STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

FINANCIAL SOLVENCY STANDARDS BOARD (FSSB) MEETING

DEPARTMENT OF MANAGED HEALTH CARE

DMHC ROOM OF INSPIRATION (ROOM 6001, SIXTH FLOOR)

980 9th STREET

SACRAMENTO, CALIFORNIA, 95814

WEDNESDAY, FEBRUARY 25, 2026

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Paul Durr, Chair

Barbara Dewey

Mark Kogan, MD (participated virtually)

Laura Josh

Andie Martinez-Patterson (participated virtually)

Jarrod McNaughton (participated virtually)

Jeff Rideout, MD (participated virtually)

David Seidenwurm, MD

Jessica Sellner (participated virtually)

Katrina Walters-White (participated virtually)

Mary Watanabe

DMHC STAFF

Lorilee Ambrosini, Examiner IV Supervisor, Office of Financial Review

Erica Chan, IT Manager

Evan Lo, Supervising Examiner, Office of Financial Review

Sarah Ream, General Counsel

Jordan Stout, Staff Services Manager

Michelle Yamanaka, Deputy Director, Office of Financial Review

APPEARANCES

PRESENTER

Doug McKeever, Chief Deputy Executive Director (participated virtually)
Covered California

MEMBERS OF THE PUBLIC COMMENTING

Rondale Holloway

Derek Schneider, Chief Financial Officer (participated virtually)
MedPOINT Management

Melissa Borrelli (participated virtually)
Borrelli Law PC

INDEX

PROCEEDINGS

10:07 a.m.

CHAIR DURR: Welcome everybody. I will restart with our housekeeping notes for everyone's edification.

The meeting is being conducted in a hybrid format, with the opportunity for public participation in person or virtually through video conference or teleconference.

Please note the following items for those joining us in person today.

The restrooms on this floor are locked. The bathroom badges are on the table near the entrance of the room. Please make sure to return them to the table.

Please remember to silence your cell phones.

For our Board Members here in person, please do not join the Zoom meeting with your computer audio.

Questions and comments will be taken after each agenda item, first from the Board Members and then from the public. For those who wish to make a comment, please remember to state your name and the organization you are representing.

If any Board Member has a question, please use the Raised Hand feature. All questions and comments from Board Members will be taken in the order in which raised hands appear.

Public comment will be taken from individuals attending in person first. For those making public comment at the podium here in front of the room, please be sure to leave your business card or write down your name and title and leave it on the podium so that our transcriber can accurately capture your

information. For those making public comment virtually, please use the Raised Hand feature.

For those joining online or via telephone please note the following:

For members of the public attending online, as a reminder, you can join the Zoom meeting on your phone should you experience a connection issue.

For the attendees on the phone, if you would like to ask a question or make a comment, please dial *9 and state your name and the organization you are representing, for the record.

For attendees participating online with microphone capabilities, you may use the Raised Hand feature, and you will be unmuted to ask your question or leave a comment.

To raise your hand, click on the icon labeled Participants on the bottom of your screen, then click the button labeled Raise Hand. Once you have asked your question or provided a comment, please click Lower Hand.

As a reminder, the FSSB is subject to the Bagley-Keene Open Meeting Act. The Bagley-Keene Act requires the Board meetings to be open to the public. As such, it is important that Board Members refrain from emailing, texting or otherwise communicating with each other off the record during Board meetings, because such communications would not be open to the public and would violate the Act. We also ask that you not use the Zoom Chat feature, as these comments or questions may not be viewable by the public.

Likewise, the Bagley- Keene Act prohibits what are sometimes referred to as serial meetings. A serial meeting would occur if a majority of the Board Members emailed, texted or spoke with each other outside of a public FSSB meeting about matters within the Board's purview. Such communications

would be impermissible, even if done asynchronously. Example, Member 1 emails Member 2, who emails Member 3, et cetera, et cetera. Accordingly, we ask that all members refrain from emailing or communicating with each other about Board matters outside the confines of a public Board meeting.

That concludes our do's and don'ts and welcome everybody. So, it is my pleasure to welcome everybody to this meeting.

We are honored to have a couple of new attendees. Certainly one, Laura Josh, who has been appointed to the Financial Solvency Board. Maybe in order of introduction I will start with Laura first. You can give us a background of yourself and welcome you to the Board, and then we will ask the other Board Members here in person and then online to introduce themselves. Laura.

MEMBER JOSH: Thank you. So, I represent large group purchasers. I play several roles in that area. I serve as General Manager for California Schools VEBA, which is a large governmental purchaser. We represent over 80 employers and 170,000 members across the state of California. I serve as President for RPA San Diego, which is Risk Program Administrators. We manage multi-employer risk pools now in all 50 states, both property and casualty and health care pools; as well as Chairman of the California Health Care Coalition, which is a coalition of coalitions, which represents over a million Californians that participate in labor management pools across the state. So, thank you. Excited to be here.

CHAIR DURR: Great to have you, thank you.

Then we will go over to Barb. You want to introduce yourself?

MEMBER DEWEY: Me?

CHAIR DURR: Yes.

MEMBER DEWEY: Okay. I was here two meetings ago but I will reintroduce myself. I am a Milliman actuary. I work a lot in the public sector space in general, but California is so (indiscernible) CalPERS. Not a health plan, but they are big enough that they need the (indiscernible), so submit that great experience is still relevant here.

CHAIR DURR: Great. Well, welcome. David.

MEMBER SEIDENWURM: Hi. My name is Dave Seidenwurm. I am a neuroradiologist with Sutter Medical and I am the Director of Quality and Safety for Sutter Medical Foundation. I am happy to be here.

CHAIR DURR: Great. And then we will do members online. Let's see. Mark. You are on mute, Mark.

MEMBER KOGAN: Yep, got it. Hi. Mark Kogan. I am a gastroenterologist in private practice in Berkeley and San Pablo. Have been a prior Board Member of California Medical Association and have been involved as Medical Director of some managed care organizations in the past as well. So, happy to be here.

CHAIR DURR: Great. Andie, are you on?

MEMBER MARTINEZ PATTERSON: Yep. Happy to introduce myself, thank you. Andie Martinez Patterson, I am the CEO of the Community Health Center Network. It is an IPA-MSO in Alameda with eight FQHCs and our main health plan partner is Alameda Health Consortia -- Alameda Alliance for Health, sorry, lots of Alameda. And I also sit on the Board of the health plan. Thank you.

CHAIR DURR: Great. Thank you. Jarrod.

MEMBER MCNAUGHTON: Well, good morning. I am Jarrod

McNaughton, the CEO at Inland Empire Health Plan in the Riverside and San Bernardino County region. We are the public entity plan, one of the 17 local health plans of California, with about 1.5 million members here in the IE, and it is great to be with you. I am sorry that I am driving out to one of our rural areas today so I apologize that I can't be with you on camera, but it is great to be with you on the phone today.

CHAIR DURR: Thank you, Jarrod. Jeff.

MEMBER RIDEOUT: Hi, I am Jeff Rideout; I am the CEO of the Integrated Healthcare Association. I am the Immediate Past Chair of this Committee, but I hope I don't look like a lame duck. And Paul, I am sure you are going to do a great job. (Laughter.)

CHAIR DURR: Thank you, Jeff. Jessica.

MEMBER WATANABE: You are on mute. There you go.

MEMBER SELLNER: I was double-muted, sorry. My computer audio wasn't working so I dialed in on my phone. Jessica Sellner, I am the CFO of Health Net, so health plan side.

CHAIR DURR: Great. Thank you, Jessica. And Katrina.

MEMBER WALTERS-WHITE: Good morning, everyone. Katrina Walters-White. I am a regulatory advocate with Health Access California, a consumer health care organization.

CHAIR DURR: Great. Thank you, Katrina.

Well, welcome everybody. All right.

The next order of business is the review of our meeting transcript from November 12. Anyone had a chance -- and summary. People had a chance to review that. Any comments from those that were attending last time?

I did not have any comments myself, it looked like an accurate summary. Someone want to --

MEMBER SEIDENWURM: Move to approve.

MEMBER MCNAUGHTON: Second.

CHAIR DURR: Thank you. All in favor?

Any against?

All right, it will pass. With that I will turn it over to our lovely Director, Mary.

MEMBER WATANABE: Thank you, Paul. Well, good morning. Mary Watanabe, Director of the Department of Managed Health Care. Thank you for your patience as we are working through all of our technical issues today.

And again, thank you to Dr. Kogan for your interest in continuing to serve on the Board and your reappointment.

And Laura, we are excited to have you on the Board. I think we have been looking for a large group purchaser here for quite some time, so excited to have your perspective on the Board.

Just quickly, usually in January we have an update on the Governor's budget. If you have been tracking the Governor's budget for January you know that most of the items were deferred to the spring and for May Revise, so I don't have a lot to update on the budget this meeting.

I will just remind the Board that we are funded through assessments on health plans. We do not receive any General Fund or federal funds. But I will note that the impacts of the state budget and a lot of the federal changes will impact the programs that DMHC-regulated plans have members in, and so we are, of course, tracking that very closely.

One other thing for the Board in particular is we will be monitoring the financial impact of these changes. Things like the impact of the risk mix, what happened, as Doug will be talking about, to Covered California enrollment. All of that will impact the work that we do. So, while there is not a direct impact of the state budget or federal funding cuts, it does impact the work that we do.

Since the Board's role is really to advise us on these matters, this is something we will be talking a lot about. As I noted, Doug McKeever is here from Covered California. We will likely have DHCS come back later in the year to talk more about the state budget and H.R. 1 impacts. We also are planning to have the Office of Health Care Affordability come back and talk about the work that they are doing. So, more to come in the rest of the year.

I will just note that there is one item in the Governor's budget that does impact the DMHC, and it is probably not a topic you thought I would talking about today, and that's menopause. There is a proposal in the Governor's budget that would really focus on increasing access to menopause evaluation and treatment. That does impact the DMHC. I will just say I really applaud both the Governor and the Legislature for taking on this important issue. It is an issue that is very important to me. As we have been talking about it within our department, it is an issue that is a hot topic to my staff as well.

But the focus here is really on provider and enrollee education. So, the proposal really reiterates the existing coverage requirements for both commercial plans licensed by DMHC and the Department of Insurance as well as Medi-Cal plans. There's existing requirements to cover the evaluation and treatment of menopause symptoms. The proposal also would require plans to use nonprofit criteria when making utilization management decisions, and there

are requirements around provider and enrollee education including an annual assessment after the age of 40. And plans would be required to send out information to both their providers and their members about menopause symptoms and treatment options. There is also $3 million for an outreach and education campaign through our California Health and Human Services, so excited to see this important topic being discussed.

And with that, that really concludes my remarks. I am happy to take any questions on any of my updates or anything else from the Board first then we will go to the public.

CHAIR DURR: So, any questions from the Board?

MEMBER SEIDENWURM: One question.

CHAIR DURR: Yes, David.

MEMBER SEIDENWURM: In the menopause rule there was initially some proposals for mandatory provider education periodically. Did they go through in the final version?

MEMBER WATANABE: So, the proposal right now includes continuing education requirements that basically would give an additional hour to two hours for every one hour of continuing education for providers that go through training and certification on menopause. There is also a requirement that plans have a menopause program that includes incentives for providers to become certified and trained in menopause. And there is a requirement for the plans to send information out to providers on the latest criteria. So, that is in the Governor's proposal. There were two bills over the last two or three years that had different requirements. But yeah, there still is that requirement that if providers go through the menopause -- training on menopause, they get

essentially double the credits.

MEMBER SEIDENWURM: Okay. And then just to help our organizations to consult and see we are monitoring.

MEMBER WATANABE: Sure.

MEMBER SEIDENWURM: It sounds like there is communication from the plans as well as education through the various societies, it sounds like.

MEMBER WATANABE: Correct.

MEMBER SEIDENWURM: Okay.

MEMBER WATANABE: Yes, yes.

CHAIR DURR: Other questions from the Board? Any raised hands?

Mary, I had a question related to the menopause, which is the thought of the additional cost on the providers to do the screening, because that will obviously trickle down from the plans to the provider organizations to do that screening.

MEMBER WATANABE: Sure.

CHAIR DURR: Is that all built into like when we -- I guess it would be a question for Vishaal at OHCA with regards to the overall cost trends and thinking about that impact overall.

MEMBER WATANABE: Sure. No, I mean, I think it is something that we take very seriously and think a lot about anytime there's new requirements, and this is something the plans will be tasked with implementing, these new requirements. We understand there could be a potential impact and recognizing the spending targets.

I will just say that, you know, this is something that will impact half

the population at some point in their life. We talk about that, you know, women will spend half of their life in some form of perimenopause, menopause or post-menopause. So, I think there has been a lot of lack of education awareness, lack of information. There has been evolving guidelines around this. So, we are really hoping that that, you know, that kind of outweighs any cost implications, is making sure that there is that awareness.

CHAIR DURR: Yeah, no, I applaud the effort, but it is the domino effect overall.

MEMBER WATANABE: It tacks on, sure, yeah.

CHAIR DURR: But I think it is, it is great that the Governor and you are leading in that effort about caring for people in our community in ways that probably haven't been done before, so it is really excellent work.

So, no other comments from the Board. Nothing online.

Are there comments from people in the room? Yes.

MS. HOLLOWAY: So, I heard you earlier, correct me if I am wrong. You said, Paul, specifically that there will be a time before the meeting started, before you got to the agenda item, for public comment. Did I miss that?

CHAIR DURR: The public comments are during the meeting.

MS. HOLLOWAY: Oh, that's not, that's not what I heard you say.

CHAIR DURR: Okay.

MS. HOLLOWAY: I heard you say that there would be a time before the meeting for public comment. So, are we not having a time for public comment?

CHAIR DURR: You can make a public comment now if you'd like.

MS. HOLLOWAY: Okay. I would like to start off by saying how

hard and difficult it was to actually get up here. The security guards that you guys have a contract with are clearly not educated on public easement rights and rights to actually come upstairs on the sixth floor to communicate verbally anything with this department. I made it very unequivocally clear that I was coming up here to the Department of Managed Health Care to converse with them in person. And then he took that information and then relayed incorrectly that I did not tell him my purpose of coming here. In fact, the security guard's supervisor, who should know better, doubled down on his subordinate's false accusations and unprofessional treatment to me and my friend and said, oh, I dealt, I dealt with her before. As if before when I came I became disruptive or argumentative for no legitimate reason, or at all, just at all.

That's a problem, and it is a problem because it opens your department up, not that you probably care, to a lawsuit, you see, because I asked for public records. And in those public records, since the last time I was here, I specifically asked where your visiting location was. And in the response to the public records I was told that your visiting location was on the sixth floor, which contradicts what your website says, mentioning the fifth floor.

In addition to telling me in your public records response that the visiting location is on the sixth floor, I was told that anybody can come up as long as it is during regular business hours, and all they would have to do is sign in. Well, the security officer downstairs still 'til this day, since the last time I was here, told me that the fifth and the sixth floor for this department is blocked to everyone from the public, and at no time did he recommend or suggest or imply that I should sign in in order to come here.

I want to say that because that was not what I wanted to use as my

public comment, but I felt like it was imperative to discuss that because this man was actually around when this occurred. And when I tried to access the elevator -- because I also heard you say, Paul, earlier that this meeting is under the Bagley-Keene Act, right? And considering that it is under the Bagley-Keene Act and it is open for all to attend, how is that happening when what occurred today occurred? That is a problem. And not only is it a problem, one would think that it would be a problem for my department if I worked for this department, you are opening yourself up to a lawsuit, automatically just like that.

But I am going to actually try my best to tell you what I came here to discuss because I got derailed downstairs trying to even do that. I will speak as fast as I can. I have to use the bathroom. Excuse me. But the only reason why I started off with saying what I said is because of what happened. It was severe. I got threatened to have the police called on me. I want to make it very clear to everyone in this room, I will not leave without getting arrested. There will never be a time that I am going to act belligerent. So, if at any time my access is prohibited, I will stand my ground.

My name is Rondale Holloway. I am here to address the Department's handling of a grievance I filed against Blue Shield. I initially filed my grievance because Blue Shield failed to provide a timely response within a 30 day window. However, the Department's determination failed to address that issue at all. Instead, it echoed Blue Shield's claim that the bill was paid as a one-time exception and falsely asserted that my Evidence of Coverage supported that claim, which it does not. And I submitted those evidence -- the evidence to you guys, recently. I submitted clear, verifiable evidence showing errors in Blue Shield's response, including misrepresentation of my Evidence of Coverage as

well as your misrepresentation.

After receiving Blue Shield's grievance response, two separate Blue Shield representatives confirmed, and not just them, but my Evidence of Coverage alone confirmed that I would owe nothing for an ambulance bill, directly contradicting the statements relied upon in the -- in the Department's grievance determination saying that it was done as a one-time exception. Make it make sense.

Despite informing the Department of their conclusionary error, I received a response from Chief Counsel Sarah Ream stating that I had not identified sufficient facts to reopen the case. That statement is factually incorrect and procedurally deficient.

At all times Director Mary Watanabe has been made aware of these issues, yet no corrective action has been taken. I have consistently raised regulatory compliance concerns with the Department, including before the recent Blue Shield matter.

This has been going on since 2015 since I moved to this state.

Over time I experienced escalating restrictions on my ability to communicate, including being blocked from official channels, online, over the phone, and limited in my ability to reach staff. I even received a letter threatening litigation based on allegations I definitely disputed. I have documented evidence of each of these events, including written responses and recorded interactions. And I have consistently disclosed that I record communications for transparency.

This is not a minor disagreement. When verifiable evidence is disregarded and access to communication is restricted it raises a serious -- serious concerns about procedural fairness, accountability and public trust.

Members rely on this Department for individual -- for independent oversight and accurate grievance review. When errors are identified they must be corrected, not copied and amplified. I believe this is a matter of public interest. The issues I experienced are not isolated. They reflect broader systemic failures in oversight accessibility. You all have accessibility issues too. An independent review, public records, consumer complaints and online reviews suggest others face similar obstacles. These appear to be ongoing, systemic problems, not one-time mistakes.

I am requesting that the Department amend its response, correct the record, and ensure that future grievances are handled in a timely, fair, transparent and legally sound manner. And this is about financial solvency too, because when a insurance company does not pay the bill correctly, and I don't find out until months later, that's a financial solvency issue.

And by the way, I have no other way of expressing publicly my grievances with you guys unless I am coming to this meeting. I checked your website; there is no other meeting for the public. And I just want to make it very clear I am still sick, but I made sure that I am not contagious. But I made sure that I came here. I also submitted a public comment to the FSSB Board with attachments, supported documents, supportive documents, about what I experienced with -- recently experienced. Because, like I said, it has been going on since 2015.

I want to also say this. I am a public servant myself. I have been a state employee for over three years. I am the only person to answer the phones at my department. Not one complaint. Let that sink in. Thank you for your time.

CHAIR DURR: Thank you for your comment.

Are there other comments from the public here in person?

Are there any comments from those online?

MR. STOUT: None at this time.

CHAIR DURR: None at this time. Okay.

MS. HOLLOWAY: Bathroom. Where is the bathroom key?

CHAIR DURR: What?

MS. HOLLOWAY: The bathroom key.

CHAIR DURR: Oh, bathroom key.

MS. HOLLOWAY: You mentioned that earlier too.

CHAIR DURR: Yes, I did, I did.

MS. HOLLOWAY: I remember everything.

CHAIR DURR: All right. So, we will now move on to our next subject, which is a Covered California Update from Doug McKeever. Doug.

MR. MCKEEVER: Good morning, everybody. Thank you, Paul. A pleasure to be with you this morning. For those of you that I know, great to see you here, and for those that I may not know, it is a very good opportunity for me to meet you. I am going to spend a little bit of time this morning going over our Open Enrollment results so you get a sense of where we are at currently with our numbers; spend a little bit of time talking about the federal challenges that are still in front of us; and then lastly, to Mary's earlier comment, speak a little bit about what we are anticipating for our 2027 plan year rates as it relates to all of the variables and the challenges that we have had to deal with over the last few months.

So, let me start with Open Enrollment. And for those of you who have access to the Chat, I put our dashboard link in there so that you can go in

and take a look at all of these numbers at your leisure.

I have also provided Mary, who will send to you later today, a copy of a document that outlines all of the federal issues that we have, some of our Open Enrollment data, so you have that at your fingertips as well.

So, as it relates to Open. As you all know, we concluded our Open Enrollment in January of this year. And I will tell you that we were down 32% of new enrollments compared to this time last year, so it is about 111,000 individuals that chose not to sign up with us in the new year. What is very interesting is that on our renewal side we actually had an increase of 4% for renewals.

Now I caveat that because there is a three month grace period for individuals to pay their bills. And we are thinking that consumers didn't pay attention to all the information that we sent them during Open Enrollment relative to the extension of the enhanced subsidies going away and the cost implications to them. Most likely ignored that information and they are going to be getting their bills now, between now and the end of March, and they are going to take a look at those bills and see the steep increases many of them will have. As a result of that we are expecting our enrollments to continue to go down over the next couple of months. To give you an example of that, as of the 17th of February we have about 1.8 million enrolled. At the end of Open Enrollment, we had about 1.9. So, we are already -- we have already lost about 100,000 individuals during the last month. So that should be an indication, and most likely is an indication that we will continue to suffer with some consumers leaving us.

One of the things that I will share with you that we experienced, and this is good news somewhat. A lot of individuals chose to go to Bronze. So, we

basically had -- of all of those who switched metal tiers during Open Enrollment, 73% of those went to our Bronze product. Now, one can argue that that's not great because as you all may know our Bronze product is pretty doggone expensive, a pretty hefty out-of-pocket for the consumers. Yet the fact that they remained covered is the key, right? They are not going to be the ones that end up going to the hospital and then having a bill presented to them for tens of thousands of dollars and then trying to figure out how to pay for that. So, there is a little bit of a silver lining relative to those individuals going to Bronze. We will see how it plays out over the year. But that's about 130,000 individuals that moved from a higher tier down to -- down to Bronze.

I think the other thing that is really important to note, as you all know, the enhanced subsidies were not extended. Because of that, those who are above 400% lost all federal assistance that they were getting last year. Unfortunately, we saw a huge decrease in renewals of 22% and our new renewals were down 78%. So, that that group, that population who is over the 400% of the federal poverty level really, really took a hit relative to them either staying with us and/or choosing not to enroll with us as a new enrollee. So, a bit disheartening that those individuals were unable to stay with Covered at this point.

Another silver lining of this, and some of you may know this, the Governor put $190 million, we put that into a state premium assistance program for those individuals who make roughly about $26,000 a year. Now that $190 million does not come anywhere close to the $2.5 billion that was lost as a result of the enhanced subsidies, but I will tell you that 390,000 enrollees are taking advantage of those dollars, and it most likely kept them covered. So, without that

money, it is very likely that many of those individuals would have canceled their coverage instead of staying on. So, again a little bit of a silver lining as it relates to that population and the fact that they are still with us as a result of the state subsidies that were added to the program.

So that's kind of just a nutshell in Open Enrollment, we will have a better idea probably in March relative to where our ending numbers translate.

Let me share a little bit about some of the upcoming challenges that we still have in front of us.

So, setting aside the fact that the enhanced subsidies were not approved, you all may be aware that for the 2027 Open Enrollment we will be operating under a two-month window instead of three. So, that condenses the time by which consumers will have to shop and compare and enroll with us. We are currently working on the dynamics of what that's going to mean not only to our agents and brokers, our navigators, our community partners, what that means for us in our service center. So, it is something that we are planning for. But unfortunately, because of H.R. 1, that timeframe has been cut by a third.

In addition, this year we are going to lose 112,000 consumers who are now categorized in what's called Lawfully Present; and those who are considered Lawfully Present will no longer receive any federal assistance. Because of that, they probably will not be able to afford to stay with us, and we are anticipating losing the majority, if not all, of the 112,000 individuals who are categorized as Lawfully Present. Another big issue for us to deal with in the coming months, developing communication strategies to let them know what the issue is, the impact to them and their families. And more importantly, trying to come up with strategies to provide recommendations and referrals so that they

can receive care elsewhere.

And then the last thing I want to mention is there is also the cap on repayment of APTC. So, if you received more federal assistance than you should have because your job changed, there was a cap put on that now. That cap has been removed. That is going to have, I think, some pretty devastating impacts on individuals who are now in a place of having to pay back potentially thousands of dollars in federal assistance that they were not prepared to do.

So, a lot of challenges and hurdles coming up in front of us that we will be continuing to monitor and watch.

Which translates now into, I think, what you all will find most interesting relative to how is this going to impact pricing for 2027 rates. Our rate process, believe it or not, has already started. We received our letters of intent last week for 2027 and applications for 2027 including the initial premium amounts for each metal tier will be submitted to us in the next couple of months.

A couple of things I think that are important to recognize.

One, with the loss of coverage that we are experiencing we believe, and we will validate this through our data warehouse and through our actuaries, is that the majority of those individuals who are leaving us are young and healthy, which is leaving us the older, sicker individuals who are receiving more care. As Barb can attest, this from an actuarial perspective really causes some angst relative to what the anticipated premium is for the current plan year, the impacts now of young and healthy individuals leaving us, and how that could most likely indicate a higher than normal and higher than average premium increase for us going into 2027. So, that is something that we are clearly looking at.

The movement of individuals to Bronze. Given the big number, as I

mentioned over 100,000 individuals moving, that also factors into our actuarial calculations and the risk of the pool itself in general, and how that will impact 2027 rates. So, what we are expecting is all of the plans that we currently contract with are probably going to be very, very conservative when it comes to their pricing strategy. I translate that into, unfortunately, we are probably going to get higher than expected premium increases for 2027. That doesn't mean we are going to end up higher, but it gives -- it makes the starting point for our negotiations probably higher than what we would expect and what we would want.

I think the last thing I will mention on this is clearly we have been keeping a close eye on OHCA and the cost targets that they have established. I know we are in conversations with them relative to the dynamics that we are faced with, and the fact that the costs that we are going to see most likely aren't going to get anywhere near that target. And so I think there is going to have to be recognition that these external factors are putting huge cost pressures on the health care system, writ large, and we are just one piece of that. Covered California is going to have its implications and its cost challenges. We already know Medi-Cal is going to have theirs. And I am going to guess on the large market, on the commercial side, they may also have some issues as well.

So, with that I would be happy to answer any questions that any of you may have.

CHAIR DURR: Thank you, Doug. A nice, wonderful overview of kind of what we were all anticipating was going to happen. So, first open it up for questions from the Board. Any questions from the Board? Yes, Katrina.

MEMBER WALTERS-WHITE: Thank you for that presentation.

First, just want to say that we are disappointed that fewer people are signing up for coverage, and those that are signing up seem like they are getting lower value coverage switching to Bronze. Are there certain populations that you are seeing that are being affected more than others? I know you mentioned that you are seeing more younger people dropping off, but are there other populations that you are --

MR. MCKEEVER: Yes. So, I will tell you right now that those -- what I can share with you is Latino communities were the most impacted where our enrollment is down 39%. For Black and African American we saw a 34% drop. So, for those two categories, yes, they have been more severely impacted than others.

CHAIR DURR: Jarrod.

MEMBER MCNAUGHTON: Thanks so much. And boy, Doug, thank you for all the work you and the team at Covered California are doing. I know it is such a unique time for all of us, so we sure appreciate that.

I was just curious, from your perspective, Doug, if there is anything you are hearing on the enhanced premium tax credits as far as do you think that the feds might do something in the future? Do you think it is a foregone conclusion that it is not going to happen? Kind of any tea leaves that you might be able to read to share on that.

MR. MCKEEVER: Yeah, thank you, Jarrod. I would, I would say, and I am not a betting person, so I am not going to go to the betting side of this. Our greatest chance of having those enhanced subsidies extended, we lost that opportunity in December. It does not mean that it is a dead issue, there still is an opportunity where Congress could act and reestablish those. We are so far into

the current plan year, however, that by doing that, maybe it is effective for 2027. So, I don't think you are going to see anything that is going to be available for 2026 which will help mitigate the current situation we find ourselves in. One can only hope that calmer heads prevail back in Washington and they try and do something for 2027. I, again, am not a not a betting person, Jarrod. I would say that the chances of them being brought back are probably less than favorable.

CHAIR DURR: And Doug, I had a couple of questions. One was on the premium assistance fund. How much of that was actually spent this year? Do you have any insight into that?

MR. MCKEEVER: Are we talking about the state one or the federal one?

CHAIR DURR: Exactly.

MR. MCKEEVER: So, the state federal program, the Governor and the Legislature allocated $190 million, which again, as a reference to the $2.5 billion that we lost, is a drop in the bucket. But because we applied those dollars to the lowest income levels of our population we really did, I think, keep a large number of those individuals from going without coverage because they are getting the state subsidies, which is helping them have a more affordable product than they otherwise would have had if those dollars were not available.

CHAIR DURR: Right. I guess my question is, is there dollars left over or did you spend it, was it all spent?

MR. MCKEEVER: No, we expect to spend the entire $190 million. We have to do an estimate at the beginning of the year of how we are going to spend it and so it comes up. We are real close to the 190, we may not hit it exactly, but we do have a good team who do estimates to ensure that we take

advantage of almost every dollar that has been allocated to us.

CHAIR DURR: No, I appreciate that. And there is no guarantee it will be there for next year.

MR. MCKEEVER: No, this is a year-over-year augmentation that the Governor and the Legislature will have to continue to appropriate.

CHAIR DURR: All right. My last question is, do you expect any health plans backing out or reducing their enrollment or eliminating it at all?

MR. MCKEEVER: That I cannot share, unfortunately, with you. I can't share with you if there are any new plans that have knocked on our door, and I cannot share with you whether a plan has indicated that they are either leaving and/or reducing their footprint in California.

Chair Wasserman: Okay, great. Are there any other questions from the Board Members?

MEMBER WATANABE: Maybe I will just make a note, just a reminder about process. So, you will get rates and kind of start your process here this spring, and then we get rates, Michelle, I believe July. So, just for the Board, this is usually something we kind of revisit later in the year about kind of where we landed and more about where Covered California lands in terms of plans, premiums, and then, of course, our rate review. But Doug, am I right that you start about spring, springtime and all of that?

MR. MCKEEVER: Yeah, we will get the applications from the plans in April. We will go through them internally and with our actuaries, prepare for our rate negotiations in June. And assuming that all goes well in June, we will then provide those proposed rates to DMHC for their review in July.

CHAIR DURR: Great.

MEMBER WATANABE: More to come.

CHAIR DURR: Okay, all right. Any other comments from -- there is no public, anyone public yet in the room.

MEMBER WATANABE: No. The one member has left.

CHAIR DURR: The one member has left, so no.

Are there any public comments from those online?

MR. STOUT: We do, we have one. When prompted, please state your name and organization.

MEMBER WATANABE: Derek.

MR. SCHNEIDER: Hi. This is Derek Schneider, I am the Chief Financial Officer for MedPOINT Management. I probably already know the answer to this question but I'd be remiss if I didn't ask. Do you have any kind of, or are you able to share any kind of estimate on your expectations for trend increases related to the adverse selection that you mentioned earlier?

MR. MCKEEVER: Yeah, Derek. Not at this point in time, it is too early. I mean, heck, we are only in February so we have no claims data really yet to look at to see how the impact is going to play out for 2027. We will know more probably in the next four to six months.

And as many of you know, it is a calculation and it is a guessing game, right? You look in the rearview mirror, you look at the claims experience for 2025, they forecasted for ’26. You look at the claims experience for ‘26 that you have and you do some modeling to try and come up with what that impact may be for 2027. So, you know, there is art and science to this process as we go through it, but it is way too early in the year for us to come up with a projection of what those rates might look like. Other than to say, given the fact that we know

young and healthy individuals are leaving us, we know historically that will have an impact on the rates.

MR. SCHNEIDER: Thanks.

CHAIR DURR: Any other questions for those online?

MR. STOUT: Not at this time. You have another question from Katrina, though.

CHAIR DURR: Oh, Katrina, go ahead.

MEMBER WALTERS-WHITE: Sorry. Hope it is not too late to ask another question. I know you were saying that with the rates that you are seeing it is concerning if they will be able to meet the target. Do we have any idea? Because I was looking at -- I remember there was something in the CHCF article that said that 25% of the cost is coming from administrative complexities. Are we able to see what some of them are doing to be able to lessen some of those administrative complexities?

MR. MCKEEVER: Yeah, that's probably a question better suited for OHCA and the Board as they have a better line of sight into those types of things. I mean, we review a host of information. Administrative is one of the areas that we look at, as opposed to facility cost and professional cost and drugs. All of that is lumped into our total premium amount. I don't think I am in a good place to provide you with any information that would be helpful relative just to the administrative side of the shop.

MEMBER WALTERS-WHITE: Thank you.

MEMBER WATANABE: I will jump in and just add. On March 11 we are going to have a public meeting on premium rates across all markets. We are planning to have OHCA come and do a presentation as well, so that may be

a question for that forum. We also are hoping to have OHCA come back and do a presentation, likely at our next meeting if we can make that work. So, put a pin in that question, Katrina, and we will reiterate that when we have the appropriate people.

CHAIR DURR: All right, no other comments, and no other raised hands. We can move on to our next agenda item, which is Regulations and Federal Update and Sarah Ream Chief Counsel.

MS. REAM: Yes, thank you. Good morning. So, I am going to be providing an update on four regulations that we have very far along in the process. Our regulations team is always, always busy. They have been extra busy the past couple of months, so I am happy to report we have made some very good progress on regulations. I am also going to talk about an All Plan Letter that we issued recently, and then I am going to give a brief federal update on some recent proposed guidance from CMS that impacts our Essential Health Benefits Benchmark Plan and updates to that going forward, so let's hop into it.

So, first with respect to regulations.

We have the Provider Directory regulation. This regulation will take effect April 1 of this year, so just in a week.

As background, SB or Senate Bill 137 required the DMHC to develop standards for Health Plan Provider Directories. The bill gave the DMHC a temporary waiver to develop those standards without first going through a formal rulemaking process. So, based on that waiver we worked with stakeholders to develop the Uniform Provider Directory Standards, which did a number of things.

So, the standards outlined minimum requirements for Health Plan

Provider Directories by defining terms for the health plans to use in those directories so there was uniformity across plans.

Set forth naming conventions for plan products and networks. Again, to hopefully increase uniformity of those terms.

Created requirements for displaying provider directory information.

And specified search functionality so that enrollees could go and use the online provider directories to search for specific providers, types of providers, those sorts of things.

The plans have had to follow those Uniform Provider Directory Standards since 2018, and last year the regulation that we promulgated will codify those standards. So, we are not going to see big changes with respect to the provider directories, really what we are doing is codifying existing practices. So, look for that reg. It takes effect April 1. This one has been a long time coming so I am very excited about that.

Next we have the Senate Bill 17 prescription drug reporting requirements. So, several years ago the Legislature enacted SB 17. It increases transparency with respect to drug pricing and drug costs. The bill requires that health plans file rate information with the DMHC annually to specify the 25 most frequently prescribed drugs, the 25 most costly drugs by annual spending, and the 25 drugs with the highest year-over-year increased total spending. Plans started submitting this information back in 2018, so it has been a while.

SB 17 also requires the DMHC to analyze and aggregate all the required prescription drug data submitted by plans and then we report that data out to the public and to the Legislature. The DMHC, working with the California Department of Insurance, created a reporting form and reporting instructions the

plans have to use when they submit this data to us. So, the rulemaking action will codify, again like the provider directory regs, will codify existing practices and the existing processes the plans have to follow when submitting information to us. It will also codify the instruction manual reporting form plans have to use. We anticipate starting this rulemaking within the next month or two, so very, very soon, and we obviously welcome public comments to those regulations.

Third, we have the Health Equity and Quality regulation. So, as background again, in 2021 the Legislature enacted Assembly Bill 133. This bill required the DMHC to convene a committee to recommend health quality measures and a benchmark standard for health plans. The goal of AB 133 was to address health disparities in California's health care delivery system.

After nine committee meetings, the DMHC adopted a benchmark standard and 13 quality measures as recommended by the committee.

AB 133 allowed the DMHC to implement the standards and measures without first having to adopt formal regulations but instead by issuing an All Plan Letter, which we issued in 2024.

We now, though, have to -- we only had that waiver for a year to issue the APL so we have to adopt formal regulations. We are getting the final approvals for that formal reg package and you are going to also see that one starting the formal rulemaking process in the next, I would say, two months.

Finally, hot off the presses and didn't make it onto my list here, are amendments to the DMHC’s general licensure regulation, or we also sometimes refer to this as the risk regulation, because it has to do with risk, taking on financial risk. And just for your reference, the rule is Section 13100.49.

I am going to go back in history here for a second. So, back in

2019 we adopted this rule. The rule does a number of things. It defines terms like global risk, institutional risk, restricted health care service plan, which had never been defined before in the Knox-Keene Act, although we used them.

The reg allowed entities to take on some amount of global risk without first having to have a health plan license and outlined an exemption process for entities to get that, you know, to be able to take on that risk without having to be a plan.

However, after we issued the reg, you know, we learned what we didn't know before, and we realized the reg was maybe a little bit unwieldy. There were many more entities that were interested in taking on some amount of global risk than we had been aware of. So, to address that we adopted a temporary, expedited exemption process whereby an entity could submit certain information to us, get a limited exemption, and they were able to take on some amount of global risk without having to be a plan or go through a more formal exemption process.

Then with like so many things, COVID happens and we got a little distracted by some other stuff. But we are now -- so we have had the exemption process in place since 2019. But we know that it is -- there is uncertainty and stakeholders are looking for us to revise the regulation to make it more clear, less unwieldy, and just have a more formalized process for the exemptions. So, we are starting that process.

We have drafted the regulation and we have shared the draft with stakeholders this week; that draft went out. If you didn't receive the draft of the regulations and you are interested, please either contact Amanda Levy, our Deputy Director of Stakeholder Relations, or you can just contact me, and I am

happy to share that with you. We are looking for stakeholder comments By April 2, if possible, so if you can give those in to us. And obviously, if you need more time, that is fine too. This is the informal, sort of preliminary part where we elicit feedback from stakeholders, so we really do want to hear the good, the bad and the ugly about the proposed regs before we start the formal rulemaking process.

Let's see. Thank you. Next, I am going to talk briefly about coverage of infertility and fertility services.

In 2024 the Legislature enacted this bill that requires all large group health plan products to cover the diagnosis and treatment of infertility. It also requires small group products to offer a rider, if the group chooses to purchase it. The rider would cover infertility and fertility services as well. So, large group must cover; small group have to offer coverage, obviously, for an additional premium if the group chooses to do that.

The original effective date of SB 729 was July 1 of 2025, however, the Legislature delayed that implementation date to the first of this year.

The Legislature also gave the DMHC the ability to issue guidance through 2027 -- excuse me -- until 2027 so that we can clarify and make specific that statute. Thereafter, we will have to adopt a reg. But based on that ability to issue guidance, we issued an All Plan Letter in late December that outlines the services the health plans must cover, the large groups must cover, and what the small group must offer to cover. Those services include the diagnosis of infertility, so services that are attendant to that diagnosis, retrieval of eggs and sperm, creation of embryos, and cryopreservation of eggs, sperms and embryo.

Given the complexity, as you can imagine, this is an extremely complex area of medicine, we have received lots and lots of questions from

stakeholders, from health plans, from consumer advocates, which we have been working through.

Based on stakeholder feedback, we issued an amended APL last week, so that is up on our website now, just trying to tweak it to better serve Californians. And we may, you know, I anticipate we will perhaps be issuing either further guidance, FAQs, something like that, as we work through questions.

We are also going to start the formal rulemaking process this year, so be on the lookout for that one as well. My team is extremely busy, as you can imagine.

Finally turning to Covered California issues, EHB and Benchmark Plan. So, as a reminder, a state's Benchmark Plan sets what is considered to be the essential health benefits for that state. All small group and individual health plan products have to cover those essential health benefits. Before a state can change its Benchmark Plan to add benefits, delete benefits, do anything, the state has to apply to CMS and get approval of the new Benchmark Plan.

Last May we submitted an application to CMS to do just that. The new Benchmark Plan would have taken effect in 2027, and it would have added three categories of benefits. Those categories would have been hearing aids, wheelchairs and other mobility devices, and infertility services. So, important benefits for the folks who need them.

However, earlier -- well, late last year in the fall, we received word from CMS that they were pausing their review of new Benchmark Plan applications. They didn't say why. They didn't say how long the pause would be. They just told California and the other states that have pending applications that

the review is paused.

Then earlier this month the CMS released their annual Notice of Benefit and Payment Parameters for Plan Year 2027. Every year CMS issues a rule update with what plans have to do, what exchanges have to do, so this is an annual thing they do.

In that notice, they reiterated the fact that they were pausing review of Benchmark Plan applications. They did not say when the pause would be lifted. They also proposed to make it difficult for states to update their Benchmark Plans. Essentially, what the proposed notice says is that if a benefit was not mandated by a state prior to January 1 of 2012, if it wasn't mandated prior to 2012, then if a state adds a new mandate the state has to pay for the cost of that benefit for enrollees who are in the state-based exchange. Which obviously, you know, in times of budget shortfalls and whatnot it could be difficult for a state to do that.

So, this is still a proposed rule. We are analyzing it, trying to see where and how it impacts our plans and our enrollees. The feds have asked for comments back by March 13, so we don't have a whole lot of time, but we will keep the Board and everyone apprised as we move through this process. Certainly disappointing to us that the Benchmark Plan for 2027, we are not sure that's going to happen this year, but we will keep everyone abreast of what's going on. That's it for me.

CHAIR DURR: Quite a lot of work there, Ms. Sarah and team, so that's great. Open it up for questions from the Board. Yes, Barb.

MEMBER DEWEY: I am not a lawyer, so I am just going to say that first. But is there more to the state defraying benefits than there was in the

first go-around?

MS. REAM: Tell me more.

MEMBER DEWEY: It kind of seems like the state may have to defray the cost even if it is part of the existing EHB. That's the part that is making me nervous.

MS. REAM: So, it is hard -- that is an unclear -- we don't know the answer to that question. CMS has -- they issued conflicting statements about whether a plan -- whether a state would need to defray the cost. They gave the example of -- thankfully, we are not in that situation. California isn't because our Benchmark Plan is what it was in 2011. But for other states that have added benefits and then had those benefits approved by CMS for their Benchmark Plan, that state will need to defray the cost of those benefits if they don't revoke their mandate. Does that answer the question.

MEMBER DEWEY: I am not, I am not sure it is a full answer, but I don't know if there is a full answer. California has mandated quite a few things, and there was no impact to the individual market because it was already part of the EHB.

MS. REAM: Correct, correct, yes. So, we can do things like clarify benefits, do things with respect to access, but it is not mandating that the benefit be -- a new benefit be covered in the individual or small group market. So, the Legislature has been very careful to not mandate a whole new benefit in the individual and small group markets such that we would have to defray.

MEMBER WATANABE: Maybe I will just say, so, the rule is proposed at this time.

MS. REAM: Right.

MEMBER WATANABE: So a lot of it, we will have to see what ends up in the final. There is, I think, a lot of questions and confusion about the interpretation. So, just, just want to note, I think we are in a little bit of a different place in California than maybe some of the other states are. But I think there is also a lot of maybe confusion too about what is currently in the Notice of Benefit and Payment Parameters that ultimately will be in the final (inaudible).

MEMBER DEWEY: Is DMHC covered in the Legislature? Who is right now looking at what that portion of that (inaudible)?

MEMBER WATANABE: All of us.

MS. REAM: DMHC, Covered California, CDI. I don't know about, I can't speak for the Legislature.

MEMBER DEWEY: I'm sure.

MS. REAM: I'm sure they have someone working on it. But we are all looking at that and trying to suss out what exactly it is.

MEMBER WATANABE: And we are still reviewing and making decisions about whether we are going to submit comments as well, so that is also still under review. I will just say we spent over a year working on this. We had stakeholder meetings. These are issues that are very important to consumers, to the Legislature, to the Administration, to us, so I think there is some disappointment that this is not, at least at this time, moving forward. But we are still kind of evaluating that (inaudible) -- hot topic right now. I am sure you are also looking at it, right?

MEMBER DEWEY: Yeah, yeah.

MEMBER WATANABE: Okay.

CHAIR DURR: Other questions from Board Members? I did have

one or two comments. Oh, David.

MEMBER SEIDENWURM: Yes. You said if we were interested in perhaps making comments on the earlier issue.

MS. REAM: Yes.

MEMBER SEIDENWURM: Could you just send those documents to the Board to make comments. Thank you.

CHAIR DURR: I was going to compliment you on getting those regulations out, that's a big thing. I know someone that is going to welcome that. He is not here to sing the praises. I wanted to do that.

(Several people speaking at once.)

CHAIR DURR: They are done, they are proposed, so they are out there, so I give you compliments.

My other question or comment is around the infertility and fertility.

MS. REAM: Yes.

CHAIR DURR: There is a lot of discussion between the health plans and provider groups as to who is financially responsible for that, as you can imagine. So that is causing a lot of angst among provider groups who really from my perspective go back to the plans and say, how did you build it into your actuarial assumptions on the risk that you were shifting to us that sometimes we don't necessarily get as we should. But just more of a comment on that also.

And then no other questions from Board Members, no questions from anyone in the room, from the public. And I do see that we do have a comment from someone online so, Jordan.

MR. STOUT: Yes. When prompted please state your name and organization.

MS. BORRELLI: Hi, can you hear me?

MEMBER WATANABE: Yes.

CHAIR DURR: Yes, we can.

MS. BORRELLI: Excuse me. Melissa Borrelli with Borrelli Law PC. I hate to sound obtuse; I just want to make sure I'm understanding what you are saying. There's a lot of unknowns here. And until the unknowns are known, the EHBs stay as they currently are, they don't change. Is that right?

MS. REAM: Melissa, that is my understanding.

MS. BORRELLI: Okay, all right, thank you.

MS. REAM: There is a lot of confusion, though, among all the states about all of this. But yes, that is our operating assumption.

MS. BORRELLI: Awesome. Thank you.

MS. REAM: In California.

MS. BORRELLI: In California.

MS. REAM: If you are in a different state, I don't know.

MS. BORRELLI: Right, right. Thank you.

CHAIR DURR: All right. Any other comments from the public online? All right.

Thank you, Sarah, great overview.

We will move to our financial summary of Medi-Cal managed care plans and Lorilee.

MS. AMBROSINI: Good morning. I am Lorilee Ambrosini, Examiner IV Supervisor for the Office of Financial Review, and I will provide you a quick update on the Financial Summary of the Medi-Cal Managed Care report for quarter ending September 30, 2025. A copy of the report is available on our

public website under the Financial Solvency Standards Board section.

This report is presented to the Board on a biannual basis and highlights enrollment and financial information for Local Plans and Non-Governmental Medi-Cal plans. You will notice that throughout the report we are now referring to both Local Initiatives and County Organized Health Systems as Local Plans.

Non-Governmental Medi-Cal plans are plans that report greater than 50% of Medi-Cal enrollment but are not a Local Plan. The report is divided into two distinct areas, first focusing on the Local Plans and second on the Non-Governmental Medi-Cal managed plans.

There are 16 plans that serve over 9.1 million Medi-Cal beneficiaries in 50 counties.

Total enrollment decreased by 1.5% compared to the prior quarter, with all local initiatives reporting a decrease in enrollment. Overall, the Local Plans' Medi-Cal enrollment increased by 122,000 or 1.4% from June 2024 to September 2025.

For September 2025, the Local Plans reported total net income of $96 million.

All Local Plans met the DMHC's reserve requirement or tangible net equity requirement. The TNE to required TNE ranged from 219% to 2,190%.

There are five Non-Governmental Medi-Cal plans that serve 3.4 million Medi-Cal beneficiaries In 21 counties. Total Medi-Cal enrollment for Non-Governmental Medi-Cal plans decreased by 2.3% or 83,000 in September of 2025.

And for the third quarter of 2025 the Non-Governmental managed

care plans reported total net income of $181 million.

And TNE to required TNE ranged from 254% to 1,439%.

CHAIR DURR: Great overview, thank you. I will open it up to questions from the Board first. Any questions? Yes, go ahead, Jarrod.

MEMBER MCNAUGHTON: Well, thanks so much for the report. And I just thought I would just share a little bit of specific information about what we are seeing in our market in Southern California when it comes to enrollment and membership numbers. As the report was shared, everybody is seeing a decrease. There are really two, kind of two or three big buckets. You heard what Doug shared on the Covered California piece, and we saw a dramatic decrease there. But on Medi-Cal specifically we are also seeing a decrease, particularly after President Biden's public health emergency era opportunities for eligibility and redetermination leniency ended just this past summer. And our counties were playing a lot of catch-up with that and that moved it all the way into January of this year, and we have seen a pretty substantial decrease in the Medi-Cal side of the house, about 15,000 or so members that we have seen.

And we are forecasting out, when you when you look out about two to three years, just so that the Board and public are aware, we are forecasting about a 20% reduction in our Medi-Cal lives due to the changes and the unsatisfactory immigration status of what DHCS and the state made the decision because of budget constraints, along with changes on work requirements and the every six month redetermination process that has to take place here shortly for the expansion population within the ACA.

So, I share that because I know health plan finances are always looked at. And when you look at an organization like our organization where we

have what some would consider healthy reserves, we are still not where we need to be and where we want to be for what DMHC's requirement is. Because our daily cash burn is about $22-23 million per day of what we are paying out in claims. And so I just thought it would be good to give a little bit of background on that, because as you start to see the membership reduction continue throughout the state and actually around the country, I think you are going to start to see other pressures that will mount, both for the provider community with increased utilization, the ERs and whatnot, along with health plan finances where you are going to just see continued strain there. So, I just wanted to share a little bit about what's happening at least in our market as well. Thank you so much for letting me share.

CHAIR DURR: That's great insight, Jarrod, appreciate you sharing firsthand what's going on with your plan and the impact to our community, so very important for us to hear that. Katrina. You are on mute, Katrina.

MEMBER WALTERS-WHITE: Okay, there we go. Yeah, I wanted to say thank you again for the presentation. And maybe this is something that Jarrod just answered. I was also looking at that the Local Plans reported a net income of $96 million, and it just seems like that's a really significant drop from March of 2025. I was wondering if the decline in net income for Local Plans was due to the decline in just overall Medi-Cal enrollment or if you were also seeing there were other -- they are having other concerns.

MS. AMBROSINI: Can you repeat the question.

CHAIR DURR: Katrina, if you could repeat the question, thank you.

MEMBER WALTERS-WHITE: I guess my question is, is the decline in net income for Local Plans, is that due to the decline, is that just due to

the decline in overall Medi-Cal enrollment?

MEMBER WATANABE: Or are there other reasons for the decline? Do you have any visibility into that or any sense of --

MS. AMBROSINI: Not right now.

MEMBER WATANABE: Yes. Jarrod, maybe can I put you on the spot a little bit and just say, would you guess that decline was mostly attributed to a drop in enrollment?

MEMBER MCNAUGHTON: Yeah, it is an excellent question. I think you are seeing a couple of different factors on that. We have seen in our organization at least post-COVID utilization increases. So, when you look at our medical loss ratio as an example, it is in the high 90s. I mean, in some cases, it has been over 100%. And so when we have an administrative cost that we are -- our target is at or below 6% for administrative costs. And if your MLR is running 98 to 99%, which is what ours is, you could start to see why we had such a huge deficit in our case back in 2024 and we stabilized that in 2025. But I think you are seeing a mixture of both post-COVID utilization changes. You are also seeing more significant pressure in markets like ours where providers, just the cost of care is increasing. And so their need for higher contractual rates is certainly a pressure cooker for them because of labor increases and whatnot. So, I think you are seeing a multitude of issues, both on the membership front as well as on the provider front.

And to their credit, DHCS is trying their best to keep up with rates, appropriate rates, through the actuarial models, but it can be very tough, as Doug had shared for Covered California, when you are kind of chasing a lot of that a year or two after. But the department, DHCS side, has really done a good job to

try their best to keep up with that as well. I certainly don't want to speak for them, but from our perspective of what they have provided for us as a local entity, they have done a good job to try to keep up with those trend changes that we are seeing. Especially because the members that are coming off, whether it is in Covered California or in Medi-Cal, generally speaking, those members are actually folks that have lower cost needs. And so you are seeing higher cost members stay on the plan, which, of course, makes sense. They are going to make that a priority for their homes to make sure that when they get that enrollment packet in the mail they complete it right away. And so you are seeing higher cost members stay on the plan, lower cost members come off of the plan.

And I would just note, if it is okay, Mary, I hope it is okay to put in a plug real quick. It is incredibly vital for folks to understand that for the undocumented or unsatisfactory immigration status members, right now they are all grandfathered into the Medi-Cal program. And if they come off of the program, even for a day, they simply cannot come back on. And so the outreach that is happening to members across the state of California is so incredibly vital right now to be able to continue that coverage for folks that need it. So, I am sorry if that was too much, but I just thought that was important to share as well.

MEMBER WATANABE: That's super helpful, Jarrod. We always appreciate your perspective and the reminder of how important that is to try to keep everyone enrolled and filling out that paperwork.

CHAIR DURR: I would agree. And I think one way to get at that question, though, would be to look at profit per-member per-month per-enrollee, because then you would identify whether it is a number of member issue or whether it is the actual profit margin that is being diminished at the plan. But I

think to Jarrod's point, one would suspect that it is because more increased utilization is driving that profit down, so it is probably a mixed bag in that regard.

So, any other questions from the Board?

MEMBER WATANABE: If I may make just a comment. I will just say this has been an incredibly valuable report for the Board. I will just say, the historical information as we head through to the rest of this year and next year will also be, I think, very telling. I think DHCS has talked about the timing of some of these changes and when we expect to see the decline in enrollment. It is something I think our team is watching very closely. This is as of September 30 of last year. So again, as we look quarter by quarter of those changes across the board, particularly, I think we are all going to be watching very closely the Medi-Cal managed health plans. And, Jarrod, of course we always appreciate your on-the-ground perspective of the things that you are doing to be responsive and (inaudible) as well. So, more to come.

CHAIR DURR: Thank you, Mary.

Open it up for comments for those in the room. None.

Public comments online? None? Okay.

MEMBER WALTERS-WHITE: I did have one other question, sorry.

CHAIR DURR: Yes, go ahead.

MEMBER WALTERS-WHITE: I was looking at the TNE and saw that some of the plans have TNE as low as 219% and then some are in the 2,000s. We just worry that plans with lower TNE not having sufficient reserves to prepare for what's happening with the cuts. But we also have concerns and questions about the plans that have excessive TNE and what that means for the Medi-Cal consumers in terms of access to necessary care.

MEMBER WATANABE: Michelle, do you want to talk about that?

(Several people speaking at once.)

MS. YAMANAKA: Let's go with the first with the lower TNE. You know, what we do is we receive the report of the financials, we review them. When we see the TNE continues to decrease or any other financial concerns we will work with the health plans. We will find out what their projections are going forward in order for them to continue to meet the metrics, the required metrics, on a monthly basis. So, those are more on our watch list there when we continue to see those declines.

Versus on the opposite spectrum, you know, the health plan that has over 2,000% of TNE. That's one health plan represented in that category. We also look at, you know -- I couldn't really -- I couldn't really speculate on it right now, I have to go look at financials for that one health plan. We also have to look at the composition of the assets in in what's represented for TNE. Because they could have a building. A building that's not quickly converted to cash, et cetera. So, the high percentage of TNE, we also look at what it represents. So, those are -- it's kind of some of the things we do when we review these financials on an ongoing basis, but I can look into a little bit more on the details of those financials for the ones that have the 2,000% or are in that area.

But for enrollees or members that continued to receive health care, that's one of the main reasons that that is -- they declined. Where is the health plan going to go from where they are at right now and how they are going to maintain compliance so we ensure that those members get services.

MEMBER WALTERS-WHITE: Thank you. And are we able to see whether or not they have a building or the type of assets?

MS. YAMANAKA: Yes.

MEMBER WALTERS-WHITE: Okay, thank you.

MS. YAMANAKA: The financials, the health plan financials are posted. They are public information, so they are posted on the DMHC website as well. So, give the link as well, so you can take a look.

MEMBER WALTERS-WHITE: Thank you.

CHAIR DURR: Great. Okay. Seeing no other questions we will move on. Thank you for that great update, appreciate that.

We will move to Provider Solvency Quarterly Update and Michelle.

MS. YAMANAKA: Thank you, Paul. Good morning. I am going to give the update for -- the RBO financial update for the quarter ended September 30, 2025. My name is Michelle Yamanaka, Deputy Director in the Office of Financial Review. Next slide, please.

For the quarter ended September 30, 2025 we have 209 RBOs reporting to us. There were two RBOs that started reporting this quarter and three RBOs that were deactivated. Of those three, all of them were on corrective action plans as of time of deactivation. For one RBO they -- that RBO closed and all of those contracts were transferred to another RBO. (Inaudible), you know, and no longer continued as an RBO, so those accounts were closed.

Then we have -- so 185 of those 209 RBOs, or 89% of the RBOs were compliant for quarter ending September 30. Of those 185 there were 8 that were on our monitor closely list where we are watching the status of those RBOs. When the financials come out they will be the first to review, or we have them on monthly reporting. We will continue to monitor them to ensure that they are meeting their financial targets.

And then we have 24 RBOs that reported non-compliance or were on a corrective action plan at quarter ended September 30.

We received 13 annual reports for the fiscal year ended March 31, and June 30, 2025.

And we received monthly financial 13 from RBOs.

To provide some additional information, there is a handout titled *RBO Enrollment and Grading Criteria*, which compiles the grading criteria for each RBO, which includes the relative TNE, the Relative Working Capital, the Cash-to-Claims calculation and the Claims Timeliness percentage. Next slide, please.

Moving on to corrective action plans. We have 24 RBOs, or 11% of the RBOs, on corrective action plans. However, there were 2 RBOs that fell into non-compliance and generated another CAP, so we have a total of 26 CAPs for the quarter ending September 30.

Of those 26, 8 are new as of September 30, and 18 are continuing from the previous quarter.

Of the 18, 16 were meeting their approved projections and 2 RBOs did not meet the -- were not meeting the projections. One of those RBOs led to an enforcement action and we froze the enrollment; and the second RBO, we are continuing to work with them to try to get an approvable CAP.

Of the 8 new corrective action plans, there were 3 RBOs that were non-compliant due to claims timeliness, 5 RBOs that were non-compliant with one of the financial metrics, one or more of the financial metrics, TNE, working capital and/or cash-to-claims.

Twenty of those 26 CAPs were approved, 6 are currently in review.

And after our September 30 review, 9 of those corrective action plans have been completed and all of those RBOs are meeting their financial metrics.

MEMBER WATANABE: Michelle.

MS. YAMANAKA: Yes.

MEMBER WATANABE: We are having a little hard time hearing, I don't know.

MR. STOUT: Yes, just a little louder.

MS. YAMANAKA: Speak a little louder, okay. Sorry, normally it's okay.

(Several people speaking at once.)

MEMBER WATANABE: The microphone is a little farther today.

MS. YAMANAKA: Okay, okay. And then we also have an attachment which lists all of the corrective action plans sorted by the Management Services Organization or MSO, and it provides information regarding the RBO, their MSO, their contracted health plan, enrollment, and the grading criteria that they were deficient with.

Moving on to the next slide, going to the grading criteria. Let's first start with TNE.

For the quarter ended September 30 we used the TNE to required TNE to calculate this ratio. RBOs that have less than 100% were non-compliant with the grading criteria. This table shows that there were 2 RBOs that were non-compliant and those 2 RBOs had less than 10,000 lives assigned to them. And 150 RBOs had more than 500% of the required TNE requirement.

Moving on to working capital, also known as the -- also known as

the current ratio, which deducts current liabilities from current assets. This metric also measures the RBO's resources available to finance its day-to-day operations.

The slide shows that over 98% of the RBOs have a working capital of 1 or more, and there were 4 RBOs non-compliant with this grading criteria requirement. Three of those RBOs have less than 10,000 lives, and 1 RBO had more than 100,000 lives assigned to them.

Moving on to the next criteria. The cash-to-claims ratio is the RBO's cash, short-term investments and health plan capitation receivables collectible within 30 days, to the RBO's total claims liability. The minimum requirement is .75. This slide represents the cash-to-claims ratio for all RBOs.

Three RBOs did not meet this requirement. Again, 2 were in the less than 10,000 lives, 1 had 25,000-50,000 lives assigned to them. And over 113 RBOs had over -- were in compliance with the cash-to-claims ratio.

And the last grading criteria requirement is claims timeliness. The requirement is 95% or higher. This slide shows a majority of the RBOs met this requirement. Of the 5 RBOs that did not, 3 had less than 10,000 lives, 1 had between 50,000-100,000 lives, 1 RBO had over 100,000 lives assigned to them.

Moving on to enrollment. The column on the far right shows the enrollment reported for the quarter ended September 30, which shows that there were 8.5 million lives assigned to 209 RBOs. There is a decrease comparative to the -- the previous year at the same time. A decrease of approximately 421,000 lives assigned to the RBOs.

This slide also -- the change from the previous quarter. June 30 there were 8.6 million lives assigned to the RBOs, which is a decrease of about

83,000 lives, and we are seeing that decrease mainly in the Medi-Cal line of business.

And then moving on to the enrollment assigned to RBOs that service the Medi-Cal enrollees. There were 70 RBOs. Approximately 4.5 million lives were assigned to 70 RBOs. This represents about 53% of the total lives assigned to the 209 RBOs.

Of those, 58 RBOs reported no financial concerns, two were on our monitor closely list, and 10 RBOs had/were on corrective action plans. Of those 10 RBOs, there were 4 that were -- had a corrective action plan for claims timeliness only, and 6 RBOs had (inaudible) solvency criteria.

Then we looked at -- next slide, please -- the RBOs that had -- the top 20 RBOs that had Medi-Cal lives assigned to them. There were approximately 3.7 million lives assigned to those 20 RBOs. Eighteen of those RBOs had no financial concerns and 2 RBOs were on corrective action plans. One of those two (inaudible) claims timeliness and the other was non-compliance with TNE. And that concludes my presentation. Happy to take any questions.

CHAIR DURR: Thank you, Michelle. Nice overview as usual.

I will open it up to questions from the Board. Any questions from the Board? Yes, David.

MEMBER SEIDENWURM: Yes. Two questions. One is, it seemed like the categories of financial ratios, there was one with 100K in two columns that was either bad or teetering. Is that the same plan?

MS. YAMANAKA: I believe it is, but I will confirm.

MEMBER SEIDENWURM: Okay. And I am assuming that we are monitoring them closely and (inaudible).

MS. YAMANAKA: Yes, that is correct. So, normally the RBOs that are on corrective action plans, we monitor them on a monthly basis.

MEMBER SEIDENWURM: Great, thank you. And then the second question is, regarding the decreases in enrollment. We have talked about the Medi-Cal decreases, but also there was about a 150 and change or 160 and change drop in the Medicare Managed Care enrollment. Is that plans dropping out of counties? Is that patients choosing other plans?

MS. YAMANAKA: Are you comparing 2024 to 2025?

MEMBER SEIDENWURM: Yes.

MS. YAMANAKA: Yes. So, for the Medicare, yes, there was a, there was an RBO in that period, they decided not to continue and so the health plan took the enrollees back assigned to them. But if we are comparing at maybe -- so it was Medi-Cal enrollment. Basically there was, for a majority of the change it had to do with the Medi-Cal -- Medicare, excuse me, Medicare enrollment. But there was an RBO that deactivated at December 31, 2024. And so at September 30 I looked at the financials, and they did not have any enrollment reported during that, so that's why, you see (overlapping).

MEMBER SEIDENWURM: Do we know what happened to the -- did they go to fee-for-service Medicare?

MS. YAMANAKA: You know, once the health plan takes them back, it is up to them to decide if they want to assign them to another RBO. Or it could have gone to, you know, one of the entities that do not report to us, for example, an FQHC, they are not required to report to the Department, by definition, yeah.

MEMBER SEIDENWURM: Okay. So the short answer is, we don't

really.

MS. YAMANAKA: We don't really know.

MEMBER SEIDENWURM: We don't have a way to know, right?

MS. YAMANAKA: We don't know. We could, yeah, we would have seen an increase in another RBO --

MEMBER WATANABE: But it was an RBO that had the Medicare.

MS. YAMANAKA: The Medicare, yes.

MEMBER WATANABE: Medicare enrollment that is no longer participating in Medicare that led to a reduction in enrollment under our jurisdiction.

MS. YAMANAKA: That is correct.

MEMBER SEIDENWURM: Right, okay, that's fine.

MS. YAMANAKA: That is correct, yes.

MEMBER WATANABE: I am getting up to speed on Medicare. Michelle has been educating me, but I cannot follow the breadcrumbs of where the people are.

CHAIR DURR: Maybe I will just comment on that. We are seeing that in San Diego. For example, the health system Scripps got out of capitation for Medicare Advantage. And I think there is more pressure collectively about Medicare Advantage enrollment across the country but let alone in California. I think there is more pressure on the plans and on the health systems pushing the plans for higher rate increases that are driving some of that. And so I know in the Scripps situation, because it was public, that Chris Van Gorder, their CEO, identified that they have done better financially, and they didn't feel that they lost the members or beneficiaries because they converted to Medicare fee-for-

service. I think it is more costly, obviously, for the enrollee or beneficiary in that case, but I do think that that is a trend, unfortunately, that will continue.

Okay. Mark.

MEMBER KOGAN: Yes. Just a general question. Those RBOs that are running into trouble, are there commonalities amongst those that are -- that seem to be the problem? I know one of the things that you said, which is obviously true, is smaller ones can't really spread the risk as well, perhaps. But is there anything we do proactively to look at who might run into trouble ahead of time?

MS. YAMANAKA: You know, once we start seeing the decline in the RBOs, we will check with the RBO and talk to them about what we are seeing and what their plan -- and what the concern may be. To see if it is a -- if it is one thing that -- for example, they pay bonuses in one quarter so then the next quarter they are going to pop right back up. We are looking to see if there -- if there is a trend in a declining. And if there is what we do is we look into it, we talk with the RBO to find out what caused the, what caused the decline. And if necessary then what we will do is if -- then we might ask for projections as well to see how they will maintain compliance. And it is also something that we can use to monitor the RBO on an ongoing basis. So, yeah, we do look at it at the end of the day.

CHAIR DURR: Okay. Jarrod.

MEMBER MCNAUGHTON: Yes, thanks so much, Paul. I was just going to add briefly, and we don't usually talk about the Medicare impacts, but I know in our region we did see a fair amount of Medicare change with our duals on the DSNP side of the house because of CMS's decision, and this impacted

the whole country. But on the VBID product, or the VBID availability within the product, they stripped that out of all these optional benefits for all of the plans across the country. And so you started to see a movement, just a migration of Medicare members into other products, or going to straight Medicare, kind of to your point, Paul. So, I just wanted to add that that, we did see about a 4500 member change in our duals at the start of the year because of that decision that. CMS made.

CHAIR DURR: Great. Thank you, Jarrod, for that comment.

One other question I had, Michelle, was you mentioned that there is one group that you haven't aligned on the CAP yet. They are still trying to work with them on getting approval for that. How long do you allow that to continue before you take enforcement action?

MS. YAMANAKA: You know, we really -- every situation, we really try to work with the RBO. Sometimes it is an education, which takes a little bit longer, and sometimes it is just (inaudible). So, it is really different. But if we are not getting what we need we also go to the health plans. We check with the health plans. Can you assist us in this process, we are not getting what we need. Because they have the direct contract with the RBO. And if we can’t get it there, then it’s something that we would look to recommending. Time frames are kind of a little bit hard, it depends on what the issues are, so it is really a case-by-case basis.

CHAIR DURR: No, I appreciate that, because you are trying to work to preserve the relationship, which I think is very -- utmost important, because ultimately it is benefiting the member who is at risk here. So, I appreciate your latitude in kind of working in that context, recognizing ultimately

the ultimate responsibility that you have, so I appreciate that.

Okay, I don't see any other comments from Board Members.

Any comments from persons -- none in the room. Are there any comments from anyone online?

MR. STOUT: None at this time.

CHAIR DURR: None at this time.

Okay, we will move on to our Health Plan Quarterly Update and Evan.

MR. LO: Thank you, Paul. Hi. My name is Evan Lo. I am a Supervising Examiner from the Office of Financial Review. Today I will give an update on the Health Plan Quarterly Update.

The purpose of this presentation is to provide an update on the financial status of health plans at quarter ended September 30, 2025. All licensed health plans are required to submit quarterly and annual financial statements to the Department. Additionally, we receive monthly financial statements from health plans that are newly licensed, have TNE or tangible net equity below the 150% requirement, or if we have concern regarding the health plan’s financial solvency.

We have also included a handout that shows the enrollment at September 30, 2025, and TNE for five consecutive quarters from September 30, 2024, to September 30, 2025, for all licensed health plans. The information is categorized into three health plan types, Full Service, Restricted Full Service and Specialized.

So, for this slide, as of January, 20, 2026, we oversee 141 licensed health plans.

Nine applications are currently under review, 6 full service and 3 specialized. Of the 6 full service applications, 3 are for a Restricted Medicare Advantage license, 1 is for a restricted Medi-Cal license, 1 is for a Medicare Advantage license, and 1 is for a Mexican cross-border full service license.

For the three specialized applications, 2 are for EAP and 1 is for a dental plan.

Additionally, we met with several entities who are interested in obtaining a Knox-Keene license. We continue to get requests and have prefiling meetings.

I want to highlight two newly licensed health plans since our previous meeting. Modern Life California, Inc. was licensed on December 4, 2025, as an EAP plan; and Patient Choice Health Plan of California, Inc. was licensed on January 5, 2026, as a restricted Medicare Advantage health plan.

As of September 30, 2025, there were 30.4 million enrollments in full service plans that are licensed by the Department. Total commercial enrollment includes HMO, PPO, EPO and Medicare supplement plans. As shown in the table, total full service enrollment decreased from the previous quarter. There was a slight increase of approximately 8,000 enrollees in Commercial enrollment and a decrease of approximately 188,000 enrollees in Government enrollment, which is Medi-Cal and Medicare Advantage.

This table shows the composition of HMO enrollment by market type. HMO enrollment in both the large group and small group markets slightly decreased from the previous quarter, while individual HMO enrollment slightly increased.

Okay, this table shows the composition of PPO enrollment. PPO

enrollment in both the large group and individual markets slightly increased compared to the previous quarter, while small group PPO enrollment slightly decreased. Please note that for the periods prior to quarter ended December 31, 2024, figures included both PPO and EPO enrollment. We started collecting PPO and EPO enrollment data separately beginning with quarter ended December 31, 2024. Next slide.

Okay. This table shows the composition of EPO enrollment in thousands. EPO enrollment increased slightly this quarter in both individual and large group markets compared to the previous quarter. Next slide.

This table shows Government enrollment, which is Medi-Cal and Medicare. As of September 30, 2025, Medicare Advantage enrollment increased by 15,000 lives, while Medi-Cal enrollment decreased by 203,000 lives from the previous quarter.

We are actively monitoring 35 health plans, consisting of 29 full service plans and 6 specialized plans. There are various reasons why we actively monitor health plans closely. Plans may be placed under close oversight due to various reasons such as recent licensure, low enrollment, financial solvency concerns, issues with the parent entity, claims processing problems, enforcement actions, or high staff turnover. Please note that the majority of these health plans tend to have low enrollment. Next slide.

Three health plans did not meet the Department's minimum financial solvency reserve or tangible net equity requirement. They are Meritage Health Plan, The CDI Group, Inc., United Healthcare Benefits Plan of California.

For Meritage Health Plan, they reported TNE deficiency on their monthly financial statements from month ending August, 31 2024 through April

30, 2025; on their quarterly financial statements for quarter quarters ending September 30, 2024 through March 31 2025; and on their annual financial statements for the year ending December 31 of 2024. There is an open enforcement action on the plan and the Office of Enforcement is working on that.

The CDI Group, Inc. reported TNE deficiency for their financial statement for the reporting periods ending September 30, 2025. The plan received a capital contribution of $245,000 in August and another $266,000 in December of 2025 from its parent to cure the TNE deficiency.

United Healthcare Benefits of California reported TNE deficiency for the quarter ending September 30, 2025, and for the month ending October 31, 2025. The plan received a capital contribution of $100 million in November and another $150 million in December 2025 from its parent to cure the TNE deficiency.

This table shows the TNE of health plans by line of business. A majority of health plans with TNE levels exceeding 500% of the required amount are specialized health plans as their required TNE is significantly lower than that of full service health plans. The required TNE is higher for full service for health plans because they assume greater medical expenses and financial risk. For most health plans, the required TNE is driven by medical expenses. Generally, the higher a health plan's medical expenses, the greater reserve requirement.

This table shows the TNE of the full service health plans by enrollment category. So, 69 health plans, or over half the total licensed full service health plans, reported TNE of over 250% of the required TNE. Health plans with less than 150% of required TNE are required to file monthly financial statements to the Department.

This table shows the breakdown of 25 full service health plans in the 150% to 250% percent TNE range. We also closely monitor health plans when we observe a declining trend in their financial performance, their TNE net income, or enrollment.

This table shows the TNE of full service health plans by quarter. It summarized the handout that was provided with the meetings materials. For detailed information on health plans' TNE and enrollment please review the handout.

This table shows the working capital for full service health plans by enrollment as of September 30, 2025. So, working capital measures a health plan's ability to pay its bills that are due within the year. Generally, a ratio over 1.0 or 100% is desirable, indicating sufficient short-term assets to cover liabilities within the year. As shown, 14 health plans reported working capital of less than 1.0.

This table shows the cash-to-claims ratio for full service health plans by enrollment. The ratio measures a health plan's ability to pay unpaid claims using cash, marketable securities, and receivables. It is calculated by dividing these liquid assets by total unpaid claims liabilities. Similar to working capital, a ratio above 1.0 or 100% is ideal.

And for my last slide table, this table shows the full service health plans with a cash-to-claims ratio of less than 1, by enrollment. For comparison, RBOs are required to maintain a cash-to-claims ratio of 0.75 or 75%. The risk is higher for the health plan side due to institutional risk. Ideally, we want a health plan to maintain a ratio above 1. Therefore, some of these health plans may be on our closely monitor list.

So, that wraps my presentation and I can take questions.

CHAIR DURR: Thank you, Evan.

So, I will open it up for questions from the Board. Yes, Laura.

MEMBER JOSH: I just have a question on the very first slide. It said discount plan. (Inaudible) what a discount plan is.

MR. LO: We actually currently license a few discount health plans. And it is really -- I don't know how you want to describe it. Michelle?

MEMBER WATANABE: Michelle, how would you describe a discount plan? Or Sarah, how would you describe a discount plan?

MS. REAM: Yeah. They don't pay claims.

MEMBER JOSH: Okay.

MS. REAM: So, they -- what they do is they offer the enrollee the opportunity to receive discounted rates from a provider. So, they are -- and I don't think we have any full service, we only have dental and maybe vision, I don't remember.

MEMBER WATANABE: I've called them coupon plans as well. You get a discount on services. And again, this goes back in our history. I don't know that we necessarily are looking to add more of these discount plans, but it is you -- you get a discount on the services that you receive. It is not anywhere near what we would see, what we typically think of our specialty plans and full service plans.

MEMBER JOSH: Thank you, Sarah.

MEMBER DEWEY: So, would the health plan (inaudible)?

CHAIR DURR: So the question for those of you online was, what is the health plan at risk for?

MS. REAM: It is not at risk.

MEMBER SEIDENWURM: So, it is like a pass-through on a provider contract.

MEMBER WATANABE: It is, essentially.

MEMBER SEIDENWURM: Okay. There is some medical risk involved here.

MEMBER WATANABE: Yes. Very, very minimal.

CHAIR DURR: Andie.

MEMBER MARTINEZ PATTERSON: Yes, thank you. I think this is my second Board meeting or maybe it is my third, so I am still trying to get my -- I know -- I understand that our role as the Board is financial solvency of health plans and RBOs. Appreciating that. I guess I am as a -- well one, the Alameda Alliance, the board -- the plan that I sit on has some of the lowest TNE and it is often cited by the CFO as an area of grave discomfort for them. I mean, they have really moved it up. We have had reasons, I don't have to go into that. But as I look I can appreciate in context why they feel that way because they are at the lowest on the local plans, and when you look at the commercial plans, really, really low, I understand that the goal is to get higher.

I guess to the point that was made -- Katrina's point earlier about -- I am trying to balance it on some of these other numbers that are just tremendous. And I know that there are small plans, right, the boutique plans, the specialized plans. But then there's others like Kaiser with 2,277% TNE, you know others in Orange County like 22. As a provider in those counties how are you balancing? The plan has, from a provider perspective, an exorbitant amount of money. The providers are saying it is impossible for me to hire providers or to

deliver this, or what about the rates? Why are you? To me as a, you know, an advocate, in some ways, it feels like the hoarding of money to what end, and so I guess I am trying to understand. Yes, it is good to have financial solvency, that's great. But shouldn't it be moderated against what you are -- what is happening on the ground? I guess I would appreciate some counsel as to our role on the Board in thinking about those things.

MEMBER WATANABE: Sure, no, Andie, and I appreciate that. I will start and then I think others in the room, and Jarrod, certainly can add his perspective too. So, there are requirements in the law around kind of the floor that we have set through regulation, but there is not a ceiling. We are getting -- I think as there's financial pressures, as we have seen, you know, budget deficits, this comes up repeatedly.

I will just share kind of things that have been discussed previously with the Board and elsewhere. I think as Michelle noted, particularly with Kaiser, a lot of Kaiser's is tied up in buildings. You really have to kind of dig into the financials for each plan.

I will just note, as Jarrod said too, this has been raised in previous meetings, but the burn rate on a daily basis is, I think, Jarrod, you said something like 20 to 23 or 30 million a day. And so some of it, as you look at what that means in terms of the plan's capacity to pay claims. We had a prior Board Chair that used to always say that really is about, you know, two to three months worth of claims payment. So, you do just kind of have to look at that on an individual basis.

Appreciate the request from providers that comes in often. If you are sitting on that much TNE can't you just increase provider reimbursement? I

will just say, one of the things that has come up in this meeting is concern from plans about temporary provider increases when there are what I will just call good times. And then when we have a decline and reimbursements are down there is a concern that providers will want those continued increases and the plan can't continue to fund them.

So, again sharing just some of the things that have been discussed here. I do think, you know, it is always a good question to ask of how high is too high? So, again, something that I think we can continue to talk about in this, in these forums.

The other thing I -- and Jarrod can certainly weigh in here too. I think the Medi-Cal plans in particular are bracing for what may be coming, and so they are always -- I think we have seen where plans are hanging on to some of their, at least what is perceived as reserves, anticipating the declines in enrollments and potential cuts as well. But, Jarrod, maybe I will let you -- see if there is anything you want to add.

MEMBER MCNAUGHTON: Yes, thanks, Michelle. It is an excellent point. We are similar to Alameda in that, I think, we are right above you folks at Alameda when it comes to our TNE. And it is interesting because, as Mary shared, that the TNE versus days of cash on hand, sometimes there is some connection to that. And other times because of holdings and things there is not and so it can be a little tough to kind of navigate that.

But to Mary's point, there have been times in the past when the state on the DHCS side, because of state budget constraints, has actually missed capitation payments to the plans and so we have had to go into reserves to continue payments to providers. That can happen. There can also be rate

reductions on the Medi-Cal side from the state if times get tough on the state budget.

But there have also been other times, to your point, where for those plans that have a huge amount of TNE and a huge amount of reserves, where we have actually seen the state auditor get involved and actually create audit reports on what they should or could be doing with those reserves to better support their community. And some of the plans that have gone through that have enacted various programs, whether it was for housing, population health or other things. And so it is a very tough situation because just crossing over a county line literally can be a change or a difference between having a healthy TNE and having one that is not so healthy and that there are concerns like what Alameda and what we have experienced in our market, so it is a very valid point. And I would just say I know in our case we are looking to Mary's point to make sure that our health and stability into the long run, that we are taking every measure that we can to bring that forward and also to be sure that our providers are paid equitably and fairly as well.

So, I know that's probably not the best answer or best help there, but it is very concerning at times when you see that kind of inequity, if you will, across the state.

MEMBER MARTINEZ PATTERSON: And I appreciate that, Jarrod. Also, I do, I want to own the role that we have. And I can wear a different hat in other meetings and advocate from that position, but in this one where solvency, the state auditor I just heard you say, comes in from another angle and can make recommendations. That is not our role and that's fine. I wholly appreciate it.

I also just want to reflect. I do -- and I don't know if this has an

impact on this board. But from sitting on the Alliance Health Plan Board, the impact to them from H.R. 1 and many of the budget cuts in Medi-Cal that are coming and will be effectuated in July, actually positions the health plan to be in a better position because -- I mean, I actually -- I think the CFO of the plan would say, that's not true, the sicker patients will be with us, but they will be paid commensurate with the patient population that they have who enroll. And it is the safety net providers who will continue to see the patients who no longer have insurance who will be most pressed.

And I just want to identify that as a challenge in the general health care delivery system when the payers will have a lot of resources for who they have, but the providers are tasked, at least the safety net providers, with a whole amount of patients who are very complicated, very sick, and who have no insurance, and the rest of the system will have to absorb those shocks. I am not saying that that's this board's role, but just as something to monitor and watch as we watch a contraction of the health care delivery system. And then the role that the plans play and their solvency as we try to manage through this probably, what, next 5 to 10 years of contraction and settling and then stabilizing. That's all. Thank you.

CHAIR DURR: Yes, I think that is a great comment, Andie, because I reflect on it similar in Medicare Advantage. A similar concept there is that the reason why Medicare Advantage plans are pulling out is because their profit margins aren't where they want it to be. And so as provider groups continue to ask for more money to pay for the physicians and to take care of those patients, there is that disconnect as you are alluding to, which is basically, you know, the health plans, if they see that, for-profit health plans will just pull out

of a market and leave the enrollees at risk. And absolutely agree with that point. Jeff.

MEMBER RIDEOUT: Yes. This borders on editorial, but a couple things to Andie's comments. First of all, this is an advisory board, and I pressed that many, many times as Chair. I mean, there is a limit to how much we can do in an advisory capacity. But I think the public square of this and the expression of concern about things like too much tangible net equity is important.

I think the other thing is, and I pushed for this before, the plans are named, you know. So, that is public information. The RBOs are not. So, the opportunity would be to say, Alameda Alliance or IHP are on this end of the spectrum, what are you going to do on the plans on the other end of the spectrum?

And then I do not want to speak for DMHC and I am not an attorney, but I have heard many, many times over the years, the limits of what DMHC itself can do are dictated by the law. And since the floor was set in the enabling legislation but no ceiling was set, that invites what do we do with people on the other end of the spectrum. So, those are probably obvious to everybody, but I think historically this particular question has come up quite a bit.

CHAIR DURR: Great. Thank you, Jeff, for reminding us.

Other questions from Board Members?

Other questions from anyone in the room? No.

Public comment from anyone online?

MR. STOUT: Not at this time.

CHAIR DURR: Not at this time, okay. Well, thank you for that.

And so we will move on to our next item, which is asking the Board

for any agenda items for future meetings that you would like to see presented.

MEMBER WATANABE: If I could just make a comment. Andie, I will just say you give me some things to think about. I do. I would like us to take this back and maybe think about what the role of the Board is in the next year as we start to see TNE and other financial metrics start to change. It is a question I get quite a bit. But let us take back kind of what the role of the Board would be, and we can, we can come back with that for a future meeting with maybe some options. I would just ask in the meantime if there's data or metrics that you would like to see, particularly maybe about the top or the low end of performance for plans or RBOs, to just let us know too if there's things that you would like to see. But we will take back more of that policy question about the role of the Board and that.

I will just note too, I think we are going to try to have HCAI come to our next meeting, if we can, and then likely DHCS in the fall after the budget is final and we see more of kind of what's happening with the H.R. 1 impacts. We have that in the queue for the remainder of the year.

CHAIR DURR: Jeff.

MEMBER RIDEOUT: Yes. I think Mary has suggested this before, and we have talked about it before, but trying to connect what OHCA expectations related to affordability to the rate increases that the Department actually oversees would be great. Because every conversation I have been in recently, there is no connection between what is happening in the real world with cost of care and higher risk claimants and things like that, to the targets that were set by the OHCA board. And I just -- that is a train wreck that is going to happen eventually so I am just wondering if we can anticipate it a little bit in terms of what

role DMHC does or doesn't have; or can or can't take in terms of rate regulation.

CHAIR DURR: Thank you, Jeff.

Katrina. Katrina, sorry.

MEMBER WALTERS-WHITE: One thing I would like to see, and I guess we are looking at those plans that have higher TNE. I don't know if it is possible to also look at some of those plans and like what sort of complaints they are having now. If they have high TNE, like higher than the 1,000s, are they having trouble with access to care? Are they receiving complaints with that?

The other thing was I was looking at one of the slides and it said three of the five governmental Medi-Cal plans are increasing dividends paid. And I guess I am wondering, should we be concerned that dividends are -- dividend payments are increasing instead of being put aside for financial solvency. I am wondering if that can be a conversation for later on or if that's something that we can continue to follow, and what that means for the larger like financial picture of the health plans.

MEMBER WATANABE: Michelle, let me just ask, is that the Non-Governmental Medi-Cal plans that are paying dividends?

MS. YAMANAKA: It would be.

MEMBER WATANABE: It would be, yes, okay.

MS. YAMANAKA: Non-government, yes.

MEMBER WATANABE: Yes. So, just to clarify, these are likely the -- like the Non-Governmental, the non-Medi-Cal. So, it is like the commercial plans just submitting to Medi-Cal that are paying dividends. But we can, we can take back your comment too about access and complaint issues.

I will just note the volume of Medi-Cal enrollees that come to our

Help Center and file complaints is generally very low in terms of Medi-Cal, but I think we can talk more broadly of the plans that are under our jurisdiction as well. So, thank you, Katrina, we will take that back.

MEMBER WALTERS-WHITE: Thank you.

MEMBER SEIDENWURM: We would have to compare that to other plans as well because that may not be the property variable, because access is a general concern.

MEMBER WATANABE: We do have our Annual Report where we report data on calls and complaints to our Help Center. I will just say it is the large commercial health plans that have the bulk of the complaints that come to our Help Center. But just let us think about maybe how we take that back and pair that with the TNE and see if there is any correlation as well. We'll think about it. We have something in our Annual Report; they're like per 1,000 members or something.

MEMBER SEIDENWURM: Yeah.

MEMBER WATANABE: Yeah, okay, we'll take that back.

CHAIR DURR: Any other suggested agenda items?

Okay. Hearing none, then move to our closing remarks.

So, I think this is -- because one of the things I had identified as well is roles and responsibilities. Now that we have a full board, we can now kind of go in through that education process. So, I had written that down.

MEMBER WATANABE: Yes.

CHAIR DURR: You had already commented on that, Mary.

MEMBER WATANABE: Yes.

CHAIR DURR: I think that will be great for us to put on the agenda

for our future.

MEMBER WATANABE: Take that back.

CHAIR DURR: And so really it has been a great discussion. Appreciate everyone's engagement in this.

And really wanted to thank certainly the DMHC team that is here to kind of shepherd this throughout, Mary, Sarah, Lorilee, Michelle, Evan, Jordan and Erica, who are all making this work. So, thank you all for the work that you do on behalf of the many millions of people that are counting on the governance and the shepherding of health care throughout the state. We applaud you for all that work and thank you for that.

Remind the Board that our next scheduled meeting is on May 20, 2026. It will be probably a hybrid option as well. If you are able to attend we would love to see you in person, but if not we understand the travel time and all of that. But appreciate your engagement here and really thank you all for your time on the Board and look forward to seeing you at our next meeting. Thank you.

(The meeting was adjourned at 12:16 p.m.)

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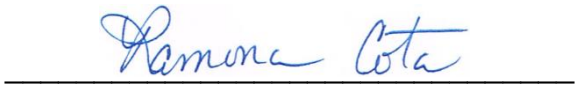
CERTIFICATE OF REPORTER

I, RAMONA COTA, an Electronic Reporter and Transcriber, do hereby certify:

That I am a disinterested person herein; that the foregoing Department of Managed Health Care, Financial Solvency Standards Board meeting was electronically reported by me and I thereafter transcribed it.

I further certify that I am not of counsel or attorney for any of the parties in this matter, or in any way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 13th day of March, 2026.



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