SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 2594
AUTHOR: Lowenthal
VERSION: April 23, 2026
HEARING DATE: June 24, 2026
CONSULTANT: Teri Boughton

SUBJECT: Voluntary employees' beneficiary association pilot program

SUMMARY: Extends three years (to December 31, 2030) an authorization of a southern California pilot program that allows health care providers to undertake risk-bearing arrangements with a voluntary employees' beneficiary association.

Existing law:
1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act (Knox-Keene Act). [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 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 RBO's administrative and financial capacity including reporting requirements, auditing, and corrective actions. [HSC §1375.4]

6) Authorizes, until January 1, 2030, the DMHC director to authorize one pilot program in southern California whereby approved providers may undertake risk-bearing arrangements with a voluntary employees' beneficiary association (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 or trust fund;
   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 VEBA submits an application for DMHC for the pilot program, including the contract of each health care provider that has entered into a contract under the pilot; 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. [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 the pilot program 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]

This bill:
1) Extends the pilot date from December 31, 2027, to December 31, 2030.

2) Replaces the final DMHC report with an interim report on costs and clinical outcomes through December 31, 2027, and maintains the report deadline date of January 1, 2029.

3) Sunsets the authority for the pilot on January 1, 2031.

FISCAL EFFECT: According to the Assembly Appropriations Committee, DMHC reports minor and absorbable costs.

PRIOR VOTES:

Assembly Floor:	77 - 0
Assembly Appropriations Committee:	14 - 0
Assembly Health Committee:	16 - 0

COMMENTS:
1) *Author's statement.* 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. 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. Early results show this approach is working, and thousands of Californians are already benefiting from it. This bill makes sure the program can keep running through 2030 so we can fully measure what's working and use that information to improve health care for everyone. We owe it to California families to follow through on solutions that are making a difference.

2) *VEBAs.* DMHC describes VEBA as a tax-advantaged vehicle for funding certain employee benefits, including health care coverage. Employees can participate in the VEBA based on their common employment-related bond, such as a common employer, coverage under one or more collective bargaining agreements, or membership in a labor union. A VEBA may be, but is not always, associated with an employee welfare benefit plan under the federal Employee Retirement Income Security Act (ERISA). California Schools VEBA (CalVEBA), as described on their website, is a joint labor-management trust established by the San Diego 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. Their website says it is the fourth largest health care purchaser in California and provides benefits for nearly 160,000 members and partners with more than 70 public sector employers. As a government plan, CalVEBA is not subject to ERISA.

3) *Existing AB 1124 pilot.* AB 1124 (Maienschein, Chapter 266, Statutes of 2020) created the pilot authority that is proposed to be extended again under this bill. The pilot authorized by AB 1124 allows a provider to accept risk or global risk payments from a specified health care purchaser that is not a licensed health plan. Initially, there were two authorized pilots to allow entities that are exempt from the Knox-Keene Act because they reimburse providers on a fee-for-service basis, to pay providers on a capitated basis. Health plans are regulated by DMHC and must comply with the Knox-Keene Act, which includes requirements to ensure delegated contractors (including risk-bearing providers who are registered as Risk Bearing Organizations [RBOs]) also follow Knox-Keene Act requirements for timely payments and consumer protections. RBOs are not regulated by DMHC but are monitored for financial solvency based on their role in accepting global risk from health plans. DMHC indicates that on December 10, 2021, Cal-VEBA in San Diego (a cosponsor of this bill) was authorized to participate in the AB 1124 pilot program effective January 1, 2022, subject to two conditions: a) submission of executed provider contracts to demonstrate compliance with the requirements that risk-bearing providers have met specified requirements; and, b) collecting and reporting of information required in the law. According to DMHC, executed contracts were submitted on April 1, 2022. In August 2022, Cal-VEBA informed the DMHC of its plan to "go-live" January 1, 2024. AB 2063 (Maienschein, Chapter 818, Statutes of 2024) extended the pilot sunset date to January 1, 2030 and the report deadline from before January 1, 2027, to January 1, 2029. There are approximately 5,500 members in the pilot. CalVEBA indicates that they are the state's first direct contracting pilot program, which they call VEBA Direct. VEBA Direct is a self-funded program based on direct contracts between CalVEBA and members of America's Physician Groups (APG), including Sharp Rees-Stealy, Sharp Community Medical Group, Rady Children's Hospital, and UC San Diego Health. CalVEBA says 23 school districts are currently participating. CalVEBA is acting as a health plan but is not subject to the same requirements as health plans licensed by DMHC. The pilot allows CalVEBA to contract with RBOs as would a health plan.

4) *Initial data.* According to CalVEBA, so far some clinical quality metrics are higher under the pilot in comparison to the 2024 PPO statewide average for example, colorectal screening 62.2% vs. 48.3%, and 60.3% for the 2024 HMO statewide average. For cervical cancer screening the 2024 pilot results were 86.2% compared to 67.1% (statewide PPO average) and 76.2% (statewide HMO average). There have been 204 provider dispute resolutions (described as standard provider payment and claims-related disputes, resolved in accordance with regulatory timelines), 111 first level appeals (mostly administrative) with over half resolved in the member's favor following review of additional information, and seven second level appeals to VEBA Ombudsperson of which six where overturned in the member's favor and one initially denied and subsequently approved through DMHC's Independent Medical Review. CalVEBA indicates appeals reflect isolated administrative issues (billing, authorization, and network alignment) and not systemic access concerns.

5) *RBOs.* An RBO is a physician-owned provider group that, in its contracts with health plans, pays claims and assumes financial risk for the cost of all health care services (inpatient and outpatient) for each enrolled person by accepting a fixed monthly payment (also referred to as "capitation"). RBOs are responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of health plans when those services are covered under the capitation or fixed periodic payment made by the plan to the RBO. RBOs are subject to financial solvency requirements and regular financial reporting but are not licensed by DMHC. RBOs are not subject to many requirements of the Knox-Keene Act, including network adequacy or mandated benefits, except to the extent they are delegated those requirements by a health plan that is subject to those requirements. As part of DMHC's financial oversight responsibilities, DMHC actively monitors RBOs to make sure they can meet their financial obligations to consumers and purchasers. According to DMHC's latest Annual Report, at the end of 2024 there were 206 registered RBOs. DMHC conducted 25 claims and provider dispute examinations of RBOs. As a result of the examinations, 19 RBOs were required to file corrective action plans to address claims processing deficiencies. Collectively, the RBOs remediated claims in the amount of $1,406,955, including additional payments, interest and penalties.

6) *Prior legislation.* AB 2063 (Maienschein, Chapter 818, Statutes of 2024) extends the sunset for one southern California pilot program authorized by DMHC to operate from December 31, 2025 to December 31, 2027, and deletes authority for a second pilot. AB 2063 extends the deadline for DMHC to report the pilot program findings to the Legislature from January 1, 2027 to January 1, 2029, and sunsets the pilot authority on January 1, 2030.

   AB 1124 (Maienschein, Chapter 266, Statutes of 2020) authorizes two pilot programs that allow health care providers to undertake risk-bearing arrangements with a VEBA with enrollment of greater than 100,000 lives, or a trust fund that is a welfare plan and a multiemployer plan with enrollment greater than 25,000 lives.

AB 1249 Maienschein of 2019 would have allowed DMHC to authorize similar pilots as authorized under AB 1124. *AB 1249 was vetoed by Governor Newsom, who stated:*

> *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 Act.*

7) *Support.* APG, a cosponsor, writes in the first year 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 fee-for-service models. APG indicates these results are measured against VEBA's prior PPO self-funded fee-for-service coverage plan. APG says the pilot enabled VEBA to offer a health maintenance organization (HMO) coverage plan at 40% lower premiums, 30% lower healthcare costs, and a reduction in out-of-pocket maximums from $5,000 to $1,500. APG indicates a key reason for extending the pilot is to ensure policymakers receive a complete and accurate evaluation of its performance. According to CalVEBA, prior to the enactment of this pilot, self-funded employers interested in direct contracting had limited options beyond traditional models that incentivize higher utilization and contribute to increased overall health care spending without improvements in patient outcomes, and to date, the pilot has shown positive outcomes and promising financial stability, achieving $3.8 million in better-than-expected performance.

8) *Policy comment.* This pilot is allowing CalVEBA to act as an HMO health plan without a Knox-Keene Act license, avoiding many legislatively mandated requirements to cover specified benefits or pay fees and taxes to support health plan oversight and other state priorities. The pilot has imposed some consumer protections of the Knox-Keene Act but the DMHC's enforcement and oversight capabilities are not to the same extent as DMHC has with its regulated health plans. Annual reports to DMHC are required. The report for the first year was due in November of 2025 but is not expected until June of 2026 because of some issues with CalVEBA's data analysis partner. Much of the cost data is comparing essentially a small, network HMO in San Diego to a statewide PPO. A thorough evaluation is necessary to inform policy makers prior to any decisions to extend or expand the pilot further, and to determine what requirements should be considered if this pilot is continued or expanded.

9) *Amendments.* The Chair has requested amendments to require DMHC to terminate the pilot upon any significant negative finding of serious deficiencies which could cause enrollee harm, and require DMHC to include policy recommendations in any reports for the Legislature to consider with respect to future authority of the pilot.

SUPPORT AND OPPOSITION:

Support: America's Physician Groups (co-sponsor)
California Schools VEBA (co-sponsor)
California Federation of Labor Unions
California School Employees Association
California Teachers Association
Sharp Community Medical Group
Sharp Rees-Stealy Medical Group

Oppose: None received

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