consideration in connection with a plan from or on behalf of persons in California unless such person has first secured from the director a license as plan or is exempted, as specified. Establishes requirements for licensure. [HSC § 1349 and § 1351]

4) Exempts from the Knox-Keene Act a health plan, including a self-insured reimbursement plan that pays for or reimburses any part of the cost of health care services, operated by any city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies specified criteria including that providers are reimbursed solely on a fee-for-service basis, so that providers are not at risk in contracting arrangements. [HSC § 1349.2]

5) Requires every contract between a health plan and a risk-bearing organization (RBO) to include specified provisions related to the RBOs administrative and financial capacity including reporting requirements, auditing, and corrective actions. [HSC § 1375.4]

6) Authorizes, until December 31, 2027, the DMHC director to authorize one pilot program in southern California whereby approved providers may undertake risk-bearing arrangements with a VEBA with enrollment of greater than 100,000 lives if specified criteria are met, including, in part:

    a) The VEBA has entered into a contract with one or more health care providers under which each provider agrees to accept risk-based or global risk payment from the VEBA;

b) Each risk-bearing provider is registered pursuant to existing law and applicable DMHC regulations, if the provider accepts professional capitation and is delegated the responsibility for processing and payment of claims;

c) Each global risk-bearing provider holds, or will obtain in conjunction with the pilot program application, a limited or restricted license;

d) Each risk-bearing provider continues to comply with applicable financial solvency standards and audit requirements, including financial reporting on a quarterly basis, during the pilot;

e) The VEBA is responsible for providing basic health care services, prescription drug benefits, continuity of care, network adequacy and timely access to care, as well as other requirements;

f) The contract between the VEBA and each health care provider contains provisions dividing financial responsibility between the parties, a delegation agreement, requirements regarding utilization review or management, as well as other requirements; and,

g) The VEBA and each participating health care provider agree to collect and report to DMHC, in each year of the pilot, in a manner and frequency determined by DMHC, information regarding the comparative cost savings when compared to fee-for-service payment, performance measurements for clinical patient outcomes, and enrollee satisfaction. Authorizes DMHC to require additional information. [HSC § 1343.3]

7) Requires the participating VEBA to appoint an ombudsperson, and if an enrollee is not satisfied with a result refer the enrollee to the DMHC grievance and appeal process, which is binding on the VEBA or trust fund. [HSC § 1343.3]

8) Requires the global and risk-bearing providers participating in the pilot to be approved by DMHC. Requires DMHC to retain the right to disapprove any pilot program at any time, as specified. [HSC § 1343.3]

9) Requires DMHC, after the termination of both pilot programs and before January 1, 2029, to submit a report to the Legislature regarding the costs and clinical patient outcomes of the pilot programs compared to fee-for-service payment models, including data on enrollee satisfaction, consumer and provider grievances, appeals, and independent medical reviews. [HSC § 1343.3]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, health care costs keep going up, and for many California families who get their coverage through their employer, that means higher premiums and fewer options. The author states that this bill extends a pilot program that tests an alternative way to pay doctors and health care providers, one that rewards better health outcomes instead of simply paying for every test and procedure. The author continues that early results show this approach is working, and thousands of Californians are already

benefiting from it. The author argues that this bill ensures the program can keep running through 2032 so we can fully measure what's working and use that information to improve health care for everyone. The author concludes that we owe it to California families to follow through on solutions that are making a difference.

2) BACKGROUND.

a) Regulation of Health Insurance. The regulatory landscape for health insurance is a patchwork, depending on the program, its funding, and historical departmental jurisdictions. Different rules apply depending on whether insurance coverage is purchased directly by individuals or on behalf of a group, as in job-based health insurance. There are essentially three relevant regulatory frameworks for health insurance and they are DMHC, the California Department of Insurance, and the federal Department of Labor for regulation of Medicare, TriCare (for military personnel, veterans, and dependents), and self-funded employer plans.

The Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from enforcing state laws relating to private sector employee benefit plans established by employers or other sponsors in order to provide health coverage. In general, ERISA requirements for employee health benefit plans are less far-reaching than the state regulations that apply to insurance carriers. Since self-insured employee benefit plans are subject only to ERISA, consumers covered by self-insured plans can have fewer consumer protections than those covered through fully insured plans that are required to comply with California's consumer protection laws.

An arrangement established pursuant to a collective bargaining agreement may be a single employer or multiemployer plan. A Taft-Hartley trust is a multiemployer plan that, in addition to being established or maintained under or pursuant to one or more collective bargaining agreements, also meets criteria outlined in the Labor-Management Relations Act of 1947 (referred to as the Taft-Hartley Act). Plans established or maintained under or pursuant to collective bargaining agreements may be governed by both the Taft-Hartley Act and ERISA.

A VEBA is a trust established to pay certain benefits—including health benefits—to VEBA "members" (generally, current or former employees) or their dependents or beneficiaries. A VEBA can be used as a funding mechanism for a self-insured health plan. California Schools VEBA (CalVEBA) is the authorized participant in the pilot program subject to this bill. CalVEBA is a joint labor-management trust in San Diego established by the County Office of Education, employee associations, and district management that innovates health care purchasing, manages rising costs, and improves care access for members and their families. CalVEBA provides benefits to nearly 160,000 members and partners with over 70 public sector employers.

b) DMHC Licensure Requirements. According to DMHC's Annual Report, in 2024, 98 full service health plans licensed by the DMHC provided health care services to more than 30.2 million Californians. DMHC assesses and monitors health plan networks and delivery systems for compliance with Knox-Keene, and evaluates compliance through onsite surveys of health plan operations performed every three years. Surveys examine health plan processes related to access, utilization management, quality improvement, continuity and coordination of care, language access and enrollee grievances and appeals.

i) **Risk Arrangements.** According to a 2018 State Health and Value Strategies report, Knox-Keene is the legal framework through which health care entities in the state are governed. The long-standing practice of providers accepting financial risk in California, and the bankruptcies of large provider groups in the 1990s, led DMHC to adopt prescriptive regulations governing health plans and provider RBOs. Knox-Keene requires licensure by DMHC of health plans that accept global risk, defined as risk for both institutional and professional services, for the provision of health care services. The primary forms of risk arrangements include capitation, risk pools, withholds and stop-loss arrangements. Capitation is a set amount of money received by or paid to a provider on a per member per month basis rather than on the level of health care services provided. DMHC is also authorized to exempt entities from Knox-Keene requirements under certain circumstances.

ii) **Risk Regulations.** DMHC regulations clarify the level of financial risk that would trigger health plan licensure. The regulations proposed different categories of licensure, including "full" and "restricted." Traditional health insurance plans would be required to obtain a full license to operate. Entities that accept global risk as a subcontractor to a fully licensed health plan could obtain a restricted license. A restricted licensee would not be subject to rules concerning marketing and enrollment. Entities that have a small market share and/or operate in well-served areas could be granted an exemption from California's licensure requirements as those dynamics reduce the risk of disrupting the delivery of care in the event of insolvency.

iii) **RBOs**. An entity in California that only takes financial risk within the scope of its professional license (e.g., primary care capitation) is required to register as an RBO. DMHC retains limited oversight of RBOs; most of the direct oversight is delegated to the health plans with which RBOs contract. RBOs are required to submit quarterly and annual reports to DMHC so the DMHC can evaluate their financial condition. The pilot program under this bill authorizes RBOs to contract with VEBAs or a trust fund.

3) **SUPPORT.** America's Physician Groups (APG) is sponsoring this bill, arguing that the changes in this bill are both timely and necessary. APG notes that early results from the VEBA Direct pilot program demonstrate that this model is achieving precisely what California's health care system seeks: lower costs, improved affordability, and strong patient outcomes. APG continues that in its first year alone, the pilot generated more than $2.2 million in savings for reinvestment into member benefits, while reducing premiums and overall health care expenditures compared to traditional fee-for-service models. APG states that a key reason for extending the pilot timeline and providing for an interim report is to ensure that policymakers receive a complete and accurate evaluation of its performance. APG continues that under the current statute governing the pilot, the Integrated Healthcare Association (IHA) will collect and analyze both cost and quality data using the nationally recognized Total Cost of Care (TCOC) framework and produce a final report to the Department. However, IHA will not be able to do so until the earliest of Q1 2027. APG states that absent this extension, the Legislature would be forced to evaluate the pilot based on incomplete and non-comparable data, undermining the core purpose of the demonstration.

4) PREVIOUS LEGISLATION.

a) AB 2063 (Maienschein), Chapter 818, Statutes of 2024, extends the sunset for the pilot program authorized by DMHC to operate from December 31, 2025 to December 31, 2027. Narrows authorized pilot programs to one in southern California, under which providers approved by the DMHC may undertake risk-bearing arrangements with a VEBA with enrollment of more than 100,000 lives, if certain criteria are met. Extends the deadline for DMHC to report the pilot program findings to the Legislature from January 1, 2027 to January 1, 2029.

b) AB 1124 (Maienschein), Chapter 266, Statutes of 2020, authorizes the DMHC Director, no later than May 1, 2021, to authorize two pilot programs, one in northern California and one in southern California, under which providers approved by DMHC may undertake risk-bearing arrangements with a VEBA, or a trust fund. Repeals these provisions on January 1, 2028.

c) AB 1249 (Maienschein) was substantially similar to AB 1124 and was vetoed by Governor Newsom who stated in part:

"This bill would authorize a pilot program that would exempt risk-bearing provider groups taking on global risk from full licensure under the Knox-Keene Act. This proposed pilot project would undermine the fundamental purpose of the Knox-Keene Act by permitting such entities to operate in the State without providing the strong consumer protections guaranteed under the Knox-Keene Act."

5) COMMITTEE AMENDMENTS. Under current law, the VEBA pilot program would expire before the outcomes report is published under DMHC. While there is a clear argument to ensure that the report is finalized before the pilot expires so further extensions, this bill proposes expanding the reach of the pilot and pushing the sunset date an additional 6 years, meaning it would be extended for 3 years after the report is due. The committee may wish to amend the bill to:

a) Reinstate the limitation of the current pilot to southern California.

b) Reinstate the initial DMHC reporting due date of January 1, 2029 to ensure pilot outcomes are reported on as soon as possible.

c) Sunset the pilot program on December 31, 2030, giving the Legislature two full legislative years after the report is complete to consider further extension or sunset elimination.

REGISTERED SUPPORT / OPPOSITION:

Support

America's Physician Groups (sponsor)
California Labor Federation
California Schools VEBA

Opposition

None on file

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