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, NOVEMBER 12, 2025

10:00 A.M.

Reported by: Ramona Cota

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APPEARANCES

BOARD MEMBERS

Jeff Rideout, MD, Chair (participated virtually)

Paul Durr (participated virtually)

Mark Kogan, MD (participated virtually)

Andie Martinez-Patterson

Jarrod McNaughton (participated virtually)

David Seidenwurm, MD

*Jessica Sellner (participated virtually)

Katrina Walters-White

Mary Watanabe

* = Joined after Roll Call

DMHC STAFF

Jennifer Clark, Supervising Examiner, Office of Financial Review

Evan Lo, Supervising Examiner, Office of Financial Review

Jordan Stout, Staff Services Manager I

Michelle Yamanaka, Deputy Director, Office of Financial Review

ALSO PRESENTING

Rafael Davtian, Deputy Director
Department of Health Care Services, Health Care Financing

John O'Dell, Vice President & Principal
Lewis & Ellis

APPEARANCES

MEMBERS OF THE PUBLIC COMMENTING

William "Bill" Barcellona
America's Physician Groups

Kimberly Carey, President
MedPOINT Management

Benjamin Pezeshki, MD, MBA

Derek Schneider, Chief Financial Officer
MedPOINT Management

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PROCEEDINGS

10:03 a.m.

CHAIR RIDEOUT: I want to welcome members of the Financial Solvency Standard Board, Board Members, and also guests and the public to our last meeting of the FSSB for 2025.

On a personal note, I want to apologize for my absence at the last meeting. And also this is my last meeting as Chair, although I will be staying on the Committee, and Mary will have more information on that.

Given that many of us are virtual and many of us are in the room, I would like to do a Board Member roll call to start, and then I will go over some housekeeping rules. I think we have a quorum but I just wanted to check. Barbara Dewey?

(No audible response.)

CHAIR RIDEOUT: Paul Durr?

MEMBER DURR: (Signaled.)

CHAIR RIDEOUT: There.

Mark Kogan?

MEMBER KOGAN: Here.

CHAIR RIDEOUT: Thank you, Mark.

Andie Martinez-Patterson?

MEMBER MARTINEZ PATTERSON: Here.

CHAIR RIDEOUT: Hi, Andie.

Jarrod McNaughton?

MEMBER MCNAUGHTON: Good morning.

CHAIR RIDEOUT: Hi, Jarrod.

David Seidenwurm?

(No audible response.)

CHAIR RIDEOUT: Okay.

Jessica Sellner?

(No audible response.)

CHAIR RIDEOUT: And Katrina Walters-White? think I saw Katrina on.

MEMBER WALTERS-WHITE: Here.

CHAIR RIDEOUT: Okay, thank you.

Oh, and hi, David. David is here as well.

All right, so we do have a quorum. I want to again welcome everybody, especially our newer members. Nice to see some new names and faces.

The housekeeping I will go over as quickly as I can. It is a rather long list, as everybody probably knows, but it is important that we understand the rules of engagement while we are on the meeting.

This 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:

(Member Jessica Sellner joined the meeting via video conference.)

CHAIR RIDEOUT: The restrooms on the 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 your 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 the raised hands appear, and I will be looking for those.

Public comment will be taken from individuals attending in person first. For those making public comment at the podium here in the 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 comments 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 attendees participating online with microphone capabilities, you may use the Raised Hand feature and you will be unmuted to ask your question or leave your 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 meeting 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 the 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. For example, Member 1 emails Member 2, who emails Member 3, et cetera. Accordingly, we ask that all members, Board Members, refrain from emailing or communicating with each other about Board matters outside the confines of a public Board meeting.

Okay, so, that covers our housekeeping and now we go back to the agenda, and I believe Item 2. Yes. We will need approval for both the transcript from the last meeting and the meeting summary or meeting minutes from May 28. So, I will start by asking, were there any corrections from Board Members in the transcript, which was rather lengthy?

Hearing none, we will accept those.

And then, were there any comments or questions or corrections for the meeting summary from May 28?

Okay, hearing none. Can I get a motion to approve?

MEMBER MCNAUGHTON: So moved.

CHAIR RIDEOUT: Can I get a second?

MEMBER KOGAN: Second.

CHAIR RIDEOUT: Great. Any objections?

Okay, the meeting summary is confirmed.

I will now turn it over to Mary for Director's Remarks. And Mary, I think I gave you a minute back, look at that.

MEMBER WATANABE: I will take it, thank you.

CHAIR RIDEOUT: All right.

MEMBER WATANABE: I did just -- Jeff, I don't know if you wanted to mention Larry.

CHAIR RIDEOUT: I am sorry I forgot that. So, many of us knew a physician leader named Larry deGhetaldi, who passed away from cancer in August of this year. Larry was just a tremendous figure of positive intellect and positive change. Did a lot of work to support CMA, IHA, and his community. And there is actually a huge community level of support where he lived, which was in Santa Cruz. So, I just wanted to call that out.

We did call out his passing at the IHA Board meeting recently and had a number of people that were close to Larry say a few words. If anybody on the committee knew Larry and wants to say anything we would be happy to hear your comments now.

MEMBER SEIDENWURM: I had the opportunity to work pretty closely with Larry at Sutter and I can just say he is one of my mentors and one of my idols. And just completely a (indiscernible). His passing is really a loss to all

of us.

CHAIR RIDEOUT: Thank you, David.

MEMBER WATANABE: Paul has his hand up as well.

CHAIR RIDEOUT: Paul. Paul. No? Okay, all right. Well, thank you. I think it is important that we remember those that have made a really positive difference, and Larry was certainly one of those so thank you for that brief remembrance.

All right. I will turn it over to Mary for Director's Remarks.

MEMBER WATANABE: Paul, we couldn't hear you. I don't know if you -- are you -- you want to try again?

MEMBER DURR: Can you hear me now?

MEMBER WATANABE: Yes, go ahead.

CHAIR RIDEOUT: Yes, yes.

MEMBER DURR: Okay. No, I just wanted to say about Larry, Larry was just an epitome of what was right about health care. Always doing what was in the best interest of the community. And his dedication and resilience to always advocate for not only the physician side, but for every patient. And his service on the Financial Solvency Board was outstanding. He always brought a lot of insight and wisdom. I learned so much from him during my time as a new person to the FSSB, and he will always be remembered as someone, from my perspective, that cared about so many people and did so much good for all of our community as a role model. So, thank you for the opportunity.

CHAIR RIDEOUT: Yes, well said, Paul.

MEMBER WATANABE: Yes, thank you, Paul. And I will just note, Larry was on the Board when I came to the Department over 10 years ago. He

actually served, if I got this right, from 2010 to 2023. He was always incredibly supportive of me, of our staff, and always had great ideas. He was texting and emailing me regularly to give me ideas of things we could do to improve the work we do. So, appreciate just taking the opportunity to recognize Larry today.

I don't normally have a PowerPoint but I do today because I have a lot of updates. And I am going to start with our Five Year Strategic Plan here so, Jordan, you can help me keep up with the slides here.

Our last Five Year Strategic Plan actually ended in 2019 and we all remember what happened promptly after that. We actually replaced most of our leadership team. I became the Director. And we have actually doubled in size since then and added a bunch of new initiatives, so it took us some time to get to our strategic planning process, but I am really excited to share this with you today.

So, our new Mission is to ensure health plan members have access to equitable, high quality, timely and affordable health care within a stable health care delivery system.

It is no small task to change your Mission Statement after you have had one in place for about close to 10 years, but we really felt like this new Mission Statement reflected the new work we do and kind of our new values.

We regulate and accomplish our Mission by regulating health plans, enforcing the law, and assisting health plan members.

We did not have a Vision Statement before, but I am actually really proud of us for taking the time to really think about why we do the work that we do. Our Vision is to improve health care access, quality, and value to empower all Californians to live healthier lives.

This Vision will be realized when all Californians under our jurisdiction can easily access high-quality, affordable health care.

We also have updated our Core Values and I am really proud of our team for continuing to prioritize Diversity, Equity, Inclusion and Belonging in all of the work we do, both internally and externally. We also prioritize Respect, Teamwork, Excellence, Integrity and Agility and Adaptability, which seems very appropriate for these times.

I will just note that while a lot of this seems very internal-focused, which is, it also has a lot to do with the expectations of how we engage both with the plans and providers that we interact with, as well as the public.

Over the next five years we are going to focus on five strategic areas including accountability, Policy, Productivity, People and Partnerships. Within each of these strategic areas there are sub-initiatives that really will drive the work and our priorities over the coming years. So, this is something I will continue to update you on as we start to actually implement our Strategic Plan starting next year. So that is our Strategic Plan.

Now I will move on to just a few other updates.

I think I shared at one of our prior meetings that Kristene Mapile has joined the Department as our Help Center Deputy Director. We split the Help Center as a result of our growth.

And then much to our sadness Pritika Dutt, Deputy Director for the Office of Financial Review, left the DMHC in July after 20 years. We are very happy for her to have moved on and used her experience at a health plan.

And I am excited to share that Michelle Yamanaka is our new Deputy Director for the Office of Financial Review and that we were able to move

quickly to put Michelle in that position. Michelle is no stranger to the Board and has over 25 years of experience at the DMHC, going back to the Department of Corporations, right?

MS. YAMANAKA: Yes.

MEMBER WATANABE: So really excited to have Michelle taking on this new role. She has brought in a number of her team members to help with our presentations today so I think this transition will be seamless.

All right. So, this is our infographic from our 2024 Annual Report that we released in August. I won't go into a lot here, but as you can see, we have over 30.2 million Californians under our jurisdiction that are enrolled in 140 health plans that we license.

I want to take a moment to share with the Board our priorities for the year ahead. I will cover these in more detail, a few of these, on the coming slides, but I really want to make sure the Board is tracking what our priorities will be.

At the top is affordability and responding to federal changes. This is probably similar for most of you.

We also have some new work with pharmacy benefit manager licensure.

Behavioral health will continue to be a focus.

Health equity and quality.

I will give you an update on where we are with Essential Health Benefits and setting new benefits as part of our Benchmark Plan.

And of course we will be busy implementing our Strategic Plan. Next slide.

So, as you can see on this slide, we are seeing some pretty significant premium increases across all markets for 2026 and the average premium across all markets is up close to $750 per month. While I don't think any of us like to see double digit or near double digit increases I do think compared to what we are seeing across the country there is a lot that we should be proud of, particularly in the individual market. We are at 10% going into 2026 where in other states we are seeing much higher numbers, and the national median increase is about 18%. We are going to have an agenda item later to talk more about rates so I am not going to talk a lot about kind of what is driving those increases, other than to say, obviously, depending on where we land with the enhanced premium subsidies and other federal changes are driving some of those increases. And then obviously rising prescription drug costs, particularly with the increased cost and use of GLP-1s. But we will have more on that.

Obviously, I think the federal changes are heavy on all of our minds and how that will impact the health care system.

I do want to just point out that while the DMHC doesn't receive any federal funding, we don't run programs, we are closely monitoring the impacts of both HR 1 and other state and federal changes on both the Medi-Cal program and Covered California and the health care delivery system more broadly. You know, you all are probably reading the concerns about what happens to the risk mix if we have healthy, younger individuals leave the individual market because it is unaffordable, which could lead to additional increases in premiums in future years. I think there is general concern about the financial stability of health plans and RBOs or hospitals or clinics, and all of that can feed into some of the work that the DMHC does when it comes to monitoring and timely access and network

adequacy. We anticipate some tense contract negotiations in the future, which affects our block transfer process.

And then ultimately all of these changes impact health plan members, and we anticipate increased calls to our Help Center as enrollees try to navigate all of these changes.

All right, moving on to the next slide here.

I do just want to flag AB 144 and some of the work that the DMHC did along with our sister agency, the Department of Public Health, recently. So, AB 144 really was in response to some of the changes that have happened or are proposed related to ACIP and USPSTF. AB 144 codified the federal recommendations that were in effect on January 1 of this year and allows the California Department of Public Health to modify or add to those recommendations while still required health plans and health insurers to cover the services with no cost-sharing or prior auth. I will just say I think this was an important way to really preserve the protections that were in place, particularly ensuring that there is no cost-sharing or prior authorization.

And then I will just note on the next slide here, specific to COVID there has been a lot of questions about coverage for COVID, who is eligible for a vaccine again. Regardless of the changes at the federal level, COVID 19 vaccines will continue to be covered without cost-sharing or prior authorization based on the recommendations that were in place at the beginning of this year or any guidance that comes out from the Department of Public Health. Next slide.

And then just this slide here shows some of the resources that we have put out. We have a fact sheet related to COVID coverage.

We issued an All Plan Letter following the signing of AB 144.

And then our California Health and Human Services Agency has been hosting, really it has become like a monthly webinar series, to talk about the federal changes. There was one that was really good on HR 1 with the Department of Health Care Services and Social Services. I think earlier this month there was one related to the rural health grants and application to the federal government. So would encourage you to check out those webinars; but you can find the link here to the one that I did specific to vaccines and preventative services. All right, next slide here.

So PBM licensure. This will be the new work for the DMHC as we head into the coming year. So, to address the need for greater transparency and drug pricing and the high cost of prescription drugs the ’25-26 budget included new requirements on PBMs,, including that they be required to obtain a license from the DMHC on or after January 1 of 2027.

Health plans are required to ensure that that licensure requirement is in their contracts with their PBMs.

They will be submitting quarterly financial statements and other operational information to the DMHC, which is going to keep Michelle and her team busy.

And then PBMs are required to report drug information, like drug level information, to the Department of Health Care Access and Information Health Care Payments Database.

And we will have the authority to enforce those reporting requirements. And so this will include direct pricing, prescription costs, fees paid to PBMs, rebates and other pharmacy information.

I am going to talk about SB 41 IN a later slide but I think this is the

companion piece. So we had the licensure first. SB 41 also adds a number of PBM practice prohibitions, so we are looking to see some quite significant PBM changes coming in the next two years.

All right, behavioral health. I always say this will continue to be a priority for me as long as I am working in state service. We have seen a tremendous amount of investments in the state in behavioral health. I won't go into any of these in detail but I will just note our behavioral health investigations, which were really intended to understand from a member perspective the challenges they face accessing behavioral health services.

We will release our Phase 3 report likely later this year or first part of next year, we are running out of time to get reports out. We have started Phase 4, and we anticipate wrapping up the behavioral investigations in 2027. So that work, we are on the second half.

And then on our Health Equity and Quality Initiative. We talked a lot about this new work to really understand where health disparities are. Health plans have filed their Measurement Year 2023 information with us. We are in the process of putting together the summary report. We anticipate that one will probably fall into early next year given the significant amount of data that we are working on and the various charts too. So, watch for that, but that continues to be a priority for the Department.

And then, Essential Health Benefits and our Benchmark Plan. I think we talked quite a bit about this at our previous meeting, so I won't go into it. But I think at our last Board meeting I had shared that on May 5 we submitted our application to CMS to update California's Benchmark Plan.

We actually did hear back from CMS in early October. They had a

number of questions for us. I will just note they weren't, I don't think anything earth-shattering, mostly clarifications or typos or things we needed to fill in. So, we filed that response with CMS towards the middle of October. We haven't heard anything since, but we have had a federal shutdown, so we will see if we get a response.

And just a reminder, those new benefits would take effect for the 2027 benefit year. And the new benefits you can see here include, sorry, hang on, get to my list here:

Services to diagnose and treat infertility, including IVF and artificial insemination.

Hearing aids. So that would include one hearing exam and one hearing aid for each ear every three years. I know there has been a lot of focus on hearing aids for children, but this would not be limited to children, it would be for all ages.

And then expanding our durable medical equipment benefit to include mobility devices such as walkers, manual and power wheelchairs and scooters. So more to come on that.

And then we normally have a presentation on legislation at this meeting. We have -- a number of our staff are at a training so I am going to hit just at a high level a few that are likely of interest.

So, AB 1041 requires health plans or their delegate to subscribe and use the Council for Affordable Quality Healthcare or CAQH credentialing form and to make a determination regarding the credentials of a provider within 90 days after receiving a completed application. If they don't meet the 90 day requirement, the applicant's credentials are provisionally approved for 120 days.

This does not apply to mental health and substance use disorders providers because we have had previous legislation on that. And the effective date for the 90 day credentialing is January 1st of 2027. And then the use of the CAQH form, the effective date is January 1st of 2028.

Let's see here. And I already mentioned AB 116, which had our PBM licensing requirement.

AB 144 has the vaccine and preventative service requirements, so I won't go into more detail on those.

And then just quickly here on SB 41. Again, this is really the companion to the licensure which enacts reforms of the allowable business practices for PBMs. Again, a lot of the provisions take effect at the beginning of next year; and our kind of licensure and enforcement of these provisions will take effect in 2027. But this bill will prohibit spread pricing and require manufacturer rebates to be passed through to health plans. It also prohibits discrimination against nonaffiliated pharmacies, and has essentially an adding a pharmacy provision as well. So, lots of work to keep us busy there.

The last bill I'll highlight is SB 306 related to prior authorization. This has been a big pain point for both members and providers and another area that we have had in our strategic planning. This will require health plans and insurers to submit data to the DMHC and CDI on approved and modified authorization requests.

We will issue instructions by July of next year, we have already started to talk to folks about that.

Health plans will submit data on how many prior authorizations they approved or modified in December of next year.

And then in July of 2027 we will publish a list of services that can no longer have prior authorization.

And then health plans will begin complying with that in January of 2028.

We will have reporting to DMHC in July of 2031 to really inform kind of the impact of removing prior authorization.

We will issue a report in January of 2032 and then this provision sunsets in 2034. So again, lots of work that we are doing now to really kind of develop a template and we will have a stakeholder process for folks to react to that, but this is a pretty aggressive timeline.

That is it. I know that was a lot of information from me, but I am happy to take questions from the Board first and then we can go to the public. Jeff, you are muted.

CHAIR RIDEOUT: We will go Katrina first, then Mark.

MEMBER WALTERS-WHITE: Well, I guess I was wondering, for SB 41 will there be any transparency of the spread? Like, will we be able to see how much, if there is any discount being provided to the actual consumer?

MEMBER WATANABE: Yes, so, I mean, we are still working through that. I would envision that part of the goal is the information similar to what we present now for health plans and RBOs, we will be sharing that publicly as well. So, they will be submitting information. In terms of spread pricing, we are essentially prohibiting spread pricing, but a lot of the other operational information the PBMs report some of that. There's different provisions in the bill about what's public, but part of this will be transparency. I will be sharing more of these meetings.

MEMBER WALTERS-WHITE: Thank you.

CHAIR RIDEOUT: Mark.

MEMBER KOGAN: Yes, just a quick question . For the health plan coverage requirements for preventative services. When there is a conflict between a recommendation from the California Department of Public Health and a federal recommendation, i.e. vaccines, is it an either one acceptable, or what do you do when there's a conflict?

MEMBER WATANABE: Yes, so, it essentially will be plans will follow what was in place on January 1st of 2025 regardless of changes at the federal level or whatever Department of Public Health puts out. So, you know, we had conversations with them. There could be, you know, new things that come out, new evidence, new guidelines, and so CDPH will ultimately be making those recommendations and putting out kind of the guidance for health plans in California.

CHAIR RIDEOUT: Paul.

MEMBER DURR: So, Mary, I just wanted to comment on a great strategic plan and outline that you laid forth. It is great to see your priorities and where the Department is focusing on so I applaud you for that.

The other thing that I always take away from all of the other summary information is, is the fact a lot of these mandates increase total cost of care and that has to be considered. And I know it is the balance with OHCA and how to make sure that they are hearing and understanding these additional burdens that are there and necessary; but also when we, when we have no cost-sharing and things like that, that it does increase the overall cost of care, or potentially could. Obviously, we have to become more efficient at what it is that

we do.

But I think that's the only comment, is the connectivity back to OHCA. Which we have them present here, which is wonderful for them and the OHCA Board to realize when we are legislating new, enhanced benefits and all of that, which are helpful for our consumers, it is tough to maintain at a 3-3.5% cost of growth target.

MEMBER WATANABE: Yes, thank you, Paul. And I will just note, I think on the prior authorization issue, this has been a data point I have long wanted to collect, because we just don't know, we don't have good data. SB 306 we will look at services that are approved 90% or more of the time. I think one of the big questions is, is that a lot of services or a small number, so I think the data will be very telling. We see legislation every year that seeks to waive prior authorization and have always recognized the concern with doing that. So, it will be very interesting over the next couple of years to see how that all plays out.

Just on OHCA I will say, I think we have been -- we have had a lot of questions too about just with all the increased premiums and increased cost of the health care system, how does that feed into the OHCA spending target. I know that's something that they are having a lot of conversations about and probably timely for us to have OHCA come back maybe the first half of next year to talk more. I know they are having a lot of discussions about the enforcement piece of that as well. So, we will put that on the list for future meetings next year.

CHAIR RIDEOUT: Thank you. I think, David, you had your hand up, but I don't see it up. And then Jarrod will go next. David, did you have a comment?

MEMBER SEIDENWURM: Did David have a comment? Yes. My

comments were better expressed by Mary and by Paul.

CHAIR RIDEOUT: Okay, thank you. Jarrod.

MEMBER MCNAUGHTON: Yes, thanks, Jeff and Mary. I just wanted to say thank you for the work on the Mission, Vision and Values piece. I think that is so incredibly important to have organizations that are grounded in their mission, vision and values. It is something that I know you folks live every day, and it's great to see when alignment happens like it did to create what you created and so thank you so much for that.

And I would just add to what Paul shared as well in that part of the other piece that will be interesting to watch through this process, because in our organization we are actually going through creating a prior auth grid to actually cut down on the administrative burden right now on this. But the thing we are watching very closely is the fraud, waste and abuse piece. And how do we make sure that we have a system in place that is tracking that at the same time as we are lifting all of the auths off of the system. And just to be sure that there's very strong payment integrity in the system, that the provider network is being narrowed as appropriate. If there are issues with providers that have fraud, waste and abuse, or suspected fraud, waste and abuse, and the recording of that. And so I think in addition to what Paul shared, which I totally agree with him, that other element which we are seeing a huge spike, a huge spike in fraud, waste and abuse across the system. The prior auth piece has always allowed us to have a little bit more insight into that. And so we are actually learning through our pilot project as well, what will that look like as we move forward with our prior auth grid here at IHP as well.

CHAIR RIDEOUT: Thank you, Jarrod. Let me see. Any other?

I have one comment, but I want to make sure we get other folks and then we will go to the public. Okay.

On the credentialing information. This is not an infomercial for Symphony, but just it's a point of information. On the credentialing information legislation we did a crosswalk between the CAQH requirements and Symphony requirements, and we already collect about 60% of that information through Symphony. So, there's a couple ways we could supply that to plans and providers to supplement what they collect on their own. Or if there's a willingness voluntarily to collect the other elements through Symphony, we could do it that way as well. And the elements are not controversial. They are like, where did someone go to medical school and their CV. Those are not typically what you need for directories, so that's why those are not there. And I know from our experience with Covered California, the accuracy of the data we are collecting and validating now is much better than they had had with previous vendors. So, I think one of the things may be more accurate information coming through that channel in the near future.

Okay. All right. Any other questions from Board Members and then I will go to the public?

Okay, hearing none or seeing none, are there any questions from the public in the room? I can't see the room, so I don't know.

MEMBER WATANABE: Just for reference, we have three people in the room and they are -- I am seeing nodding heads that they do not have questions, so I think we can move on to those on the phone.

CHAIR RIDEOUT: Okay, any questions from those on the phone or via video?

MR. STOUT: None on the phone.

CHAIR RIDEOUT: Okay, all right.

Thank you very much, Mary, great report, and we will move on to the next agenda item, which has to do with Board composition. So, Mary, you are up again.

MEMBER WATANABE: Yes. And I failed to mention this at the beginning of my remarks. So, as Jeff noted, this is his last meeting as the Chair. He is staying on the Board, but Paul Durr has graciously agreed to step up and be our Chair heading into next year. So, Paul, thank you and I apologize in advance, you will get to read the very long housekeeping notes at the beginning of our next meeting. But thank you, Paul and Jeff, thank you for your, I think, many years of services as our Chair, I really appreciate that.

So, Mark, Dr. Mark Kogan, his term is ending in February, so we will be releasing a solicitation for that vacancy. And Dr. Kogan, of course, is welcome to reapply.

We also continue to have a vacancy for a large group purchaser, so we will include that in the solicitation as well. So, if there is a large group purchaser that you are aware of that might be interested, we do have that vacancy.

And then just looking ahead to next year, Jarrod and David, I am showing your terms are ending in August, so also will be advertising those positions and, of course, you are welcome to reapply.

So that's -- we kind of have a staggered term ending over the next couple of years. But watch for that if anybody is interested.

And then Jeff, just before I let you turn it over to DHCS, I do just

want to acknowledge and then thank Rafael in advance, because I don't think we have had DHCS here for over a year. It has been very, very busy for our colleagues over there and I know we have had kind of a pending list of questions for DHCS, which we have shared, and I know Rafael is going to try to cover as much as he can.

But with that, Jeff, maybe I will let you see if there are questions on the Board Member solicitation.

CHAIR RIDEOUT: Any questions on the solicitation from the Board Members themselves?

Okay, I don't see any. Any questions from the public in the room?

MR. STOUT: There are none.

CHAIR RIDEOUT: None. And any questions from participants from the public on phone or video?

MR. STOUT: No questions on the phone.

CHAIR RIDEOUT: Okay, well, let's move on to Rafael and DHCS. As Mary noted, it has been a little while and DHCS has been a little busy, but we are really pleased with their participation today. So, Rafael, please take it away.

MR. DAVTIAN: Thank you, and thank you, Director, for that, for that earlier introduction.

Good morning, good morning, everyone. I am pleased to be sharing some information today regarding the Medi-Cal program, particularly around, around, around some of the areas of interest, some of the areas of interest that folks had, folks had highlighted, particularly with respect to federal and state changes affecting the Medi-Cal program. Some, some things to watch and then a few updates regarding topics that, topics that we have discussed in

this, in this forum in previous years, related to medical loss ratio and targeted rate increases that the Department has implemented. So without further ado, I will dive right into it.

As the Director mentioned there have -- there has been a lot of information shared about HR 1 by DHCS and by CalHHS in other forums so I am not going to focus too much on that today, although I am happy to, happy to spend some time on it if helpful and to take any questions folks may have. But as we look at the landscape of federal and state changes affecting the Medi-Cal program currently and looking ahead at 2026, there are a few key, key drivers that that loom large.

First and foremost, of course, HR 1, which was enacted in July of this year and significantly -- and includes significant changes in the, in the space of eligibility and access requirements as well as payment and financing provisions and other areas. HR 1 includes a variety of provisions, including work requirements for certain Medi-Cal members, more frequent eligibility redeterminations, limitations on provider taxes and state-directed payments, and gradual -- and in the future, gradual, a gradual ramp-down and reduction of both provider tax and state-directed payment limits, as well as -- as well as many, many other provisions that impact the Medi-Cal program.

A we grapple with the impacts of HR 1, we are at the same time working to implement requirements of and changes implemented through the 2024 Medicaid and CHIP Managed Care Final Rule that our federal partners at CMS published last year. That Final Rule on access, finance and quality included, again, significant changes affecting the Medi-Cal program over a multi-year period. Some of those changes are already in effect. They came into effect

essentially almost immediately in 2024, and others are being phased in over a multi-year period, so I will, I will be talking about some of those, some of those today.

Then there are other federal changes, both changes that have come to us through, through sub-regulatory guidance that CMS has issued, as well as other changes that we -- that have not been finalized yet, but that we do anticipate. CMS had published a proposed regular regulatory change earlier this year specific to provider taxes. They had solicited, solicited public comment on that rule and have yet to finalize that regulation.

CMS has also noticed future regulatory action with respect to state-directed payments, which we anticipate will in part be used to implement, implement in regulation some of the provisions in HR 1, but may have, may have a more expanded scope than that as well.

And then lastly there are, there are, there are significant changes, or were significant changes in the ‘25-26 state budget that affect the Medi-Cal program, particularly, particularly enrollment provisions in the Medi-Cal program, which I will touch on briefly on the next slide.

So as we consider all of these, all of these changes, you know, what are, what are some things to watch for, for the next year, for the next 12 months or so?

Well, first and foremost, Medi-Cal enrollment. Both total enrollment as well as enrollment mix, the risk mix, if you will. These are being impacted by HR 1’s work requirements and six-month eligibility predeterminations. They will be impacted by the enrollment freeze for full-scope state-only Medi-Cal expansion adults age 19 and older, that is implemented in the state budget. And

also by larger changes in in the market and in the economy, which can affect Medicaid, Medicaid enrollment.

Provider taxes, or rather new federal guidance is another area to watch, particularly on provider taxes but in other areas as well. We are -- with the 2024 Final Rule and with HR 1, we are in a time of significant -- I am not going to use -- I am going to steer away from the word unprecedented, although it feels like it, but it is at least significant change in the Medi-Cal program. And quite possibly, quite possibly unprecedented, at least, at least in recent memory, as we look across the spectrum of changes to baseline Medicaid coverage and eligibility rules as well as the financing mechanisms, the payment mechanisms that are, that are available to states to implement, implement and fund their Medicaid programs.

And then lastly, some things to watch. We do anticipate there to be, we do anticipate the next year to be characterized by changes in Medi-Cal financial arrangements. Some of these are federally driven, some of these are state driven. But there are new requirements for provider incentive payments that are taking effect. Some that took effect in 2024, others that are taking effect as of January of this coming year.

In the final rule that CMS published last year, we are required to implement significant changes to our, some of our state-directed payment programs, to shift them away from pooled approaches. And in doing so, in doing so, essentially, transition over $20 billion of Medi-Cal payments from a limited-risk arrangement to a fully, fully at-risk arrangement for health plans, for our Medi-Cal managed care plans. This is also a change driven by, by Final Rule provisions.

We will be adapting -- implementing, or at least preparing to implement, many of the changes that HR 1 requires with respect to state-directed payments, provider taxes and other, other financing arrangements.

And lastly, and on a more, I think, more optimistic or positive note, we are initiating, initiating conversations in certain, in certain areas to think more strategically, more intentionally about purchasing and value strategies in Medi-Cal starting with, starting in the hospital and skilled nursing facility space first and foremost, where we are looking forward to conversations within the state with -- within, within the administration, within -- with our stakeholders, with plans, with providers, with advocates to really look at, look at how Medi-Cal, how Medi-Cal purchases and reimburses for services today. How those existing mechanisms are impacted by the myriad federal changes that are taking place and how we can as a state more, more strategically, how we can as a state strategically adapt to these, to the changing landscape, and move forward in a fashion that is best for our program, for our state and for our Medi-Cal members by prioritizing, prioritizing value through these purchasing or payment strategies. Next slide, please.

So I do want to narrow, narrow our focus a little bit now to move away from the larger picture and focus on a few specific, specific items of potential interest with respect to medical loss ratio requirements, provider incentive payments and then targeted rate increases that DHCS implemented in 2024.

On medical loss ratio we are forging ahead with implementing federal -- federally required medical loss ratio requirements for subcontractors. These are organizations or entities that contract with Medi-Cal managed care

plans to, to take on risk for, take on risk for some or all Medi-Cal services. These can include other, other MCOs or can be RBOs.

In our, in our managed care Cal-AIM waiver Terms and Conditions. CMS imposed requirements that medical loss ratio requirements that apply to Medicaid plans must also be imposed on subcontractors starting in 2023 on a reporting-only basis, and then shifting to a remittance requirement starting in 2025.

And then additionally pursuant to state law, we starting with, starting with the calendar year 2024, prime managed care plans or direct managed care plans that contract with DHCS that do not meet a minimum MLR standard of 85% are required to provide a remittance to the state.

Now the years in question here are the MLR reporting years. There is typically, there is a one year lag in terms of reporting MLR, and there is an additional roughly 6 to 12 month lag before calculations are finalized. So when we are talking about 2024 remittances, for example, that is for the 2024 contract year, which will be reported by plans to DHCS at the end of 2025 with calculations to be completed in late 2026. So, the requirements are in force, are in effect, but we do not, we are not, we are not at a point yet where we have calculated data to share yet. But we will soon have data specific to the 2023 program year. Next slide.

One change that is -- one change that merits mention in particular in the space of MLR is a change that came through in the 2024 Final Rule that the federal government published regarding provider incentive payment contracts or provider incentive arrangements between Medicaid managed care plans or their subcontractors and network providers.

Effective July 9 of last year, the federal government requires that incentive payments must be tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards to be considered an MLR. Historically, incentive payments have been, have been an allowed medical expense and they continue to be an allowed medical expense under, under Medicaid MLR. But starting July 9, 2024, the federal allowance for incentive payments is limited to those that have a clear tie to clinical or quality improvement standards.

And then effective January of 2026, CMS is requiring that, that states impose additional, additional criteria for incentive payment contracts. This will be done through forthcoming, forthcoming guidance and contract language that, that DHCS will provide to Medicaid MCOs requiring that incentive payment contracts have a defined performance period, be signed and dated before that performance period, include those clinical or quality improvement standards that, that we previous -- that I previously referenced, and specify a dollar amount or a percentage of a verifiable dollar amount that is linked to the achievement of the metrics. In essence, the contract must indicate how much the -- must indicate the amount or the methodology by which an amount is calculated that the provider can earn for achieving the clinical or quality improvement metrics documented in that contract. This is a -- some, some, some existing incentive payment contracts already incorporate these, these requirements or these elements and so there will -- those will not necessarily be impacted. Others may not do so and so this will be a significant change in those, in those plan provider or subcontractor provider arrangements. Next slide, please.

The last topic I will briefly touch on are the targeted rate increases

that DHCS implemented for dates of service on or after January 2024 for primary care, maternal and non-specialty mental health services.

As a recap, DHCS implemented these increases, these rate increases, to elevate Medi-Cal reimbursement for these services to no less than 87.5% of the Medicare rate in both our fee-for-service delivery system, those changes were implemented in January of 2024, as well as in the managed care delivery system.

In the managed care delivery system, implementation occurred over a longer time span. Still for dates of service starting January 2024 but it took longer to, to reach implementation. In part due to, due to guidance coming out, guidance from the Department coming out later. Formal guidance came out in June of 2024, and additional work being required on the part of plans to update contracts, perform actuarial analyses in certain cases, and to update systems. And so we had, we had implemented or set a December 2024 target for full compliance with, with the targeted rate increases. Most plans were able to able to, to meet that, that compliance target. A few, a few plans needed, needed additional time, and typically came into compliance within the quarter that followed.

But the experience of implementing the targeted rate increases has, has highlighted various implementation challenges and lessons, lessons that we can, we can take and apply to, to future programs and future rate increases. Including among them the need to consider complex -- really consider how rate increases flow through, through complex, delegated arrangements. The need to consider the time that is, that is needed, and the significant time that may be needed to, to negotiate contract changes or contract updates. And the

significant time and effort required to, to provide to, implement system, the necessary system updates to come into compliance.

And from the DHCS side, of course, acknowledging and recognizing the importance of providing timely and early guidance. Understanding that our, our partners' plans and their subcontractors are dependent on that guidance to be able to move forward.

So we continue to work through some of these implementation challenges, continue to hear to continue to receive and answer questions from both plans, plans and their -- plans and their subcontractors, as well as network providers and are intending to continue these rate increases under the umbrella of, under the umbrella of Prop 35. Certainly impacted by some of the federal -- impacted by some of the federal changes and risks to provider taxes, but these rate increases in particular, we are continuing to, continuing to implement and prioritize despite some of those other larger federal risks or uncertainties.

So, I will pause there and I am happy to, happy to spend, spend a bit more time on any of these topics, or happy to take any questions folks may have.

CHAIR RIDEOUT: So first of all, thank you, Rafael, for a really comprehensive overview and very calmly delivered given the circumstances.

Before we go to questions from the Board, I wanted to recognize that Board Member Jessica Sellner has joined very soon after we took roll, so she should be added to the roll list. All right.

Are there questions from Board Members at this point?

MEMBER WATANABE: We have got Jarrod and then Andie.

CHAIR RIDEOUT: Okay. Jarrod, why don't you go; and then I see

Andie.

MEMBER MCNAUGHTON: Yes, thanks so much. And Rafael, thank you for the work you and your team are doing.

I would say from a health plan perspective this is certainly unprecedented territory that we are in with all the changes that are happening across the country and just really give the team at DHCS a lot of kudos for helping us to navigate through these incredible changes.

I think one of the biggest ones, in addition to all of the membership change potential, the forecast that all of us have for membership impact on this and things that we are trying to do with local nonprofits to be able to have folks still have some kind of coverage in the future as they come off of the Medi-Cal program because of HR 1. One of the significant lifts, and you mentioned that, is around the re-contracting on the amendment side for those quality programs. And I will just share with folks that at least for our organization where you have almost 10,000 providers, that is not a small leap to get to. It is a huge lift. In our situation it's one of those things where when 70% of the membership is cared for by smaller or solo group practices, which is the case in the Inland Empire, the amount of time that you have to spend with a provider to help them understand why this change is in place, why it is important for them to continue and to Pay for Performance programs; and I think they get that, it is just the technical component behind it.

And just really wanted to say thank you to the state for helping to manage some of those expectations and some of those, even understandings with the different groups across the state to help make that transition as smooth as possible. So, lots of change, there is no question, but I do think there's been a

lot of good partnerships that have come out of that as well.

CHAIR RIDEOUT: Thank you, Jarrod. Andie.

MEMBER MARTINEZ PATTERSON: Thank you, Rafael, for the presentation. My first question is about the targeted rate increase, but to Jarrod's point on the changes on the incentive, the Pay for Performance. Just to note that our organization, an RBO in Alameda, went through. And it seems the saga never ends because to Jarrod's point, it is a lot of work for individual providers to understand the changes.

But would note that I think it has helped us propel years forward in the local providers' understanding of their role in the larger delivery system. And so why the structure is really important and helped reveal practices that could be improved and a little bit more of a focus, especially on utilization settings that providers don't tend to experience. But our Pay for Performance is trying to target inpatient and ER utilization, appropriate specialty utilization, and it has really elevated our thinking. I think it will still take us about 10 years in lived experience to manifest it, but I do want to acknowledge the really important, though challenging, new requirement that we are living through right now.

The point that I wanted to bring up, though, is on the -- so the targeted rate increase, Rafael, if you can help me understand it. With Prop 35. Which, from my lived experience, feels like it was shot dead in ‘25 and then ‘26 there is a new life to it based upon HR 1. And I am reading this slide in front of us saying, we are going to keep going on targeted rate increases for these, these services that were listed here. There is no end date. So I would ask that you confirm that.

And then I am also curious when you expect to be able to

demonstrate the impact of the targeted rate increase? Because, yes, we know that Medi-Cal rates have been too low. But the expectation here, you would surmise that we will have better access to care with these targeted rate increases. And I am curious when you will see data to demonstrate if that is actually the case or not? So, two questions. Thank you.

MR. DAVTIAN: Thank you, Andie. And before, before I answer your, your two questions, just acknowledging your, your and Jarrod's points about the provider payment, provider incentive, incentive programs. And thank you, Jarrod, for the, for the acknowledgement of our, of our partnership with, with plans.

I think in a normal, normal year, that change would probably have dominated our conversations around Medi-Cal managed care. But given, given HR 1 it is, unfortunately, one of, one of many changes that we are, we are all contending with. And those of, you know. Those of you who are essentially, of course, closer to the, to the ground more so than we at the state.

Andie, with respect to your to your questions. So first, yes, the targeted, the targeted rate increases are part of the, are part of the Proposition 35 framework and funded, funded using MCO tax. But we are, we are moving forward with, we are moving forward with these increases without an end date, unlike most of the other, unlike -- actually, unlike all of the other investments that we have funded using, using MCO, MCO tax. This one, our federal authority for these targeted rate increases, how we have operationalized this, does not have an end date in place.

Now, I don't want to, you know, I don't want to speculate about what the, you know, what the long-term future might hold with respect to the, to

the MCO tax, but it is our intention to -- as we, as we designed these targeted rate increases we, we intended these to be permanent increases, permanent changes to the base rates. Hence why they were, in part, implemented as base rate increases rather than as supplemental payments. And so we do view this sort of in a -- it is part of Prop 35 but in a category of its own, if you will.

With respect to your second question about the impacts of these, of these targeted rate increases. That is something we have been, we have been thinking about as well. It is a challenging question to answer because as significant as these targeted rate increases were for the Medi-Cal program, they were far from the only significant changes happening in 2024, and even now and next year. And so one of the challenges we face in in thinking about the, in thinking about evaluating and assessing the impact of these targeted rate increases is to differentiate how much of what we are seeing is due to the targeted rate increases versus due to other positive, positive changes and transformations under CalAIM, or other negative influences of, you know, federal, federal changes, potentially larger economic changes or larger market changes that may be, may be driving the results that we see.

So we are -- I don't have a, I don't have a specific ETA to share at this, at this time; but it is, it is something we are, we are thinking about and I think right now really grappling with that challenge of is it even feasible to isolate the impact of these targeted rate increases from the larger changes in the health care market and in the Medi-Cal space. But we are, you know, we are, we are certainly seeing this funding flow to, flow down to providers. We are hearing, you know, we are hearing information anecdotally about the positive effect that it is, it is having, and believe that it is, it is an important part of our program to be able to

continue to maintain these, these higher, higher reimbursement rates, higher than typical or higher than historical reimbursement rates for these critical, for these three critical service lines.

CHAIR RIDEOUT: All right. Are there any other questions from Board Members?

I am not seeing any. We will move to questions or comments from the public, first those in the room.

MR. BARCELLONA: Okay. Bill Barcellona with America's Physician Groups.

Good morning, Rafael. I just wanted to follow up with you on your comments regarding medical loss ratio implementation. As you know, we submitted a letter to you on October 3, 2025, asking for some critical information on compliance for the 2024 reporting year template. And our 70-plus RBOs that remain in Medi-Cal managed care are well into the reporting time periods with their contracted MCPs. We have not heard back from the Department on a number of these questions, and I am concerned that the templates that they are submitting are going to be incomplete and that they are going to be subject to remittance based on incomplete submittals. So, we are hoping to hear from you in response to our letter as soon as possible. Could you confirm a date when we may hear back from you?

MR. DAVTIAN: Certainly, Bill, and acknowledging the outstanding questions that we have, we have from you. We are -- at this point, basically, I would say several, just several days away from being able to respond to the, to the questions. Understanding that folks have, in some cases, had to move forward based on their, you know, their best understanding at the, at the time.

So, understand that, you know, when we provide responses or information those may differ, may shed additional light on reporting that was not available at the time reports may have been due.

From an implementation, from an implementation standpoint, in terms of actually implementing any remittances for the 2024 time period. We will, we will, we will proceed deliberately and with, with due diligence, including allowing for some time for conversations to occur. And to the extent that there is just further discussion or a new understanding of something new that comes from the guidance that we provide, time for that to occur.

Just to share the high-level timeline. So we expect to receive, we expect to receive Medicaid MCO reported MLRS by December 31 of this year for the, for the calendar year 2024 reporting period. After that point it will take approximately, it will take at least about six months for the Department to review that information, have back and forth conversations with managed care plans, before we, before we get to a point where, where remittance amounts are being calculated or put on the table. So we will, we will look to leverage that at that time to identify where timely or guidance, or earlier guidance would have perhaps resulted in a different, different approach being taken, or different information being reported, and work with, work with folks as necessary, either directly or through the prime managed care plan to make adjustments that may be needed.

MR. BARCELLONA: Thank you. Just wanted to ask you a quick question about the 2025 policy that you had previously announced regarding the removal of the $30 million reporting threshold. Was that a CMS directive, or was that determined internally by DHCS on its own?

MR. DAVTIAN: We have -- and apologies, Bill, just one additional

clarification to my earlier comment before I answer your question about the threshold. I do also, I should also note that with respect to, with respect to remittance, we are, we are requiring a remittance from direct Medicaid contractors, so direct MCOs that directly contract with DHCS for the 2024 MLR reporting period. But that requirement is not being extended to subcontractors until, until the 2025 reporting period.

With respect to your threshold question, we have, we have not removed the threshold. The threshold continues to be in place with respect to those entities that are or aren't, those subcontractors that are or are not required to report an MLR. However, there is a -- to your point, there is a new interaction between this requirement and the information that we are requiring, information that we are requiring direct Medicaid managed care plans to collect and report to us, starting with the, starting with this latest MLR period. It is not that we are, it is not that we are abandoning the $30 million threshold, or some materiality threshold for when we will or will not require a subcontractor to report their own MLR. However, regardless of whether a subcontractor is reporting their own MLR we are, we are now requiring managed care plans to collect -- we are now requiring managed care plans to report not only what they paid to the subcontractor but also to report the payments that the provider rendering services received. So, that is a, that is a change in policy. It is, it is a change that is, that stems from our shift away from reliance on the, reliance on the four part test as part of Medicaid MLR, but we recognize a shift around which we do need to provide some additional clarification given APG's question and similar, similar questions we have heard from, from a few others, a few others as well.

MR. BARCELLONA: Thank you, Rafael. Is that policy change

documented in writing anywhere that's accessible?

MR. DAVTIAN: It is yes. As we respond to your letter in the next, in the next several days, we will, we will share those resources as well.

MR. BARCELLONA: Thank you very much.

CHAIR RIDEOUT: Thank you. Thank you, Bill.

Any other questions from the public in the room?

Then we will move to questions from the public on the phone or on video.

MR. STOUT: We have one question on video. When prompted, please state your name and organization.

MR. DAVTIAN: I'm sorry, could you ask that question again?

MR. STOUT: We just have one participant on Zoom. Benjamin, you can ask your question now.

DR. PEZESHKI: Hello, thank you. My name is Dr. Pezeshki, Benjamin Pezeshki, I am a primary care physician in Los Angeles. I also represent an RBO that takes care of about 40,000 Medi-Cal members throughout Los Angeles. I don't have a question. I have a comment about TRI in Los Angeles, but I am sure for all of California it is very difficult to find providers that are willing to treat our Medi-Cal patients and the number one, two and three reason is always the reimbursement. So my comment and feedback is that the TRI program has been a great help to find more primary care providers that are willing to care for our Medi-Cal patients, so we appreciate that on behalf of the provider community for that. And we are not FQHCs, we are mostly private practice providers, so it has been a great help in recruiting more providers to care for our patients. Thank you so much.

CHAIR RIDEOUT: Thank you. Any other questions or comments from video or phone?

MR. STOUT: One more. Kimberly, please unmute when prompted.

MS. CAREY: Hi. Hi, it's Kimberly Carey from MedPOINT Management. Thank you, DHCS and Rafael especially for all the work you guys have done and you have been a great resource to us.

I have a clarification question that I am not sure has been formally noticed to us. And I hear you on the P for P (phonetic) that there is going to be a formal guidance coming out shortly, but in the meantime we are at, what, November 12.

We do understand that our delegated entities have to have a formal P for P program prior to December 31 on record, approved by leadership, and in place to be able to start, you know, the process of data collection for those P for Ps. And we already for the most part do this, and most of our delegated entities have a formal P for P program already.

The one step that I am unclear about, and I know that Jarrod spoke to this a minute ago but I wanted to kind of get my head around it, is when we have delegated entities that have initiated formal P for Ps and our physicians have been notified, mostly at the primary care level, to understand what they are working towards. Is there a requirement of the subdelegates to get physician signatures prior to 12/31 in order to meet the MLR requirements? Or is the delegated entity's formal program in place with notification to the providers adequate to be able to meet the MLR regulation status? And I will stop there for Rafael to comment.

MR. DAVTIAN: Yes. So there is the federal regulation, the federal regulation prescribes that the incentive payment contract must be signed and dated before the performance period. It does not go to the, it does not go to the, to the specific question you are asking, though, which is, does it does it need to be a signed contract that incorporates the incentive, incentive payment arrangement or does the incentive payment arrangement itself need to be, need to be separately, separately signed. I am happy to follow-up offline with additional detail with you on that question and to make sure that this is something we -- this is something we address in more, in more detail in our guidance. I hesitate to provide, hesitate to provide a sort of quick, quick answer or verbal answer because it is, it is a rather nuanced issue in terms of what the federal regulation strictly requires versus what might be best, best practice.

MS. CAREY: Okay.

MR. DAVTIAN: What we are implementing, what we will -- the guidance that we will be issuing will include a bit of both. And we are intending to draw a clear line between what is an actual formal requirement under the 2024 Final Rule versus what is perhaps good implementation practice from the, from the Department's perspective but not strictly speaking, a requirement.

MS. CAREY: So, two follow-up questions to that. When do you expect your guidance to come out again? Do you have a date?

MR. DAVTIAN: We are, we are working on, working on parallel tracks to get contract language to our, to our Medicaid, direct Medicaid MCOs, as well as supplemental, supplemental guidance. I don't have a date off the top of my head. I don't have the date at my fingertips right now to share but can follow-up with that too.

MS. CAREY: Okay. And then one more follow-up question. Well, one more suggestion, okay. Is hopefully your guidance could suggest that the subdelegated provider organization has to agree in writing and can notify their provider network. I am very concerned about this requirement as it relates to thousands of providers for all of us. That over a holiday period we are expected to get countersigned amendments. I think that might be absolutely impossible. So, I just am pleading with the state to consider the guidance to include the delegated entities but not the individual providers that they contract with, and I will leave it there. Thank you so much.

MR. DAVTIAN: No, thank you, thank you. We will certainly, certainly consider that. And I will say, when we are, when we are -- from an MLR standpoint, as we are considering, as we are considering a provider incentive payment contract, when that payment is occurring from a direct Medi-Cal managed care plan to a subdelegated entity, from our lens the contract is between, between those two entities. Now we may be measuring performance, we may be measuring performance by hundreds of or thousands of individual providers, but our focus is, our focus is on the parties to the actual contract or payment arrangement itself.

MS. CAREY: Okay. And the only thing I would add to that is, that's the best news I have heard. And what I think the state needs to hopefully guide the plans as to what their delegated entities responsibility is, and hopefully it will not include individual provider agreements. It's just to confirm that each delegated entity has a P for P program in place by 12/31 if they want it included in the MLR. So that would be our hope. And again, I will not hog any more time. Thank you.

CHAIR RIDEOUT: That's absolutely fine, Kimberly.

All right, any other questions from video or phone?

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

CHAIR RIDEOUT: I think we have Derek.

MR. SCHNEIDER: Yes. Hi, this is Derek Schneider; I am also with MedPOINT Management. It is more of a comment, but just to tag on to what Kimberly mentioned. As you are evaluating the requirement versus best practice, particularly getting countersignatures from PCPs and or specialists if you are trying to incentivize for access and availability in a specialty network to see Medi-Cal patients. Making a requirement to do countersignatures not only is from a time perspective concerning, given that we are close to the end of the year, although that's certainly real. What is also real, particularly as a CFO, when you are looking at MLR, the whole intent was to lower and make sure that we are not spending undue dollars on administrative expense. And to require countersignatures, the effort that is involved in the follow-up and the multiple follow-ups with providers to get them to return a contract, even normal circumstances, is large. And to do something like this every year for an incentive program would add undue administrative expense to the IPAs, which the whole intent of MLR was to reduce. So, I would keep that in mind as you are looking at what's a requirement versus what's best practice.

CHAIR RIDEOUT: Thank you.

MR. SCHNEIDER: Thank you.

CHAIR RIDEOUT: Any other questions or comments from the public on the phone or video?

Okay, we are running a bit behind but those were really important things to discuss. Mary, I think you are next up for the budget.

MEMBER WATANABE: Yes. I will just really thank Rafael for attending and answering a lot of questions, I think, that have been pending for quite a while. I will just say we thought we used the term unprecedented quite a bit during COVID and it seems to continue. It seems to be, unfortunately, the term of the day. But, Rafael, thank you, this has been really helpful.

MR. DAVTIAN: Thank you very much.

MEMBER WATANABE: I will try to move this quickly. I just wanted to give a quick budget update. Dan Southard our Chief Deputy normally gives this, but I will move quickly to the next slide here.

So, for Fiscal Year '25-26 our budget is $180 million and 814 authorized positions. Next slide here.

That's a slight increase from last year's budget. But I will note if you look compared to '21-22 we had a 75% increase in budget authority and a 69% increase in number of positions, which is certainly keeping us very busy. Next slide.

We had a total of 16 what we call Budget Change Proposals. This is how we make augmentations to our budget. We received a total of 42 additional positions. I am not going to go into these in detail; you can read these in detail on the Department of Finance website. I will just call out a couple that I think are probably most relevant to the Board.

AB 3275 increased the claims payment timeline to 30 days after receipt of the claim and we got about 24 positions to implement that. I know a lot of those were in our Office of Financial Review.

Also, AB 116 related to pharmacy benefit manager licensure. We received six positions to get that initial work started.

And then I think the last one I will just flag here is SB 729, which requires large group health plans to provide coverage for the diagnosis and treatment of infertility, and small group plans to offer that coverage. And we received seven positions to get that work started as well.

So with that I think I will wrap it up there on the budget update, but happy to take questions, or I will leave some time for others since we are running a little bit behind.

CHAIR RIDEOUT: And Mary, I just want to make sure. The Board does not formally advise on the budget unless it has questions. Is that correct?

MEMBER WATANABE: No, advisory-only role for the Board. And yes, now the budget is done.

CHAIR RIDEOUT: Sorry, I am being a little governance kind of --

MEMBER WATANABE: I know, I know.

CHAIR RIDEOUT: Okay. Are there any questions from Board Members on the budget in the room?

MEMBER WATANABE: We have got Andie and Jarrod with their hands up.

CHAIR RIDEOUT: Okay, let's do Andie first and then we will come back to Jarrod.

MEMBER MARTINEZ PATTERSON: Yes. So just curious because I feel like we have to ask this every meeting now. Does AI have applicability to the work at DMHC?

MEMBER WATANABE: No, I --

MEMBER MARTINEZ PATTERSON: We keep hiring. No offense to the humans, but just curious.

MEMBER WATANABE: Yes, no. I mean, I will say this is the hot topic. Everywhere I go, every conference, every meeting, everybody wants to talk about AI. I think we are very cautiously dipping our toe into AI. There's actually a number of initiatives across state government. One of the things we are piloting is, can we put the Knox-Keene Act back into whatever AI is and have it do analysis for us. Obviously still a role for humans to check and validate and make sure things make sense. But I think we are certainly curious about how it could be used to streamline and make our work more efficient. As the Board knows, there's a lot of work we do that takes a long time, and so are there ways to streamline what the analysis reports. So just a lot on the regulatory where I think it could be used, but we want to be very cautious. So more to come. I think everybody's kind of trying to figure out that fine line between more efficient but also making sure it's accurate. We tested it where it's made up some like case law, so some tricky things, but, yes, exciting.

CHAIR RIDEOUT: Jarrod.

MEMBER MCNAUGHTON: Yes, thanks so much. Mary, I am just curious because I think and you would have to remind me on this because I am probably going to get this wrong that the Department's budget is based off of dues, if you will, for the revenue from the plans. Because so many of us are projecting and forecasting a decline in membership over the next two years, And I know our own budget we are retracting, we are pulling down FTEs using attrition-only by 10%, are you folks forecasting that all of that's going to impact you with the membership decline in the budget as well?

MEMBER WATANABE: Yes, no. I mean, I think it's something we are going to watch very closely as we head into next year. So, you are correct, the Department does not receive any General Fund, no federal funding; we are funded through assessments on the plan. So, we essentially put together our budget for the year and then that's divided by the plans based on enrollment. So, I think potentially what we will see is with declines in enrollment, assuming our budget stays the same or goes up a little bit, those assessments on the plans could go up a little bit as well.

I think we had a pretty modest increase this past year. We tried to, obviously, be good fiscal servants of the money and try to be very strategic, just as the state is also looking to make, to make cuts. But yes, I think very valid point. As I mentioned, we have 30.2 million Californians now. I think it is very likely we will drop below 30 million again if, you know, we will see how well that goes. But that all trickles down to assessments on the health plans as well.

CHAIR RIDEOUT: Any other questions from Board Members on the phone or virtual?

Okay, we will move to questions or comments from the public in the room.

MEMBER WATANABE: None in the room.

CHAIR RIDEOUT: No one. Okay. And questions or comments from the public on the phone or video.

MR. STOUT: None at this time.

CHAIR RIDEOUT: Okay, we will consider that section done.

Next we move on to the Federal MLR Ratio Summary. Jennifer Clark, Supervising Examiner of the Office of Financial Review, is up. Hope I got

that right.

MS. CLARK: Thank you. Good morning, everyone. My name is Jennifer Clark, excuse me, and I will be providing you an overview of the 2024 Annual Federal Medical Loss Ratio, or MLR reports that were filed by health plans subject to the federal MLR reporting requirements. For the details related to this presentation you may refer to the *Federal Medical Loss Ratio Summary for Reporting Year 2024* report that was included in the meeting handouts. Next slide, please.

Federal laws require health plans that sell health care products directly to members and employer groups to spend a certain percentage of their premium dollars on health care and medical expenses. The MLR requirement went into effect for reporting year 2011. Health plans in the small group and the individual markets have to spend 80% of their premium revenue on medical services, whereas the requirement for plans in the large group market is 85%.

If health plans fail to meet this requirement, they were required to pay a rebate to the members or employer groups.

MLR is based on a three year average. For example, for reporting year 2024 the MLR and rebate calculation is based on the three-year average of health plan premiums and medical expenses reported in 2022, 2023 and 2024.

This slide shows a high level calculation of MLR. Basically, MLR is calculated by dividing the amount of health insurance premiums spent on medical services and quality improvement activities by the total amount of health insurance premiums collected, less certain taxes and fees. The resulting figure is the preliminary MLR, which may be adjusted further by a credibility adjustment, if applicable. Next slide please.

As indicated in the previous slide, total incurred claims is the first component of the numerators and is generally the largest contributor. Total incurred claims are payments made for services provided to members. Mainly, this amount consists of payments to health care providers for covered medical services, but it also includes unpaid claim liabilities for the reporting year or claims incurred but not reported, reserves for unpaid claims, and provider medical incentives. Next slide please.

Health care quality Improvement expenses are the second component of the MLR numerator. These are expenses incurred for activities that improve health care quality. All activities must be designed to improve health care quality, and every activity must fall into one of the specified categories, such as improving health outcomes mainly through direct interaction with the member or preventing hospital readmissions through a comprehensive hospital discharge program.

Some examples of amounts that should be excluded from the quality improvement expenses reported are routine administrative costs, marketing expenses, costs associated with utilization management, cost containment efforts, broad prevention activities, provider credentialing, tongue twisters today, and a few others. Next slide, please.

Premium revenue is the denominator of the MLR calculation. It consists of all monies paid by policyholders or members for health care coverage.

When calculating MLR, premium revenue is adjusted for federal and state taxes and licensing and regulatory fees. Next slide.

This slide corresponds with page 2 of the report and shows the

MLR for the plans in the individual market.

As I mentioned earlier, the Federal MLR reporting requirement for the individual market is 80%.

In 2024 the MLR for the 13 plans in the individual market ranged from 85.2% to 113%. No rebates were paid for the individual market.

For the 2023 MLR reporting year there were 13 plans in the individual market, and the MLR range from 85.5% to 124.6%. No rebates were paid. Next slide.

Page 3 of the report shows the MLR for the health plans in the small group market.

For the small group market, the MLR requirement is also 80%.

For the 12 plans in the small group market, MLR ranged from 78.5% to 99.8%. One plan, United Healthcare Benefits Plan of California, reported an MLR below 80% and was required to pay rebates totaling $13.4 million.

For reporting year 2023 there were 12 plans in the small group market, and the MLR ranged from 77.1% to 98.4%. One plan, also United Healthcare Benefits Plan of California, reported an MLR below 80% and was required to pay rebates totaling $24.4 million. Next slide, please.

The table on the next page, or page 4, shows the MLR for full service plans in the large group market. All 22 plans offered products in the large group market and met the MLR requirement of 85%.

The MLR ranged from 85.2% to 119.5% and no rebates were required to be paid.

In 2023 the MLR in the large group market for full service plans

ranged from 86.8% to 116.1%. All plans met the MLR requirement in this reporting year as well so no rebates were paid. Next slide.

Table 4 on page 5 shows the MLR for the one and only specialized plan subject to the federal MLR reporting requirement in the small group market. OptumHealth Physical Health of California reported an MLR of 68.8% and paid a rebate of $2,147.

In reporting year 2023, OptumHealth Physical Health of California also reported an MLR below 80% and paid $1,130 in rebates. Next slide.

Table 5, also on page 5, shows the MLR for the three specialized plans subject to the federal MLR reporting requirement for their large group products.

Two plans reported an MLR below 85% and paid rebates totaling just shy of $2 million. OptumHealth Behavioral Solutions of California reported an MLR of 74.4% and paid rebates of $1.6 million; and OptumHealth Physical Health of California reported an MLR of 71.2% and paid rebates of $342,000.

For the 2023 reporting year, we had three specialized plans and the MLR ranged from 67.1% to 98.8%. OptumHealth Behavioral Solutions of California reported an MLR of 73.7% and paid rebates of $1.8 million; and OptumHealth Physical Health of California reported an MLR of 67.1% and paid rebates totaling $507,000. Next slide.

This chart shows the total rebates paid since 2011. Health plans are required to issue rebate checks by September 30. Rebates issued for reporting year 2024 totaled $15.3 million. Rebates may be processed in a number of ways such as a check sent by mail, a deposit paid into the account used to pay the premium, or a direct reduction to a future premium.

And that is actually it for me, if anyone has any questions.

CHAIR RIDEOUT: Thank you very much.

First, questions or comments from Board Members? I will start with Paul.

MEMBER DURR: Yes, Jennifer, thank you for the overview. Just a question. How do you audit to ensure, one, that they are not including anything that shouldn't be included in the formula of what is quality? And then secondly, how do you audit to make sure that the rebates actually do take place?

MS. CLARK: Sure. So, every year we look at all of the MLR reports that are received and so we do kind of a high-level review of those to make sure that the numbers are accurate as far as we can see, but we do an in-depth dive two times a year. We actually perform MLR examinations. And during those examinations we review all of the data to support all of the numbers. We work with the plans to learn what their quality improvement activities are and if they do actually conform with the federal guidance. And as for making sure that the rebates are paid. We do a sample of checks that were issued if you know rebates were applicable in that year.

MEMBER DURR: Excellent, thank you.

MS. CLARK: You're welcome.

CHAIR RIDEOUT: Andie.

MEMBER MARTINEZ PATTERSON: Yes, thank you for that. Two questions. I am assuming for Medi-Cal the rebate checks go back to the state?

MS. CLARK: I can't directly speak to that, but I believe so, but I can't actually speak to that, to Medi-Cal.

MS. YAMANAKA: This is for commercial only.

MS. CLARK: Only for commercial plans, yes.

MEMBER MARTINEZ PATTERSON: But it will be applicable to Medi-Cal plans, true? No? Never. Well, I mean MLR.

MEMBER WATANABE: DHCS has MLR requirements.

MEMBER MARTINEZ PATTERSON: That's right.

(Several people speaking at once and voices overlapping.)

MEMBER MARTINEZ PATTERSON: And then the other question I had is, what do you -- the trend in the reduction in the rebates being paid out has gone -- got up to 109 and then to 15. I am curious of your theories on why that change has happened. Is it just the regulations and everyone is making adjustments would be my theory, but I am curious for what you have seen.

MS. CLARK: You know, honestly, at this point, I don't, I don't necessarily have a theory per se. I mean, like I said, we don't do in depth dives except for the two exams that we do each year. So, you know, it's up to the health plans in their reporting. But, you know, I can go back and look at the trend analyses and see, you know, which numbers that we have noticed have changed, if that would be of interest, and get back to you on that.

MEMBER MARTINEZ PATTERSON: Just as a regulator I think it is interesting to see that how regulations directly impact behavior and what is working, what is not working. Something of your support was interesting.

MEMBER WATANABE: I will just say we watch this closely because what we don't want to see is that plans are not spending enough on health care and there's rebates being issued. This is the backstop of having rebates. But it's something we watch closely, particularly in our rate review. We ask questions about this. We are seeing it. I think in prior years we have seen

some of the large commercial plans paid rebates year after year and it's something that we really try to dig in on. Again, others can probably speculate, but I think just we are seeing increased utilization, increased cost of health care, which could also be --

MEMBER MARTINEZ PATTERSON: Right.

MEMBER WATANABE: But something we watch closely.

MEMBER MARTINEZ PATTERSON: Thank you.

CHAIR RIDEOUT: All right. Other questions from members of the Board or comments by video?

MEMBER WATANABE: Katrina had a question here in the room.

CHAIR RIDEOUT: Katrina.

MEMBER WALTERS-WHITE: Yes. To that point, I am just wondering, do you guys also look at what changes they are actually making to be able to increase -- I believe some of the plans, I believe they have like 96%. Are you guys looking at like some of the changes that they are actually doing?

MS. YAMANAKA: So, one of the things, if the MLR is high, you know, one of the things we also do is when the financial reporting of the health plans, if there's a high MLR we continue to monitor them to see if that trend continues, as well as our rate review. Because like Mary mentioned the rate review team, they look at those in depth to figure out, to look to see, is that trend going to continue in the upcoming year. So.

MEMBER WALTERS-WHITE: And is there something that if they are just creating like this, if there's significant money going towards the care, is there, has there been a, I guess, like sort of a constant to where that they have been -- anything that they have been doing to increase that?

MEMBER WATANABE: This is where -- I mean -- so part of this is what plays out in our rate review, which I think John is going to do a presentation in a few minutes just to talk about what we are seeing is driving, driving the premium rate increases. And then I think on the MLR side we dig into like what they are doing on the quality side and other pieces of that, so. I don't know if that answers your question.

(Several people speaking at once.)

MEMBER WATANABE: --the premium rates too and the rate process.

MEMBER WALTERS-WHITE: And I guess a little different plan to plan, but I am just, I guess, wondering, what are they doing like on the quality to the drive that increase?

MEMBER WATANABE: We would need specific examples.

MS. YAMANAKA: Exactly. And maybe (inaudible) John, is that if they have additional questions (inaudible). Yes.

CHAIR RIDEOUT: Okay. Any other questions from Board Members?

Let's move on to questions or comments from the public in the room.

Okay. Again, I can't see who's in the room so it's a little bit -- give me a sign there, okay.

MEMBER WATANABE: No questions in the room or online.

CHAIR RIDEOUT: Okay. And no questions online?

MR. STOUT: Correct.

MEMBER WATANABE: Correct.

CHAIR RIDEOUT: Okay. We will move on then to our next section and that's 2024 risk adjustment transfers with John O'Dell from Lewis & Ellis.

MR. O'DELL: Hello, thank you. Just really quick before we jump in I will just introduce myself. I am John O'Dell, I am a consulting actuary with Lewis & Ellis. We assist DMHC working alongside their internal actuaries with various actuarial functions, notably the premium rate review of the DMHC plans. I appreciate you having me. So, we will jump in here.

The risk adjustment report for 2024. Each year CMS releases this report, typically in late June, and it outlines how the funds are redistributed among the various health plans in order to balance differences in the enrollee risk. This year was a little interesting in that CMS needed to release a revised report, which came about two or three weeks later. This was due to a data issue from a large national carrier. I don't think it caused too much trouble other than just time constraints in certain areas.

Originally there was the, you know, the three premium stabilization programs created by the Affordable Care Act, this risk adjustment, the risk corridors and reinsurance. The latter two, those programs were temporary and have concluded several years ago; now just the risk adjustment program remains. So essentially, it transfers funds from the lower risk non-grandfathered plans in both the individual and small group markets to the higher risk plans for both on and off exchange markets. This goal is to discourage the health plans from pursuing lower risk cases or essentially cherry picking. The strategy, they didn't want health plans and insurance carriers to be focused on just trying to find the best risk. This helps ensure that plans serving members with higher health care needs are adequately compensated by the plans covering healthier

members.

So, for 2024, approximately $1.54 billion was transferred between the California health plans and insurers. This amount is the aggregate between the DMHC plans and also the carriers under California Department of Insurance regulation.

Among those DMHC plans, Blue Shield of California, they remained the largest recipient with about $1.5 billion in net risk adjustment receivables.

Thirteen of the DMHC plans paid into the risk adjustment pool. Of these, Kaiser continued to be the largest with total transfers of approximately $663 million. Anthem Blue Cross also paid into the program. And then several other plans such as Health Net and Sutter, those ones reported smaller payment or receipt positions just depending on their market segment.

Overall, so $20 million was transferred from the DMHC plans to the CDI insurers. This reflects a continuing trend of the PPO-dominant products and plans which typically serve higher risk enrollee populations to receive the transfers from the lower risk, more integrated HMO type plans. This was consistent with prior years. Driving this is just mostly differences in market composition, enrollment distribution across the two regulatory frameworks. And you can tell that $20 million is relatively small when you consider the total of the $1.54 billion that was transferred.

One more thing to note here, overall, the transfer payments were definitely concentrated among the largest plans. The largest five plans had the majority of the statewide total. Next slide, please.

Okay. So, in addition to the risk adjustment transfers, the high-cost risk pool was introduced in 2018. This one works a little bit different in that what

it does is it helps ensure that the risk adjustment program, it more accurately reflects the average actuarial risk when providing protection for issuers with exceptionally high-cost enrollees, so people that have just a lot of claims. The pool reimburses 60% of the aggregate cost when an enrollee exceeds $1 million in claims, and it is funded through the risk adjustment program on the percent of premium charge basis. For 2024 the DMHC plans received $290 million from this pool, and then the CDI regulated plans just over $2 million. Of that $290 million and DMHC, Blue Shield, again, was the largest receiver, $134 million. And then both Anthem and Kaiser were about $63 million each. Next slide.

Regarding the impact on the MLR. The risk of adjustment transfers represented about 10.9% of premium statewide. This directly flows into that MLR calculation that was just being discussed. So, the health plans that pay into the program, those amounts they paid are added to their medical expenses, and conversely the plans that receive the funds, those amounts are deducted.

As in prior years, these risk adjustment transfers also are involved in the rebate calculations. And one last function is that they are used to inform the rate setting assumptions for the coming 2026 rate filings.

And so I believe that concludes the risk adjustment transfers. If there's any questions, happy to take them.

CHAIR RIDEOUT: We will take questions from Board Members in the room.

Board Members virtually.

Hearing none I will move to questions or comments from the public in the room.

MR. STOUT: None at this time.

CHAIR RIDEOUT: Okay. And hearing none, questions or comments from the public on the phone or video.

MR. STOUT: None at this time.

CHAIR RIDEOUT: Okay. John, thank you very much for that and you are up again, I think, for the 2026 premium rates.

MR. O'DELL: Yes, we will jump into the premium rates here. Again, there was a supplemental premium rate report that was included in the meeting materials so that will contain more detail and information.

We will go ahead and start with the individual market. So, for the individual market on September 30th the Department completed its review of the 12 individual market rate filings with their changes being effective January 1, 2026. After evaluating those filings and the supporting documentation, the Department determined that the proposed rate increases were not unreasonable. Out of the 12 plans filing, 11 of those participate on the Exchange, and as usual they negotiated their rates with Covered California before submitting them to the DMHC for review.

Across all the filings the rate changes ranged from 7.0 to just over 20% with the average being approximately 10%.

Average premium is just over $750, although of course we know the rates themselves can vary considerably by case characteristics.

Among the major carriers what stood out, Kaiser, which continues to have the largest market share, they reported an average increase of 7%, and Blue Shield, with the second largest market share, reported an increase of 9.3%. So, this was kind of interesting as the two largest carriers actually had lower rate increase levels relative to that 10% overall average.

What else did we have here? Okay, yes, drivers. The main factors driving these were the familiar ones, the ongoing growth in health care utilization of services, rising pharmacy costs, notably the GLP-1 and the new expensive drugs that have been coming to market. And then also the general inflationary pressures, whether it's, you know, health care -- health care worker salaries or different supplies, that kind of thing, that's always a component.

Additionally, this year there was, you know, the material changes at the federal level. Which for the individual market notably, this was the discontinuation of the enhanced premium subsidies that were created through the American Rescue Plan Act. As of now those are not being continued for 2026. This made up, oh, contributed, I believe, overall just under 2% to the overall rate increase average. So that 10% figure would be closer to 8 had this not occurred. So, we would consider that a material impact to the rates.

But of note, California seemed to have a much lower impact than other states across the country experienced. We assisted, I believe, 13 or so states this year in a similar capacity, reviewing the rates, and we saw some crazy high numbers, so it was good to see that California didn't have that same impact.

One other kind of smaller, unique item. Aetna this year exited the market for individual. This didn't really cause anything disruptive because their membership was just under 1% of the market so there wasn't nothing material that really happened through there but it was just kind of interesting that they decided to exit it. Okay, next slide, we'll turn to small group.

Okay, so the small group market. October 3 the Department completed the review of the 12 filings that are effective January 1, 2026. The rate changes here ranged from 3% to just under 27% with the weighted average

being approximately 9.2%. So, this was a little bit interesting in that typically the individual would see a little bit lower average increase than small group. And this was directly attributable to those enhanced premium subsidies going away. If you take away that 2%-ish you would see that the individual would have come in a little lower than small group as we have seen in prior years.

Average premium in the small group market is roughly $740 per member per month, and just under 2 million Californians receive coverage through the small group market.

Overall, when compared to last year where the average increases were more in the 7 to 8% range. These 2026 figures are showing, yes, health care costs are continuing to rise, but that pace has been generally consistent with national trends.

That's all on the slides. I wanted to make a couple of additional comments regarding the large group market. So just recently the Department completed the review of the large group rate methodology filings. Those were just finalized last week. The average change here was approximately 8.5% across the 22 plans in the large group market. The rate increases ranged from about 0 to 30% with the average premium being about $720 a month. And so we just wanted to touch base on that one since that just concluded. But that's all I had here so we can open it up for questions.

CHAIR RIDEOUT: Thank you, John.

Questions or comments from Board Members in the room?

Seeing none, questions or comments from Board Members on the phone or video?

MEMBER DURR: Yes.

CHAIR RIDEOUT: Paul. Paul.

MEMBER DURR: Yes, thank you. John, nice overview. Just a quick question. So, when you look at that perspective again, trying to balance that with what our cost target is with regards to OHCA, I think that your review is demonstrating the validity and the need for these rate increases to continue to support the growth in health care costs, whether it's GLP-1s, customized drugs, or just increased overall utilization. I think you referenced the fact that balancing that with the fact that some of the plans in the individual market were obviously decreasing enrollment, with the fact that people would lose coverage and therefore people that are left, which is what, Mary, you alluded to earlier, is that you are having a higher risk population that you are insuring, which therefore necessitates an increased cost. And just your independent review of that is helpful for us to see what is really going on in the market, let alone what the impact is to physicians and their ability to continue to provide care. So just wanted to comment on a nice overview.

MR. O'DELL: Thank you. And I think that the, I think the decrease was about I think 12% projected. So, I mean, that's pretty material when 12% of the market might be going away, so. And of those are going to be the healthier members.

CHAIR RIDEOUT: Mary, maybe a follow-up question. Does this work get to OHCA in a formal way? I know a lot of the information would be anecdotally shared, but this is an independent review.

MEMBER WATANABE: Yes, no, I will say, I mean, we have been working very closely with OHCA on a lot of things, not just our rate review, our enforcement process and all of the oversight. So, I know this is something that

they are tracking as well. I mean, I think the real -- we are seeing, obviously, with the potential for the Covered California subsidies to go away, the real impact for individuals, which I think just highlights the importance of the work that OHCA is doing. I think I have said previously in these forums, the intent really is that the entire health care system, not just health plans but providers, are working together to try to control costs. So again, that remains the goal here in California.

But I think, you know, we talked a lot about the challenges, the potential challenges ahead if we see changes to the risk mix. I think for our team, we are really focused on asking good questions, poking and probing in the rate filings to make sure they are truly actuarially sound. But yes, and again, I think it probably would be good to have OHCA come and do another update on some of the factors that they may consider in the spending target as well. But there's certainly some challenges with meeting that spending target.

CHAIR RIDEOUT: Other questions or comments from Board Members virtually or on video?

Okay, we will move to the public. Questions or comments from the public in the room?

MR. STOUT: None at this time.

CHAIR RIDEOUT: Questions or comments from the public on video or the phone?

MR. STOUT: Also none at this time.

CHAIR RIDEOUT: Okay, thank you. And thank you, John, again for the report and information.

MR. O'DELL: Yes, thanks for having me, I appreciate it.

CHAIR RIDEOUT: Next up, fan favorite Michelle is going to talk to

us about provider solvency, our quarterly update. Michelle.

MS. YAMANAKA: Thank you. Thank you, Jeff. Michelle Yamanaka, Deputy Director of Office Financial Review. Today, I am going to give you an update on RBO, risk bearing organization, RBO quarterly reporting for quarter ending June 30, 2025. Next slide, please.

We have 210 RBOs that are required to report to the Department. As of when these slides were prepared, 206 had reported and there were 4 non-filers. I want to start with those 4 non-filers. Two of them reported subsequently. Of those, 1 reported compliance, 1 reported non-compliance, and that is not included in the CAP count above or in the slide. And then there are two RBOs That did not report. We deactivated 1 this month and the second we will be deactivating. That happens to be Meritage, where administrative action was taken, so that will be deactivated.

So going back to the 206 RBOs that reported to the Department, 181 or 86% of them reported compliance with all grading criteria. Six RBOs are on our monitor closely list, but are reporting compliance. And we have 25 RBOs that are on corrective action plans that filed their reports.

We also received one annual filing for Fiscal Year-End 2025 and we have 13 RBOs that are reporting monthly financial statements to the Department.

Moving on to corrective action plans. Again, the 25 RBOs that reported to the Department are listed on this report and there are 2 non-filers, which I mentioned. Of those 25 RBOs. 22 are continuing from the previous quarter, and 5 are new as a quarter ended June 30. Of the 22 RBOs, 19 are improving from the previous quarter, 1 RBO did not meet their projections, and

we are working with that RBO to determine next steps. Again, 2 RBOs are non-filers and those CAPs will be closed because those RBOs will be deactivated. Of the five new CAPs that we received, 3 are due to not meeting claims timeliness, 2 are due to not meeting financial metrics, TNE, working capital and/or cash-to-claims. Of the 27 CAPs in total, 23 are approved, 4 were not. And after our quarter end June 30 review, 5 of the CAPs were completed and 2 of the CAPs were closed.

For additional information on the corrective action plans there's a handout listing all of the RBOs that are on corrective action plans. It is sorted by MSO and it has additional information. The non-compliant rating criteria, the quarter the CAP was initiated, and the grading criteria deficiencies.

Moving on to the grading criteria, let's first start with TNE. For the quarter ended June 30, 2025, the TNE to required TNE to calculate this ratio.

RBOs reporting less than 100% were non-compliant with the grading criteria. There were 5 RBOs that reported non-compliance. And we have 143 or 69% of the RBOs reporting a TNE ratio of 500% or more. Next slide please.

For working capital we calculated the relative working capital, also known as the current ratio, deducting current liabilities from current assets. This metric measures the RBO’s resources available to finance its day to day operations. At quarter end June 30, over 98% of the RBOs were able to cover their current liabilities with a ratio of 1 or higher. Four RBOs reported non-compliance with the grading criteria. Three RBOs had less than 10,000 enrollees, and 1 RBO had between 25,000-50,000 enrollees reporting non-compliance.

Moving on the cash-to-claims ratio. This ratio is calculated by the RBO's cash, health plan capitation receivables collectible within 60 days, divided by the total claims liability. The minimum cash-to-claims ratio is .75. And as of June 30 there's one RBO that reported non-compliance with this ratio grading criteria and they have less than 10,000 lives.

Moving on to the next slide, which is claims timeliness. The minimum requirement is 95% of claims need to be processed within 45 working days. There were 7 RBOs that reported non-compliance. Three of the RBOs had less than 10,000 enrollees, 1 RBO had between 25,000-50,000 enrollees, 2 RBOs had between 50,000-100,000 enrollees, and 1 RBO had over 100,000 enrollees.

Moving on to enrollment. This the slide represents the total enrollment assigned to RBOs as of June 30, 2025. We capture this information in the quarterly survey reports filed by the RBOs. There was a total of 8.6 million lives assigned to the 206 RBOs reporting. This is a decrease from the previous year of about 1.5 million. Not shown on the slide is the change between June 30, 2025 and March 31, 2025. There was a change of approximately 26,000, a reduction in enrollment of approximately 26,000 from the previous reporting quarter of March 31, 2025.

Moving on. Medi-Cal enrollment assigned to the RBOs is approximately 4.6 million lives assigned to 71 RBOs. This is approximately 54% of the total lives assigned to the 206 RBOs. Of those 71 RBOs, 58 RBOs are compliant with the grading criteria and there are no financial concerns. Two are on our monitor closely list and 11 of those RBOs are on corrective action plans.

We also took the top 20 RBOs that had a majority of the Medi-Cal

lives assigned to them. Next slide please. Approximately 3.7 million enrollees are assigned to these 20 RBOs, roughly 43% of the total involvement. Seventeen of these RBOs had no financial concerns, 3 were on corrective action plans. And that concludes my presentation. Happy to answer any questions.

CHAIR RIDEOUT: Thank you, Michelle.

We've got some questions, we'll will start with David.

MEMBER SEIDENWURM: Yes. Thank you for that excellent report, by the way. That's always a highlight of the meeting, because I guess that's what we are here for.

It looks like there's a trend from 2023 to 2025 between 5 to 13% of the organizations are on CAPs. It looks like a pretty good chunk of the Medi-Cal population is in plans that are on CAPs. Is there a real trend here and is there anything that we can do to help those members versus (indiscernible) plans?

MS. YAMANAKA: You know, a lot of -- there are some that -- so we didn't have a meeting in the previous -- at the quarter end March 31. And between the two, March 31 and June 30, a lot of the annual reports came in. So those are for the year end December 31. There were several RBOs that filed non-compliance with their year-end because there were audit adjustments. So, some of those, some of those CAPs were the result of those -- for year end December 31. Those RBOs have subsequently -- are obtaining compliance as of the June 30, the June 30 financial filings. There really isn't a trend showing that, there's just a few indicators showing that we anticipate more, but we will just have to see. Every RBO has their own circumstances, but we don't see a trend. I think there are several that are on corrective action plans for claims timeliness. Three of the 5 new ones this quarter -- and again, those are, those are different

areas, you know, changes to their system. There was one that had a problem with scanning paper claims. So, it's just not something that we are seeing right now. But there, there definitely was an increase and part of that was --

MEMBER SEIDENWURM: Okay, thank you. So we will kick (inaudible).

MS. YAMANAKA: Yes, we will. We are definitely keeping an eye on it though, yes.

CHAIR RIDEOUT: Great. Next we will go to Jarrod and then Paul.

MEMBER MCNAUGHTON: Yes, thanks so much; and thanks, Michelle. You know always, you are always one of the, I think, most popular ones everybody wants to chat about, which is, which is great.

And I just thought I would share. First and foremost, thank you for the partnership that we have with you folks on this particular topic. It's a topic that, as many know, gets talked about a lot, both on the TNE part of the house as well as days of cash on hand, the differences between those two. And I thought it would be helpful to provide a little context from at least our point of view, because we are in one of those seasons at IHP where we are at an all-time low of days of cash on hand, while our TNE stays healthy because of the assets that we have in the organization, which we own our buildings and whatnot. We have really tried to make sure that our community, especially on the safety net side, is able to continue caring for our members and for the broader community.

And just as an example of that, in the last 90 days or so I have had three different hospital CEOs reach out and say they can't make payroll in two weeks and what can we do as a plan to help offer cash advances for their state-directed payments, for their IGTs or intergovernmental transfers. And we do, we

really are acting like a bank. We are funding our providers through those cash advances which changes, of course, the days of cash on hand. And so when folks, kind of the general public sees these massive amounts of cash on hand, I think it's really important for folks to understand that the public entities, at least, I can't speak for the commercials, but on the public side, we are doing cash advances constantly. We are absorbing state rate reductions, which have happened in the past, without passing those on to our providers.

We are making sure that the revenue cycle of the business is super stable because most folks probably don't understand that when lookbacks, financial lookbacks happen all the time within the health plan space, risk corridors, settlements, that can be in the hundreds of millions of dollars. And all of that is why those reserves are so important. We have even had seasons that I have seen where the state, DHCS hasn't been able to make their payment to us on time, and that allows us to buffer for our provider community to be able to make sure that we are making on-time payments to the providers even when our revenue cycle has been actually compromised.

And so for those plans that have healthier days of cash on hand than we do, you are seeing folks invest in housing and other projects in their communities, which I think is great. But I do -- I did want to just point out, Michelle, that I think that whole TNE conversation, the days of cash on hand conversation, super important to just share some contextualizing framing, if you will, about why some of the reserves are as high as they are, and how those reserves are actually being put into place for the communities that they serve. So, I just wanted to share that, Michelle, and really appreciate your report.

CHAIR RIDEOUT: Thank you, Jarrod.

Paul, and then we will go to Mark.

MEMBER DURR: And Michelle, I always love your report, as you know, so thank you for that. And my comment is, two.

One is on the non-filers. Did you mention how many impacted lives were a result of those being exited out of the market?

MS. YAMANAKA: One is under is under 10,000 lives, and one is between, I think, the 10,000 and 25,000. Yes, yes.

MEMBER DURR: Okay.

MS. YAMANAKA: Yes.

MEMBER DURR: Thank you. That's obviously a greater concern with regards to having to move those, those people you know, when they are, when they become non-compliant and not meeting our standards. So, I know that you are working diligently with them to try to make sure that we minimize that, but obviously we have to take care of the enrollees first and foremost. So that's, that's great.

The other comment I just had was just reflecting on the total enrollment and seeing the decrease from 10 million, 10.2 million a year ago to 8.6 million and reflecting on the fact what that means to our overall health care delivery. Whether those people are going uninsured or going into other types of arrangements that are maybe PPO arrangements where you don't have as much coordinated care around that I think is not a great trend overall for where we want to try to get to more value-based care overall. So, I don't know if you have any more insight into that reduction. If it's really the growth in PPO or uninsured or something else.

MS. YAMANAKA: Yes. And it could also be -- so these are RBOs

reporting. They could also be going to some areas that are not reporting to us. So, I am just going to put it out there, FQHCs. FQHCs don't report to us so that could be part of it. There was also, I believe, a behavioral health plan where they took the risk back, so that was, that's also part of it as well. The health plan took the risk back, so that could be a chunk of it as well, yes.

MEMBER DURR: Great insight, thank you.

MS. YAMANAKA: Sure.

CHAIR RIDEOUT: Mark, I think you are up next.

MEMBER KOGAN: Yes, thank you, and thanks for this great report. I actually have, it's almost the same question. But looking at that decrease in enrollment, it's almost all in the Medi-Cal population, about 20% or so. And I just, I don't know if your answer is the same, if you think it's transferred to FQHC or something, but that seems to me over the course of a year to be a huge drop.

MS. YAMANAKA: Yes, and I agree it is. We don't have, we don't drill down all the details. I don't have the information. It's really what the RBOs are reporting to us and we confirm it with the health plan enrollment reporting. So the enrollment is, it could be, yes, it could just be going to a different, a different source. Like I mentioned, the FQHCs are somewhere that's not reported within the RBOs, yes.

CHAIR RIDEOUT: Okay.

MS. YAMANAKA: But we can look into it a little bit more and see if we can get additional information just to, kind of just to kind of find out from the health plans.

CHAIR RIDEOUT: Any questions or comments from Board

Members on the phone or video that we haven't heard?

Okay, moving on, questions or comments from the public in the room?

MR. STOUT: Not at this time.

CHAIR RIDEOUT: Okay. Questions or comments from the public on the phone or video?

MR. STOUT: Yes, we have one. Kimberly, when prompted please unmute.

MS. CAREY: Thank you for taking my -- it's not really a question it's kind of a clarification for the question around drop in enrollment. We have seen in our -- in our 2 million membership that we have, a drop, a continuous drop in commercial that has been monitored over the past couple of years. Not significant, but it has not grown in any, in any case. The real drop that we are seeing, which is totally significant, is in June the state started the redetermination financial qualification process for the Medi-Cal population, and we have seen a consistent drop in our membership to the tune of about anywhere from 5,000 to 20,000 a month because of the redetermination process. So, I just wanted to clarify that that's really where we are seeing the significant drops in enrollment. And we can only assume that those members are going uninsured. So, I just wanted to put my two cents in. Thanks.

CHAIR RIDEOUT: Thank you, Kimberly.

Any other questions or comments from the public?

MR. STOUT: Not at this time.

CHAIR RIDEOUT: Okay, we are in the home stretch. And next up, if I can get my agenda, hold up, again. Mary, you tell me just to save time.

MEMBER WATANABE: Health Plan Quarterly Update, we have got Evan.

CHAIR RIDEOUT: Okay, Evan Lo. Thank you, Evan.

MR. LO: Thank you. Good afternoon. I am Evan Lo. I am a Supervisor from the Office of Financial Review. I am here today to give the health plan quarterly update. The purpose of this presentation is to provide you with an update of the financial status of health plans at quarter ended June 30, 2025. All licensed health plans are required to submit quarterly and annual financial statements for the --

CHAIR RIDEOUT: Evan, Evan.

MR. LO: Yes.

CHAIR RIDEOUT: I can hear you, but I have to work pretty hard. Can you either speak a little louder or maybe go to a different mic?

MR. LO: I am just so far away from the mic.

MEMBER WATANABE: That's okay. Come sit right here. We will borrow my charger, if you want.

CHAIR RIDEOUT: I am an aging, you know, person, so I am probably not like I used to be.

MEMBER WATANABE: So we are adjusting our mic and camera setup here.

CHAIR RIDEOUT: Thank you.

MR. LO: Let's test this out. The purpose of this presentation is to provide you with an update of the financial status of health plans at quarter ended June 30, 2025. Is the audio okay? I just want to check it.

CHAIR RIDEOUT: Yes, it's good.

MR. LO: Okay, thank you. All licensed health plans are required to submit quarterly and annual financial statements with the Department. Additionally, we get monthly financial statements from the health plans who are newly licensed with tangible net equity or TNE below 150% of required TNE or if we have concerns with the health plan's financial solvency.

We also included a handout that shows the enrollment at June 30, 2025, and TNE for five consecutive quarters from June 30 of last year to June 30 of this year for all licensed health plans. The information is categorized into three health plan types, full service, restricted full service and specialized. Next slide please.

As of September 26, 2025, we had 139 licensed health plans. We are currently reviewing 10 applicants for licensure, 5 full service and 5 specialized. Of the 5 full service applications, 3 are for a restricted Medicare Advantage license, 1 for a restricted Medi-Cal license and 1 for Medicare Advantage. For the five specialized applications, 4 are employee assistance programs and one for dental. Additionally, we have been meeting with several entities that are interested in obtaining a Knox-Keene license. We continue to get requests. I want to highlight two newly licensed health plans since our previous meeting. Elite Health Plan, Inc. was licensed on May 29, 2025, as a Medicare Advantage health plan. LaSalle Health Plan was licensed on June 24, 2025, as a restricted Medicare Advantage health plan. Next slide please.

As of June 30, 2025, there were 30.58 million enrollees in full service plans who are licensed with the Department. Total commercial enrollment includes HMO, PPO, EPO and Medicare supplement plans. As shown on the table, total full service enrollment decreased from the previous

quarter. There was a slight decrease of about 67,000 enrollees in total in commercial enrollment, and a modest increase of about 17,000 enrollees in the total government enrollment. And when I say government enrollment, this is Medi-Cal and Medicare Advantage. Next slide please.

Okay. 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 remains stable. Next slide, please.

Okay. This table shows the composition of PPO enrollment. PPO enrollment slightly decreased from the previous quarter. Please note that for periods prior to quarter ended 12/31/24, figures include both PPO and EPO enrollment. We started collecting PPO and EPO enrollment data separately beginning with period ending December 31, 2024. Next slide, please.

This slide shows the composition of EPO enrollment. The figures reported here are in thousands. EPO enrollment remained relatively stable. Next slide, please. This table shows government enrollment, which is Medi-Cal and Medicare. Enrollment for both Medi-Cal and Medicare enrollment plans have experienced consistent growth. At 6/30/2025, Medicare Advantage enrollment increased by 18,000 lives from the previous quarter. Next slide.

All right. We are currently closely monitoring 35 health plans, 28 full service health plans and 7 specialized health plans. There are various reasons why we monitor health plans closely. Plans may be, may be placed under close monitoring for various reasons, including but not limited to recent licensure, low enrollment, financial solvency concern, issues with a parent entity, claims processing problems, enforcement action, or significant change in

leadership. A majority of these plans tend to be smaller in terms of enrollment. Next slide. All right.

So, this slide describes the general definition of tangible net equity. TNE is a plan's net worth after subtracting the value of intangible assets, unsecured related-party amounts, and nonreturnable deposits. In short, TNE is the health plan’s net worth that is backed by real measurable assets such as cash, investment, receivables and properties. Next slide, please.

So, this slide describes how required TNE is calculated for both full service and specialized health plans. Please note that TNE and required TNE are the main measures used to assess a health plan's solvency. In addition, we review other quantitative ratios and financial information to assess solvency, such as current ratio, cash ratio, profit ratio, notes to financial statements, independent auditor’s report, and financial statements from the parent company. Next slide, please.

Okay. So, I want to point out that we have two health plans that did not meet the Department's minimum financial solvency reserve or TNE requirement. One is Meritage Health Plan who reported TNE deficiency on their monthly financial statement for month ended August 31, 2024, through April 30, 2025, and their quarterly financial statement for quarter ending September 30, 2024, through March 31, 2025, and on their annual financial statement for year ending December 31, 2024. There is an active enforcement action on the plan and the Office of Enforcement is leading that role.

The next plan is the CDI Group, Inc. reported a TNE deficiency on their financial statement for quarter ending June 30, 2025. The plan received a capital contribution of $245,000 from their parent to correct the TNE deficiency.

Next slide, please.

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

Okay. This table is the TNE for full service health plans by enrollment. Sixty-seven health plans, or over half the total licensed full service health plans, reported TNE of over 250% of required TNE. Health plans with less than 150% of required TNE are required to file monthly financial statements with the Department. Next slide please.

This table shows the breakdown of the 26 full service plans in the 150% to 250% TNE range. We also closely monitor health plans when we observe a declining trend in their financial performance, TNE, net income or enrollment. Next slide.

This table shows the TNE of full service plans by quarter. It summarizes the handout that was provided with the meeting materials. For detailed information on Health Plan TNE levels and enrollment please review that handout. Next slide.

This table shows working capital for full service health plans by enrollment as of June 30, 2025. Working capital measures a health plan's ability to pay its bills that are due within the year. Generally, you want a ratio to be over

1.0 or 100%. This indicates that the health plan has sufficient short term assets to cover its liabilities that will be due within a year. As you can see, 13 health plans reported working capital of less than 1.0. Next slide.

This table shows a cash-to-claims ratio of full service health plans by enrollment. The cash-to-claims ratio measures a health plan's ability to pay its unpaid claims using cash, marketable securities and receivables. It is calculated by dividing the cash and marketable securities and receivables by its unpaid claims liabilities. Similar to working capital, we want the health plan to maintain a cash-to-claims ratio above 1.0 or 100%. Next slide, please.

And finally, the last table. This table shows a less than 1.0 cash-to-claims ratio for full service our clients by enrollment. For a general comparison, RBOs are required to maintain a cash-to-claims ratio of 0.75 or 75%. For the full service plan side, the risk is higher. They are taking institutional risks. Ideally, we want them to maintain a cash-to-claims ratio above 1.0, so some of these plans may be on our closely monitored plan list.

So that wraps up my presentation. I can take any questions.

CHAIR RIDEOUT: Okay. Any questions from Board Members in the room?

MEMBER WATANABE: Jeff?

CHAIR RIDEOUT: Yes.

MEMBER WATANABE: This is Mary. Maybe I will just jump in here, maybe just to reiterate Jarrod's point earlier. There is a lot of interest lately in TNE. And I think we have had a lot of good discussions here at our Board meetings that while a high TNE percentage I think gives the perception that there are high reserves, it does not always translate to that and I think Jarrod did a

good job of articulating that. I know in prior years at Board meetings we have seen the ups and downs, particularly at the state budget, the impact to the Medi-Cal plans. There's often requests to give higher reimbursements to providers. And one of the things I think prior Board Members have reiterated is the inability to sustain those increased rate increases when we see downturns in the budget.

But just wanted to highlight too, I think the financial review team did a really good job at our last Board meeting to just provide an overview of all the various metrics that we use to monitor both health plans and RBOs. I think it's a good refresher for anybody that wants to understand what these percentages mean.

But I think particularly as we head into the next two years in particular as we see more financial pressures across the health care delivery system, potential declines in enrollment, it will be very important for the Board to help us monitor these various metrics very closely and the enrollment and where we see likely decreases and changes. So just wanted to flag that for the Board that I think these metrics become even more important as we head into the next couple of years.

CHAIR RIDEOUT: Yes. And Mary, we have talked about this at probably pretty much every meeting. But there's also a feeling that TNE is not in any way the best metric to me, measuring liquidity or solvency. What is the flexibility that DMHC does or doesn't have in emphasizing some of the other metrics, like the quick ratio or cash on hand or things like that? Because I think a lot of Jarrod's comments go right to the number can look awful big, but it's not sort of what drives solvency and liquidity at all.

MS. YAMANAKA: Jeff, thank you for that. I agree with you. The

number may be big, but it really depends on what the composition is of those, of the assets, right. You can have -- just to give you an example. It could be 1,000% or higher, however, the assets could be a building. So in order to get cash, you have got to sell the building. So, when Evan and his team, when they review these financials, it's just not TNE, there's a bunch of other metrics. Evan showed working capital, cash-to-claims, but it's also on the trends. What's going on with that, with that health plan now? Are they seeing declines, you know, in net income, or is there losses, et cetera. And they also have filings that they receive from -- health plan filings on what, maybe what's coming. So, they can take those things into consideration as well. So, there's a lot that goes in to determine, you know, the financial health and where they are. Each health plan -- and each health plan is different. You can't put it, it is not a one size fits all, just with that.

CHAIR RIDEOUT: Other questions or comments from Board Members, maybe by video or phone?

MEMBER DURR: Yes, Jeff, this is Paul. I had a quick comment. Evan, very nice job. Thank you for that. It was really very well done. Very, very clear and concise and very helpful to us so very well, very well done.

My general comment was one to Mary's point about declining enrollment and just wanted to clarify that this does capture -- or my question is, does this capture the FQHC enrollment as well? Is this more complete of that? Because these are not RBOs that are reporting under what you have, Michelle, but does this take into account what we know of all enrollment in the state of California? And if so, is there ability to also track the uninsured? I don't know if we have that. Because, to your point, Mary, I get more concerned about what

that number is doing relative to what is happening here, or is it people moving out of the state or something like that?

MEMBER WATANABE: So, maybe I will answer the uninsured. So, there are a number of entities that track kind of health care in California broadly, not just under DMHC's jurisdiction. The California Health Care Foundation is one. I know CHBR, the California Health Benefit Review program, also usually does a summary level report that they use for their analysis. And I am trying to think. There is another. California Health Interview Survey. I forget the frequency of that, but that usually will also assess enrollment status. So, we usually at least on an annual basis can get some sense of the landscape of, you know, about 30 million are under DMHC's jurisdiction, I think we have got about around 1 million under Department of Insurance, we have self-insured, and then the uninsured. So, I am sure there will be a lot of focus as we head into the next year on that uninsured rate and what that looks like.

Evan, maybe to the question of this is all enrollment. Not just RBOs, it would include FQHCs. So, all enrollment in that plan?

MR. LO: Yes, it's all enrollment.

MEMBER DURR: Great. Thank you, Mary. Thank you again, Evan, wonderful job.

CHAIR RIDEOUT: All right. Questions from the public in the room for Evan?

Any questions on the phone or video?

MEMBER WATANABE: Bill had a question for us.

CHAIR RIDEOUT: Who? I'm sorry, who? Oh, Bill, good. Hey, Bill.

(Several people speaking at once.)

CHAIR RIDEOUT: No, even over the wire I can recognize your voice, so yes. Bill Barcellona, please.

MR. BARCELLONA: It looks like based on Evans report there was no drop in governmental plan enrollment, but there was a significant drop in RBO enrollment. That's quite a mystery, so I will be reporting that to OHCA shortly. We are supposed to be expanding value based payment in California. That's a pretty big movement in the wrong direction. So, I hope we can get to the bottom of it and see (overlapping).

MEMBER WATANABE: Well, we'll dig into our data and see if we can figure out where that went, whether it was direct enrollment.

MR. BARCELLONA: Yes.

MEMBER WATANABE: Not to an RBO, FQHC, or someone that's not reporting to us. But yes, I think that was the first thing that jumped at me when I saw the report as well.

MR. BARCELLONA: Yes, okay. Just another comment on TNE. You know, if you dial it all the way back to the early days of the DMHC, there was always such a, such concern over adopting the TNE standard. We are the only state that uses it. But I have to say, after 20 years of monitoring financial solvency along with Michelle, that it seems to have worked pretty darn well. Because we haven't had, you know, the huge disruptions in financially troubled medical organizations and plans since 2002. So, yes, there you have it.

CHAIR RIDEOUT: All right.

MEMBER WATANABE: I will just say, I mean, I think, to the Board's credit, I have watched over the last 10 years just how our reports have

evolved too so we are becoming much more transparent with the data and the other metrics particularly. I think now at both the RBO and the plan level you can see in our attachments as part of Board materials by plan, including cash-to-claims and working capital too. So, I think we have evolved to try to be more transparent and have the Board assist us in monitoring all of those. The things that we have always been doing behind the scenes, which is to publicly report.

MR. BARCELLONA: Yes. And you know, what we have learned at APG from the old CAT-T (phonetic) days since we have gone national is that when the other states use the risk-based capital basis, it is very difficult for medical groups to take financial risk because they have to acquire really significant levels of reserves, and it prohibits them from adding, you know, thousands of patients like the way we do here in California. So, we have a much more flexible model that can respond to demand when it happens than other states do.

MEMBER WATANABE: Thank you, Bill.

CHAIR RIDEOUT: Okay. All right. Anybody else that I missed? I'm sorry, Bill.

So, I think the next item is meeting dates for next year. Mary.

MEMBER WATANABE: Yes. And I don't have a handout so hopefully someone could put them up on the screen here. We did cross reference this with Jeff's schedule and mine and I think everybody else has confirmed there are no conflicts so this is our planned schedule for next year, February 25, May 20, August 19 and November 18. We will continue to have it in-person as well as a virtual option. Plan on having those dates on your calendars for next year.

CHAIR RIDEOUT: Hope Paul can make it.

MEMBER WATANABE: I know. Paul, hopefully you can make it. Otherwise, maybe Jeff can fill in for you.

CHAIR RIDEOUT: Yes, you will be stuck with me. All right.

The last item is any items for future meetings that either the committee members or the public at large want to suggest.

MEMBER WATANABE: I will maybe just note. As I alluded to a couple of times, I think we would like to have OHCA come back and do an update on what they are doing. Probably Covered California as well. Maybe we will wait until May, kind of when we see where the dust settles on open enrollment and the enhanced premium tax credits. But I think we would like to get both of them back. And always will invite DHCS to do an update as well as their schedule allows.

CHAIR RIDEOUT: Mary, can I make a suggestion when we talk to OHCA? And I don't know whether it be Elizabeth or Vishaal. But if we have some very specific questions as a committee that we would like to ask, like reconciling rate increases with the 3.5% or, you know, I know it puts people on edge a little bit. But oftentimes a general update doesn't get around to something that specific and I think you are hearing from us that we need to understand whether that's really connected or not. So that would be my request on those kind of visits. And I thought Rafael did a very nice job today of getting to some of the nub of that.

MEMBER WATANABE: Yes, no, agree. And I think we were able to kind of prepare Rafael to say, here's the three things that keep coming up, if you can talk about this. Similarly with OHCA. If Board Members separately want

to email me questions or suggestions you can do that. And then I think Bill has a suggestion here in the room.

MR. BARCELLONA: Mary, you said that you were going to do a report on the AB 133 compliance here in the near future, or maybe first of the year.

MEMBER WATANABE: (Inaudible) 133?

MR. BARCELLONA: It's the equity and quality.

MEMBER WATANABE: Yes, yes, yes. As soon as that report -- we have I think about five reports in the queue, and so I think the health equity is probably the one that will be of most interest to the Board. But of course we will do a presentation on that when that's available, yes.

MR. BARCELLONA: Okay. So, a number of us have been concerned about the declining rates of compliance with Combo 10.

CHAIR RIDEOUT: Yes.

MR. BARCELLONA: Jeff, he knows this better than anybody. But, you know, the state does have a separate push through public health on vaccine messaging and adherence, but it would be good to see what your data shows. We are hearing from, you know, individual physicians that one of the problems with the Combo 10 metric is that parents will schedule their child for their two-year immunizations on their birth date. Then because of the strict 48-month timeline, we are missing a lot of compliance. At least, that's the theory, okay. So, there's potential maybe for an extension of the 48 months. An argument there behind that if we really want to show where compliance is. Because what we are hearing anecdotally from a lot of APG physicians is that if you add 3 more months to that 48 month period they are getting compliance. Thanks.

CHAIR RIDEOUT: And Bill, I am I am not the expert that you ascribe to me, but I have heard this a number of times in a number of forums. That is a big part of what makes Combo 10 so difficult. The other part is general vaccine hesitancy, so. I am hearing anecdotally a lot of really tough stories on that part of it too. But Paul or Jarrod or others may have comments on that, but that's coming up pretty regularly.

MEMBER WATANABE: I will just say I have been in a number of forums where this has come up. Particularly we have some communities that are very reluctant to bring their children in period because of fear, and so we are seeing a general drop in immunizations because of that as well.

I will just kind of highlight for you. This is one challenge with a regulatory approach to quality is we don't have the ability to pivot and make changes to our measures without -- we are promulgating these in regulation. It's something we have been having conversations with the purchasers and Covered California and DHCS of when are you going to make justice to your measures? And so we obviously have some discretion in just how we prosecute and hold health plans accountable because of these changes. But it is just one little wrinkle in the regulatory approach is it's pretty -- it's pretty stuck in law and codified until we can reconvene the committee and make changes. But anyways, we will be as nimble as we can but appreciate you highlighting that.

MR. BARCELLONA: Thanks.

CHAIR RIDEOUT: All right, I think that concludes today's agenda.

Is there anyone that would like to make a motion to adjourn from the Board?

David, I see your hand up. Second?

MEMBER KOGAN: (Raised hand).

CHAIR RIDEOUT: Somebody?

MEMBER DURR: Second.

CHAIR RIDEOUT: Okay, thank you, Paul.

All right. We are adjourned and we will see you in 2026 when everything is figured out, right.

MEMBER WATANABE: Happy Holidays to everybody too and we will see you in the new year. And hopefully, fingers crossed, we will have a, I don't know, some good news before the end of the year.

CHAIR RIDEOUT: Thank you, everyone.

(The meeting was adjourned at 12:51 p.m.)

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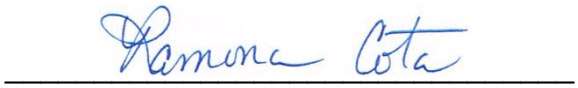
CERTIFICATE OF REPORTER

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 5th day of December, 2025.



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