Finance Committee Meeting Agenda

June 17, 2026: 8:00 a.m. – 9:30 a.m.

In-person Locations:

Partnership's Chico Office located at 1000 Fortress St, Chico, CA
Partnership's Fairfield Office located at 4605 Business Center Drive, Fairfield, CA (Conference Center)
Partnership's Redding Office located at 2525 Airpark Dr., Redding, CA
Partnership's Santa Rosa Office located at 495 Tesconi Circle, Santa Rosa, CA
Partnership's Eureka Office located at 1036 5th Street, Eureka, CA
Partnership's Auburn Office located at 281 Nevada Street, Auburn, CA

Finance Committee Members: Chris Champlin, Dave Jones, Chair, Ryan Gruver, Alicia Hardy, Dean Germano, Nancy Starck, Nolan Sullivan

Public Participation

Public comment is welcome during designated "Public Comments" time frames or by emailing comments to the Board Clerk at Board_FinanceClerk@partnershiphp.org by 5:00p.m on June 16, 2026. Comments received will be read during the meeting.

8:00A.M – Opening			
1.1 **Call to Order**			*Dave Jones, Chair*
1.2 **Roll Call**			*Clerk*
1.3	***ACTION:*** Approval of Agenda	1	*Chair*
1.4	***ACTION:*** Approval of Finance Committee Minutes from May 20, 2026	2-9	*Chair*
1.5 **Commissioner Comment**			*Chair*
1.6 **Public Comment**			*Public*
New Business			
2.1	***INFORMATION:*** CEO Health Plan Update	10	*Sonja Bjork*
2.2	***ACTION:*** Accept April 2026 Metrics and Financials	11-24	*Jennifer Lopez*
2.3	***ACTION:*** Approve the Final Budget for Fiscal Year 2026-2027	25-46	*Jennifer Lopez*
Adjournment			

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular finance meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the committee. The Finance Committee has designated the Board Clerk as the contact for Partnership HealthPlan of California located at 4665 Business Center Drive, Fairfield, CA 94534, for the purpose of making those public records available for inspection. The Finance Committee Meeting Agenda and supporting documentation is available for review from 8:00 AM to 5:00 PM, Monday through Friday at all PHC regional offices (see locations above). It can also be found online at www.partnershiphp.org. PHC meeting rooms are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Board Clerk at least two (2) working days before the meeting at 707-863-4516 or by email at *ascott@partnershiphp.org*. Notification in advance of the meeting will enable the Clerk to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it. This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda.

MINUTES OF THE MEETING OF
PARTNERSHIP HEALTHPLAN OF CALIFORNIA FINANCE COMMITTEE
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On
May 20, 2026

Members Present: Jayme Bottke, Dean Germano, Alicia Hardy Dave Jones, Chair, Nancy Starck
Members Excused: Chris Champlin, Ryan Gruver, Nolan Sullivan
Staff: Leigha Andrews, Katherine Barresi, Wendell Coats, Marisa Dominguez, Ryan Eberle, Naomi Gordon, Melanie Lam, John Lemoine, Jennifer Lopez (*participated virtually*), Kathryn Power, Ashlyn Scott, Rebecca Stark, Amy Turnipseed, Colleen Valenti

AGENDA ITEM	DISCUSSION	MOTION / ACTION
1.2 Roll Call	Ashlyn Scott, Clerk of the Commission, called the roll indicating there was a quorum.	None
1.3 Approval of Agenda	Chairman Jones asked if anyone had changes to the agenda. Hearing no requests for modification, he asked for a motion to approve the agenda.	*Commissioner Starck moved to approve the agenda as presented, seconded by Commissioner Hardy.* ***ACTION SUMMARY:***

		Yes: 6 *No: 0* *Abstention: 0* *Excused: 3 (Champlin, Gruver, Sullivan)* **MOTION CARRIED**
1.4 Approval of the April 15, 2026, Finance Committee Meeting Minutes	Chairman Jones asked if anyone had changes to the April 15, 2026, minutes. Hearing no requests for modification, he asked for a motion to approve the minutes.	*Commissioner Starck moved to approve the minutes as presented, seconded by Commissioner Bottke.* ***ACTION SUMMARY:*** *Yes: 5* *No: 0* *Abstention: 0* *Excused: 3(Champlin, Gruver, Sullivan)* **MOTION CARRIED**
1.5 & 1.6 Public Comment and Commissioner Comment	Chairman Jones asked if there were any public or commissioner comments. There were none.	None
New Business		
2.1 CEO Report	Sonja Bjork, Chief Executive Officer, reported on the following topics: ***May Revision—*** Ms. Bjork reported that the Governor's May Revision of the California State Budget was released the previous week. Partnership continues to review the proposal and make adjustments to our own proposed budget. Under the Governor's proposal, the state intends to seek federal approval for a new Managed Care Organization (MCO) tax to take effect January 1, 2027; however, there is a concern that the federal government may reject California's initial proposal. The state is prepared to submit a second proposal that aligns closely with HR1 requirements. The May Revision proposes the re-implementation of Medi-Cal asset tests that would limit the amount of assets beneficiaries may hold while remaining eligible for services. Concerns have been raised that reducing the asset limit could result in thousands of disabled Californians losing Medi-Cal coverage. In addition, individuals with uncertain immigration status (UIS) may be subject to increased premiums of up to $50 per month, which could create affordability challenges for some families.	None

	Commissioner Starck asked whether there was any additional information related to the quality withhold included in the budget proposal. *Ms. Lopez responded that the information was included in an obscure section of the proposal. She explained that Partnership is currently subject to a 1% withhold that plans work to earn back, unearned funds are redistributed via an incentive based on the achievement of defined metrics. The Governor's budget proposes to eliminate the incentive portion of the withhold and would instead redirected unearned withhold funds to the State General Fund.* ***Rural Health Transformation Fund –***California was awarded $233.6 million for Federal Fiscal Year 2026 through the Rural Health Transformation Fund. The Department of Health Care Access and Information (HCAI) will administer California's share, and the Centers for Medicare & Medicaid Services (CMS) must also review and approve proposed projects. HCAI hosted a webinar on April 21, followed by two Partnership-hosted webinars that drew more than 80 attendees, primarily providers seeking guidance on eligible projects. Funded projects must demonstrate transformative models of care, include clear deliverables, and provide documentation demonstrating outcomes were achieved. HCAI has indicated that only a limited number of projects will be funded and that preference will likely be given to the most transformative proposals. Partnership is available to assist providers with technical support and has retained a grant-writing consultant who will review applications. Additional details regarding due dates and timelines are expected in June. However, turnaround times will be tight, as HR1 requires the funds to be distributed by October of this year, creating compressed implementation timelines for project deliverables. ***Community Reinvestments*** – Ms. Bjork reported that Partnership received the state formula to determine required reinvestment amounts for the 14 legacy counties. She explained there are two categories of Community Reinvestment funding: one based on Medi-Cal population and another based on county quality performance scores. Since many Partnership counties fall within quality tiers 2 or 3, quality-related funding will be available for those counties. Partnership has been meeting with leaders in each of the 14 legacy counties to identify collaborative projects eligible for Community Reinvestment funding. *Commissioner Germano acknowledged that providers are attempting to manage the impacts of numerous legislative changes and financial constraints, and commented that developing innovative uses for these funds presents a significant challenge.* *Ms. Bjork agreed and stated that she would provide the Board with an email update should additional information become available.*	

2.2 *ACTION*: Accept March 2026 Metrics and Financials	Jennifer Lopez, Chief Financial Officer, presented Metrics and Financials for March 2026. Partnership ended the month with a minor surplus of just under $1 million, bringing the year-to-date surplus to $32.5 million. She noted that lower administrative costs continue to drive the surplus. Total revenue was reported as $43.4 million below budget for the month and $438.6 million below budget year-to-date, primarily due to unfavorable state-directed payments. Interest income was $8.3 million favorable to budget as a result of higher-than-anticipated interest rates; however, anticipated future interest rate reductions may impact this favorability. Total healthcare costs were $45.6 million below budget for the month and $446.4 million below budget year-to-date. Ms. Lopez stated that transportation costs continue to rise, though the state is expected to implement additional efficiency controls related to transportation benefits, which may impact future costs. Ms. Lopez further reported that Partnership currently has 146 days cash on hand, though that amount is expected to decrease once hospital-directed payments are distributed.	*Commissioner Champlin moved to approve the March metrics and financials as presented, seconded by Commissioner Sullivan.* ***ACTION SUMMARY:*** *Yes: 5* *No: 0* *Abstention: 0* *Excused: 3 (Champlin, Gruver, Sullivan)* **MOTION CARRIED**
2.3 *ACTION:* Resolution to Approve the Preliminary Health Care Expense Budget for Fiscal Year 2026-2027	Ms. Lopez presented Partnership's Preliminary Health Care Expense Budget for Fiscal Year 2026-2027, noting that the organization is developing the budget with limited available information. Ongoing changes in enrollment levels will impact revenue projections and Partnership has been working closely with actuaries to further refine the budget assumptions. The current proposal represents an initial draft. Ms. Lopez outlined the three-month budget development process, which includes presenting budget assumptions in April, developing draft healthcare assumptions in May, and finalizing the budget in June following review of updated state budget information and incorporation of administrative and capital expenses for presentation to the Finance Committee and Board. Ms. Lopez reported that the California May Revision does not include significant new expenditures. The Legislative Analyst's Office (LAO) had previously cautioned that the state was spending beyond its available revenues. The Governor exercised considerable fiscal restraint in the revised budget proposal, reflecting a more fiscally conservative approach. General Fund revenues are trending upward, particularly due to higher-than-anticipated personal income tax receipts, though those revenues remain highly volatile. The May Revision includes reserve funding and reflects a balanced budget through July 2028. However, significant uncertainty remains regarding Medi-Cal enrollment and costs, and Partnership anticipates the state may pursue additional cost-efficiency measures for managed care plans. Regarding membership projections, the Governor's budget assumes Medi-Cal enrollment will reach 13.9 million members in the next fiscal year, representing a 3.75% decrease over the prior fiscal year. This estimate includes individuals in the unsatisfactory immigration status (UIS)	*Commissioner Bottke moved to approve Agenda Item 2.3 as presented, seconded by Commissioner Gruver.* ***ACTION SUMMARY:*** *Yes: 4* *No: 0* *Abstention: 1 (Bottke)* *Excused: 3(Champlin, Gruver, Sullivan)* **MOTION CARRIED**

	category, despite plans to transition those members into the fee-for-service delivery system. Partnership currently has approximately 90,000 UIS members enrolled. The Governor proposed a new Managed Care Organization (MCO) Tax structure in the FY 2026-27 budget proposal. The proposal would establish a new MCO Tax effective January 1, 2027, applying an $8.85 per member per month tax rate to both Medi-Cal and non-Medi-Cal plans. She explained that federal requirements under H.R. 1 and other federal changes require uniform tax rates across Medi-Cal and non-Medi-Cal plans. Changes to the MCO Tax will require approval by a three-quarter vote of the Legislature and therefore will require bipartisan support. The state is relying heavily on the proposed tax structure as part of its strategy to balance the budget, though the proposal must still receive approval from the Centers for Medicare & Medicaid Services (CMS) as well as the State Legislature. Ms. Lopez reported that the state continues to move forward with the proposed elimination of Prospective Payment System (PPS) rates for State-Only Services for UIS members, in the budget proposal. She noted that the change would have a significant financial impact on Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).. *Commissioner Hardy stated that she is not optimistic the state would reverse course regarding the elimination of PPS rates. She shared that, following discussions during legislative visits, no clear financial solution has emerged and expressed concern about the absence of a contingency plan. She acknowledged that providers will likely ultimately need to adjust to the changes.* The budget proposal includes enhanced County administrative funding only for Fiscal Year 2026-27.. Ms. Lopez acknowledged the significant workload counties are expected to face in implementing the various H.R. 1-related programs and requirements. *Commissioner Starck commented that the proposed county funding level remains substantially below what will be necessary to maintain Medi-Cal enrollment and support individuals who may lose coverage.* *Commissioner Germano expressed concern that thousands of people may be shifted out of managed care and back into fee-for-service coverage, and questioned the downstream impacts this could have on providers, particularly community health centers. He asked whether providers are adequately prepared to manage care delivery, as well as the increased administrative burden associated with the fee-for-service model. He noted that this is especially concerning given that Medi-Cal fee-for-service operations have been significantly scaled back over time as beneficiaries were transitioned into managed care.* *Ms. Lopez agreed and noted that DHCS will need to significantly increase staffing levels to manage the anticipated rise in fee-for-service claims. She added that the department is currently operating on an outdated system, and it remains unclear whether the system will be capable of handling the*	

increased workload.

Ms. Bjork added that the state will need to make substantial operational changes to accommodate more members in fee-for-service while also implementing H.R. 1 changes, such as Medicaid work requirements. She emphasized that this type of large-scale transformation typically requires extensive preparation, yet the state has only a matter of months to adjust. She also noted that certain benefits available under managed care, such as transportation services, may not be accessible to members in fee-for-service. In addition, she expressed concern that the quick turnaround times currently seen in managed care for treatment authorization requests (TARs) and claims processing are unlikely to be replicated at the state fee-for-service level.

Commissioner Hardy shared that the current strategy from the state does not appear to be achievable or sustainable, as expectations continue to grow across all areas while quality standards increase as well. She asked whether this is a period where the organization simply has to "hunker down" and react to constant changes coming from the federal government and state, or whether there are opportunities to continue making progress and building toward a better future despite the challenges. She asked if there is room to focus on advancement rather than solely reacting to demands.

Ms. Bjork responded that all of Partnership's chiefs are actively involved at the state level through workgroups, advocacy efforts, and related activities, and emphasized that Partnership has a strong team. However, she noted that it is not possible to sustain the same level of performance while meeting every new requirement the state continues to add, including services such as transitional rent and other new programs. She stated that organizations may need to accept that maintaining the same high level of performance during this period may not be realistic. She also expressed appreciation for Partnership's local association, LHPC, highlighting the frequent collaboration among health plan CEOs, CFOs, government affairs directors, and other leaders. While Medi-Cal programs may ultimately be scaled back, she expressed confidence that Partnership will emerge from this period as a strong health plan.

Commissioner Hardy replied that it is important to clearly communicate these expectations to the full Board, so Commissioners understand what to anticipate during this period. She noted that while she is always looking for bright spots and opportunities for progress, there also needs to be a realistic understanding that although some areas may continue to perform at a high level, there will likely be other areas where challenges and performance struggles are expected during this time.

Ms. Lopez continued her presentation, explaining that DHCS operates on a cash-based budget and has recently taken out a $4 billion loan. She stated that in the future, there is a high likelihood that DHCS could withhold revenue from health plans such as Partnership.

The state budget proposal includes $50 million in funding for financially distressed hospitals, intended to provide short-term relief to hospitals with fewer than 10 days of cash on hand. This funding will be especially helpful as directed payments are phased down. However, DHCS has

	indicated that it does not intend to backfill any losses resulting from reduced directed payments. Additional Managed Care rate efficiency adjustments are scheduled to be implemented by January 1, 2027, which are expected to result in revenue reductions for Partnership. DHCS has indicated that several new efficiency adjustments are under consideration, including measures related to readmissions, short hospital stays, cesarean section mix, cellulitis, durable medical equipment, and outlier radiology utilization. Partnership experienced a loss of 40,095 members between December 2025 and May 2026, representing nearly a 4.5% reduction in membership. Significant declines continue across all membership categories, and we will continue to closely monitor these trends. Ms. Lopez explained that Partnership's revenue is directly tied to membership levels, and there is concern that the remaining membership population may have higher acute care needs. We believe the required DHCS monthly eligibility data scrubbing against HHS eligibility lists, mixed immigration status households, and general confusion on when federal H.R. 1 policy changes go into effect are contributors to these declines. As noted in prior budget cycles, Long-Term Care costs are difficult to predict because DHCS rate increases are often delayed and issued retroactively in multiple updates. Inflation and reimbursement changes continue to drive costs higher, requiring Partnership staff to regularly review and adjust prior payments. The budget assumes a year-over-year decrease for the Inpatient Hospital and Ancillary Services line items mainly due to UIS members leaving managed care on January 1, 2027, along with new H.R.1 eligibility limits and more frequent eligibility reviews. Due to continued uncertainty in Medicaid, Partnership must carefully manage health care costs through strong medical management and thoughtful contracting decisions. When reviewing hospital contract requests, it is important to consider other Medi-Cal funding sources available to providers, including the Private Hospital Directed Payment (PHDP) and District Hospital Directed Payment (DHDP) programs. Additional updates will be included in the June budget proposal. Because of ongoing uncertainty and the State's budget challenges, Partnership staff expect to bring forward an updated budget after the June budget is finalized to address any major changes in programs, enrollment, or costs.	
2.4 *ACTION:* Resolution to Approve Commissioner Jayme Bottke's	Ms. Bjork announced the resignation of Tehama Board Commissioner Jayme Bottke from the Partnership Board and Finance Committee. She expressed her appreciation for Commissioner Bottke's many valuable contributions to Partnership since February 2024.	*Commissioner Germano moved to approve Agenda Item 2.4 as presented, seconded by Commissioner Starck.*

Resignation from the Finance Committee and Board of Commissioners		***ACTION SUMMARY:*** *Yes: 5* *No: 0* *Abstention: 0* *Excused: 3 (Champlin, Gruver, Sullivan)* **MOTION CARRIED**
Adjournment	Chairman Jones adjourned the meeting at 9:33AM.	None

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Committee Approval Date: 6/17/2026

Signed: _____
Ashlyn Scott, Clerk

Finance Committee
Chief Executive Officer Update
June 17, 2026

1. **Community Reinvestments**
2. **UIS Proposal**
3. **Program Integrity**

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan of California
For the Period Ending April 30, 2026

Financial Analysis for the Current Period

Total Surplus

For the month ending April 30, 2026, Partnership reported a deficit of $6.1 million, bringing the year-to-date surplus to $26.4 million. Key variances are outlined below.

Revenue

Total Revenue is lower than budget by $45.8 million for the month and $484.4 million for year-to-date. The following summarizes the year-to-date variances. Medi-Cal revenue is $86.1 million favorable to budget primarily due to retro membership and the prior and current period risk corridor adjustments. Directed Payments are $594.6 million unfavorable to budget due to lower than anticipated rates with a corresponding offset recorded in Healthcare Investment Funds (HCIF). Supplemental revenues are $9.7 million above budget, reflecting higher Proposition 56 revenue and higher than expected volumes for Maternity Kick, partially offset by the timing of DHCS submissions for American Indian Health Services (AIHS) payments. Interest income is $9.8 million favorable to budget due to higher interest rates than anticipated. The remaining $4.6 million favorable variance is attributed to other revenues.

Healthcare Costs

Total Healthcare Costs are lower than budget by $47.2 million for the month and $493.6 million year-to-date. The following summarizes the year-to-date variances. Non-Capitated Physician and Ancillary expenses are $133.3 million unfavorable to budget primarily due to adjustments to Incurred but Not Reported (IBNR) reserves which reflect the latest cost and utilization trends. Capitation expenses are $5.9 million favorable to budget due to changes in the funding methodologies for certain healthcare providers. Long-term care costs are favorable to budget by $4.8 million due to lower than expected utilization. Inpatient Hospital Fee-For-Service (FFS) expenses are favorable to budget by $47.0 million, driven by adjustments to IBNR reserves attributed to lower utilization. HCIF expenses are $556.9 million favorable to budget due to lower than anticipated Directed Payment rates, which are partially offset by the recording of the accrual for Community Reinvestments. Transportation costs are $4.1 million unfavorable to budget, attributed to increased utilization and an accrual for an increase in the Ground Emergency Medical Transportation – Public Provider (GEMT-PP) rate. Quality Assurance expenses are $16.4 million favorable to budget due to the timing of medical administrative costs.

Administrative Costs

Total Administrative costs are overall favorable to budget by $5.6 million for the month and $62.3 million for the year-to-date. The primary driver of favorability is in Employee costs due to the timing of the filling of open positions geared towards fulfilling our regulatory requirements, which offsets the utilization costs of consultants in the Professional Services category. Additionally, the favorable variance in Occupancy is due to the timing of building related costs including repairs, maintenance, and utilities, as well as the depreciation expenses that accompany capital asset purchases. Lastly, the favorable variance in Computer and Data is due to the timing of software purchases, which typically correlates to the variance in staffing.

Balance Sheet / Cash Flow

Total Cash & Cash Equivalents decreased by $522.4 million for the month. Typical significant cash transactions include State Capitation payments received; healthcare cost payments to providers; and administrative and capital payments out to vendors, employees, and other entities. Items of note for the month include payouts of $391.4 million in directed payments for calendar year 2024 and $188.4 million in MCO quarterly tax payments.

General Statistics

Membership

Membership had a total net decrease of 7,586 members for the month.

Utilization Metrics and High Dollar Case

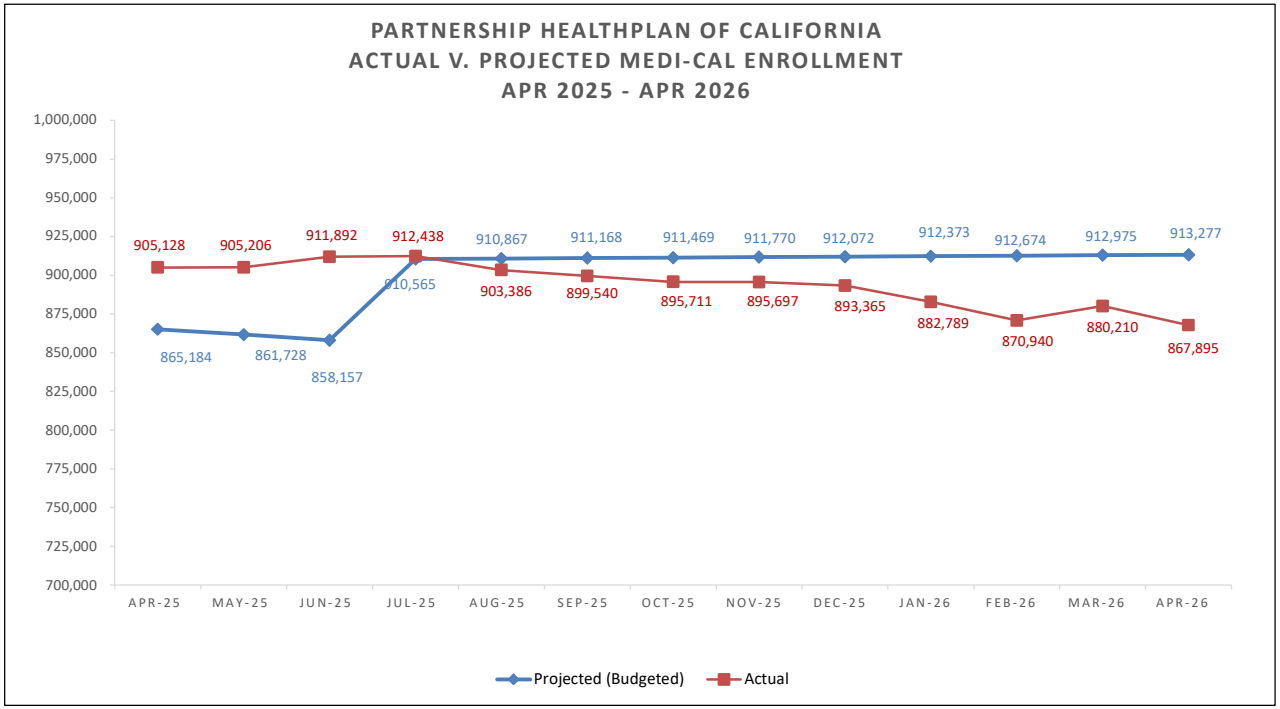
For the fiscal year 2025/26 through April 2026, 796 members reached the $250,000 threshold with an average cost of $497,450. For fiscal year 2024/25, 1,292 members reached the $250,000 threshold with an average cost per case of $513,792. For fiscal year 2023/24, 900 members reached the $250,000 threshold with an average claims cost of $512,459.

Current Ratio/Reserved Funds

Current Ratio Including Required Reserves:	**1.50**
Current Ratio Excluding Required Reserves:	**1.02**
Required Reserves:	**$ 1,430,019,743**
Total Fund Balance:	**$ 1,483,902,863**

Days of Cash on Hand

Including Required Reserves:	**110.18**
Excluding Required Reserves:	**48.43**



Member Months by County:

County	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Solano	102,189	102,658	103,987	104,011	102,676	102,240	101,767	101,583	101,555	98,608	97,031	98,109	96,112
Napa	27,339	27,450	27,826	27,732	27,619	27,642	27,529	27,480	27,355	26,951	26,540	26,659	26,242
Yolo	53,213	53,722	55,109	54,845	54,223	54,152	53,995	54,252	54,140	53,283	52,229	53,552	52,558
Sonoma	112,643	111,321	112,499	112,958	111,588	110,631	110,400	109,596	109,061	107,549	104,697	105,595	104,205
Marin	46,629	46,873	47,047	47,313	46,806	46,609	46,235	46,089	45,096	44,197	43,709	44,101	43,451
Mendocino	40,682	40,941	40,852	41,104	40,506	40,390	40,244	40,200	40,229	39,247	39,125	39,376	38,850
Lake	34,124	34,105	33,983	33,960	33,568	33,236	33,298	33,359	33,389	33,107	32,715	32,770	32,563
Del Norte	12,246	12,336	12,400	12,362	12,314	12,197	12,191	12,220	12,169	12,188	12,077	12,027	11,967
Humboldt	58,149	57,830	57,528	57,819	56,962	56,678	56,451	56,095	55,976	55,830	55,208	55,173	54,632
Lassen	8,767	8,764	8,656	8,575	8,358	8,439	8,412	8,406	8,491	8,375	8,305	8,255	8,204
Modoc	4,013	3,930	3,893	3,878	3,888	3,827	3,743	3,747	3,845	3,836	3,703	3,706	3,658
Shasta	65,219	65,101	65,377	65,400	64,714	64,742	64,786	65,062	64,124	64,876	63,940	64,314	63,758
Siskiyou	17,605	17,791	18,056	18,058	17,782	17,760	17,739	17,786	17,928	17,691	17,590	17,564	17,409
Trinity	5,321	5,325	5,250	5,193	5,220	5,103	5,169	5,118	5,081	4,955	4,955	5,000	4,962
Butte	85,897	85,920	85,649	84,789	84,665	84,532	84,241	84,407	84,874	84,412	83,486	83,679	83,341
Colusa	10,340	10,306	10,362	10,260	10,152	9,996	9,913	9,968	10,006	10,025	9,825	9,899	9,867
Glenn	13,690	13,682	13,647	13,764	13,687	13,672	13,523	13,497	13,456	13,358	13,182	13,222	13,064
Nevada	28,579	28,602	28,731	28,787	28,464	28,369	28,250	28,148	28,633	28,415	28,427	28,548	28,346
Placer	61,260	61,300	62,271	62,355	61,883	61,676	61,371	61,679	61,561	60,619	59,451	62,164	60,536
Plumas	5,886	5,807	5,755	5,784	5,783	5,616	5,575	5,478	5,429	5,395	5,292	5,270	5,278
Sierra	862	832	862	851	825	832	820	810	813	828	823	817	814
Sutter	43,739	43,829	44,348	44,796	44,471	44,294	43,923	44,223	44,067	43,956	43,584	44,445	43,563
Tehama	30,011	29,932	30,038	30,166	29,626	29,551	29,266	29,219	29,095	29,098	29,019	28,962	28,589
Yuba	36,725	36,849	37,766	37,678	37,606	37,356	36,870	37,275	36,992	35,990	36,027	37,003	35,926
All Counties Total	**905,128**	**905,206**	**911,892**	**912,438**	**903,386**	**899,540**	**895,711**	**895,697**	**893,365**	**882,789**	**870,940**	**880,210**	**867,895**

Medi-Cal Region 1: Sonoma, Solano, Napa, Yolo & Marin; Medi-Cal Region 2: Mendocino & Rural 8 Counties; Medi-Cal Region 3: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama & Yuba

Partnership HealthPlan of California
Comparative Financial Indicators Monthly Report
Fiscal Year 2025 - 2026 & Fiscal Year 2024 - 2025

FINANCIAL INDICATORS	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26			YTD	Avg / Month As of Apr-26
Total Enrollment	911,768	903,653	898,537	895,299	893,778	892,208	880,183	870,940	869,706	862,120			8,878,192	887,819
Total Revenue	593,945,794	596,614,742	614,951,654	605,173,794	589,922,935	597,186,401	597,564,630	582,105,182	598,248,494	584,419,840			5,960,133,466	596,013,347
Total Healthcare Costs	498,796,206	506,539,614	512,291,047	520,182,134	500,456,939	496,774,321	509,948,545	476,842,427	505,708,177	497,005,879			5,024,545,294	502,454,529
Total Administrative Costs	24,791,602	22,017,598	26,477,113	24,878,941	26,778,257	26,528,471	26,108,033	23,515,181	26,583,549	29,267,043			256,945,784	25,694,578
Medi-Cal Hospital & Managed Care Taxes	66,396,128	65,722,340	65,436,800	65,176,911	65,100,207	65,268,296	65,351,788	64,457,740	65,122,231	64,257,297			652,289,738	65,228,974
Total Current Year Surplus (Deficit)	3,961,858	2,335,190	10,746,694	(5,064,192)	(2,412,468)	8,615,313	(3,843,736)	17,289,834	834,537	(6,110,379)			26,352,650	2,635,265
Total Claims Payable	629,390,689	669,310,022	649,369,505	691,165,158	693,242,993	695,889,424	733,344,288	698,356,590	626,293,648	646,605,440			646,605,440	673,296,776
Total Fund Balance	1,461,512,071	1,463,847,260	1,474,593,953	1,469,529,761	1,467,117,293	1,475,732,606	1,471,888,870	1,489,178,704	1,490,013,242	1,483,902,863			1,483,902,863	1,474,731,662
Reserved Funds														
State Financial Performance Guarantee	1,135,173,000	1,146,059,000	1,166,267,000	1,181,553,000	1,195,372,000	1,208,212,000	1,221,224,000	1,191,261,000	1,175,457,000	1,173,987,000			1,173,987,000	1,179,456,500
Board Approved Capital and Infrastructure Purchases	100,733,349	100,103,601	98,688,437	97,620,158	94,941,438	93,782,664	92,028,380	90,442,990	89,322,236	88,490,275			88,490,275	94,615,353
Capital Assets	161,362,815	161,328,374	162,223,752	162,679,193	164,744,577	165,348,675	166,558,763	167,531,839	168,044,105	167,542,468			167,542,468	164,736,456
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	68,377,668	68,377,668	68,377,668	68,377,668			68,377,668	69,952,668
Unrestricted Fund Balance	(6,759,761)	(14,646,383)	(23,587,903)	(43,325,258)	(58,943,390)	(62,613,402)	(76,299,941)	(28,434,793)	(11,187,767)	(14,494,548)			(14,494,548)	(34,029,315)
Fund Balance as % of Reserved Funds	99.54%	99.01%	98.43%	97.14%	96.14%	95.93%	95.07%	98.13%	99.25%	99.03%			99.03%	97.74%
Current Ratio (including Required Reserves)	1.49:1	1.46:1	1.44:1	1.45:1	1.43:1	1.43:1	1.46:1	1.44:1	1.43:1	1.50:1			1.50:1	1.45:1
Medical Loss Ratio w/o Tax	94.55%	95.41%	93.23%	96.33%	95.36%	93.39%	95.82%	92.12%	94.86%	95.55%			94.66%	94.66%
Admin Ratio w/o Tax	4.70%	4.15%	4.82%	4.61%	5.10%	4.99%	4.91%	4.54%	4.99%	5.63%			4.84%	4.84%
Profit Margin Ratio	0.75%	0.44%	1.96%	-0.94%	-0.46%	1.62%	-0.72%	3.34%	0.16%	-1.17%			0.50%	0.50%

FINANCIAL INDICATORS	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD	Avg / Month As of Jun-25
Total Enrollment	898,490	898,153	897,450	895,408	895,235	905,698	901,907	904,947	906,317	904,513	903,817	910,264	10,822,199	901,850
Total Revenue	516,467,263	505,732,274	517,421,674	517,491,108	507,895,691	520,768,067	518,706,967	759,253,557	692,900,747	592,855,121	595,592,203	643,816,561	6,888,901,232	574,075,103
Total Healthcare Costs	455,570,291	455,587,935	449,203,390	445,671,531	422,571,150	440,227,707	443,280,032	430,197,038	480,694,520	490,255,409	527,157,036	443,488,949	5,483,904,985	456,992,082
Total Administrative Costs	17,164,116	20,965,109	20,303,694	22,663,983	19,787,655	21,565,508	23,537,967	22,873,201	21,628,246	26,832,114	23,265,462	26,309,568	266,896,625	22,241,385
Medi-Cal Hospital & Managed Care Taxes	46,566,563	46,437,851	46,436,856	46,083,262	46,460,193	46,509,845	46,696,106	298,302,026	105,449,368	66,370,265	66,176,548	66,663,236	928,152,119	77,346,010
Total Current Year Surplus (Deficit)	(2,833,707)	(17,258,621)	1,477,734	3,072,332	19,076,693	12,465,007	5,192,862	7,881,292	85,128,613	9,397,333	(21,006,843)	107,354,808	209,947,503	17,495,625
Total Claims Payable	884,509,979	911,448,691	890,651,592	852,864,933	830,533,762	775,002,932	770,859,204	759,273,827	639,166,969	601,722,478	648,998,299	613,302,418	613,302,418	764,861,257
Total Fund Balance	1,244,769,003	1,227,510,382	1,228,988,116	1,232,060,447	1,251,137,140	1,263,602,149	1,268,795,012	1,276,676,303	1,361,804,917	1,371,202,250	1,350,195,407	1,457,550,213	1,457,550,213	1,294,524,278
Reserved Funds														
State Financial Performance Guarantee	1,092,899,000	1,093,798,000	1,096,923,000	1,100,211,000	1,102,840,000	1,046,032,000	1,049,745,000	1,091,605,000	1,119,293,000	1,130,765,000	1,143,805,000	1,121,915,000	1,121,915,000	1,099,152,583
Board Approved Capital and Infrastructure Purchases	79,941,518	79,360,193	77,250,794	76,202,434	75,447,816	73,742,888	72,667,651	71,478,836	70,124,244	66,296,695	66,344,624	63,186,278	63,186,278	72,670,331
Capital Assets	134,500,819	148,731,129	150,227,245	152,420,562	152,556,243	152,888,655	154,088,260	154,631,556	155,340,379	157,165,923	157,852,579	160,862,612	160,862,612	152,605,497
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668
Unrestricted Fund Balance	(133,575,002)	(165,381,608)	(166,415,591)	(167,776,217)	(150,709,587)	(80,064,063)	(78,708,568)	(112,041,757)	(53,955,374)	(54,028,036)	(88,809,464)	40,583,655	40,583,655	(100,906,801)
Fund Balance as % of Reserved Funds	90.31%	88.13%	88.07%	88.01%	89.25%	94.04%	94.16%	91.93%	96.19%	96.21%	93.83%	102.86%	102.86%	92.77%
Current Ratio (including Required Reserves)	1.45:1	1.41:1	1.40:1	1.40:1	1.40:1	1.39:1	1.41:1	1.37:1	1.44:1	1.45:1	1.43:1	1.48:1	1.48:1	1.42:1
Medical Loss Ratio w/o Tax	96.95%	99.19%	95.38%	94.54%	91.58%	92.82%	93.91%	93.33%	81.83%	93.12%	99.57%	76.84%	92.00%	92.00%
Admin Ratio w/o Tax	3.65%	4.56%	4.31%	4.81%	4.29%	4.55%	4.99%	4.96%	3.68%	5.10%	4.39%	4.56%	4.48%	4.48%
Profit Margin Ratio	-0.60%	-3.76%	0.31%	0.65%	4.13%	2.63%	1.10%	1.71%	14.49%	1.78%	-3.97%	18.60%	3.52%	3.52%

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Membership and Financial Summary
For The Period Ending April 30, 2026

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
862,120	869,706	(7,586)	**Total Membership**	887,819	900,812	(12,993)

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
584,419,840	630,257,112	(45,837,272)	**Total Revenue**	5,960,133,466	6,444,539,207	(484,405,741)
497,005,879	544,184,238	47,178,359	**Total Healthcare Costs**	5,024,545,294	5,518,132,386	493,587,092
29,267,043	34,870,547	5,603,504	**Total Administrative Costs**	256,945,784	319,243,543	62,297,759
64,257,297	66,501,448	2,244,151	**Medi-Cal Managed Care Tax**	652,289,738	665,908,987	13,619,249
(6,110,379)	**(15,299,121)**	**9,188,742**	**Total Current Year Surplus (Deficit)**	**26,352,650**	**(58,745,709)**	**85,098,359**
95.55%	96.53%		**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	94.66%	95.49%	
5.63%	6.19%		**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	4.84%	5.52%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of April 30, 2026

	April 2026	March 2026
A S S E T S		
Current Assets		
Cash & Cash Equivalents	**990,206,181**	**1,512,648,196**
Receivables		
Accrued Interest	384,800	1,172,500
State DHS - Cap Rec	1,599,416,471	1,499,298,122
Other Healthcare Receivable	47,450,036	43,089,039
Miscellaneous Receivable	6,264,075	6,232,740
Total Receivables	**1,653,515,382**	**1,549,792,401**
Other Current Assets		
Payroll Clearing	(2,843)	(1,463)
Prepaid Expenses	17,048,778	16,142,936
Total Other Current Assets	**17,045,935**	**16,141,473**
Total Current Assets	**2,660,767,498**	**3,078,582,070**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	1,096,330	1,096,330
Furniture & Fixtures	7,701,728	7,701,728
Computer Equipment	22,832,149	21,552,145
Computer Software	9,060,595	9,048,571
Leasehold Improvements	124,288	124,288
Land	11,330,439	11,330,439
Building	79,474,549	79,474,549
Building Improvements	46,822,607	46,107,883
Accum Depr - Motor Vehicles	(578,014)	(562,987)
Accum Depr - Furniture	(6,786,618)	(6,767,303)
Accum Depr - Comp Equipment	(19,805,304)	(19,044,299)
Accum Depr - Comp Software	(9,015,479)	(8,989,896)
Accum Depr - Leasehold Improvements	(124,288)	(124,288)
Accum Depr - Building	(15,908,322)	(15,738,505)
Accum Depr - Bldg Improvements	(18,441,686)	(18,098,835)
Construction Work-In-Progress	59,759,494	60,934,285
Total Fixed Assets	**167,542,468**	**168,044,105**
Other Non-Current Assets		
Deposits	83,280	83,280
Board-Designated Reserves	1,262,177,275	1,264,479,236
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	9,073,573	9,354,099
Net Pension Asset	5,714,523	5,714,523
Deferred Outflows Of Resources	2,745,009	2,745,009
Net Subscription Asset	3,120,175	3,120,175
Total Other Non-Current Assets	**1,283,213,835**	**1,285,796,322**
Total Non-Current Assets	**1,450,756,303**	**1,453,840,427**
Total Assets	**4,111,523,801**	**4,532,422,497**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of April 30, 2026

	April 2026	March 2026
L I A B I L I T I E S & F U N D B A L A N C E		
Liabilities		
Current Liabilities		
Accounts Payable	251,861,655	378,497,815
Unearned Income	51,882,426	52,470,131
Suspense Account	11,252,121	15,600,034
Capitation Payable	7,720,702	6,840,525
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	1,495,127,170	1,802,345,555
Claims Payable	291,787,634	165,123,996
Incurred But Not Reported-IBNR	354,817,806	461,169,652
Quality Improvement Programs	121,202,690	118,392,813
Total Current Liabilities	**2,618,285,317**	**3,033,073,634**
Non-Current Liabilities		
Deferred Inflows Of Resources	6,657,637	6,657,637
Net Subscription Liability	2,677,984	2,677,984
Total Non-Current Liabilities	**9,335,621**	**9,335,621**
Total Liabilities	**2,627,620,938**	**3,042,409,255**
Fund Balance		
Unrestricted Fund Balance	**(14,494,548)**	**(11,187,767)**
Reserved Funds		
State Financial Performance Guarantee	1,173,987,000	1,175,457,000
Board Approved Capital and Infrastructure Purchases	88,490,275	89,322,236
Capital Assets	167,542,468	168,044,105
Strategic Use of Reserve-Board Approved	68,377,668	68,377,668
Total Reserved Funds	**1,498,397,411**	**1,501,201,009**
Total Fund Balance	**1,483,902,863**	**1,490,013,242**
Total Liabilities And Fund Balance	**4,111,523,801**	**4,532,422,497**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Statement of Cash Flow
For The Period Ending April 30, 2026

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Services	475,336,121	6,101,950,102
Other Revenues	195,422	2,466,783
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(20,595,795)	(206,868,712)
Medical Claims Payments	(761,978,387)	(4,741,739,886)
Drug Medi-Cal		
DMC Receipts from Counties	1,341,978	55,075,747
DMC Payments to Providers	(5,778,316)	(54,313,915)
Cash Payments to Vendors	(196,980,563)	(862,452,203)
Cash Payments to Employees	(23,869,035)	(207,284,917)
Net Cash (Used) Provided by Operating Activities	**(532,328,575)**	**86,832,999**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(1,357,776)	(14,502,501)
Net Cash (Used) by Capital Financial & Related Activities	**(1,357,776)**	**(14,502,501)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	2,301,961	(77,375,997)
Interest and Dividends on Investments	8,942,375	77,642,744
Net Cash Provided by Investing Activities	**11,244,336**	**266,747**
NET (DECREASE) INCREASE	**(522,442,015)**	**72,597,245**
CASH & CASH EQUIVALENTS, BEGINNING	**1,512,648,196**	**917,608,936**
CASH & CASH EQUIVALENTS, ENDING	**990,206,181**	**990,206,181**
RECONCILIATION OF TOTAL OPERATING LOSSTO NET CASH (USED) PROVIDED BY OPERATING ACTIVITIES		
TOTAL OPERATING LOSS	**(14,265,054)**	**(50,711,394)**
DEPRECIATION	**1,333,597**	**6,670,489**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(4,392,332)	11,086,089
California Department of Health Services Receivable	(100,118,349)	155,493,084
Other Assets	(98,121)	(1,570,246)
Accounts Payable and Accrued Expenses	(437,909,985)	(109,030,866)
Accrued Claims Payable	20,311,793	33,303,023
Quality Improvement Programs	2,809,876	41,592,820
Net Cash (Used) Provided by Operating Activities	**(532,328,575)**	**86,832,999**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses
For The Period Ending April 30, 2026

****The Notes to the Financial Statement are an Integral Part of this Statement****

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	ACTUAL MONTH PMPM	BUDGET MONTH PMPM		ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD	ACTUAL YTD PMPM	BUDGET YTD PMPM
862,120	**862,120**	**-**			**TOTAL MEMBERSHIP**	**8,878,192**	**8,878,192**	**-**		
					REVENUE					
575,454,042	623,409,012	(47,954,970)	667.49	723.11	State Capitation Revenue	5,876,402,973	6,375,231,387	(498,828,414)	661.89	718.08
8,154,675	6,639,370	1,515,305	9.46	7.70	Interest Income	77,064,044	67,278,940	9,785,104	8.68	7.58
811,123	208,730	602,393	0.94	0.24	Other Revenue	6,666,450	2,028,880	4,637,570	0.75	0.23
584,419,840	**630,257,112**	**(45,837,272)**	**677.89**	**731.05**	**TOTAL REVENUE**	**5,960,133,466**	**6,444,539,207**	**(484,405,741)**	**671.32**	**725.89**
					HEALTHCARE COSTS					
					Physician Services					
9,255,567	9,391,885	136,318	10.74	10.89	Pcp Capitation	89,356,973	96,569,848	7,212,875	10.06	10.88
198,897	206,937	8,040	0.23	0.24	Specialty Capitation	2,100,799	2,085,035	(15,764)	0.24	0.23
85,231,308	84,108,780	(1,122,528)	98.86	97.56	Non-Capitated Physician Services	898,896,426	828,552,978	(70,343,448)	101.25	93.32
94,685,772	**93,707,602**	**(978,170)**	**109.83**	**108.69**	**Total Physician Services**	**990,354,198**	**927,207,861**	**(63,146,337)**	**111.55**	**104.43**
					Inpatient Hospital					
16,429,328	15,908,829	(520,499)	19.06	18.45	Hospital Capitation	168,862,736	166,402,911	(2,459,825)	19.02	18.74
110,709,015	112,369,857	1,660,842	128.41	130.34	Inpatient Hospital - Ffs	1,105,375,866	1,152,420,275	47,044,409	124.50	129.80
790,140	790,140	-	0.92	0.92	Hospital Stoploss	8,086,301	8,086,301	-	0.91	0.91
127,928,483	**129,068,826**	**1,140,343**	**148.39**	**149.71**	**Total Inpatient Hospital**	**1,282,324,903**	**1,326,909,487**	**44,584,584**	**144.43**	**149.45**
59,375,298	60,963,541	1,588,243	68.87	70.71	Long Term Care	608,306,175	613,127,547	4,821,372	68.52	69.06
					Ancillary Services					
1,275,282	1,297,813	22,531	1.48	1.51	Ancillary Services - Capitated	12,211,941	13,412,499	1,200,558	1.38	1.51
104,230,628	98,284,342	(5,946,286)	120.90	114.00	Ancillary Services - Non-Capitated	1,064,273,289	1,001,309,525	(62,963,764)	119.88	112.78
105,505,910	**99,582,155**	**(5,923,755)**	**122.38**	**115.51**	**Total Ancillary Services**	**1,076,485,230**	**1,014,722,024**	**(61,763,206)**	**121.26**	**114.29**
					Other Medical					
6,261,753	8,393,253	2,131,500	7.26	9.74	Quality Assurance	59,274,849	75,671,757	16,396,908	6.68	8.52
82,922,470	132,286,973	49,364,503	96.18	153.44	Healthcare Investment Funds	799,272,728	1,355,917,796	556,645,068	90.03	152.72
115,500	151,560	36,060	0.13	0.18	Advice Nurse	1,222,500	1,439,830	217,330	0.14	0.16
13,149,280	12,968,915	(180,365)	15.25	15.04	Transportation	134,840,996	130,672,369	(4,168,627)	15.19	14.72
102,449,003	**153,800,701**	**51,351,698**	**118.82**	**178.40**	**Total Other Medical**	**994,611,073**	**1,563,701,752**	**569,090,679**	**112.04**	**176.12**
7,061,413	7,061,413	-	8.19	8.19	Quality Improvement Programs	72,463,715	72,463,715	-	8.16	8.16
497,005,879	**544,184,238**	**47,178,359**	**576.48**	**631.21**	**TOTAL HEALTHCARE COSTS**	**5,024,545,294**	**5,518,132,386**	**493,587,092**	**565.96**	**621.51**
					ADMINISTRATIVE COSTS					
17,412,501	22,177,527	4,765,026	20.20	25.72	Employee	161,285,706	203,544,736	42,259,030	18.17	22.93
95,152	201,064	105,912	0.11	0.23	Travel And Meals	850,027	1,910,282	1,060,255	0.10	0.22
2,090,676	3,342,790	1,252,114	2.43	3.88	Occupancy	13,880,331	26,871,650	12,991,319	1.56	3.03
655,317	956,246	300,929	0.76	1.11	Operational	6,576,492	9,083,920	2,507,428	0.74	1.02
4,754,613	3,461,288	(1,293,325)	5.52	4.01	Professional Services	37,182,537	32,882,398	(4,300,139)	4.19	3.70
4,258,784	4,731,632	472,848	4.94	5.49	Computer And Data	37,170,691	44,950,557	7,779,866	4.19	5.06
29,267,043	**34,870,547**	**5,603,504**	**33.96**	**40.44**	**TOTAL ADMINISTRATIVE COSTS**	**256,945,784**	**319,243,543**	**62,297,759**	**28.95**	**35.96**
64,257,297	66,501,448	2,244,151	74.53	77.14	**Medi-Cal Managed Care Tax**	652,289,738	665,908,987	13,619,249	73.47	75.01
(6,110,379)	**(15,299,121)**	**9,188,742**	**(7.08)**	**(17.74)**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**26,352,650**	**(58,745,709)**	**85,098,359**	**2.94**	**(6.59)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
April 30, 2026

1. ORGANIZATION

The Partnership HealthPlan of California (the HealthPlan) was formed as a health insurance organization and is legally a subdivision of the State of California but is not part of any city, county or state government system. The HealthPlan has quasi-independent political jurisdiction to contract with the State for managing Medi-Cal beneficiaries who reside in various Northern California counties. The HealthPlan is a combined public and private effort engaged principally in providing a more cost-effective method of healthcare. The HealthPlan began serving Medi-Cal eligible persons in Solano County in May 1994. That was followed by additional Northern California counties in March 1998, March 2001, October 2009, two counties in July 2011, and eight counties in September 2013. Beginning July 2018 and in accordance with direction from the Department of Health Care Services (DHCS), the HealthPlan consolidated its reporting from these fourteen counties into two regions, which are in alignment with the two DHCS rating regions. Beginning January 2024, the HealthPlan expanded into ten additional counties, which comprise a third region.

As a public agency, the HealthPlan is exempt from state and federal income tax.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

ACCOUNTING POLICIES:
The accounting and reporting policies of the HealthPlan conform to Generally Accepted Accounting Principles and general practices within the healthcare industry.

PROPERTY AND EQUIPMENT:
Effective July 2015, property and equipment totaling $10,000 or more are recorded at cost; this includes assets acquired through capital leases and improvements that significantly add to the productive capacity or extend the useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Depreciation for financial reporting purposes is provided on a straight-line method over the estimated useful life of the asset. The costs of major remodeling and improvements are capitalized as building or leasehold improvements. Leasehold improvements are amortized using the straight-line method over the shorter of the remaining term of the applicable lease or their estimated useful life. Building improvements are depreciated over their estimated useful life.

INVESTMENTS:
The HealthPlan investments can consist of U.S. Treasury Securities, Certificates of Deposits, Money Market and Mutual Funds, Government Pooled Funds, Agency Notes, Repurchase

Agreements, Shares of Beneficial Interest and Commercial Paper and are carried at fair value.

RESERVED FUNDS:
As of April 2026, the HealthPlan has Total Reserved Funds of $1.5 billion. This includes $68.4 million of funds set aside for Board approved Strategic Use of Reserve (SUR) initiatives; this also includes funding for the Wellness & Recovery program. The total SUR amount represents the net amount remaining for all SUR projects that have been approved to date and is periodically adjusted as projects are completed. Reserved Funds also includes $0.3 million of Knox-Keene Reserves.

RECLASSIFICATIONS:
Certain reclassifications of prior period balances have been made to conform with the current period presentations. Such reclassifications do not affect the total increase in net position or total current or noncurrent assets or liabilities.

3. STATE CAPITATION REVENUE

Medi-Cal capitation revenue is based on the monthly capitation rates, as provided for in the State contract, and the actual number of Medi-Cal eligible members. Capitation revenues are paid by the State on a monthly basis in arrears based on estimated membership. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the State for projected changes in membership and trued up monthly through a State reconciliation process. These estimates are continually monitored and adjusted, as necessary, as experience develops or new information becomes known.

4. HEALTHCARE COST

The HealthPlan continues to develop completion factors to calculate estimated liability for claims Incurred But Not Reported. These factors are reviewed and adjusted as more historical data becomes available. Budgeted capitation revenues and healthcare costs are adjusted each month to reflect changes in enrollee counts.

5. QUALITY IMPROVEMENT PROGRAM

The HealthPlan maintains quality improvement contracts with acute care hospitals and primary care physicians. As of April 2026, the HealthPlan has accrued a Quality Improvement Program payout of $121.2 million.

6. ESTIMATES

Due to the nature of the operations of the HealthPlan, it is necessary to estimate amounts for financial statement presentation. Substantial overstatement or understatement of these estimates would have a significant impact on the statements. The items estimated through various methodologies are:

- Value of Claims Incurred But Not Reported
- Quality Incentive Payouts
- Earned Capitation Revenues
- Total Number of Members
- Retro Capitation Expense for Certain Providers

7. COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, the HealthPlan is party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, the HealthPlan's Management is of the opinion that any liability which may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of the operations of the HealthPlan.

8. UNUSUAL OR INFREQUENT ITEMS REPORTED IN CURRENT MONTH'S FINANCIAL STATEMENTS

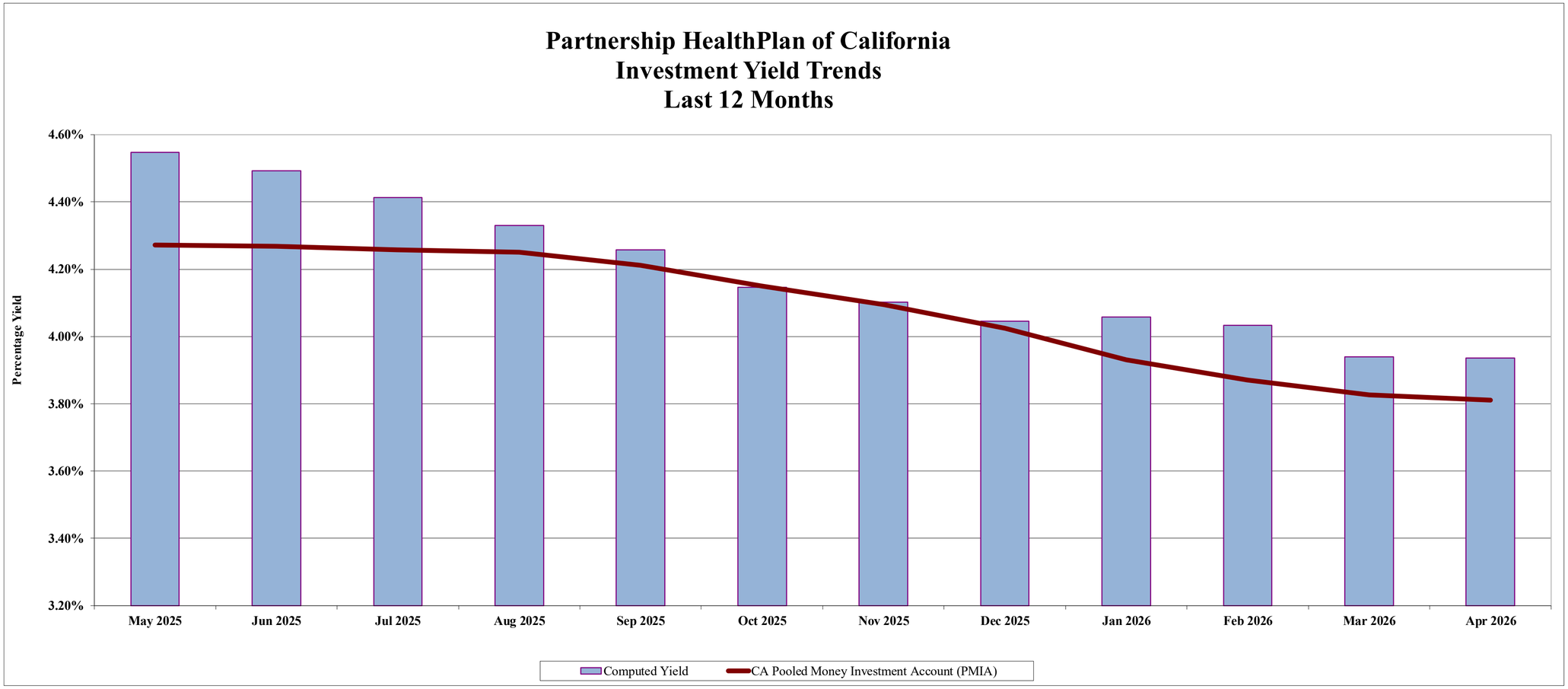
None noted.

Partnership HealthPlan of California
Investment Schedule
April 30, 2026

Name of Investment	Investment Type	Yield to Maturity	Trade Date	Maturity Date	Call Date	Face Value	Purchase Price	Market Value	Credit Rating Agency	Credit Rating
FUNDS HELD FOR INVESTMENT:										
Highmark Money Market	Cash & Cash Equiv	NA	Various	NA	NA	NA	$ 1,828,645	$ 1,828,645	NA	NR
Certificate of Deposit for Knox Keene	Cash & Cash Equiv	0.0405	1/31/2025	1/30/2030	NA	$ 300,000	$ 300,000	$ 300,000	NA	NR
FUNDS HELD FOR OPERATIONS:										
Merrill Lynch Institutional	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 81,337,228		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 702,102		
US Bank - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 2,046,756,502		
Government Investment Pools (LAIF)	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 75,000,000		
Government Investment Pools (County)	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 46,607,450		
West America Payroll	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 148,229		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:								$ 2,252,683,456		

Partnership HealthPlan of California
Investment Yield Trends

PERIOD		May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026
Interest Income		7,671,506	7,390,920	7,568,557	7,456,341	7,941,176	8,116,523	6,918,278	7,880,097	8,365,738	6,897,186	7,765,472	8,154,675
Cash & Investments at Historical Cost	(1)	2,207,098,027	2,102,710,214	2,160,202,257	2,286,589,057	2,474,845,534	2,254,168,286	2,239,590,881	2,602,840,892	2,355,098,087	2,373,599,880	2,777,427,432	2,252,683,455
Computed Yield	(2)	4.55%	4.49%	4.41%	4.33%	4.26%	4.15%	4.10%	4.05%	4.06%	4.03%	3.94%	3.94%
CA Pooled Money Investment Account (PMIA)	(3)	4.27%	4.27%	4.26%	4.25%	4.21%	4.15%	4.10%	4.03%	3.93%	3.87%	3.83%	3.81%



NOTES:

(1) Investment balances include Restricted Cash and Board Designated Reserves

(2) Computed yield is calculated by dividing the past 12 months of interest by the average cash balance for the past 12 months.

(3) LAIF limits the amount a single government entity can deposit into LAIF; currently that amount is set at $75 million.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: June 17, 2026 2.3
Board Meeting Date: June 24, 2026

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Finance Committee & Partnership Staff

Topic Description:
On April 22, 2026, the Board approved Budget Assumptions for Fiscal Year 2026-2027 and directed staff to prepare a comprehensive operational budget. in May, a Preliminary Health Care Budget for Fiscal Year 2026–2027 was prepared in accordance with the approved assumptions and the Final Health Care Budget for Fiscal Year 2026–2027 is now presented to the Board for review and approval.

Reason for Resolution:
To give the Board the opportunity to review and approve the Final Budget for Fiscal Year 2026-2027.

Financial Impact:
The impact to the HealthPlan is implicit in the budget.

Requested Action of the Board:
Based on the recommendation of the Finance Committee and Partnership Staff, the Board is asked to approve the Final Budget for Fiscal Year 2026-2027.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: June 17, 2026
Board Meeting Date: June 24, 2026

Agenda Item Number:
2.3

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE FINAL BUDGET FOR FY 2026-2027

Recital: Whereas,

A. The Board has responsibility for establishing budget policy and specific budget approval.

B. In prior meetings, Partnership staff, the Finance Committee and Board provided direction and input.

C. The final Budget conforms to general assumptions established.

Now, Therefore, It Is Hereby Resolved As Follows:

1. The Board hereby approves the Final Health Care Budget for Fiscal Year 2026–2027 as presented.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 24th day of June 2026 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Dean Germano, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

FY 2026-27

Annual Operating Budget

June 2026

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Introduction

The next phase of the Partnership budget process is to present the 2026-27 Operating Budget to the Finance Committee and Board of Directors for final consideration and approval. Partnership Staff has consolidated the prior components of the budget into one comprehensive summary. A version history is provided at the conclusion of this report to walk between the healthcare assumptions presented in May 2026 and the final healthcare costs presented below.

Outlook for 2026-27 State Outlook – May Revise

As of the May Revise the State presented a total budget of $349.4 billion total fund ($246.6 billion State General Fund) for FY 2026-27, $1.8 billion lower than estimated in January). The May Revise does not propose any significant new ongoing expenditures. General Fund revenues (excluding transfers and loans) are projected to be $16.8 billion higher than what was assumed in January for FY 2025-26 and FY 2026-27, largely driven by personal income tax. The May Revise maintains reserves and reduces previously forecasted operating deficits. The increased revenue and the restraint of not introducing new sizeable ongoing expenditures have allowed the Governor to present a balanced budget for FY 2026-27 through FY 2027-28. The next Governor and State Administration will be tasked with addressing outyear budget deficits.

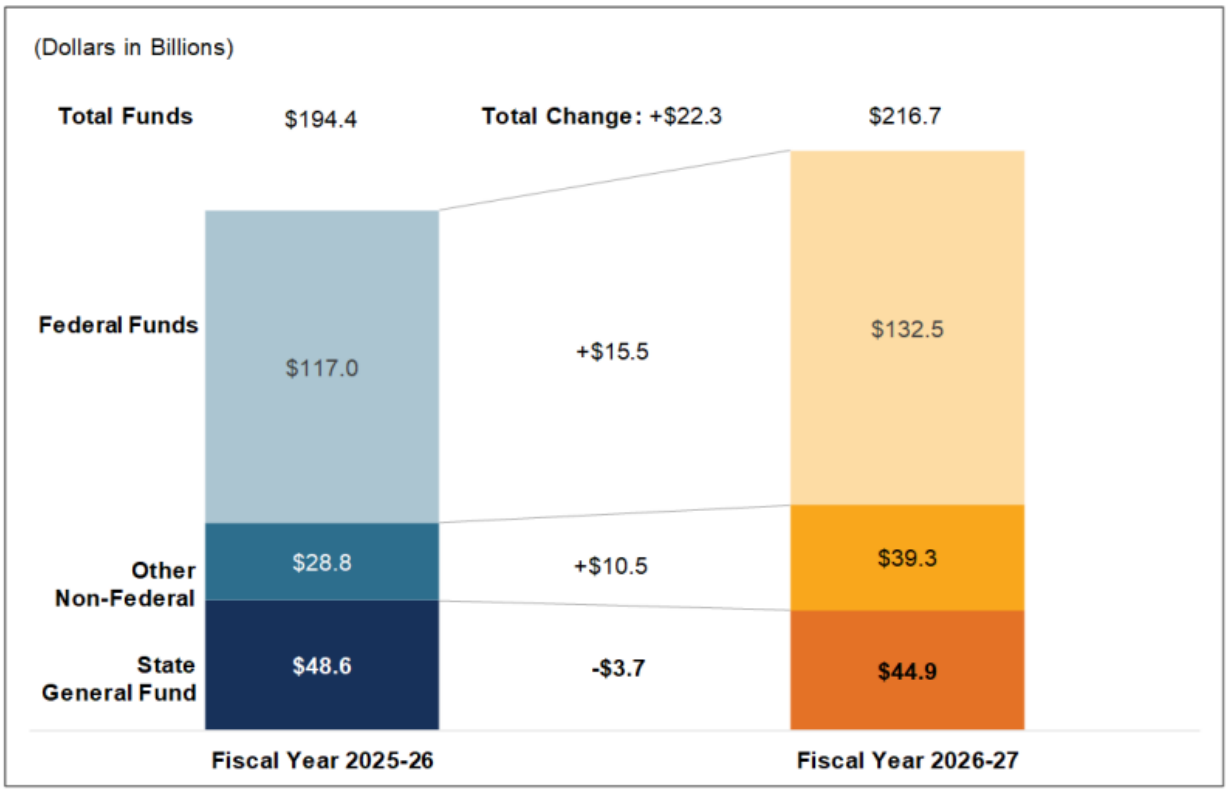
The May Revise combined reserves for FY 2026-27 are $29.9 billion, of which:

- $15.1 billion in the Budget Stabilization Account, an increase of $3.9 billion from the FY 2025-26 Enacted Budget.
- $4.5 billion in the Special Fund for Economic Uncertainties, no change from FY 2025-26 Enacted Budget.
- $10.3 billion deposit into the Public School System Stabilization Account, an increase of $6.2 billion from the January Budget.

Further the May Revises assumes a $9.7 billion transfer into the Surplus Holding Account, this account was established in 2024 and allows the State to set aside a portion of anticipated surplus funds and allocate them in a subsequent fiscal year.

Medi-Cal is a large portion of overall State expenditures and continues to be a focus of this Administration. The below Department of Health Care Services (DHCS) May Revise Highlights budget chart[1], outlines the May Revise year-over-year Medi-Cal program estimated expenditures.

Medi-Cal Year Over Year Change from FY 2025-26 to FY 2026-27



[1] https://www.dhcs.ca.gov/Budget/Documents/DHCS-FY-2026-27-May-Revise-Highlights.pdf

As displayed above, $216.7 billion total fund ($44.9 billion General Fund) was requested to operate the Medi-Cal program for FY 2026-27. This is a $5.7 billion total fund ($3.9 billion General Fund) decrease from the January Budget for FY 2026-27. The budget assumes 13.9 million individuals will receive coverage through the Medi-Cal program in FY 2026-27, which is a 3.75% membership decrease from revised FY 2025-26 membership. The DHCS Medi-Cal membership projections are inclusive of Managed Care and Fee-for-Service (FFS) members.

Notable May Revise Budget details that affect the Medi-Cal program are highlighted below.

- **Unsatisfactory Immigration Status (UIS) Members transitioned from Medi-Cal Managed Care to Medi-Cal FFS** - The May Revise proposes to transition all UIS members from Medi-Cal Managed Care to Medi-Cal FFS effective January 1, 2027. Per the DHCS this change is a result of federal prohibitions tied to risk-based payments for federally eligible emergency services for these members. The budget proposes to transition these members to full scope Medi-Cal FFS. Under the Administration's proposal, UIS members would lose Enhanced Care Management and Community Supports, which are currently available only through the Medi-Cal Managed Care delivery system. As of June 2026, Partnership serves nearly 88,000 UIS members.
- **Increased UIS Adult Member Medi-Cal Premiums** - The Governor's FY 2025-26 Budget included a $30 monthly premium for all UIS members aged 19 to 59 who are enrolled in full scope Medi-Cal. The May Revise proposed to increase the monthly premium to $50

effective July 1, 2027. Questions have been raised about whether the State would consider providing counties with indigent care funding to cover health care costs for UIS members who lose Medi-Cal coverage due to the implementation of premiums and the UIS member enrollment freeze that took effect January 1, 2026.

- **Eligibility Changes for Qualified Non-Citizens** - H.R.1 implemented federal eligibility changes for qualified non-citizens and narrowed eligibility for federal funding. As a result, effective October 1, 2026, this group will transition to state-only full scope Medi-Cal with no dental coverage. Effective January 1, 2027, these members that are enrolled in Managed Care will transition to limited-scope Medi-Cal FFS. Effective July 1, 2027, this group will shift to restricted-scope Medi-Cal FFS. The cost of this change is estimated to be $668.1 million General Fund in FY 2026-27.
- **Modify the Asset Test for Medi-Cal Eligibility** - The budget proposed to modify the asset limit for the Seniors and Persons with Disabilities population. As of January 1, 2026, Medi-Cal changed their asset test; limiting Medi-Cal eligibility to members with no more than $130,000 of assets for one person and an additional $65,000 for each additional family member. The budget proposed to modify the asset test effective January 1, 2027, Medi-Cal eligibility would be limited to members with assets of $2,000 for an individual and $3,000 for a couple. This change is expected to result in additional Partnership membership losses.
- **New Managed Care Organization (MCO) Tax** - The FY 2026-27 budget proposes adopting a new MCO Tax effective January 1, 2027, that would assess a higher tax rate on non-Medi-Cal plans. The new tax structure proposes to impose an $8.85 PMPM tax on Medi-Cal and Non-Medi-Cal plans. H.R. 1 and other federal changes require the tax rate of non-Medi-Cal and Medi-Cal plans to be uniform. The new tax revenue is expected to result in $575 million in FY 2026-27, $2.3 billion in FY 2027-28 and FY 2028-29, and $1.7 billion in FY 2029-30. Full details of the new MCO Tax have not been released at this time.
- **Existing MCO Tax Revenue Timing Adjustments** - The budget was adjusted to reflect changes in the timing of when existing MCO Tax revenues will be collected and expended. The budget proposes to spread this revenue over FY 2025-26, FY 2026-27, and FY 2027-28. Our understanding is the MCO tax revenue will be used to fund the Governor's May 2025 Proposition 35 spending plan. Subject to Centers for Medicare and Medicaid Services approval, the spending plan includes investments for the:
    - Continuation of Medi-Cal Targeted Rate Increases (TRI)
    - Time-limited supplemental payments, over and beyond TRI for primary care, specialty care, maternal health, and non-specialty mental health providers.
    - Behavioral Health Facility Throughputs
    - Graduate Medical Education
    - Medi-Cal Workforce
- **Elimination of the Adult Acupuncture Benefit** - This policy would eliminate the optional benefit for adult members effective January 1, 2027.
- **Implement Medi-Cal Efficiencies through Utilization Management** - This policy would implement applied behavioral analysis (ABA) and transportation utilization management controls. DHCS has established a joint Chief Financial Officer and Chief Medical Officer workgroup to discuss these new policies. DHCS will consider the feedback from this workgroup to help shape final policy requirements.

- **Revisions to Community Supports and Enhanced Care Management (ECM)** - The current budget proposes to scale back California Advancing and Innovating Medi-Cal (CalAIM). Specifically, the May Revise assumes General Fund reductions of $41.4 million in FY 2026-27 and $99.2 million ongoing for ECM tied to refined eligibility criteria, service definitions, utilization management criteria, and payment adjustments. Further General Fund reductions of $26.9 million in FY 2026-27, $58.8 million in 2027-28, and $51 million ongoing were included for Community Supports tied to refined referral pathways, eligibility criteria, service definitions, and utilization management criteria for select Medi-Cal community supports. The proposed policy changes would be effective January 1, 2027.

Other notable items:

- **Reduced Medical Assistance Percentage for Emergency Services** - The May Revise includes $669 million in increased General Fund costs in FY 2026-27 due to the emergency services federal match reductions (match reduced from 90 percent to 50 percent) for UIS adult expansion members. This change goes into effective October 1, 2026.
- **Eliminate Prospective Payment System (PPS) funding for State-Only Services for UIS Members** - The May Revise proposes to eliminate PPS rate funding for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for state-only-funded services for UIS members effective no sooner than July 1, 2026. If implemented clinics would be reimbursed at the applicable Medi-Cal managed care rate for the period of July 1, 2026 to December 31, 2026. Effective January 1, 2027, clinics would be reimbursed at the applicable Medi-Cal FFS rate. FQHCs and RHCs are safety net providers that serve as the primary care backbone of Medi-Cal.
- **Funding for Hospitals in Immediate Financial Distress** – The May Revise allows for an augmentation of up to $50 million General fund in FY 2026-27 for the Department of Health Care Access and Information. This funding will provide limited financial support to hospitals with less than 10 days of cash on hand, whose patient mix is at least 50 percent government funded or uninsured. Given the fiscal hardships hospitals and specifically rural hospitals have faced this funding can serve as a stopgap to keep hospitals afloat as longer term solutions are explored.

In previous times of budgetary hardship, the State has implemented a variety of cost cutting measures in the Medi-Cal program outside of the budget. Based on recent discussions with DHCS and history we expect:

- Additional Managed Care rate efficiency adjustments to be implemented by January 1, 2027. This will result in Partnership revenue reductions. DHCS has indicated the following new efficiency adjustments are being considered for implementation: readmissions, short hospital stays, cesarean mix, cellulitis, durable medical equipment and outlier radiology utilization. Implementation of new revenue reductions through efficiency adjustments will create additional fiscal pressure.
- DHCS will continue to focus on cost-effective spending in managed care and expect pressures to be amplified.

- As noted in our prior budgets, Partnership has faced increased scrutiny from DHCS on contracted heath care cost levels, some of which resulted in prior year's downward rate adjustments.

FY 2026-27 Legislative Version of the Budget

On June 11, 2026, the legislative version of the budget was released and proposes a total budget of $355.9 billion total fund ($253 billion State General Fund) for FY 2026-27. The legislative budget is $6.5 billion greater than the Governor's May Revise proposal and earmarks $3.1 billion less to state reserves (inclusive of the surplus set-aside).

Notable legislative budget details that affect the Medi-Cal program are highlighted below.

- **Unsatisfactory Immigration Status (UIS) Members transition from Medi-Cal Managed Care to Medi-Cal FFS** – The legislature accepted the Governor's proposal to transition UIS members into the FFS delivery system but allowed UIS members to maintain their CalAIM benefits. The legislature notated they will work with the Administration to consider maintaining managed care for non-emergency services. As of June 2026, Partnership serves nearly 88,000 UIS members who are at risk of losing access to managed care providers.
- **Delayed UIS Adult Member Medi-Cal Premium Increases** - The legislature delayed the Governor's proposed monthly premium increase from $30 to $50 and deferred this decision to our incoming Governor.
- **Delayed UIS Dental Benefit Elimination -** The legislature delayed the Governor's proposed elimination of adult dental for UIS members until July 1, 2027.
- **Delayed Eligibility Changes for Qualified Non-Citizens** -The legislature delayed the transition of these members to limited-scope Medi-Cal to July 1, 2027, and indicated they are committed to maintaining Medi-Cal eligibility past July 2027.
- **Delayed Implementation of the Modified Asset Test for Medi-Cal Eligibility** - The legislature delayed the Governor's proposed asset test modification to July 1, 2027, and proposes a limit of $21,000 per individual in place of the proposed $2,000 per individual.
- **Approved the Proposed Managed Care Organization (MCO) Tax** - The legislature approved the Governor's proposed new MCO Tax effective January 1, 2027, that would assess a higher tax rate on non-Medi-Cal plans.
- **Rejected Elimination of the Adult Acupuncture Benefit** - The legislature rejected the Governor's proposed elimination of this optional benefit.
- **Delayed the Elimination of Prospective Payment System (PPS) funding for State-Only Services for UIS Members** - The legislature delayed the Governor's proposed elimination of PPS rate funding for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for state-only-funded services for UIS members until July 1, 2027.
- **Funding for Distressed Hospitals** - The legislature increased distress hospital funding to up $190 million through additional forgivable loans. And an additional $250 million was allocated to support public hospitals.
- **Reproductive Health Care and Gender-Affirming Care** - The legislature added $40 million for reproductive health care and $26 million for gender-affirming care.

- **Increased County Administration Funding** – The legislature allocated additional funding over and beyond what was proposed in the May Revise for county workload tied to Medi-Cal and CalFresh and the impacts of H.R. 1.

National Medicaid Changes and Other Potential Federal Changes

H.R.1 implemented sweeping changes to Medicaid Nationally. Notable eligibility and financing changes, and Medicaid policy pressures are highlighted below.

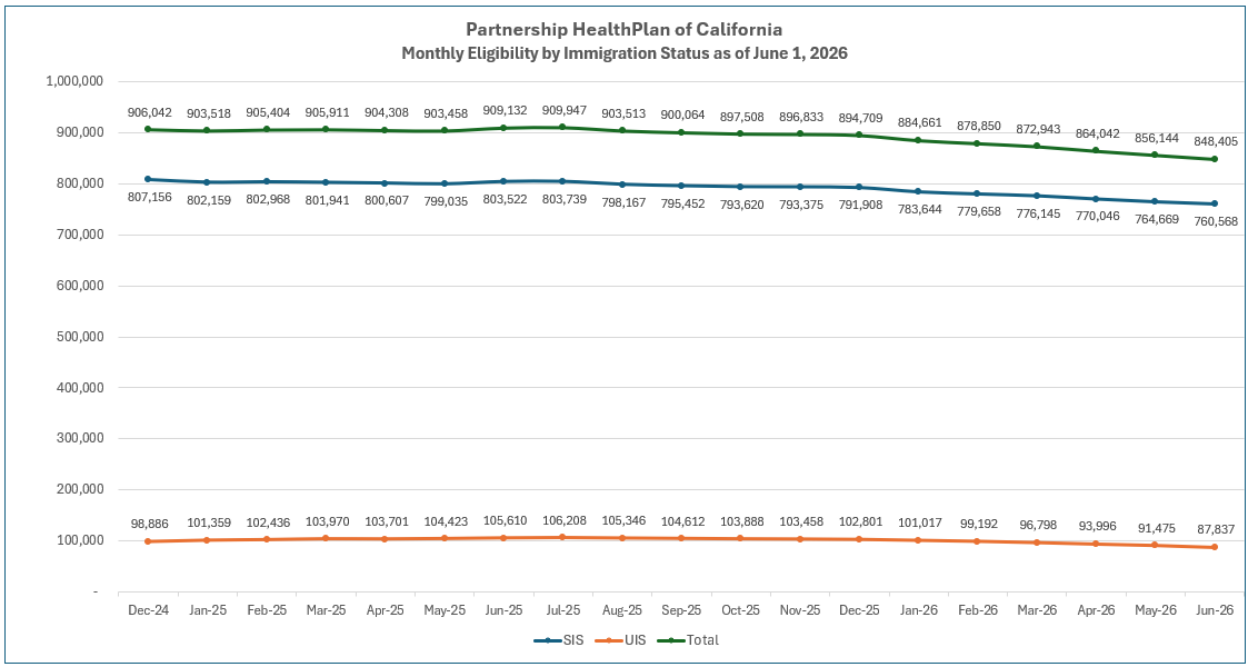
- **Medicaid Community Engagement and Work Requirements** - H.R. 1 mandated States to implement community engagement and work requirements for able-bodied adults aged 19 to 64 without children under 13. Effective January 1, 2027, these members must meet work, volunteer, school, or training requirements to keep Medi-Cal. Exemptions apply for pregnancy, disability, serious health conditions, and other circumstances. This change is expected to result in additional Partnership membership losses.
- **Semi-annual Adult Expansion Member Medicaid Eligibility** - Effective January 1, 2027, eligibility verification for the adult expansion population must occur every 6 months instead of annually as are result of H.R.1. This change is expected to result in additional Partnership membership losses.
- **Medicaid Retro Eligibility Changes** - Effective January 1, 2027, retroactive Medicaid eligibility will be reduced from 90 days to 30 days for the adult expansion population and reduced from 90 days to 60 days for all other members. This change is expected to result in additional Partnership membership losses.
- **Limit Medicaid Directed Payments to the Medicare Payment Levels** - Effective January 1, 2028, Medicaid State Directed Payments (SDPs) must be phased-down over a multiyear period to 100% of Medicare for expansion states while non-expansion States must be phased down to a 110% of Medicare. California hospitals heavily rely on supplement SDP funding. Each Medi-Cal hospital SDP program exceeds the new Medicare limit. DHCS has indicated they will not be able to backfill hospital SDP losses. The SDP funding reductions are expected to put significant financial strain on hospital systems.
- **Risk of Future Medicaid Changes** - There is risk that future CMS regulatory changes and additional rulemaking could further alter the Medicaid program without requiring federal legislative action. Additional uncertainty remains regarding whether federal lawmakers will pursue further Medicaid funding reductions.
    - In late May of 2026, CMS issued a proposed rule on Medicaid managed care SDPs that would implement provision 71116 of H.R. 1, cap SDP payment rates at 100% of Medicare payment rates, apply similar limits to certain targeted Medicaid fee-for-service payments, and establish consistent national standards to improve transparency and accountability.

Membership

As noted in our April assumptions, and as displayed in the June membership chart below, sizeable declines outside of prior eligibility trends have been observed in both the UIS category and in the members with satisfactory immigration status (SIS) category.

Partnership lost 46,304 members (nearly a 5.2% membership reduction) between December 2025 and June 2026. UIS membership declines are largely explainable due to recent federal and state policy changes along with dual SIS membership declines which can be attributed to the increased Medi-Cal eligibility asset limits that went into effect on January 1, 2026. Outside of the explainable membership losses, Partnership continues to see declines in the Child, Adult, and ACA Adult Expansion SIS categories which is concerning. We believe the required DHCS monthly eligibility data scrubbing against HHS eligibility lists, mixed immigration status households, and general confusion on when federal H.R. 1 policy changes go into effect are contributors to these declines.

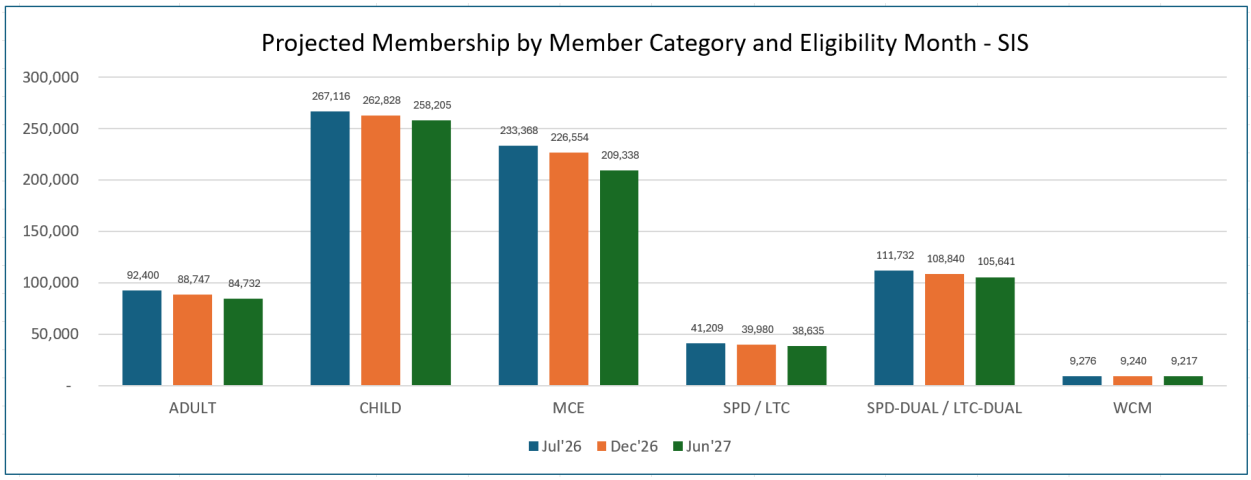
Partnership's recent membership reductions and the proposed UIS member transition from Managed Care to Medi-Cal FFS will significantly reduce the amount of revenue Partnership receives from DHCS. As of June 2026, Partnership serves 87,837 UIS members, the May Revise proposal would result in a 10.35% membership loss. Further, there is considerable uncertainty on how many members Partnership will lose because of upcoming January 1, 2027, H.R.1 eligibility changes.

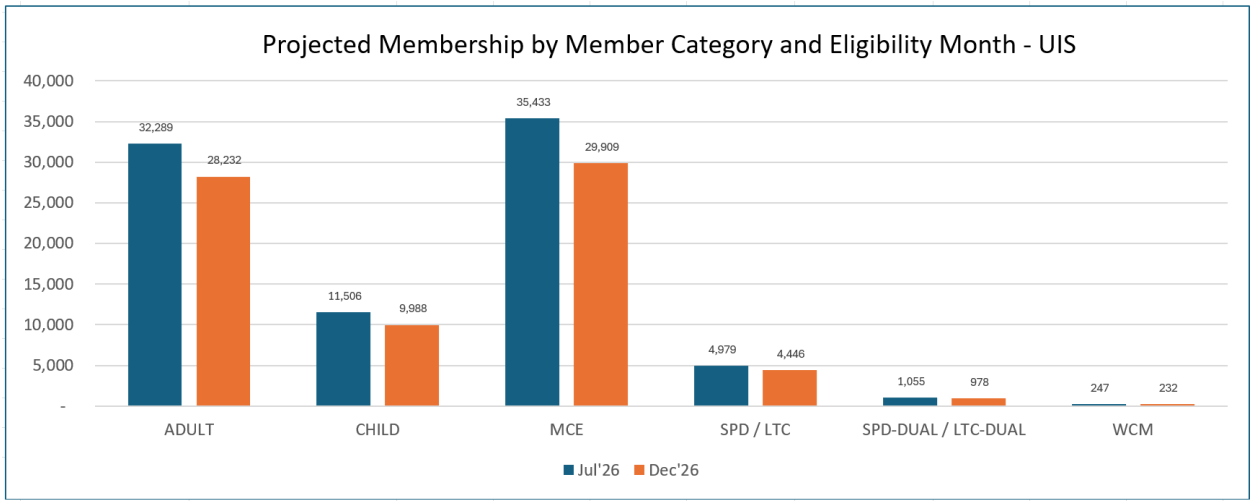


Partnership engaged our actuarial consultants to assist with membership projections for FY 2026-27 budget year given the recent volatility we have observed over the last several months. Based on the best available information and year-to-date membership trends, Partnership anticipates

SIS membership to drop to 705,768 by June of 2027. The charts below reflect estimated point in time membership assumptions for July 2026, December 2026, and June 2027 by membership category and membership type.

Enrollment losses represent the plan's greatest fiscal risk in the coming year as declining membership directly reduces revenue and is expected to compress margins. Further financial risk is tied to revenue adequacy for CY 2026 and CY 2027. With the observed and anticipated future membership loss, Partnership expects to serve a higher-needs population. It is unclear if the State will adjust CY 2026 revenue and how the forthcoming CY 2027 revenue will account for these uncertainties. Rate advocacy efforts are underway through our health plan associations specific to rate adequacy and risk mitigation protective measures.





Revenue

Partnership budgeted overall revenue of $6.0 billion, representing a $1.1 billion year-over-year decline, primarily driven by the assumed UIS population transition to Medi-Cal FFS. The budget incorporates CY 2026 draft rates received from DHCS for the period of July through December

2026. Given the CY 2027 draft rates will not be delivered to Partnership until the last quarter of CY 2026, Partnership relied on actuarial revenue projections for the period of January through June 2027.

Rate development continues to grow increasingly dynamic. Anticipated coverage volatility from the new H.R. 1 eligibility requirements, along with shifts in acuity mix, present added challenges to prospective rate development. Ongoing membership declines and new efficiency adjustments are expected to further pressure Partnership's future revenue. Additionally, DHCS revisions to draft CY 2025 and CY 2026 rates remain pending.

Medi-Cal State Capitation Revenue

2026-27: $5.9 billion | 2025-26 Δ : -$1.1 billion or -15.8%

Medi-Cal Base Capitation reflects offsetting variances driven by base revenue, membership trends, and other supplemental revenues. Because capitation premium revenue is directly tied to enrollment, the year-over-year decrease is primarily attributable to lower enrolled membership, including the anticipated UIS population shifting to Medi-Cal FFS and the H.R.1 eligibility requirements taking effect on January 1, 2027. Partnership continues to observe monthly enrollment declines in the Child, Adult, and ACA Optional Expansion cohorts and has incorporated assumptions to reflect these decreases even before the H.R.1 requirements take effect. Partnership worked closely with actuarial consultants to project our CY 2027 revenue for the anticipated members that we will continue to serve.

Revenues related to "at-risk" programs, including hospital directed payments and the voluntary rate range are recognized as top-line revenue. These programs account for an estimated $1.1 billion in total revenue. The contraction in membership and the total funding pool change for the Private Hospital Directed Payment (PHDP) program are the primary drivers of the year-over-year decrease in directed payment programs.

DHCS implemented a 0.5% quality withhold on plan capitated revenue effective January 1, 2024, and increased the withhold to 1% effective January 1, 2025, for all counties. The budget assumes a 1% withhold for CY 2026 and CY 2027. We do not have final details on the CY 2026 and CY 2027 withholds at this time and have held prior year measurement earn back percentages constant for budgetary purposes. Actual CY 2026 and CY 2027 outcomes may differ materially from these estimates due to the unknown impacts of membership mix changes and final program details.

Interest & Other Income

2026-27: $76.2 million | 2025-26 Δ : -$7.0 million or -8.5%

Interest and other income consist of interest income and building tenant revenue. Interest income is projected at $73.5 million, based on an assumed annual rate of return of 3 percent. The year-over-year decrease is primarily attributable to an assumed lower average cash balance and a lower rate of return. Building tenant revenue is projected at $2.7 million, reflecting occupancy of previously vacant space and modest lease renewal increases. Consistent with prior years, DHCS incentive grant revenue and related offsetting expenses are excluded from the FY

2026-27 budget due to uncertainty regarding the timing of award recognition. Revenue and related expenses will be recorded if awarded and recognized.

Health Care Expenses

The health care cost projections for FY 2026-27 were forecasted based on historical claims experience, anticipated membership reductions, and further adjusted for anticipated member acuity. Partnership utilized cost experience from January 2025 through December 2025 when developing these projections. All UIS member expenses were removed for the period of January to June 2027 based on the May Revise proposal. Completion factors were applied to incomplete CY 2025 months where appropriate to account for incurred but not yet reported claims.

The revenue and membership uncertainty noted above cascades down to health care expense uncertainty. The health care expense projections were revised in June based on:

- June 2026 membership trends
- Incorporating actuarial assumptions on leavers, joiners and stayers
- Refined FY 2026-27 acuity assumptions
- Additional claims data and other emerging information.
- Our estimates account for the anticipated transition of all UIS members effective January 1, 2027, to Medi-Cal FFS. If subsequent budgetary actions are made regarding this population, adjustments will be addressed in an off-cycle budget.

The associated revenue and costs tied to Governor's Proposition 35 spending plan are not included in the budget as estimable details are unknown at this time. Necessary adjustments may be addressed in an off-cycle budget.

The health care budget assumes an overall expense of $5.7 billion, representing a decrease of $1.1 billion, or 16.2%, from the FY 2025-26 budget. The budget will allow for flexible reallocation authority across budget categories as necessary. Additional considerations and estimates by cost category are provided in more detail, below.

Inpatient Hospital

2026-27: $1.4 billion | 2025-26 Δ : -$286.8 million or -17.5%

The Inpatient Hospital line item includes inpatient FFS, hospital capitation, and stoploss expenses. The year-over-year decrease is primarily driven by the disenrollment of UIS members from managed care effective January 1, 2027, as well as the implementation of H.R.1 related eligibility restrictions and more frequent eligibility redeterminations.

Despite the overall decline in enrollment, inpatient hospital costs are projected to increase on a PMPM basis due to higher acuity among the remaining membership. Anticipated impacts include longer average lengths of stay and increased severity, leading to higher unit cost trends.

Given ongoing uncertainty in Medicaid, Partnership must remain disciplined in managing health care expenses through appropriate medical management and prudent contracting decisions. As contract requests are evaluated, it is imperative to consider other hospital revenue sources that

are afforded to contracted providers in Medi-Cal managed care, including the PHDP program and the District Hospital Directed Payment (DHDP) program. While we recognize a phase-down of funding for these programs will occur beginning in CY 2028, DHCS has advised they will not have the ability to backfill these program losses and neither will plans given our revenue comes directly from the State.

We continue to highlight that Partnership is an outlier in its inpatient contracting levels relative to other Medi-Cal plans statewide, this puts further strain on the ability to implement contracting increases. The State's actuaries assess the reasonableness of Partnership's contracting levels inclusive of the hospital directed payments and have raised concerns on our inpatient payment levels during each rating period, some of which has resulted in downward inpatient rate adjustments.

Physician Services

2026-27: $1.1 billion | 2025-26 Δ : -$72.0 million or -6.3%

Physician Services include Proposition 56 payments (Prop 56), specialty capitation, primary capitation, and physician FFS expenses. FFS expenses are decreasing year-over-year due to the disenrollment of UIS members from managed care and impacts of H.R.1. However, the disenrollment of historically younger and lower-utilizing UIS members increases the concentration of medically complex members requiring ongoing physician care.

Primary Care spending is expected to remain slightly elevated due to increased demand for preventative services and stabilization efforts associated with transitional care management following acute episodes. Specialty Physician costs are projected to increase, driven by a higher prevalence of comorbid conditions and resulting increases in cost per visit. In addition, utilization for Indian Health Service (IHS) reimbursement have risen significantly.

Effective January 1, 2024, TRI rate increases were implemented for eligible contracted providers. This brought eligible provider minimum reimbursement levels for TRI procedure codes to at least 87.5% of the lowest Medicare locality in the state for certain Medi-Cal services. Noting a subset of the TRI procedure code rates exceed Medicare payment levels. The CY 2024 TRI payment levels will continue for FY 2026-27.

TRI will be further be augmented by the Proposition 35 time-limited supplemental payments for primary care, specialty care, maternal health, and non-specialty mental health providers. Details surrounding these new augmentations are unknown at this time and are not included in our health care expense estimates.

Long-Term Care

2026-27: $701.7 million | 2025-26 Δ : -$38.7 million or -5.2%

As noted in prior budget cycles, the Long-Term Care expense category is inherently difficult to forecast due to the timing and complexity of retroactive DHCS rate increases. Annual DHCS per diem rate increases remain the largest driver, reflecting inflationary pressures and cost-based reimbursement updates. Rates are often published several months after their effective dates and

issued in multiple revisions. This requires Partnership staff to perform detailed analyses to reconcile and adjust prior payments. In addition, under Assembly Bill (AB) 86, DHCS established the Workforce Standards Program, through which participating facilities receive an enhanced per diem rate. Workforce-related investments, including the AB 86 Workforce Standards Program and the implementation of SB 525 minimum wage requirements, are further elevating provider labor costs and contributing to higher reimbursement levels.

Ancillary Services

2026-27: $1.1 billion | 2025-26 Δ : -$142.2 million or -11.4%

Ancillary Services is comprised of FFS and capitated ancillary services, Outpatient Facility, Emergency Department, ECM, and Community Supports. The budget assumes decreases primarily driven by the UIS disenrollment from managed care, tighter eligibility H.R.1 requirements, and utilization management initiatives. Additional offsets by a continued rise in high-cost specialty drug spend, particularly advanced cell and gene therapies that are episodic in nature but carry a substantial fiscal impact.

Other Medical

2026-27: $457.8 million | 2025-26 Δ : -$37.4 million or -7.5%

The Other Medical category includes transportation, quality assurance, health care investment fund, nurse advice line, and the DHCS voluntary rate range program. Transportation expense is also projected to decrease due to lower utilization association with UIS disenrollment from managed care, H.R.1 eligibility restrictions, and utilization management initiatives. These reductions are expected to be partially offset by Public Providers Ground Emergency Transportation (PP-GEMT) rate increases and ongoing inflationary pressures, including higher fuel and operating costs driven by global supply instability.

The voluntary rate range program is also expected to decrease as this is tied to overall managed care revenue, primarily due to the exclusion and carve-out of UIS populations from managed care and the broader eligibility tightening tied to H.R.1. Beginning in Program Year CY 2026, Partnership will implement a 3 percent administrative fee to support operational, compliance monitoring and reporting requirements of this program.

The increase in quality assurance and medical administrative expenses is generally aligned with the overall growth in administrative costs and is primarily attributable to staffing and employee benefit assumptions, as described in the Administrative Expense section below.

DHCS Facility Directed Payment Programs

2026-27: $899.0 million | 2025-26 Δ : -$527.3 million or -37.0%

The following facility directed payments are included in this category: PHDP program, DHDP program, Designated Public Hospital Enhanced Payment program, the Designated Public Hospitals Quality Improvement programs, Health Equity Practice Transformation payments, and the new Children's Hospital Supplement Payment program. The significant decrease in directed payments is driven by reductions to the PHDP program statewide funding. These reductions were necessary to comply with H.R.1 grandfathering provisions.

Quality Improvement Programs (Incentives)

2026-27: $94.4 million | 2025-26 Δ : $5.2 million or 5.8%

The year-over-year increase in QIP expenses is due to the implementation of the Extended Care Facility QIP (EXT QIP) program on January 1, 2026. The EXT QIP, formerly known as the LTC QIP, was originally established in 2016. The program was suspended in August 2020 due to the COVID-19 pandemic, reinstated in January 2022, and subsequently sunset in December 2023 following the launch of the Skilled Nursing Facility Workforce Quality Incentive Program (WQIP) by DHCS. After WQIP was phased out of the State budget on December 31, 2025, Partnership's Board of Commissioners approved the EXT QIP, effective January 2026.

In addition, Partnership continues to invest in quality improvement programs and the member experience. The goal of these investments is to improve overall member experience and increase performance on quality metrics prioritized by the DHCS Quality Withhold program and to provide quality, equitable and cost-effective care for our members. As in previous periods, incentive funding remains contingent on final revenue projections.

Off-Cycle Budget

Partnership's enrollment projections reflect our best estimates of policy changes but are highly uncertain. They therefore depend on several assumptions about disenrollments, utilization, and costs. Given these uncertainties and given the timing of the State's enacted budget, Partnership staff expect to produce an off-cycle budget to account for any significant programmatic or cost changes after the June budget is finalized.

Administrative Expense

Overall administrative spending is budgeted at $391.9 million, an increase of $4.0 million, or 1.0%, over the prior year's budget. The year-over-year increase is primarily attributable to staffing and employee benefit cost assumptions. Excluding future capital requests, the administrative operating expense base remains generally consistent with the prior year. FY 2026-27 capital requests are expected to return to the Board for approval in the Fall of 2026. Administrative cost growth continues to be limited to essential operational requirements. The budget will allow for flexible reallocation authority across budget categories as necessary.

Employee Workforce

2026-27: $257.7 million | 2025-26 Δ : $9.8 million or 4.0%

Partnership continues to assess workforce needs in response to ongoing regulatory obligations and changes in Medi-Cal enrollment. For FY 2026-27, budgeted headcount is expected to remain consistent with FY 2025-26. As in the prior year, temporary resources remain incorporated into the staffing model and may be converted to permanent positions based on final operational requirements. The increase in workforce expense is primarily attributable to a projected 4.0% merit increase and an assumed overall 12% increase in medical, dental, and vision benefit costs. As reflected in the previously approved budget assumptions document, the proposed merit

increase is based on the latest Employment Cost Index for the Western Region published by the U.S. Bureau of Labor Statistics.

Occupancy

2026-27: $25.2 million | 2025-26 Δ : -$8.2 million or -24.4%

The year-over-year decrease in occupancy costs is primarily driven by lower projected depreciation expense. Depreciation associated with existing capital is included in the FY 2026-27 budget; however, depreciation associated with future project requests is excluded until those capital requests return to the Board for review and approval in the Fall of 2026.

Professional Services

2026-27: $39.5 million | 2025-26 Δ : No Change

Professional Services primarily include consulting, contracted claims processing, and other third-party processing vendors. The FY 2026-27 budget assumes these expenditures will remain consistent with the prior year across all Partnership regions. These costs will be revisited in the Fall of 2026.

Computer & Data

2026-27: $54.0 million | 2025-26 Δ : No Change

The FY 2026-27 budget assumes hardware, software, and data processing costs across Information Technology and other departments will remain consistent with the prior year across all Partnership regions. These costs will be revisited in the Fall of 2026.

Profit & Loss Statement

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

Annual Capital & Operating Budget

	2026-27 Budget	2025-26 Budget	$ VARIANCE	2026-27 Budget PMPM	2025-26 Budget PMPM
REVENUE					
State Capitation Revenue	5,930,930,957	7,046,897,376	(1,115,966,419)	640.51	643.75
Interest Income	73,500,000	80,779,000	(7,279,000)	7.94	7.38
Other Revenue	2,679,900	2,447,000	232,900	0.29	0.22
TOTAL REVENUE	**6,007,110,857**	**7,130,123,376**	**(1,123,012,519)**	**648.74**	**651.35**
HEALTHCARE COSTS					
Physician Services					
PCP Capitation	100,128,377	119,415,716	19,287,339	10.81	10.91
Specialty Capitation	2,352,079	2,570,827	218,748	0.25	0.23
Non-Capitated Physician Services	970,121,708	1,022,631,615	52,509,907	104.77	93.42
Total Physician Services	**1,072,602,164**	**1,144,618,158**	**72,015,994**	**115.84**	**104.56**
Inpatient Hospital					
Hospital Capitation	165,694,928	206,752,864	41,057,936	17.89	18.89
Inpatient Hospital - FFS	1,178,540,266	1,423,506,378	244,966,112	127.28	130.04
Hospital Stoploss	9,181,839	9,999,852	818,013	0.99	0.91
Total Inpatient Hospital	**1,353,417,033**	**1,640,259,094**	**286,842,061**	**146.16**	**149.84**
Long Term Care	701,659,419	740,374,189	38,714,770	75.78	67.63
Ancillary Services					
Ancillary Services - Capitated	13,843,128	16,574,512	2,731,384	1.49	1.51
Ancillary Services - Non-Capitated	1,089,457,399	1,228,900,510	139,443,111	117.66	112.26
Total Ancillary Services	**1,103,300,527**	**1,245,475,022**	**142,174,495**	**119.15**	**113.78**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

Annual Capital & Operating Budget

	2026-27 Budget	2025-26 Budget	$ VARIANCE	2026-27 Budget PMPM	2025-26 Budget PMPM
Other Medical					
Quality Assurance	98,339,060	92,329,487	(6,009,573)	10.62	8.43
Healthcare Investment Funds	218,584,865	241,427,350	22,842,485	23.61	22.05
Advice Nurse	1,560,000	1,729,200	169,200	0.17	0.16
Transportation	139,268,537	159,645,568	20,377,031	15.04	14.58
Total Other Medical	**457,752,462**	**495,131,605**	**37,379,143**	**49.44**	**45.23**
DHCS Facility Directed Payment Programs	899,026,750	1,426,371,794	527,345,044	97.09	130.30
Quality Improvement Programs	94,412,000	89,200,150	(5,211,850)	10.20	8.15
TOTAL HEALTHCARE COSTS	**5,682,170,355**	**6,781,430,012**	**1,099,259,657**	**613.65**	**619.50**
ADMINISTRATIVE COSTS					
Employee	257,660,943	247,828,143	(9,832,800)	27.83	22.64
Travel And Meals	3,023,332	2,294,006	(729,326)	0.33	0.21
Occupancy	25,240,416	33,393,279	8,152,863	2.73	3.05
Operational	12,461,223	10,909,163	(1,552,060)	1.35	1.00
Professional Services	39,490,454	39,490,454	-	4.26	3.61
Computer And Data	53,983,631	53,983,631	-	5.83	4.93
TOTAL ADMINISTRATIVE COSTS	**391,860,000**	**387,898,676**	**(3,961,324)**	**42.32**	**35.44**
Medi-Cal Managed Care Tax	-	-	-	-	-
Surplus / (Deficit)	**(66,919,497)**	**(39,205,312)**	**(27,714,185)**	**(7.23)**	**(3.58)**

Fund Balance

Total Fund Balance includes reserves for the State Financial Performance Guarantee, Capital Assets, and Strategic Use of Reserves (SUR). The State Financial Performance Guarantee allows for calculation of the reserve at two months' (2x) worth of state capitation revenue; the Guarantee also satisfies the regulatory requirements for State Tangible Net Equity (TNE) as well as Knox-Keene. Net capital assets are included as part of Fund Balance. Lastly, SURs are initiatives that were approved by the Board in previous years. The reserves for these SURs have been utilized over the years in a manner that has expanded member access, increased provider reimbursement, and improved overall operational efficiency; Partnership will continue to utilize the funds as approved. The remaining SUR balance is primarily comprised of funds set aside for the Drug Medi-Cal Program, quality initiatives and capital investments. Note also that Fund Balance includes an unrestricted amount that is projected to be negative, which represents the shortfall of funds needed to meet the reserve requirements. Like in prior county expansions, it is not uncommon to reflect a negative fund balance for the first several years of a coverage expansion. The total fund balance for the year ending June 30, 2027 is estimated at $1.4 billion.

Partnership Healthplan of California
Fiscal Year 2026/27 Fund Balance Analysis
Projected through June 2027
Fund Balance Analysis / TNE

Fund Balance at April 30, 2026		1,483,902,863
Actual Year to Date Surplus at April 30, 2026	26,352,650	
Projected Year to Date Surplus at June 30, 2026	14,131,892	
Projected (Deficit) for May - June 2026		(12,220,758)
Projected Fund Balance at June 30, 2026		**1,471,682,105**
Projected (Deficit) for Fiscal Year 2026/27		(66,919,498)
Estimated Fund Balance at June 30, 2027		**1,404,762,607**
Estimated Fund Balance Allocated at June 30, 2027		
Reserved Funds		
State Financial Performance Guarantee		1,102,845,000
Capital Assets		245,274,000
Strategic Use of Reserve-Board Approved		68,377,668
Unrestricted (Shortfall)		(11,734,061)
Estimated Fund Balance at June 30, 2027		**1,404,762,607**

Capital Projects

As part of developing the capital budget, each of the projects were evaluated based on the current economic conditions along with the strategic goals and priorities of the organization. For 2026-27, ongoing projects that were approved in previous years will continue until completion. No new capital projects are being presented in this current budget and additional capital projects will be deferred for Board presentation in the Fall of 2026.

Version History

This table was created for Committee Members to quickly review changes between the preliminary healthcare budget presented in May 2026 and the final budget presented above.

	FY 2026-27		Final vs HCC Assumptions Version △		
Health Care Categories	**Budget - Final**	**HCC Assumptions (1st Pass)**	**$**	**%**	**Notes**
Inpatient Hospital	$1,353,417,033	$1,342,360,258	$11,056,775	0.8%	Adjusted to account for acuity mix
Physician Services	$1,072,602,164	$1,070,455,955	$2,146,209	0.2%	
Long Term Care	$701,659,419	$719,325,240	($17,665,821)	(2.5%)	Adjusted to account for current LTC cost trends based on latest rate adjustments
Ancillary Services	$1,103,300,527	$1,089,077,296	$14,223,231	1.3%	Adjusted to account for acuity mix
Other Medical	$457,752,462	$458,872,239	($1,119,777)	(0.2%)	
DHCS Facility Directed Payment Programs	$899,026,750	$899,054,927	($28,177)	(0.0%)	
Quality Improvement Programs	$94,412,000	$98,412,000	($4,000,000)	(4.1%)	Refinement of Extended Care QIP estimate
Total Health Care Expense	**$5,682,170,355**	**$5,677,557,915**	**$4,612,440**	**0.1%**	