CONCURRENCE IN SENATE AMENDMENTS
AB 2594 (Lowenthal)
As Amended June 29, 2026
Majority vote

## 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.

**Senate Amendments**

1) Require DMHC to include policy recommendations for the Legislature's consideration regarding the future of the pilot program in the interim report; and,

2) Authorize DMHC to terminate the pilot program for any reason, including but not limited to, failure to demonstrate adequate enrollee protection and compliance with all criteria and requirements under current law. Require DMHC to terminate the pilot program prior to the sunset date based on any significant negative findings in any report, including if DMHC identifies any serious deficiencies that could cause enrollee harm.

## COMMENTS

*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.

*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.

1) *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 risk-bearing organization (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.

2) *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.

3) *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.

**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.

**Arguments in 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 the first quarter of 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.

**Arguments in Opposition**
None on file.

## FISCAL COMMENTS

According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

## VOTES:

**ASM HEALTH: 16-0-0**
**YES:** Bonta, Chen, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Mark González, Johnson, Patel, Patterson, Rogers, Sanchez, Schiavo, Sharp-Collins, Stefani

**ASM APPROPRIATIONS: 14-0-1**
**YES:** Wicks, Hoover, Aguiar-Curry, Caloza, Dixon, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache, Ta, Tangipa
**ABS, ABST OR NV:** Arambula

**ASSEMBLY FLOOR: 77-0-3**
**YES:** Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Castillo, Chen, Connolly, Davies, DeMaio, Dixon, Elhawary, Ellis, Fong, Gabriel, Gallagher, Garcia, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Johnson, Kalra, Krell, Lackey, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Ta, Tangipa, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas
**ABS, ABST OR NV:** Arambula, Flora, Celeste Rodriguez

## UPDATED

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