OHCA

Office of Health Care Affordability
Department of Health Care Access and Information

Health Care Affordability Advisory Committee Meeting

April 15, 2026

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Welcome and Call to Order

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Agenda

1. **Welcome and Call to Order**

2. **Executive Updates**
   Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

3. **Spending Target Enforcement – Continued Performance Improvement Plan Discussion**
   Vishaal Pegany; CJ Howard, Assistant Deputy Director

4. **Introduction to Equity Adjustment and Quality Adjustment to Spending Targets**
   Margareta Brandt, Assistant Deputy Director; Maggie Heidmann, Health Equity and Quality Performance Manager

5. **Non-Supervisory Organized Labor Adjustment and Assessment – Introductory Discussion**
   Vishaal Pegany; CJ Howard

6. **General Public Comment**

7. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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Public Comment

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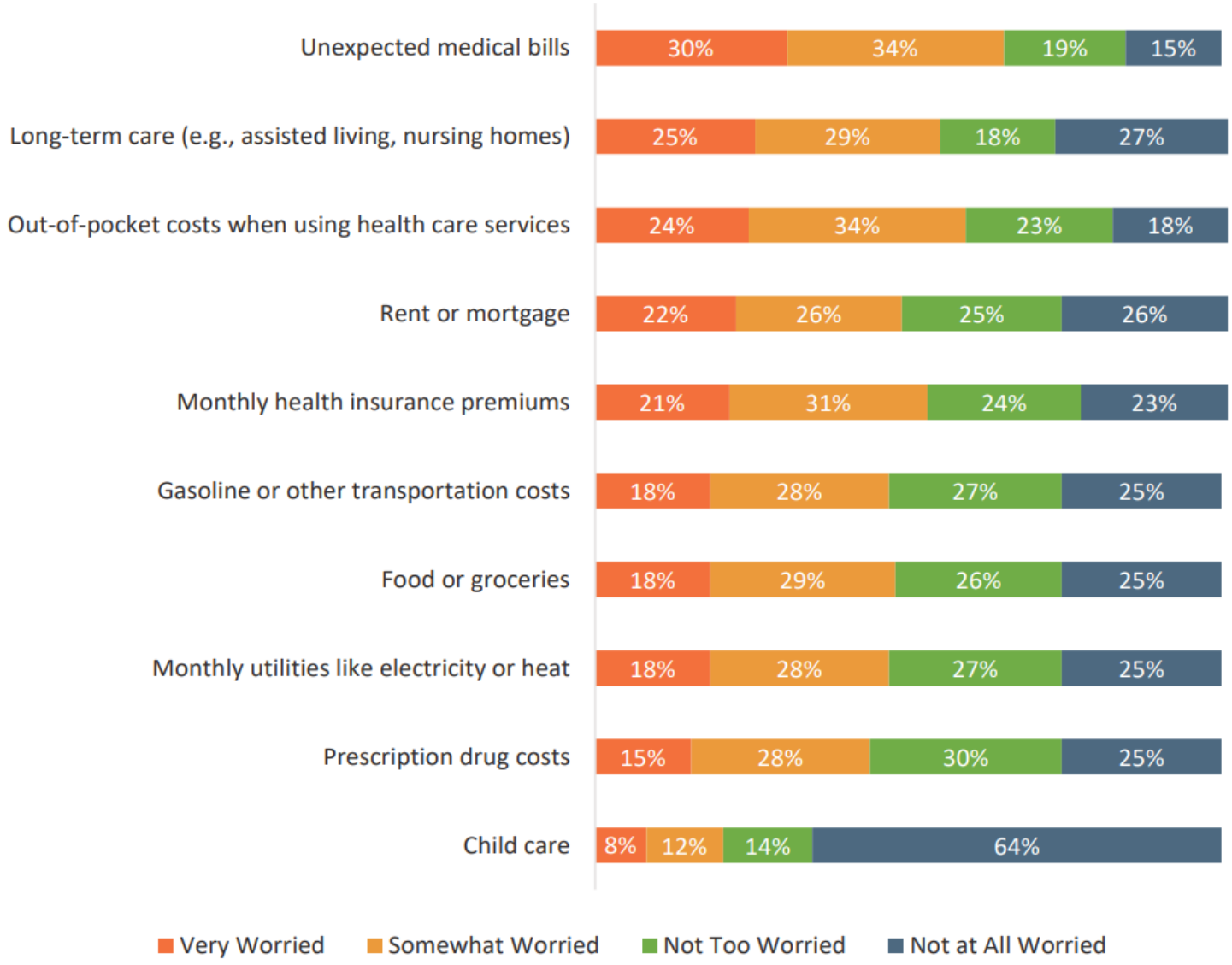
Spring Patient and Consumer Forum Debrief

- Staff engaged around 100 patients, patient advocates and consumer advocates.
- Multiple participants expressed support for OHCA's work and appreciation for the forum discussion, noting that they felt more comfortable voicing their opinions in this setting.
- Some participants representing patients with rare diseases shared their concern over possible incentives to deny health care services for patients with chronic conditions that require high levels of costly care.
  - These advocates suggested implementing carveouts for Specialized Treatment Centers/ Centers of Excellence to ensure no negative unintended consequences for these patients due to entity responses to the spending target.
  - Advocates expressed their interest and willingness to collaborate with OHCA and provide their input in future discussions to inform enforcement of spending targets.
- Labor union representatives and small business owners noted their struggles in negotiating benefits for employees without sacrificing wage increases.
- The meeting materials, including the presentation, can be accessed at the Patient and Consumer Forum webpage.

Health Care Costs Cause Economic Hardship

More Than 6 in 10 Californians Are Worried About Being Able to Afford Unexpected Medical Bills, Far Exceeding Worries About Rent, Gas, and Groceries (Figure 38)

Q: HOW WORRIED ARE YOU ABOUT BEING ABLE TO AFFORD THE FOLLOWING FOR YOU AND YOUR FAMILY?

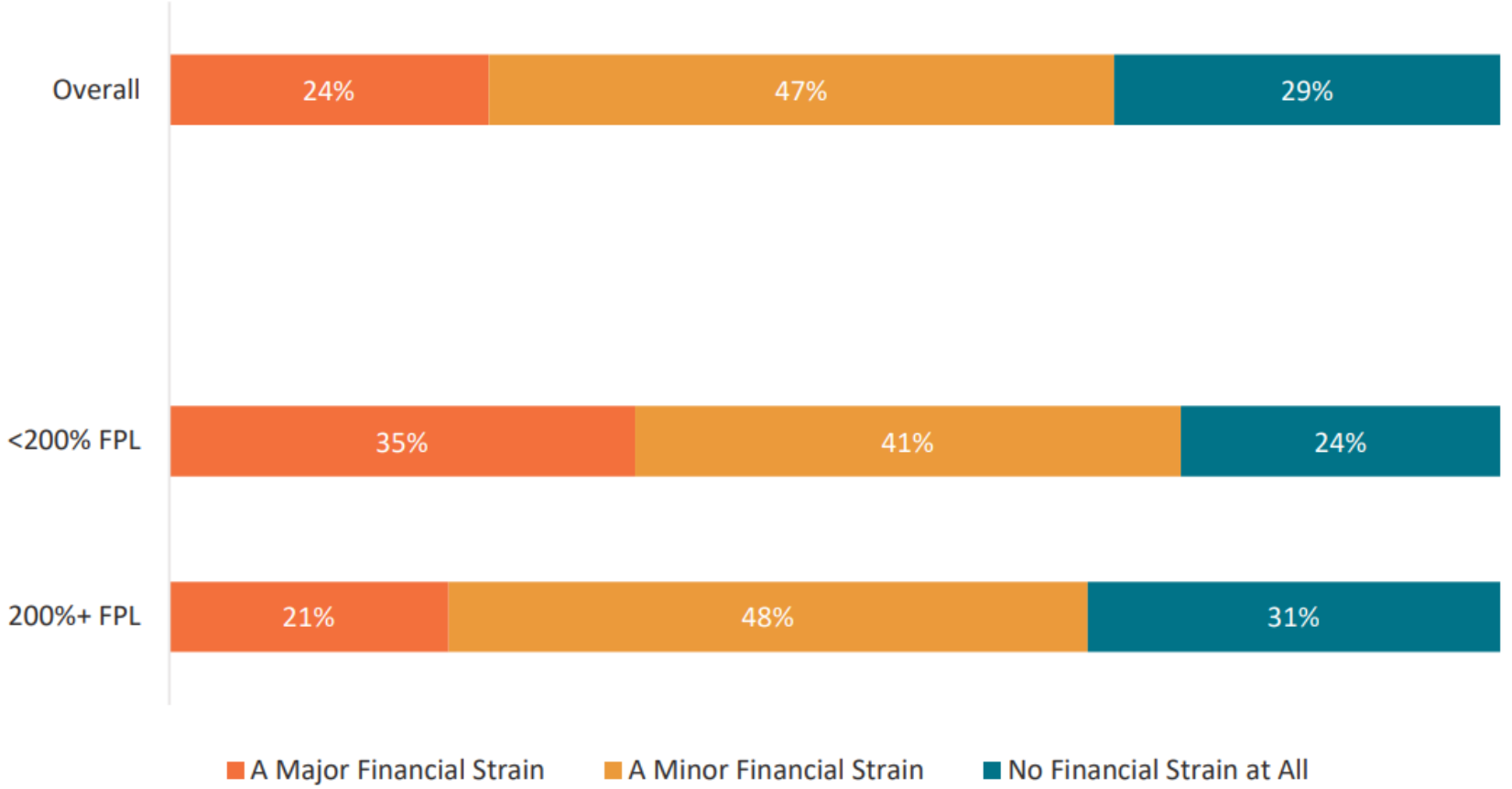


Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation. https://www.chcf.org/resource/2026-california-health-policy-survey/

Health Care Costs Cause Economic Hardship

Seven in 10 Californians Feel That Health Care Expenses Place a Financial Strain on Their Household (Figure 33)

Q: HOW MUCH FINANCIAL STRAIN, IF ANY, DO YOU FEEL YOUR HEALTH CARE EXPENSES PLACE ON YOUR HOUSEHOLD?

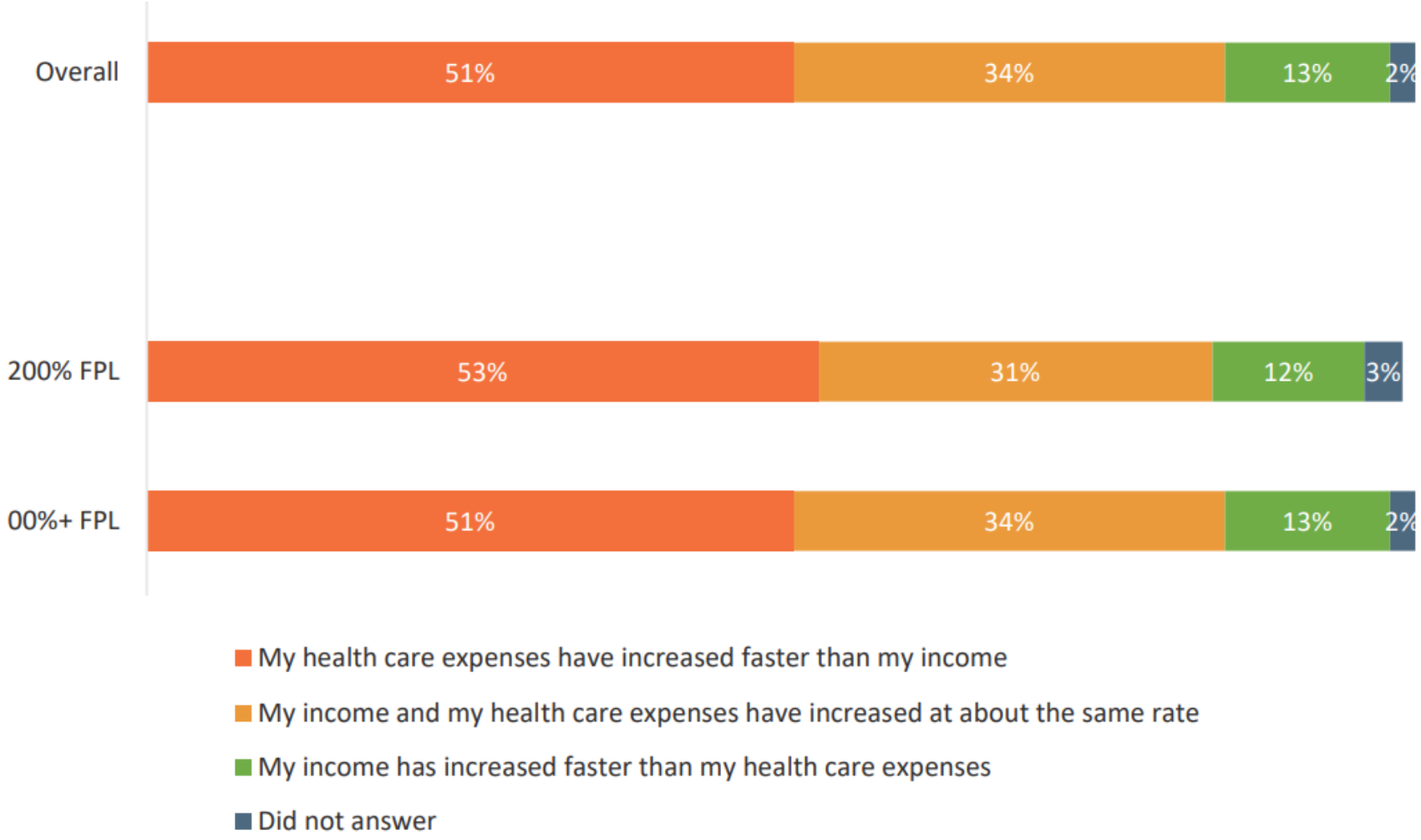


Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation. https://www.chcf.org/resource/2026-california-health-policy-survey/

Health Care Costs Cause Economic Hardship

Half of Californians Across Income Groups Say Their Health Care Expenses Have Increased Faster Than Their Income
(Figure 36)

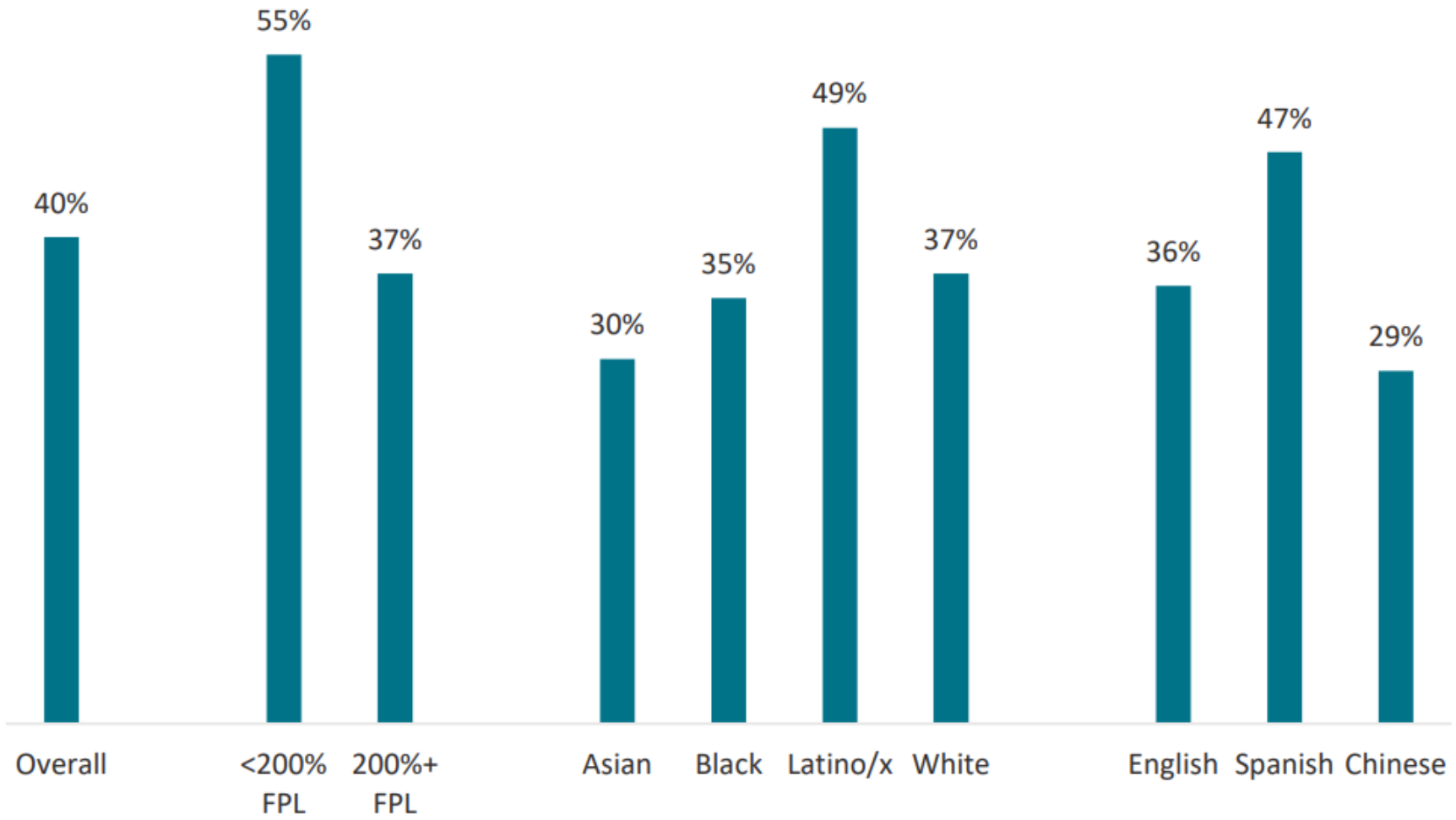
Q: WHICH OF THE FOLLOWING STATEMENTS COMES CLOSEST TO YOUR EXPERIENCE, EVEN IF NONE ARE EXACTLY RIGHT?



Health Care Costs Cause Economic Hardship

Four in 10 Californians and More Than Half of Californians with Low Incomes Have Medical Debt (Figure 43)

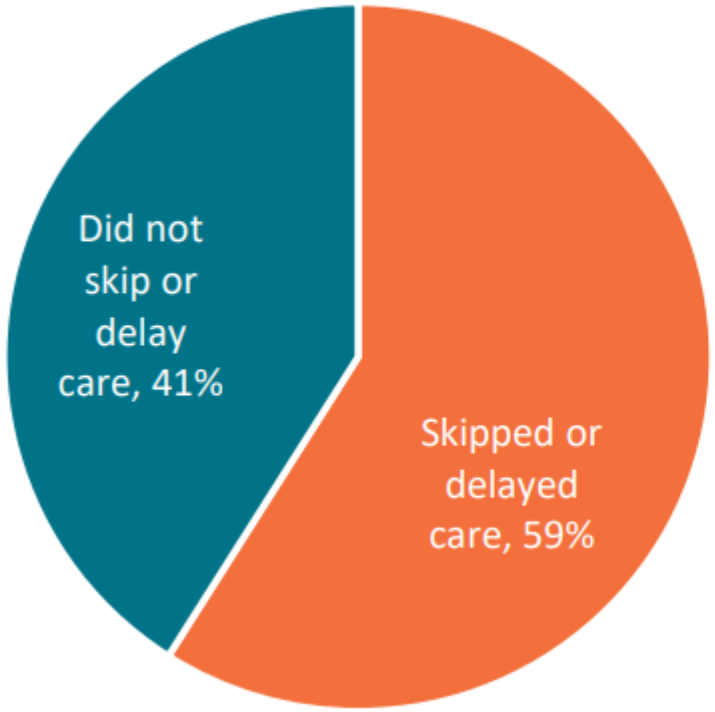
PERCENTAGE WHO SAY THEY HAVE ANY TYPE OF MEDICAL DEBT

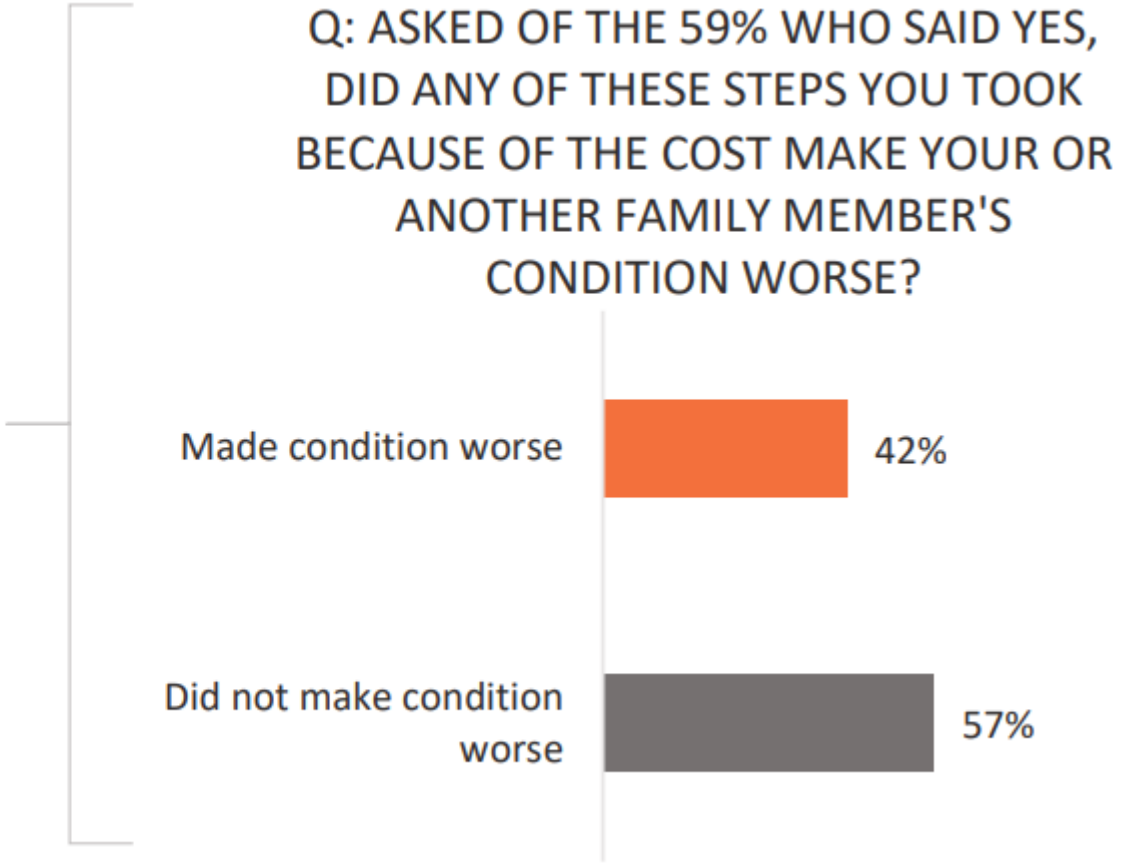


Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation. https://www.chcf.org/resource/2026-california-health-policy-survey/

Health Care Costs Cause Economic Hardship

Six in 10 Californians Report Skipping or Delaying Care Due to Cost; 4 in 10 of Those Say Skipping Care Made Their Condition Worse (Figure 21)



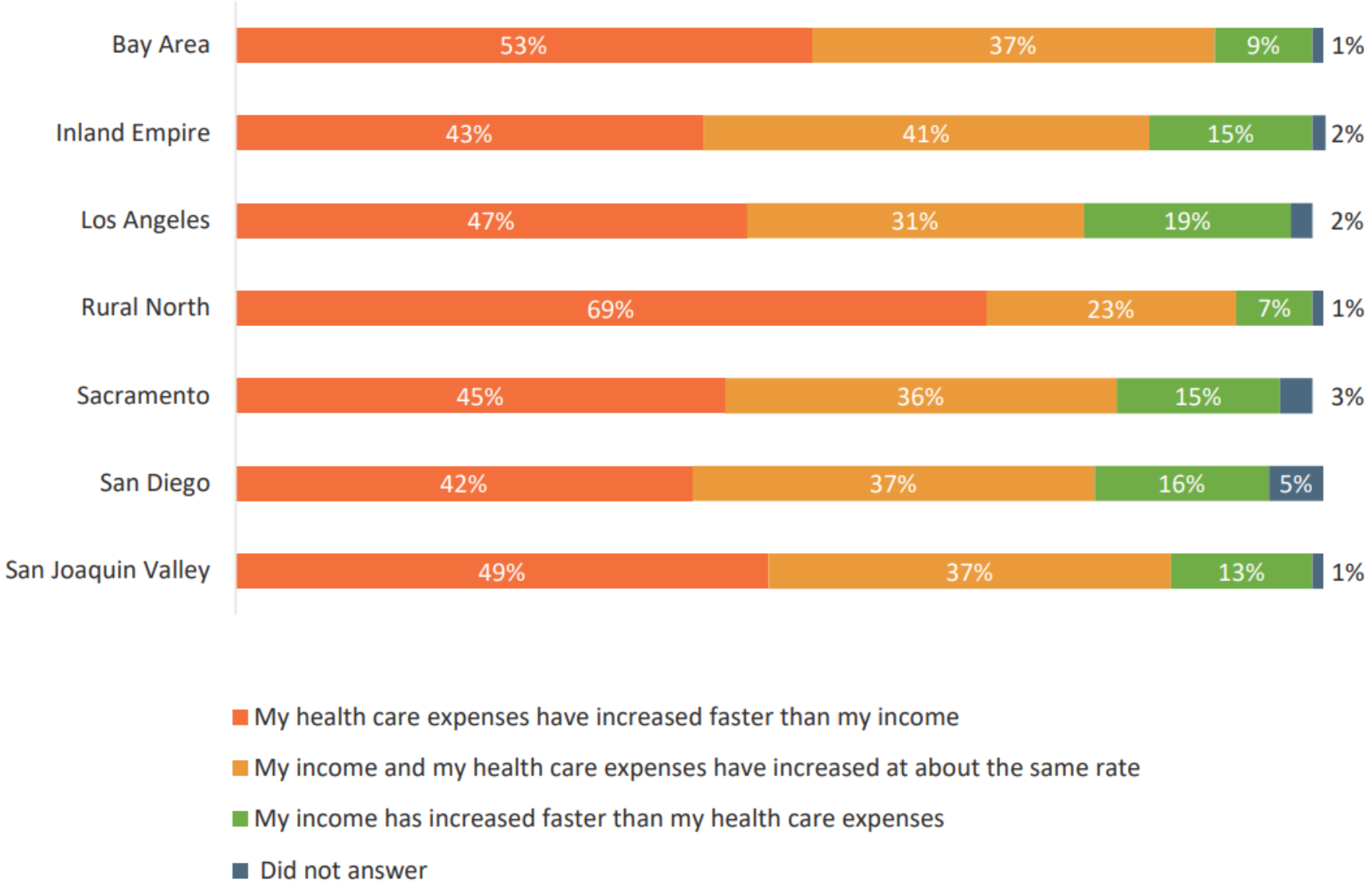


Joynt, J., Catterson, R. Alvarez, E. (2026, February). *The 2026 CHCF California Health Policy Survey*. California Health Care Foundation. https://www.chcf.org/resource/2026-california-health-policy-survey/

Health Care Costs Cause Economic Hardship

Seven in 10 Rural North Respondents Say Their Health Care Expenses Have Increased Faster Than Their Income (Figure 37)

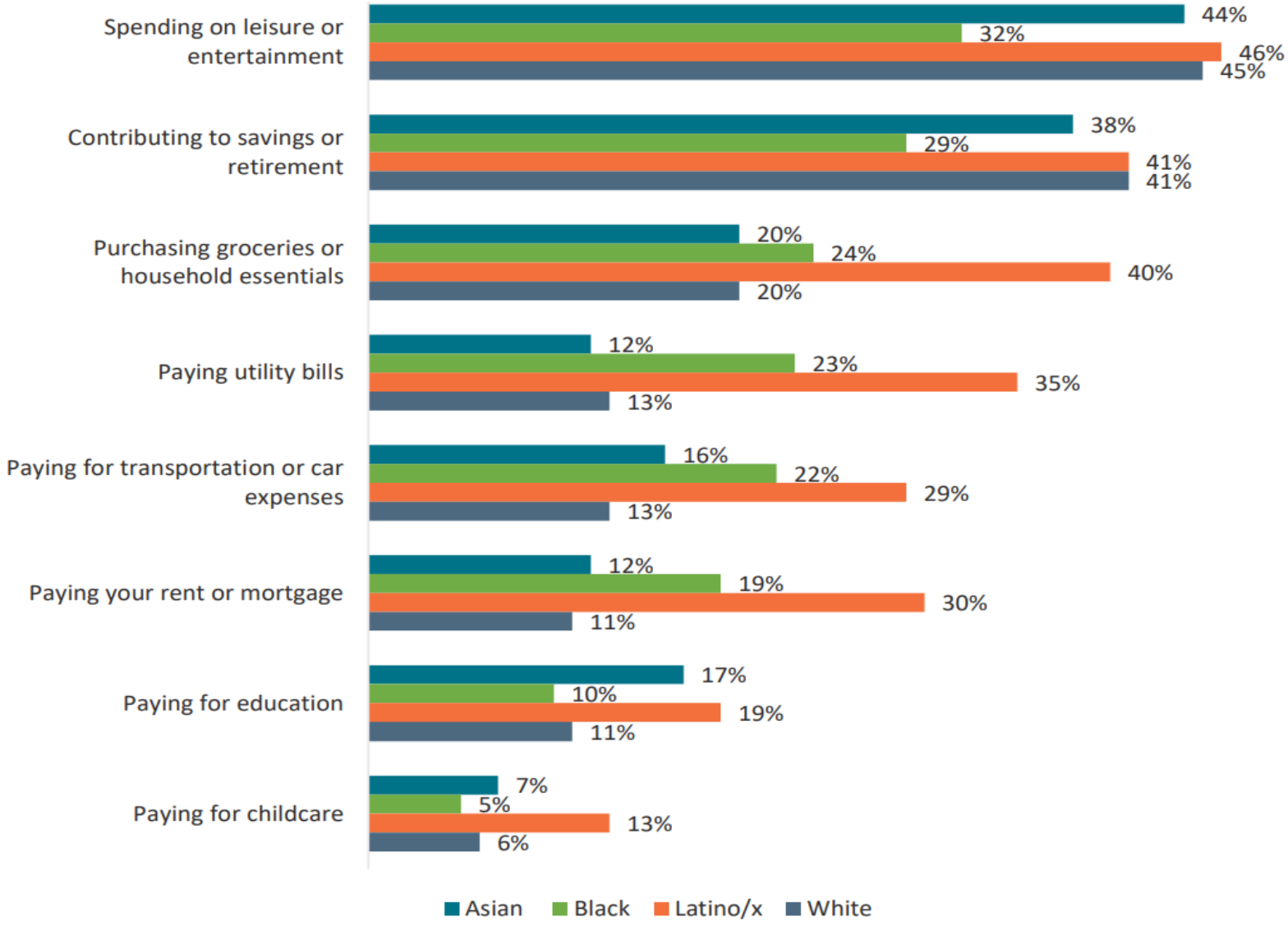
Q: WHICH OF THE FOLLOWING STATEMENTS COMES CLOSEST TO YOUR EXPERIENCE, EVEN IF NONE ARE EXACTLY RIGHT?



Health Care Costs Cause Economic Hardship

Many Latino/x Californians Report Reducing Spending on Many Things to Afford Health Care (Figure 30)

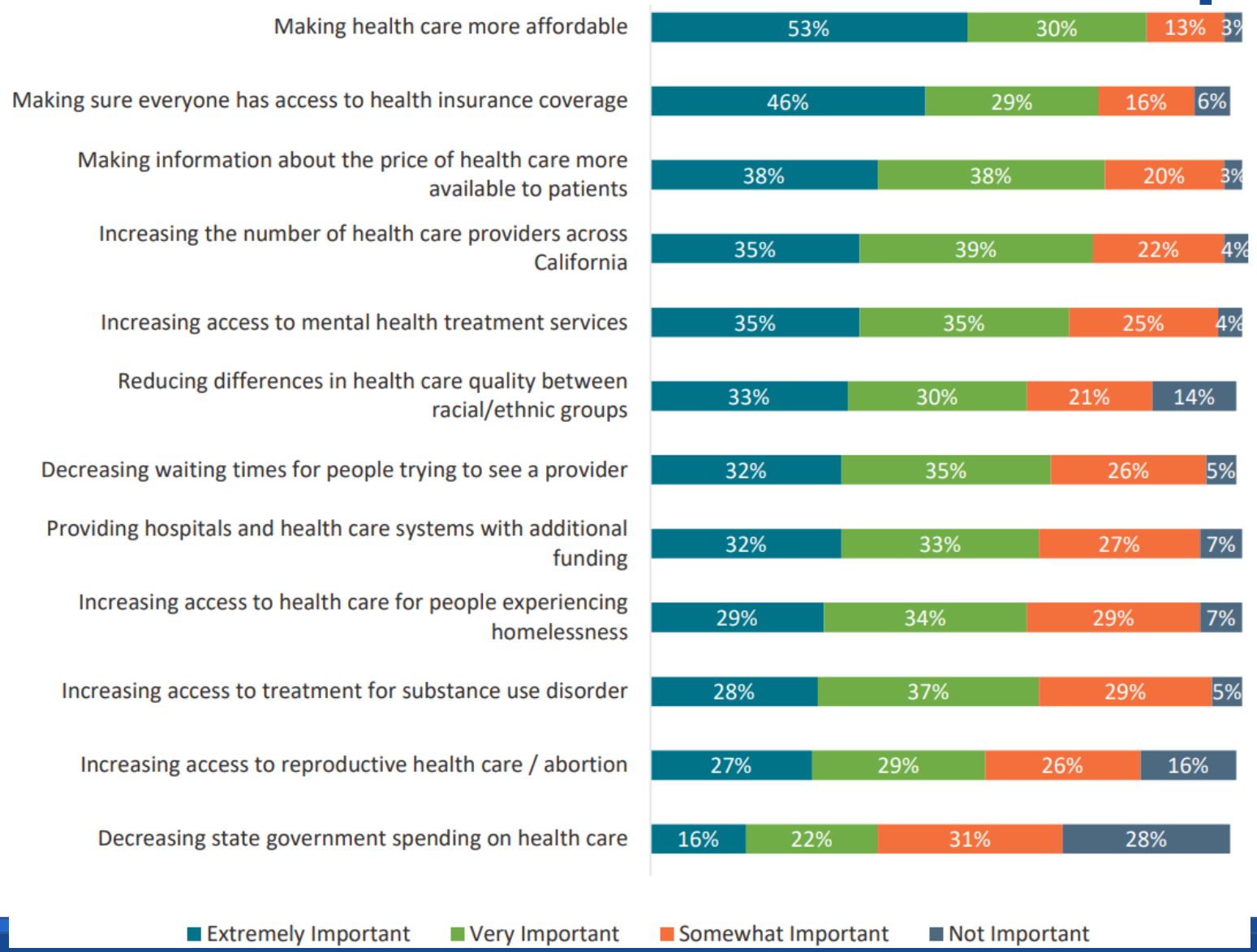
PERCENTAGE WHO SAY THEY OR A FAMILY MEMBER DELAYED, REDUCED, OR SKIPPED ANY OF THE FOLLOWING IN ORDER TO AFFORD HEALTH CARE EXPENSES IN THE PAST SEVERAL YEARS



Health Care Costs Cause Economic Hardship

About 8 in 10 Californians Say Making Health Care More Affordable Is an Important Priority for Policymakers in 2026 (Figure 7)

Q: HOW IMPORTANT DO YOU THINK IT IS FOR THE CALIFORNIA GOVERNOR AND LEGISLATURE TO WORK ON THE FOLLOWING THINGS IN 2026?



Administrative Spending and Profit Across Insurance Markets – *Health Affairs*

- An article in the March 2026 issue of Health Affairs examines administrative spending and profit across U.S. states for calendar year 2023 across health insurance markets – specifically fully insured commercial, Medicaid managed care, and self-funded employer plans – and finds substantial variation in this "non-medical spending," with particularly wide variation in profit levels.
- In the fully insured commercial market, median administrative spending is estimated at $599 per member per year (PMPY) and median profit at $63 PMPY.
- Across insurance markets, the spending is roughly $600 - $700 PMPY in the fully insured and Medicaid managed care markets, compared with about $285 PMPY in the self-insured employer market.
- Because these spending levels show wide variation, the authors suggest that moving higher spending states toward median levels could yield meaningful savings.

Source: Buxbaum, J. D., Arnold, D. R., Fuse Brown, E. C., & Whaley, C. (2026). *Substantial variation in administrative spending and profit across state insurance markets, 2023*. Health Affairs, 45(3). https://doi.org/10.1377/hlthaff.2025.00779

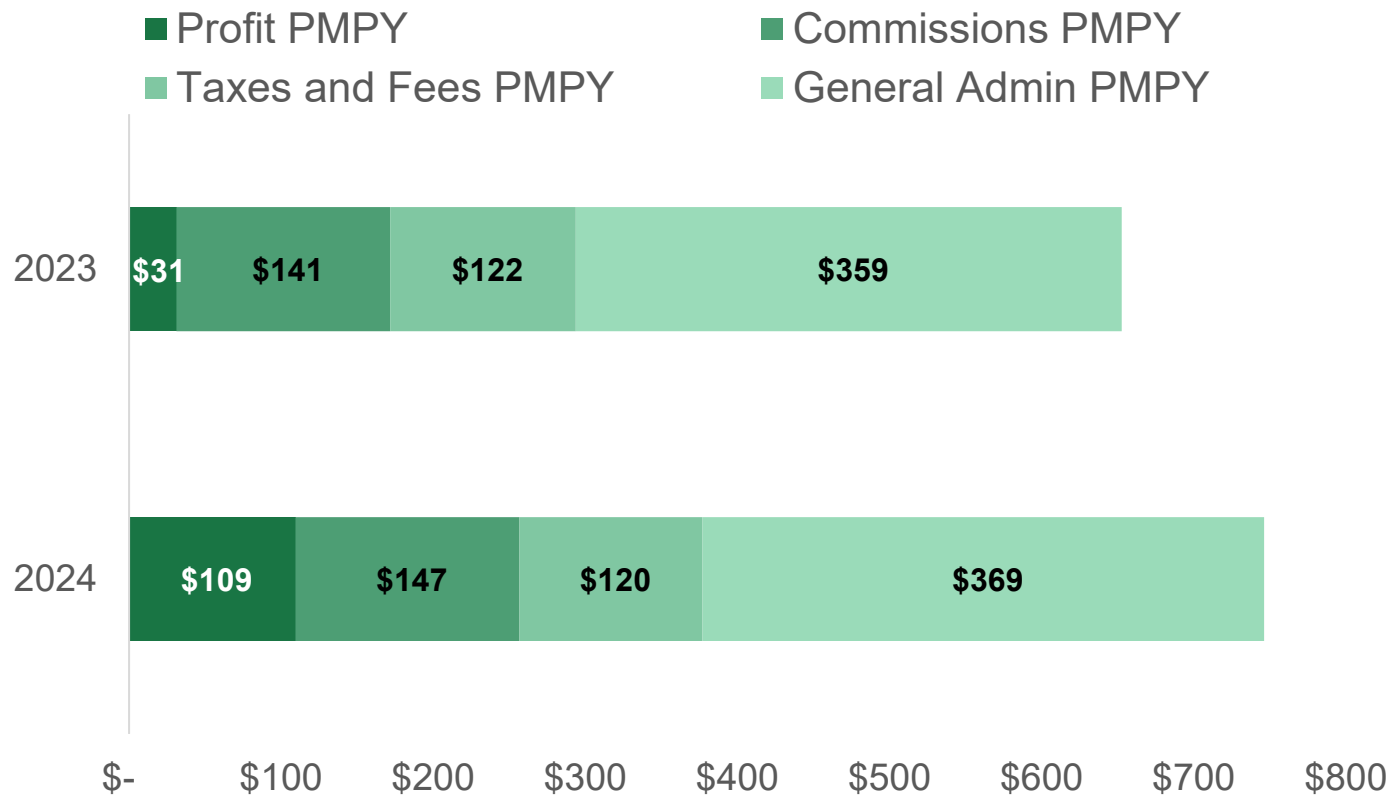
Potential Savings from Administrative Spending Reductions– *Health Affairs*

- The authors estimate that reducing above median states to the median level of non-medical spending could save approximately:
  - **$6 billion in the fully insured markets**
  - **$9 billion in Medicaid managed care**
  - **$4 billion in self-funded employer market**
- While the study highlights potential savings, it also notes that some non-medical spending supports necessary plan functions, including activities related to plan operations and oversight.
- At the same time, the authors note that a substantial share of the spending is not directly tied to improving care quality or reducing health care costs.
- The article highlights opportunities to reduce administrative costs in the health system including standardizing quality reporting requirements, simplifying contracting processes, and streamlining prior authorization.

Source: Buxbaum, J. D., Arnold, D. R., Fuse Brown, E. C., & Whaley, C. (2026). *Substantial variation in administrative spending and profit across state insurance markets, 2023*. Health Affairs, 45(3). https://doi.org/10.1377/hlthaff.2025.00779

Non-Medical Spending in California's Fully Insured Commercial Market

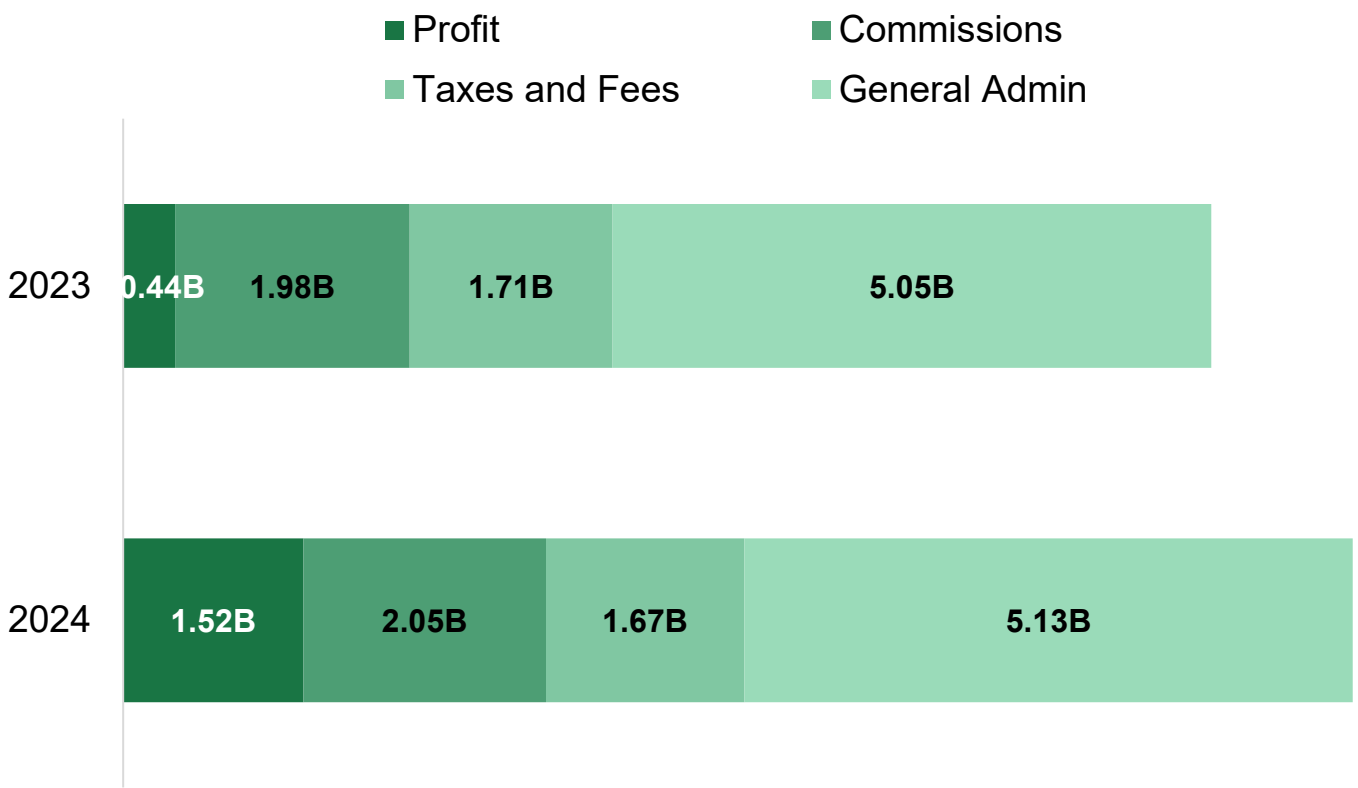
- Using CCIIO medical loss ratio filings for the fully insured commercial market in California, administrative components – general administrative costs, taxes and fees and commissions – total $622 PMPY, slightly higher than the article's median of $599, while profit at $31 PMPY was below the national median of $63.
- From 2023 to 2024, administrative spending components grew 2.4% from $622 to $637, while profit grew 252% from $31 to $109.
- Consistent with OHCA statutory definitions, this analysis excludes quality improvement expenses, making this a conservative estimate of administrative spending.



Source: CCIIO MLR Filings 2023 and 2024 among OHCA health plan submitters. Note: Consistent with OHCA statutory definitions used for MLR reporting, quality improvement expenses are excluded.

Non-Medical Spending in California's Commercial Market

- When translated into aggregate dollars across the fully insured commercial market, administrative spending components grew 1.3% from $8.74 to $8.85 billion, while profit grew 247.5% from $0.44 to $1.52 billion.

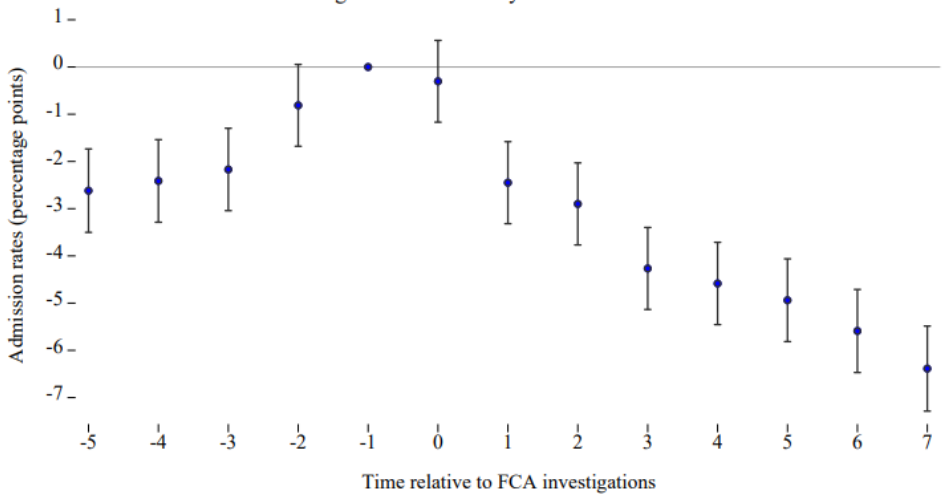


Source: CCIIO MLR Filings 2023 and 2024 among OHCA health plan submitters. Note: Consistent with OHCA statutory definitions used for MLR reporting, quality improvement expenses are excluded.

Reducing Waste through Anti-Fraud Enforcement

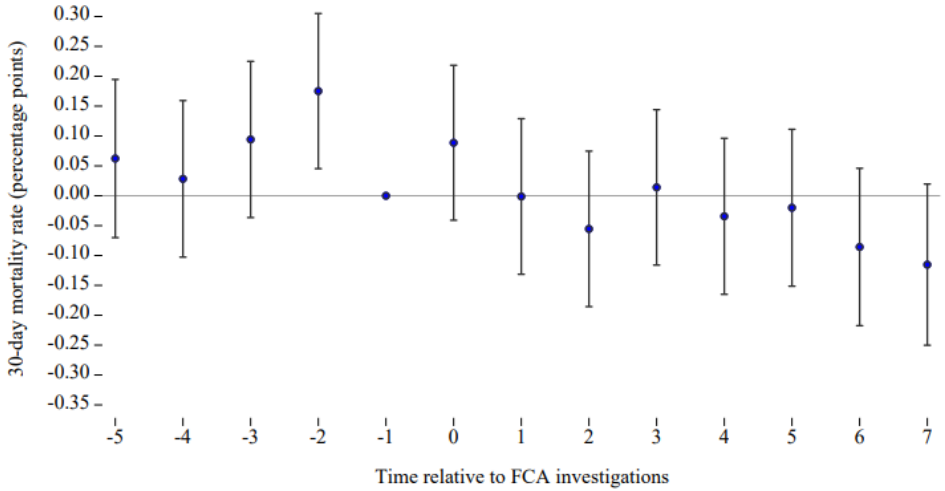
- A March 2026 National Bureau of Economic Research Working Paper examined the effects of anti-fraud enforcement on hospital admissions, Medicare spending and patient mortality.
- Using Medicare claims data from 2005-2019 and Department of Justice False Claims Act lawsuits where the federal government alleged hospital systems admitted patients unnecessarily, the authors found – compared to hospitals with no False Claims Act lawsuits – at hospitals subject to False Claims Act lawsuits, admissions decreased by 3.6 percentage points (9.7%), mortality rates decreased by 0.13 percentage points (2.3%), and spending decreased by $380 per patient (3.9%).
- This pattern of results suggests hospital administrators were encouraging inappropriate admissions, and the federal government's enforcement decisions resulted in reduced admissions (and thus lower spending) without harming patients.

Figure 4a: Event study of admission rates



Brackets indicate 95% confidence intervals.

Figure 4b: Event study of patient mortality

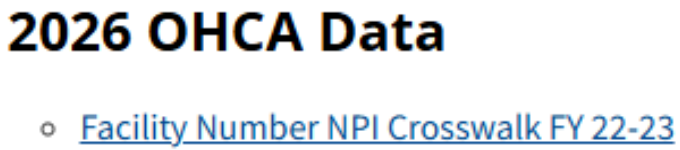


Brackets indicate 95% confidence intervals.

Howard, D., Leder-Luis, D. (2026, March). *Reducing Waste through Anti-Fraud Enforcement: Evidence from Hospital Admission Cases*. National Bureau of Economic Research. https://www.nber.org/papers/w34938

OHCA March 2026 Publication

- In January, OHCA posted on its website a preliminary crosswalk to support implementation of its hospital spending workstream and asked hospitals to review the NPIs associated with it and to provide feedback by the end of February on whether any NPIs were missing or incorrectly assigned.
- OHCA received over 130 responses and incorporated comparable hospitals' feedback in March and posted an updated facility number-to-NPI crosswalk.



Total Health Care Expenditures, Data Submission Guide 3.0 (DSG 3.0) - Update

- OHCA published draft updates to data submission regulations and incorporated documents on January 5, 2026.
- Public comments were accepted until January 30, 2026.
- OHCA received three comment letters.
- Final drafts of the proposed data submission regulations, including Data Submission Guide 3.0 and all addenda, were posted to the HCAI website after the March Board meeting.

Final Drafts included the following:

- Revisions to Regulation Text
- Revisions to Total Health Care Expenditures (THCE) Data Submission Guide (DSG Version 3.0)
- Revisions to OHCA Attribution Addendum
- New OHCA Behavioral Health Addendum
- New OHCA Medi-Cal Payments Addendum
- New OHCA Primary Care Addendum

Next Steps

- The final drafts were submitted to the Office of Administrative Law on April 8th. If approved, they will become effective April 20, 2026.
- Annual data submitter registration will begin in May 2026.

Cost and Market Impact Review Program Update - ResCare-Sevita

- On March 23, 2025, ResCare, a subsidiary of BrightSpring Health Services, filed a material change notice (MCN) to sell its subsidiaries and assets to National Mentor Holdings, the parent company of Sevita, for $835 million.
- The transaction would combine two large national providers of services for individuals with intellectual and developmental disabilities (IDD).
- OHCA announced its decision to conduct a CMIR on this transaction last December, because it may result in the following:
    - Reduction in the availability and accessibility of services;
    - Diminished quality of care;
    - Increased costs for payers; and
    - Contribute to ongoing consolidation in the health care market.

ResCare-Sevita CMIR Update

- OHCA issued its preliminary report on March 10, 2026, that outlined its conclusions regarding the transaction's impact on health care costs, quality, accessibility, and market consolidation.

- After issuing the preliminary report, OHCA accepted public comments from the public and the parties for 10 business days.

- OHCA received a comment supporting OHCA's preliminary findings. The letter also expressed concerns regarding Sevita's quality-of-care issues and financial practices.

- OHCA did not make any changes to the preliminary report in response to public comment. On April 8, 2026, OHCA posted the final report on its website. The transacting parties must wait 60 days after the release of the final report to close the transaction.

Slide Formatting



Indicates items that the Advisory Committee provides input or recommendations on based on statute and other areas as requested by the Board or OHCA.

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Informational Items

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Spending Target Enforcement – Continued Performance Improvement Plan Discussion

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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Review of Spending Target Enforcement

Performance Improvement Plans (PIPs)

- PIPs are the action plans, subject to final approval by OHCA, entities implement to come into compliance with the spending growth target(s) during a specified time-period.
- Entities will include in their PIPs the causes for spending growth, specific goals, strategies, adjustments, and action steps, and proposed measurements to track performance improvement.
- OHCA will monitor entities for compliance with their approved PIP.
- The success of a PIP will depend on an entity's compliance with their approved PIP and their performance against spending growth targets.
- PIPs ***are not*** developed by OHCA staff – entities are responsible for developing a proposed PIP that will be evaluated and approved by OHCA.
- Decisions about which entities submit and implement a PIP are made by the director.

OHCA's Proposed PIP Process

	Pre-Implementation
1.	OHCA determines if PIP is required
2.	OHCA consults with DMHC, DHCS, and CDI before requiring an entity to submit a PIP
r2.	OHCA gives entity 45 days to submit a proposal; entities can request 1 extension of up to 30 days, with explanation of need and regular updates
3.	OHCA evaluates proposal, consults with regulatory agencies, obtains Board input, and discusses proposal with entity
4.	OHCA makes decision to either approve PIP or require modifications and resubmission of a revised plan
	Implementation
5.	Entity begins implementing PIP – initial implementation period must end within 3 years
6.	Entity provides progress report(s) and meets with OHCA staff in accordance with approved PIP's timeline
7.	OHCA evaluates entity's progress and determines if entity is complying with PIP and/or if entity must modify PIP. Significant modifications may require consultation with regulators and input from Board

	Post-Implementation
8.	After PIP's implementation period ends, entity has 45 days to submit final progress report
9.	OHCA evaluates final progress report and determines if entity was compliant with their PIP

What is Included in a Performance Improvement Plan?

127502.5 (c)(1)

"…**The office may require a health care entity to submit and implement a performance improvement plan** that identifies the causes for spending growth and shall include, but not be limited to, specific strategies, adjustments, and action steps the health care entity proposes to implement to improve spending performance during a specified time period.

PIPs will likely include:

- Description of health care entity cost driver analysis: description and data-support analysis of the reasons for spending growth
- Summary of the PIP, including goals, strategies, and start and end dates, which will be included in public updates
- Specific, measurable, achievable, realistic, and time-bound (SMART) goals + specific strategies and rationale for each goal, evidence-base, and expected cost savings
- Assessment plan for each goal
- Description of PIP impact on consumer affordability
- Plan to sustain achieved goals and efficiencies
- Description of how implementing the PIP will maintain or improve access, quality, equity, and workforce stability
- Risk Mitigation Plan: Identification of potential barriers and mitigation approaches.
- PIP strategies that must be reported to other state regulators, as necessary
- Timeline for implementation, including deadlines, progress reports, meetings, etc.

How Will OHCA Monitor PIPs?

127502.5 (c)(2)
The office shall monitor the health care entity for compliance with the performance improvement plan.

OHCA will monitor entities' compliance with PIPs via:

Regular progress reports –

- Submitted on regular intervals
- Submission deadlines will be included in the PIP proposal's timeline
- Progress reports may include:
  - Summary of performance
  - Updates on progress toward SMART goals and related strategies
  - Timeline updates
  - Details on barriers or delays that impact PIP goals and entity's efforts to mitigate these risks

Final progress report –

- Submitted within 45 days of the end of a PIP's implementation period
- Submission deadline will be included in the PIP proposal's timeline
- Final progress report may include:
  - Summary of performance
  - Outcomes of PIP goals and strategies
  - Information on lowered costs for consumers
  - Impact on consumer cost, access, quality, equity, and or workforce stability
  - Steps taken to sustain achieved goals and efficiencies

How Will OHCA Evaluate PIPs?

127502.5 (d)(1)
If the director determines that a health care entity is not compliant with an approved performance improvement plan and does not meet the cost target, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target.

OHCA may assess the following factors when evaluating a PIP for compliance:

- Did the entity come into compliance with the spending target?
- Did the entity achieve the PIP's goals?
- Did the entity implement the planned strategies?
- Did the entity mitigate negative consequences on access, quality, equity, and workforce stability?
- Did the entity take steps to ensure achieved goals or efficiencies will be sustained in future years to maintain compliance with the spending target(s)?
- Did the entity comply with the PIP's timeline?
- How do reported outcomes compare with relevant data recently submitted as part of OHCA's data collection to support the annual report and compliance with the spending target?

Discussion: Performance Improvement Plans

Does the Advisory Committee have input on what is included in Performance Improvement Plans or how OHCA should evaluate them?

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Introduction to Equity Adjustment and Quality Adjustment to Spending Targets

Margareta Brandt, Assistant Deputy Director
Maggie Heidmann, Health Equity and Quality Performance Group Manager

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Key Terms and Definitions

- **Social drivers of health (also known as social determinants of health):** the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2030).
- **Social risk:** refers to an individual's social and economic conditions shaped by underlying social drivers of health (SDOH) (UCSF SIREN).
- **Social Vulnerability Index (SVI):** a place-based SDOH index developed by the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) (Social Vulnerability Index).
- **Social Vulnerability Index (SVI) Quartiles:** the SVI ranks California census tracts to give a measure of relative social vulnerability ranging from 0 to 1. These scores have been categorized into quartiles, four equal groups, with higher SVI scores (SVI Quartile 4) indicating higher social risk.
- **SVI Quartile 4**: indicates members with the highest social risk as assessed through the SVI. For example, a member with higher social risk could be below 150% of the poverty level and aged 65 & older with a disability.

Equity Adjustment

Statutory Requirements

- In consultation with the board, the office **shall establish** equity adjustment methodologies to take into account social determinants of health and other factors related to health equity, **to the extent data is available and methodology has been developed and validated**.
- The methodology for setting a sector target for an individual health care entity shall be developed taking into account the following:
  - Allow for the setting of cost targets that **encourage an individual health care entity to serve populations with greater health care risks** by incorporating an equity adjustment **accounting for the social determinants of health and other factors related to health equity** for the entity's patient mix.

Health and Safety Code § 127502
Social determinants of health are also referred to as social drivers of health.
This presentation uses social risk which refers to an individuals' social and economic conditions shaped by underlying social drivers of health (UCSF SIREN).

What is the Purpose of an Equity Adjustment?

Purpose

• Avoid potential unintended consequences of spending targets.
  • Do not want to discourage/penalize spending growth for services or populations where the level of care is insufficient.
  • Do not want health care entities to limit access or services for members with high social risk.
• Avoid undermining affordability by making health care more costly.
• Address social drivers of health and advance health equity.
• Encourage health care entities to address disparities in care for members with varying levels of social risk.
• Improve access, affordability, and equity of health care for all Californians.

OHCA would want an equity adjustment to meet one or more of these desired outcomes.

What an Equity Adjustment Is and Is Not

What the equity adjustment is	What the equity adjustment is not
• An adjustment to a health care entity's spending growth that does not change the spending targets. • For example, all health care entities would still have the 3.5% statewide spending target, but OHCA could use an equity adjustment based on social risk to adjust a health care entity's spending growth downward. • A method to identify health care entities serving a disproportionate share of members with high social risk by using available data, such as an SDOH index. • An allowance for higher spending growth for health care entities who are serving a disproportionate share of members with high social risk.	• A source of additional funding for health care entities to invest in efforts to address social risk. • A single solution to address health equity challenges in California. • A requirement for health care entities to spend more on initiatives to address social risk and reduce health disparities.

Equity Adjustment Development Process

Scope

- Assessed an equity adjustment for payers. Will separately assess for physician organizations and hospitals.

Process

- Since 2023, OHCA worked with health care experts, Mathematica, OnPoint Health Data, analysts, and researchers to review data analyses and discuss policy approaches to an equity adjustment.

Analyses

- Assessed programs by other states and CMS that apply social risk adjustments to the payments providers and health plans receive.
- Used the Social Vulnerability Index (SVI) and Health Care Payments Data (HPD) Program data to assess variation in social risk among members served by payers from 2018 to 2023.
  - Contracted with Mathematica to conduct an analysis.
  - Key findings:
    - Payers' distribution of members by SVI quartile is very stable and there is very little year-over-year change.
    - Even for members with the highest social risk (SVI Quartile 4), there is very little year-over-year change.

The SVI ranks California census tracts to give a measure of relative social vulnerability ranging from 0 to 1. These scores have been categorized into quartiles, four equal groups, with higher SVI scores (SVI Quartile 4) indicating higher social risk.

Assessment of Social Risk Distribution Among Payers

About the Analysis

- This analysis 1) examined social risk of California health insurance members and how social risk is distributed across payers to identify payers who take on members with disproportionate social risk within a market and 2) observed trends in payers' distribution of social risk over time.
- The Health Care Payments Data (HPD) Program data was used to assess variation in social risk among members served by California payers from 2018 to 2023.
  - Members' social risk was assessed by first applying a Social Vulnerability Index (SVI) score to each member based on address.
  - Members were then grouped based on their SVI quartile and variation across three key markets were assessed: Commercial, Medicare Advantage, and Medi-Cal Managed Care.
    - Both distribution by SVI quartile and volume of members in SVI Quartile 4, which indicates members with higher social risk, were considered.
- Social risk variation was analyzed at the payer-level; the analysis does not address social risk variation at the provider-level or hospital-level.

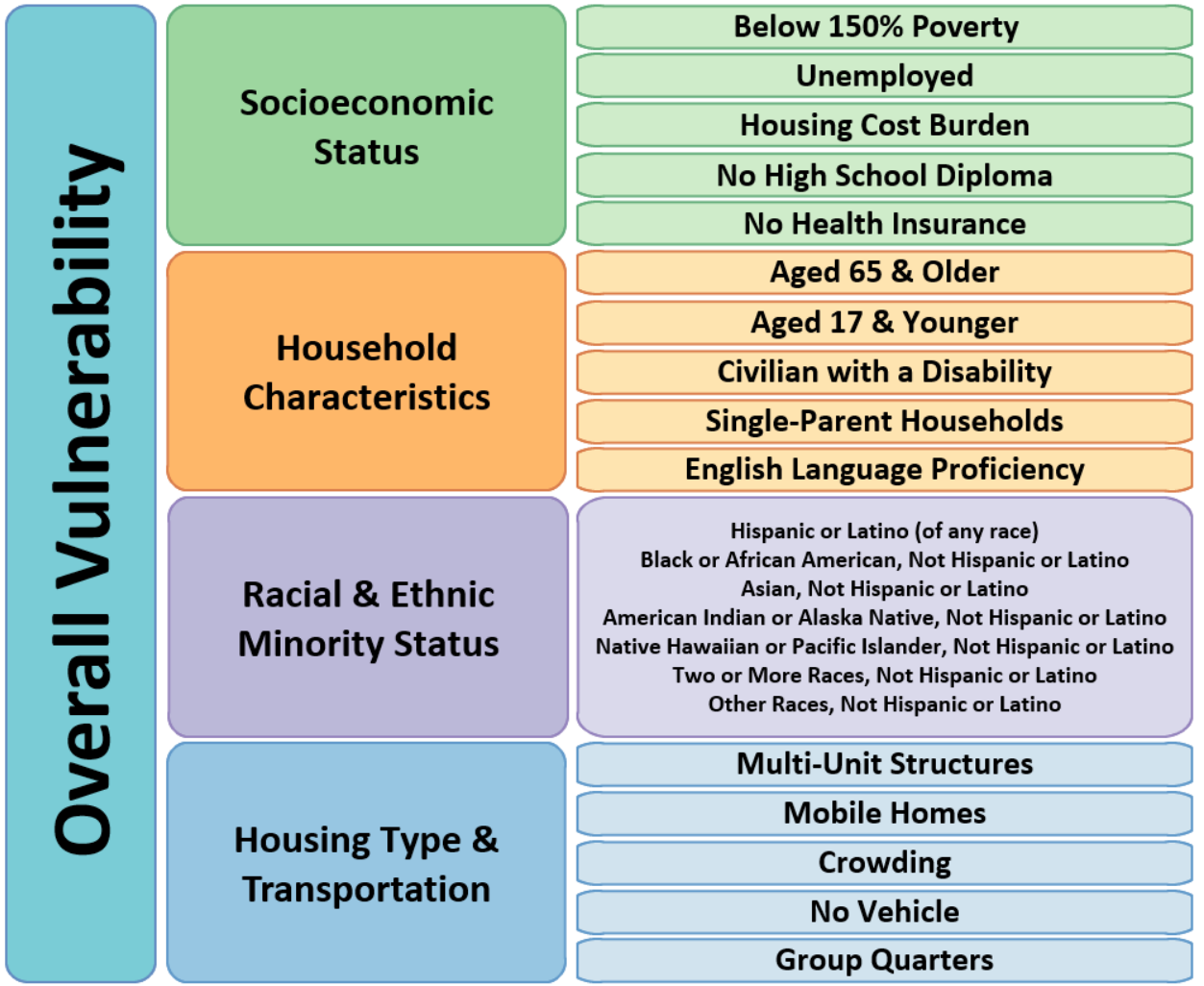
Data Notes and Limitations

- This analysis includes payers who submit data to the HPD. The HPD includes approximately 82% of Californians.
  - The HPD does not have complete self-funded commercial data or data on uninsured Californians.
- Data completeness in the HPD is between 99.2% - 100%[1] for required data elements such as: market category, payer, member zip code, etc.
  - Over 99% of member months were successfully linked to an SVI score for all 3 market categories.
- This analysis includes data for Medi-Cal Managed Care members. Medi-Cal fee-for-service data is not included.
  - Members without a Medi-Cal Managed Care Plan code, meaning a member could not be assigned to a Medi-Cal Managed Care payer, were excluded from the analysis.
- This analysis includes data for Medicare Advantage members. Medicare fee-for-service data is not included.
- The payers in this analysis differ slightly from the OHCA Baseline Report.
  - Two payers are in the OHCA Baseline Report but are not included in this analysis because they do not have data in the HPD.
  - One payer is included in this analysis but is not listed in the OHCA Baseline Report.

Source: Department of Health Care Access and Information. (2024). *2024 Health Care Payments Data (HPD) Program Legislative Report*. https://hcai.ca.gov/wp-content/uploads/2024/03/2024-Legislative-Report-HPD-Exec-Summary-Long-6.pdf

The Social Vulnerability Index (SVI)

- The Social Vulnerability Index (SVI) is a place-based index developed by the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR).
- This analysis uses the 2022 SVI, which equally weights 16 US Census variables from the American Community Survey (ACS) 2018-2022 (5 year) data and 2020 census tracts, to assign an SVI score.
- A higher SVI score indicates higher social risk.
  - SVI Quartile 4 indicates members with higher social risk.
  - For example, a member with higher social risk could be below 150% of the poverty level and aged 65 & older with a disability.
- SVI has a high correlation to the Healthy Places Index (HPI) and uses census tracts as the geographical unit.
- Very few California census tracts do not have an SVI score. Census tracts with no SVI score may have missing ACS data, therefore an SVI score could not be calculated.
  - Approximately 0.25% of the California population is missing an SVI score.

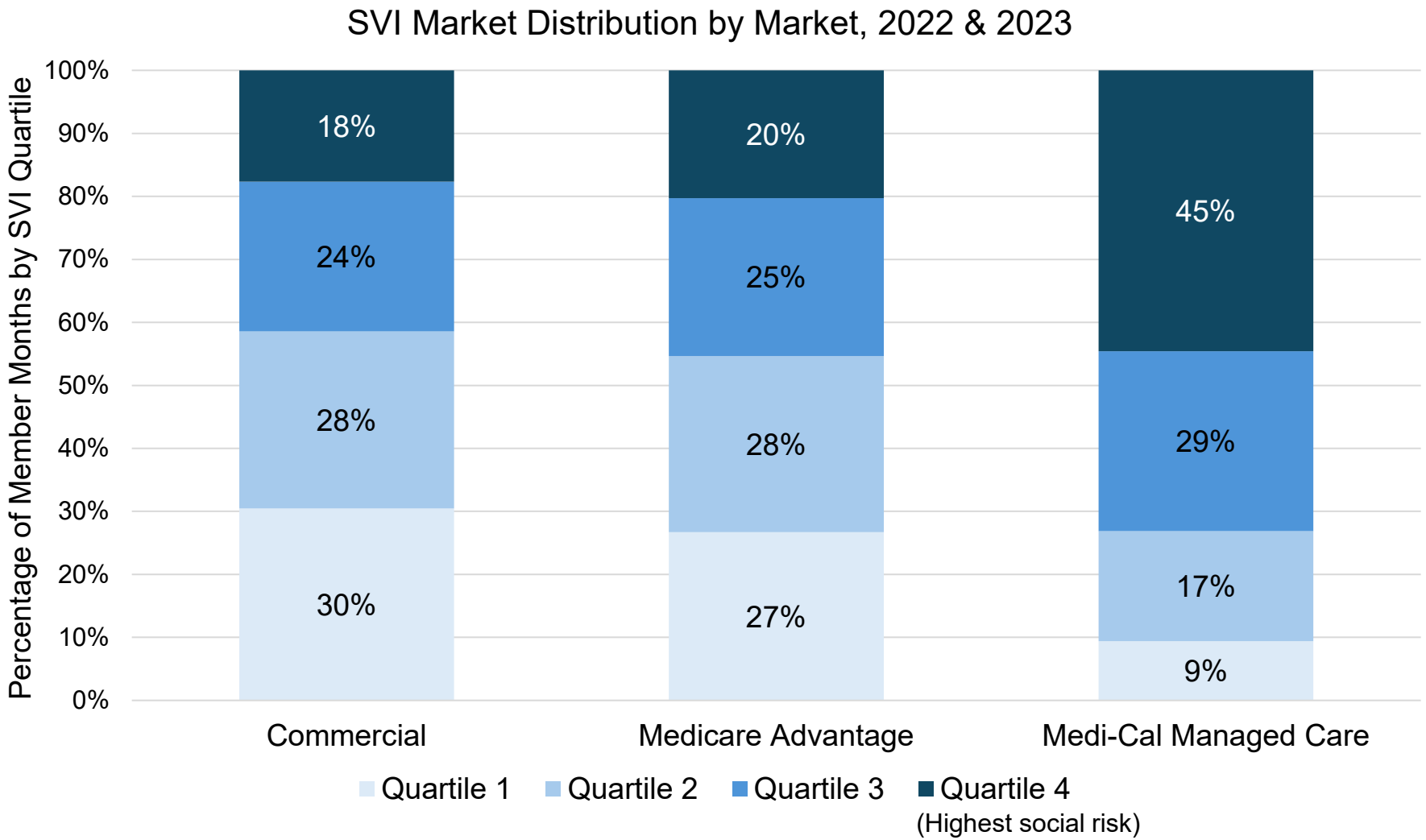


Source: Place and Health- Geospatial Research, Analysis, and Services Program (GRASP), Social Vulnerability Index, https://www.atsdr.cdc.gov/place-health/php/svi/index.html

Key Findings

- Payers' distribution of members by Social Vulnerability Index (SVI) quartile is very stable and there is very little year over year change from 2018-2023.
  - The Commercial market has very little year-over-year variation in the percentage of members in SVI Quartile 4, whereas the Medicare Advantage and Medi-Cal Managed Care markets have slight year-over-year variation from 2018-2023.
- Commercial market members disproportionately have lower social risk than members in Medicare Advantage and Medi-Cal Managed Care markets.
- Medi-Cal Managed Care insures the largest percentage of members with higher social risk.
- In the Medicare Advantage market, members are almost evenly distributed across quartiles.

SVI Scores by Market



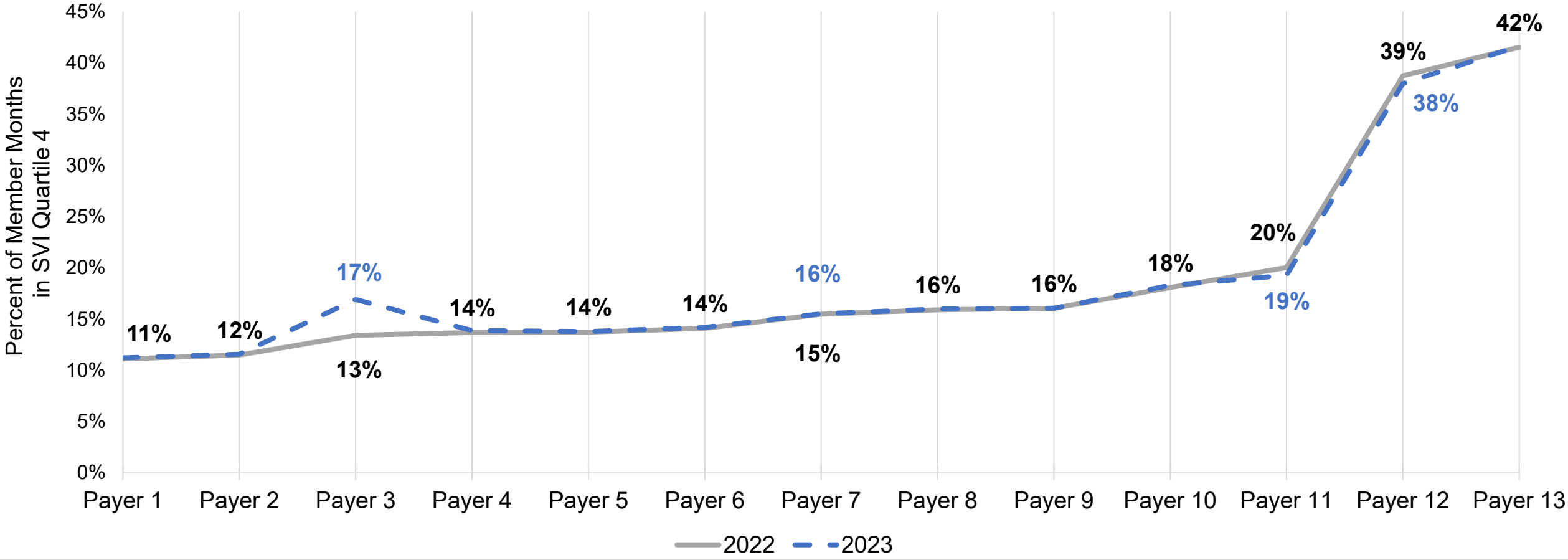
Note: Data from all 2022 and 2023 and all payers were combined to form the pooled dataset.

- Overall patterns within market categories are also observed at the individual payer-level.
- SVI score distribution remains relatively stable in all markets from 2018-2023.
- The Commercial market SVI score distribution skews towards lower social risk compared to other markets.
- The Medicare Advantage SVI scores are fairly evenly distributed across quartiles.
- The Medi-Cal Managed Care market enrolls members with higher social risk.

Note: SVI Quartile 4 represents members with the highest social risk.

Percentage of Commercial Members with the Highest Social Risk (SVI Quartile 4), 2022 and 2023

- Little variation for each payer's percentage of members with the highest social risk (SVI Quartile 4) from 2022-2023.
- Aside from two payers, the remaining 11 payers have only 11% to 20% of members with the highest social risk (SVI Quartile 4) in 2023.

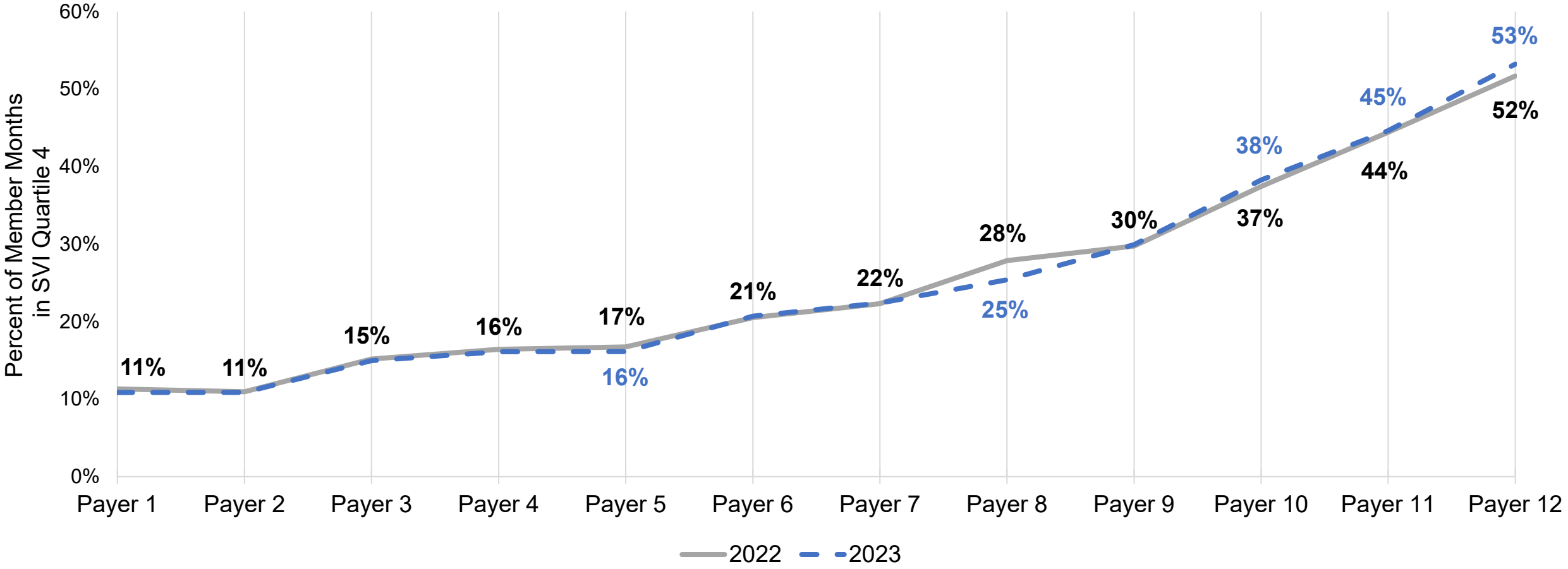


Additional years of data in Chart 1 in the Appendix

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Department of Health Care Access and Information

Percentage of Medicare Advantage Members with the Highest Social Risk (SVI Quartile 4), 2022 and 2023

- Little variation for each payer's percentage of members with the highest social risk (SVI Quartile 4) from 2022-2023.
- The percentage of payer's members with the highest social risk (SVI Quartile 4) range from 11% to 53% in 2023.

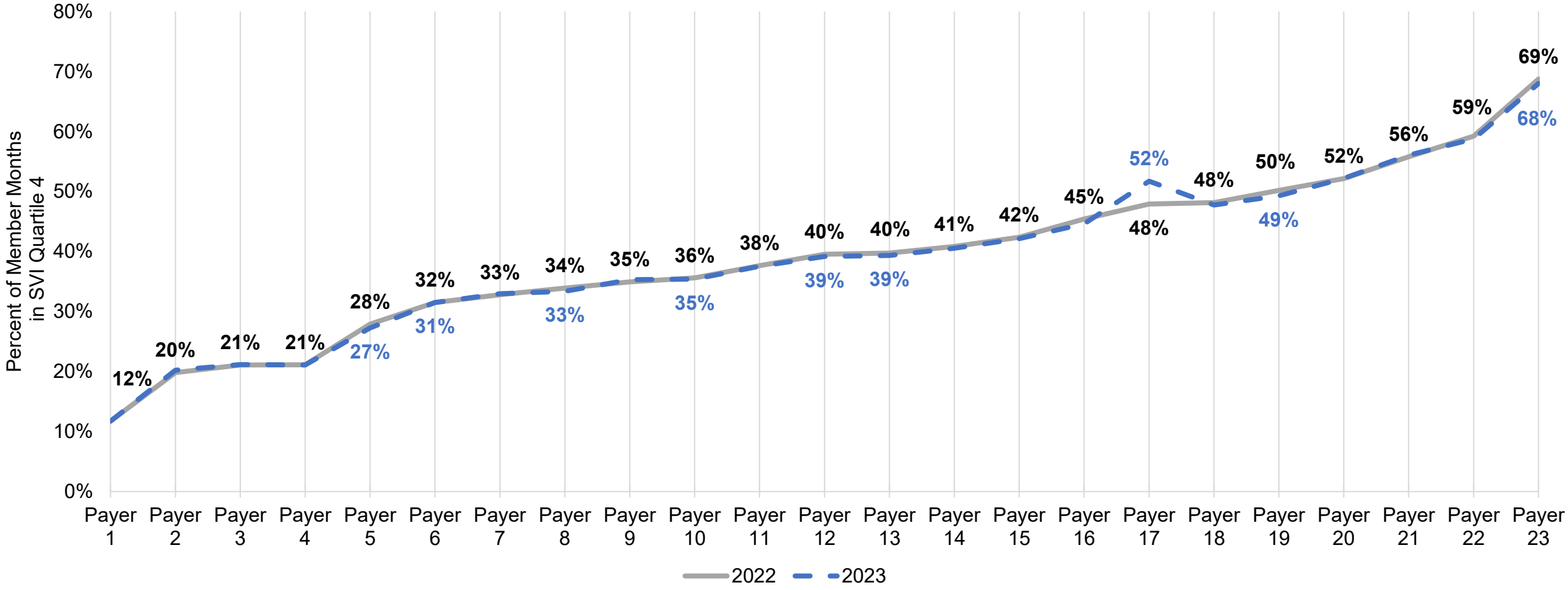


Additional years of data in Chart 2 in the Appendix

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Percentage of Medi-Cal Managed Care Members with the Highest Social Risk (SVI Quartile 4), 2022 and 2023

- Little variation for each payer's percentage of members with the highest social risk (SVI Quartile 4) from 2022-2023.
- Greatest variation of payer's percentage of members with the highest social risk (SVI Quartile 4) in 2023.



Additional years of data in Chart 3 in the Appendix

Proposed Equity Adjustment Recommendation for Payers

Proposed Equity Adjustment Recommendation and Rationale

Our proposed recommendation is not applying an equity adjustment to payers' performance against spending targets.

Key rationale themes:

- OHCA's analysis of social risk does not indicate that payers are seeing year-over-year variation in social risk trends.
- The relationship between health equity and cost is inconclusive.
- Administrative burden and cost outweigh the benefits and value of an equity adjustment.

Year-Over-Year Social Risk Trends are Stable

- Since the spending targets measure year-over-year Total Medical Expense (TME) per member, OHCA assessed year-over-year social risk trends using the Social Vulnerability Index (SVI) and Health Care Payments Data (HPD) Program data.
- This analysis showed that while social risk distribution varies between payers, there is little year-over-year change for each payer from 2018 to 2023.
  - Markets' and payers' social risk distribution remain very stable from year to year.
- The stability of payers' social risk mix suggests that changes in members' social risk profiles are not driving annual per capita spending increases, and therefore an equity adjustment might not be needed.
  - Given the stability of members' social risk, an equity adjustment methodology based on member social risk may have minimal impact on the payer's performance against the spending targets.

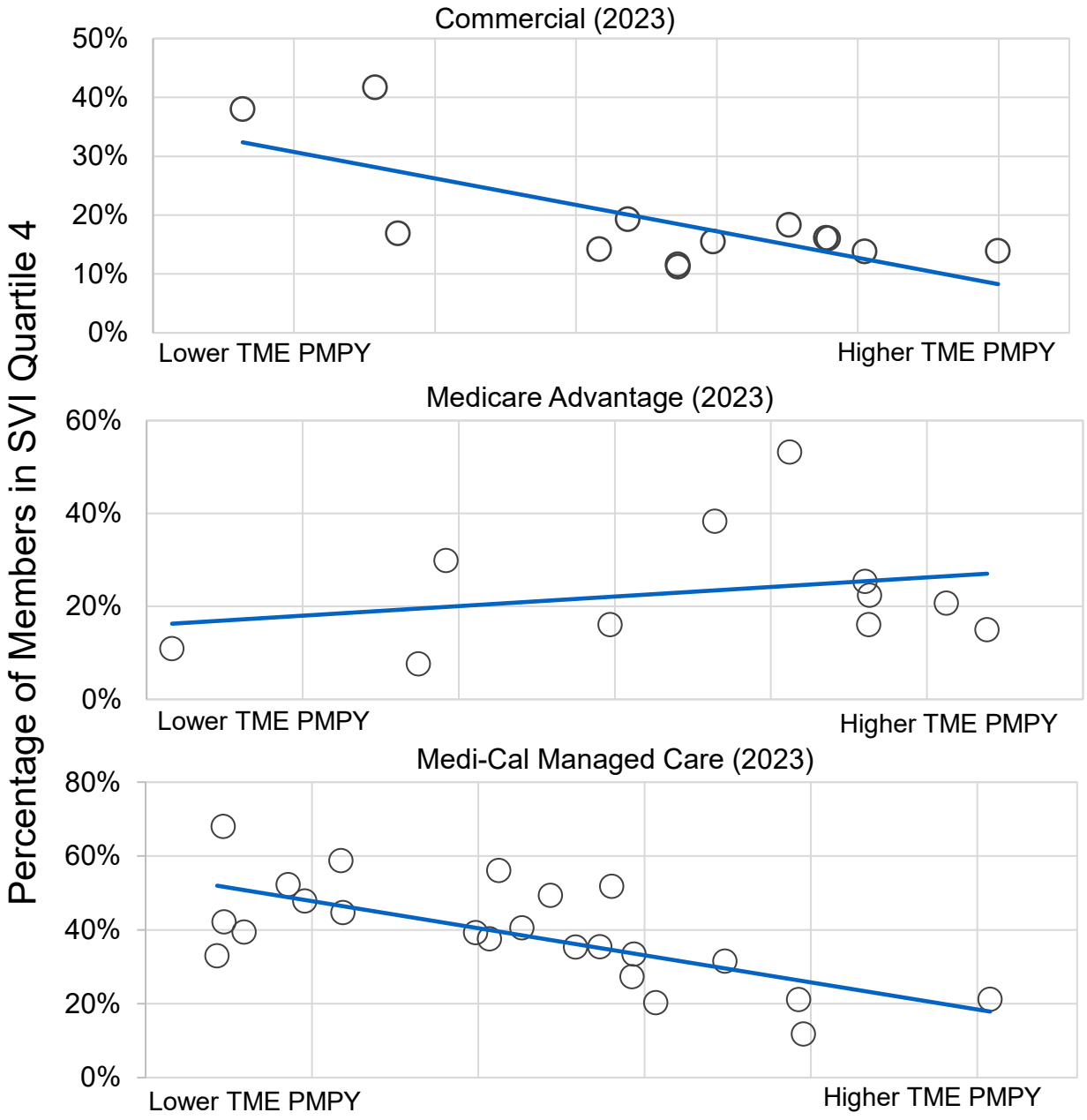
The Relationship Between Health Equity and Cost is Inconclusive

- While there is social risk data available through the SVI and other sources, the relationship between cost and health equity is inconclusive.
  - A cohort study of members with complex medical comorbidity found that social risks were associated with higher odds of inpatient admissions, emergency department visits, and mental health visits during a 1-year period. This could indicate that members with social risks have greater health care spending.
  - Conversely, lower health care spending could be attributed to certain populations skipping needed care for a chronic condition due to cost or access challenges. In 2025, 70% of Californians with low incomes (under 200% of the federal poverty level) reported skipping or delaying care due to cost.
  - Research continues to emphasize the need to better understand the interaction between social risk and cost.
- OHCA's spending targets are centered on median household income and advance health equity by focusing on a metric that directly reflects what consumers can afford.
  - The impact of incentivizing additional spending, particularly for members with the highest social risk, is unknown.
- OHCA cannot guarantee that additional spending growth allowed through an equity adjustment would address social risk.

Sources: 1. Tucher, E. L., Steele, A. L., Uratsu, C. S., McCloskey, J. K., & Grant, R. W. (2024). Social Risks and Health Care Use in Medically Complex Patients. *JAMA network open*, *7*(9), e2435199. https://doi.org/10.1001/jamanetworkopen.2024.35199 2. Flaherty, G., & Kanneganti, D. (2022, April 13). Ensuring Health Care Cost Growth Targets Promote Health Equity. *The Milbank Quarterly*. https://www.milbank.org/2022/04/ensuring-health-care-cost-growth-targets-promote-health-equity/#top. 3. The 2026 CHCF California Health Policy Survey. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2026/02/CHCFHealthPolicySurvey2026.pdf. 4. Chen, A.M. Barriers to health equity in the United States of America: can they be overcome?. Int J Equity Health 24, 39 (2025). https://doi.org/10.1186/s12939-025-02401-w

Correlation between Payer-Level Percentage of Members in SVI Quartile 4 and Total Medical Expense Per Member Per Year

- Payer-level analysis shows a strong negative correlation between the percentage of members in SVI Quartile 4 and Total Medical Expense (TME) per member per year (PMPY) in Commercial (-0.72) and Medi-Cal Managed Care (-0.69) markets, while Medicare Advantage shows a weak positive correlation (0.26).
  - Commercial and Medi-Cal Managed Care payers with larger proportions of members with high social risk show less spending, and payers with a smaller proportions of members with high social risk show more spending.
  - Medicare Advantage payers with larger proportions of members with high social risk show somewhat more spending, but the relationship is minimal.



Correlations are unweighted for 13 Commercial payers, 23 Medi-Cal Managed Care payers, and 11 Medicare Advantage payers.

Administrative Burden and Cost Outweigh Benefits and Value

- The administrative burden and cost of implementing an equity adjustment for both payers and OHCA may outweigh the benefits and value.
- Administrative burden and cost of implementing an equity adjustment:
  - To implement an equity adjustment, payers may be required to submit additional data to assess the distribution of their members' social risk.
    - For example, the populations reported in the HPD may differ from populations reported in OHCA TME data collection, therefore OHCA may need additional member address data from payers.
  - Payers would be required to engage with OHCA on additional data validation.
  - An equity adjustment would be resource intensive to ensure data completeness and accuracy and conduct detailed analysis.
- Benefits and value of implementing an equity adjustment:
  - The benefits to affordability are unclear.
  - In addition, the value is not compelling since social risk trends are stable and the relationship between health equity and cost is inconclusive.

Monitoring and Evaluating Health Equity may be More Appropriate

- In the absence of meaningful changes in social risk profiles and because the relationship between health equity and cost is inconclusive, implementing a systematic equity adjustment at this time may not be necessary.
- Continued monitoring may be more appropriate, rather than immediate implementation of a systematic equity adjustment.
    - To avoid unintended consequences of the spending target, evaluating changes in social risk can be a consideration during enforcement.

Evaluating Health Equity and Social Risk in Enforcement

- OHCA would still assess if a payer met the spending target using unadjusted data but could consider evaluating changes in social risk when determining if a payer proceeds in the enforcement process.
- The enforcement process would allow OHCA to ensure that entities have an opportunity to explain how large increases in members with the highest social risk and/or a disproportionate number of members with the highest social risk are commensurate with spending growth greater than the spending targets.
- OHCA cannot validate the explanations noted above from entities based on data we already collect. We may need to ask for more data during the enforcement process.
    - Changes in social risk may not appear in claims or non-claims data.

Continue to Assess an Equity Adjustment Over Time and Support Efforts to Improve Health Equity

- While presenting a proposed recommendation against a systematic payer-level equity adjustment, we want to emphasize our commitment to supporting efforts to improve health equity.
- Over time, we will continue to assess an equity adjustment's suitability for improving health equity.
  - We will monitor and assess new equity adjustment methodologies used by other programs.
  - We will separately assess whether and how to develop equity adjustments for physician organizations and hospitals through additional analyses and research.
- OHCA continues to pursue other work to advance health equity by implementing the spending targets to improve affordability, as well as through the OHCA Quality and Equity Measure Set, Workforce Stability Standards, Primary Care Investment Benchmark, Behavioral Health Investment Benchmark, and cost reducing strategies.

Summary of Proposed Equity Adjustment Recommendation

Our proposed recommendation is not applying an equity adjustment to payers' performance against spending targets.

- Our proposed approach is to evaluate changes in social risk through the enforcement considerations process.
- The proposed recommendation rationale focuses on payers.

Next Steps

- Present proposed equity adjustment recommendation to the Board in May 2026.
- Assess whether and how to develop an equity adjustment for physician organizations and hospitals.
  - Based on the analysis of SVI and HPD data for payers, we hypothesize an analysis for hospitals and physician organizations will show similar results – that there is little year over year variation in the distribution of members by SVI quartile for hospitals and physician organizations.
  - OHCA will conduct more literature research and engage expert consultants about an equity adjustment for physician organizations and hospitals.

Discussion: Introduction to Equity Adjustment for Spending Targets

Does the Advisory Committee have any questions about the assessment of social risk distribution among payers?

Does the Advisory Committee have input on OHCA's proposed approach for the equity adjustment for spending targets?

Proposed Quality Adjustment Recommendation

Quality Adjustment

Statutory Requirements

- The methodology for the spending target should:
  - Allow the Board to **adjust targets downward**, when warranted, for health care entities that deliver **high-cost care that is not commensurate with improvements in quality.**
  - Allow the Board to **adjust targets upward**, when warranted, for health care entities that deliver **low-cost, high-quality care**.
- Data sources on cost and quality performance of health care entities may include, but are not limited to, all of the following:
  - Cost and quality performance data reported by or sourced from recognized quality improvement and transparency initiatives.
  - Any other relevant supplemental data, such as financial data on health care entities, submitted to state agencies, and data on costs, payments, and quality from the Health Care Payments Data Program.
  - Any relevant federal, state, or local data.

Health and Safety Code § 127502 (d)(6)

Proposed Quality Adjustment Recommendation

Our proposed recommendation is not applying a quality adjustment to the spending targets.

- Our proposed recommendation applies to both groups of entities under consideration:
  - Entities that deliver high-cost care not commensurate with improvements in quality; and
  - Entities that deliver low-cost, high-quality care.
- This would help continue the path of slowing the trajectory of spending growth and improving quality simultaneously, promoting a high-value health care system that is affordable for all.

Cost and Quality of Care

- Adjusting the spending targets downward for high-cost care that is not commensurate with improvements in quality is not necessary:
  - Entities providing high-cost care are more likely to exceed the spending targets and are subject to OHCA's progressive enforcement process, making a quality adjustment unnecessary.
  - OHCA's position is that the provision of high-quality care should be possible within the spending targets.
- Adjusting the spending targets upward for low-cost and high-quality care is not consistent with OHCA's focus on affordability:
  - Allowing an increase to the spending targets could make high-quality health care more expensive.
  - 8 in 10 Californians say reducing what people pay for health care is "extremely" or "very" important. Health care costs are a burden for Californians, especially those with low incomes.
- There is no link between health care cost and quality for payers, physician organizations, or hospitals.

Source: Joynt, J., Catterson, R., Alvarez, E., Bye, L., Pineau, V., & Liu, L. (2024, January 31). *The 2024 CHCF California Health Policy Survey*. https://www.chcf.org/resource/2024-chcf-california-health-policy-survey/; OPA. (2024). Health Care Quality Report Cards. Center for Data Insights and Innovation. https://www.cdii.ca.gov/consumer-reports/health-care-quality-report-cards/; Integrated Healthcare Association. (n.d.). Cost & Quality Atlas. https://www.iha.org/performance-measurement/cost-quality-atlas/; Hussey, P., Wertheimer, S., & Mehrotra, A. (2013). The association between health care quality and cost: a systematic review. *Annals of Internal Medicine*, 158(1), 27-34. https://doi.org/10.7326/0003-4819-158-1-201301010-00006; Jamalabadi, S., Winter, V., & Schreyögg, J. (2020). A Systematic Review of the Association Between Hospital Cost/price and the Quality of Care. *Applied Health Economics and Health Policy*, 18(5):625-39. https://doi.org/10.1007/s40258-020-00577-6.

No Link Between Cost and Quality

In addition to findings presented by Christopher Whaley at the August 2024 Board meeting, below is further research showing no link between cost and quality:

- Higher-cost care does not necessarily mean higher-quality care.
- From the Office of the Patient Advocate Health Care Quality Report Cards, some physician organizations demonstrate high quality and lower costs, whereas others have high quality and higher costs.
- The Integrated Healthcare Association's Cost & Quality Atlas showed variation in payer cost and quality, particularly by product type (HMO and PPO) and financial risk sharing.
- For hospitals, cost might be associated with better outcomes in competitive markets but not in concentrated markets. Implying that prices might reflect market power and not superior quality. (Jamalabadi et al., 2020)
- From a systematic review of published literature for studies that examined the association between quality and cost or spending measures, the review showed evidence that the direction of association between health care cost and quality is inconsistent. Most studies have found that the association between cost and quality is small to moderate, regardless of whether the direction is positive or negative. (Hussey et al., 2013)

Source: August 2024 Board Meeting Slides; OPA. (2024). Health Care Quality Report Cards. https://www.cdii.ca.gov/consumer-reports/health-care-quality-report-cards/; Integrated Healthcare Association. (n.d.). Cost & Quality Atlas. https://www.iha.org/performance-measurement/cost-quality-atlas/; Hussey, P., Wertheimer, S., & Mehrotra, A. (2013). The association between health care quality and cost: a systematic review. *Annals of Internal Medicine*, 158(1), 27-34. https://doi.org/10.7326/0003-4819-158-1-201301010-00006; Jamalabadi, S., Winter, V., & Schreyögg, J. (2020). A Systematic Review of the Association Between Hospital Cost/price and the Quality of Care. *Applied Health Economics and Health Policy*, 18(5):625-39. https://doi.org/10.1007/s40258-020-00577-6.

Summary of Proposed Quality Adjustment Recommendation

Our proposed recommendation is not applying a quality adjustment to the spending targets.

- Our proposed recommendation applies to both entities that deliver high-cost care not commensurate with improvements in quality and entities that deliver low-cost, high-quality care.
- This would help continue the path of slowing the trajectory of spending growth and improving quality simultaneously, promoting a high-value health care system that is affordable for all.

Next Step: Present the proposed quality adjustment recommendation to the Board in May 2026.

Discussion: Introduction to Quality Adjustment for Spending Targets

Does the Advisory Committee have input on OHCA's proposed approach for the quality adjustment for spending targets?

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Public Comment

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Non-Supervisory Organized Labor Adjustment and Assessment – Introductory Discussion

Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

HCAI

Department of Health Care Access and Information

Statute

127502 (c)(7)

The health care cost targets shall… Be adjusted for a provider or fully integrated delivery system's cost target, as appropriate upon a showing that **nonsupervisory employee organized labor costs are projected to grow faster than the rate of any applicable cost targets**.

127502 (d)(7)

The methodology shall **require the board to adjust cost targets** for a provider or a fully integrated delivery system as appropriate **to account for actual or projected nonsupervisory employee organized labor costs**, including increased expenditures related to compensation. For an adjustment to be effectuated, the provider, the fully integrated delivery system, or other associated party **shall submit a request with supporting documentation in a format prescribed by the office**. To validate the basis for the requested adjustment, the office may request or accept further information, such as any single labor agreement that is final and reflects the actual or projected increased nonsupervisory employee organized labor costs. *The office may audit the submitted data and supporting information as necessary.*

127502 (m)(1)-(4)

(1) The board shall hold a public meeting to discuss the development and adoption of recommendations for statewide cost targets, or specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities. The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting. The meetings shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code) consistent with paragraph (2) of subdivision (e) of Section 127501.10.

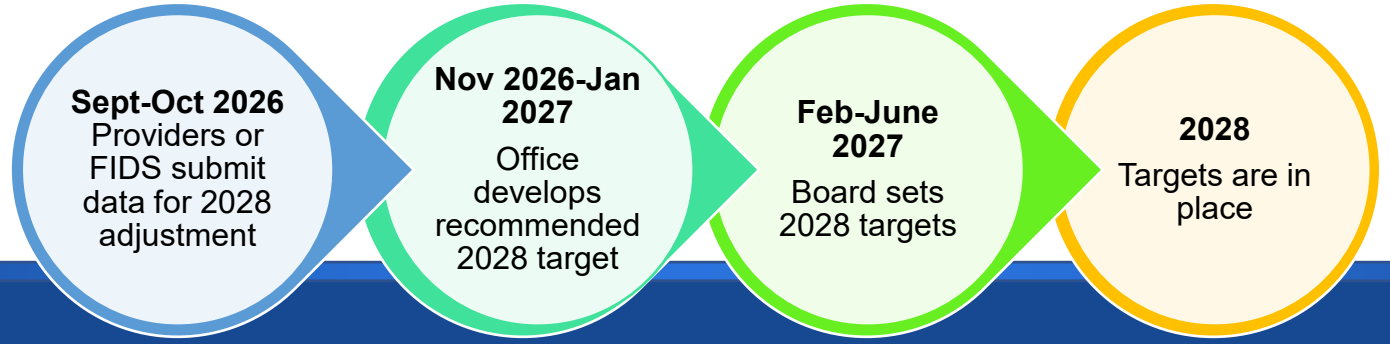
(2) The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. **The board shall discuss recommendations** at a public meeting for proposed targets **on or before March 1 of the year prior to the applicable target year**.

(3) The board shall receive and consider public comments for 45 days after the board meeting.

(4) The **board shall adopt final targets on or before June 1**, at a board meeting.

Operational Implications

- The Board is the entity that sets and adjusts spending targets during the annual target setting process. The Office cannot adjust targets for entities.
- Timeline and Target Adjusting: Because the Board will need to approve any adjustments to the target, providers need to submit requests ahead of the annual target setting timeline.
- Example timeline for 2028 target setting:
  - September-October 2026: Providers, fully integrated delivery system (FIDS), or labor unions may initiate a request for a Non-supervisory Organized Labor (known hereafter as “organized labor costs”) adjustment.
  - On or before March 1, 2027: OHCA will publish recommendations for targets for 2028.
  - A 45-day public comment period commences after the Board discusses OHCA’s recommendations at a Board meeting. All organized labor cost adjustment requests would be made public with OHCA’s recommendation. OHCA may consult ahead of this date as needed with parties associated with the organized labor cost adjustment (i.e., providers or FIDS and affiliated labor unions)
  - On or before June 1, 2027: The Board approves targets for 2028.



Potential Conceptual Framework

1. OHCA will calculate, based on information provided by the entity, the cost of each organized labor contract as a percentage of the entity's total operating expenses for the baseline and performance years. This determines the relative weight of each contract compared to overall operating expenses. This will also yield the cost share of all other operating expenses (i.e., those not related to nonsupervisory employee organized labor costs).
2. OHCA will calculate the year-over-year change in the cost of each organized labor contract from a baseline to performance year to determine whether those total costs are projected to grow faster than the entity's spending growth target.
3. Using both the growth rate of each contract and the proportional cost share, OHCA will calculate a weighted average growth rate. In this weighted calculation, each organized labor contract grows at its negotiated rate, while all other operating costs grow at the entity's applicable calendar year spending target rate.

- The resulting value is a preliminary adjusted spending target for the performance year.
- OHCA would assess actual spending for organized labor during the enforcement process.

Potential Conceptual Framework

Scenario: Spending Target Year (performance year) is 2028

Total Entity Operating Expenses in 2028 was $100 million

Contract	2028 Projected Cost ($Millions)	Projected Growth Rate (2027-2028)	Cost Share of Total Operating Expenses	Weighted Growth
RN Union	22	5%	22%	0.011
MA Union	10	7%	10%	0.007
All Other Operating Expenses	68	3.5%	68%	0.024
			Entity's Adjusted Spending Target	**.042**

Calculation for Preliminary Adjusted Spending Target

$(0.22 \times 0.05) + (0.10 \times 0.07) + (0.68 \times 0.035) = 0.011 + 0.007 + 0.024 = (0.042)100 =$ **4.2%**

Methodological Implications

- The Board would adjust targets for a performance year before having access to data for the base year. The Board will adjust targets for 2028 in March-June of 2027. To determine the projected growth rate from 2027 to 2028, the office would need to rely upon projected entity spend and cost structures for 2027 and 2028.
- Data availability: Currently a data source does not exist to vet or validate that expenditures are related to organized labor costs. The Office may be able to determine if spending was for a particular type of labor (e.g., RNs) but is not able to delineate between organized and non-organized labor costs.
- If adjustments are made, entities would need to submit data to the Office demonstrating the actual growth in organized labor costs.

Policy Considerations

Should the Board adjust for one non-supervisory organized labor (organized labor) agreement at a time or the projected total change in all organized labor costs for a given provider?

- If the net effect of all organized labor cost increases are projected to be less than or equal to the target, then an organized labor adjustment may not be merited.
- If the Board adjusts for one organized labor agreement, where the projected increase exceeds the target, the Board could adjust the target upward.

What happens if the entity's organized labor costs do not grow as much as projected?

- The Board could approve adjustments to the target that are conditioned on the entity demonstrating during the enforcement process that their actual organized labor costs aligned with the projected values the Board used to approve the target adjustment.

Policy Considerations

Should the Office evaluate organized labor costs as an enforcement consideration for entities that exceed the target?

- Organized labor agreements can be executed at any time during a calendar year. An organized labor agreement can impact spending in more than one calendar year (or spending target measurement / performance year).
- For organized labor agreements executed after the annual target setting process, OHCA could factor organized labor cost increases that exceed the target through the enforcement process.

Stakeholder Engagement

- OHCA staff have had some initial meetings with labor and provider representatives and will continue engagement with stakeholders.
- Advisory Committee members and health care entities have expressed concern that increases to organized labor costs will lead to increases in non-organized labor costs because health care entities compete for the same workforce in a market. These commenters note this could impact their ability to meet the spending targets if the targets are not adjusted for non-organized labor costs as well.

Discussion: Non-Supervisory Organized Labor Adjustment and Assessment

Does the Advisory Committee have input on the process for adjusting the targets for Non-supervisory Organized Labor costs?

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Public Comment

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General Public Comment

Written public comment can be emailed to:
ohca@hcai.ca.gov
To ensure that written public comment is included in the posted board materials, e-mail your comments at least 3 business days prior to the meeting.

HCAI
Department of Health Care Access and Information

Next Advisory Committee Meeting:

July 8, 2026
10am

Location:
2020 West El Camino Ave, Conference Room 900, Sacramento, CA 95833

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Adjournment

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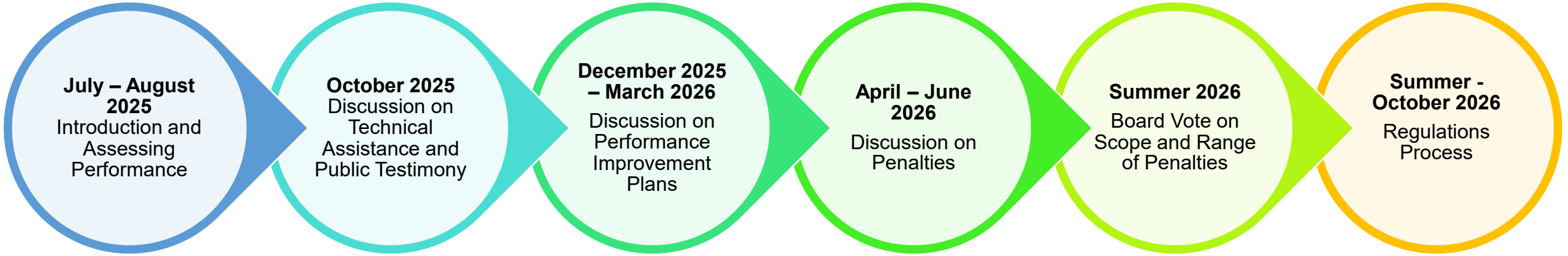
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Appendix

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Spending Target Enforcement Timeline



- OHCA is gathering feedback July 2025 – June 2026
- A discussion on spending target penalties is scheduled for spring 2026
- OHCA will develop regulations from summer – October 2026

Review of Spending Target Enforcement

Assessing Performance

- Entities are noticed they exceeded the target and given 45 days to provide additional information
- The intent is to consider spending increases driven by factors outside the entity's control (e.g., high-cost patient outliers) and increases that could be potentially beneficial in improving the system long-term (e.g., investments in primary care).
- Enforcement Considerations are factors or circumstances that OHCA could consider when determining which entities would proceed beyond technical assistance to additional enforcement steps, like public testimony and performance improvement plans.
- These considerations will **NOT** change or modify an entity's reported performance or directly exempt or waive an entity from enforcement each year.

Potential Enforcement Considerations
Historical Spending Growth
Entity Baseline Costs
Impact on Consumer Access and Affordability
Population Characteristics
High-Cost Patient Outliers
High-Cost Drugs
Investments in Primary and Preventive Care
Changes in State and Federal Law
Acts of God or Catastrophic Events

Review of Spending Target Enforcement

Technical Assistance

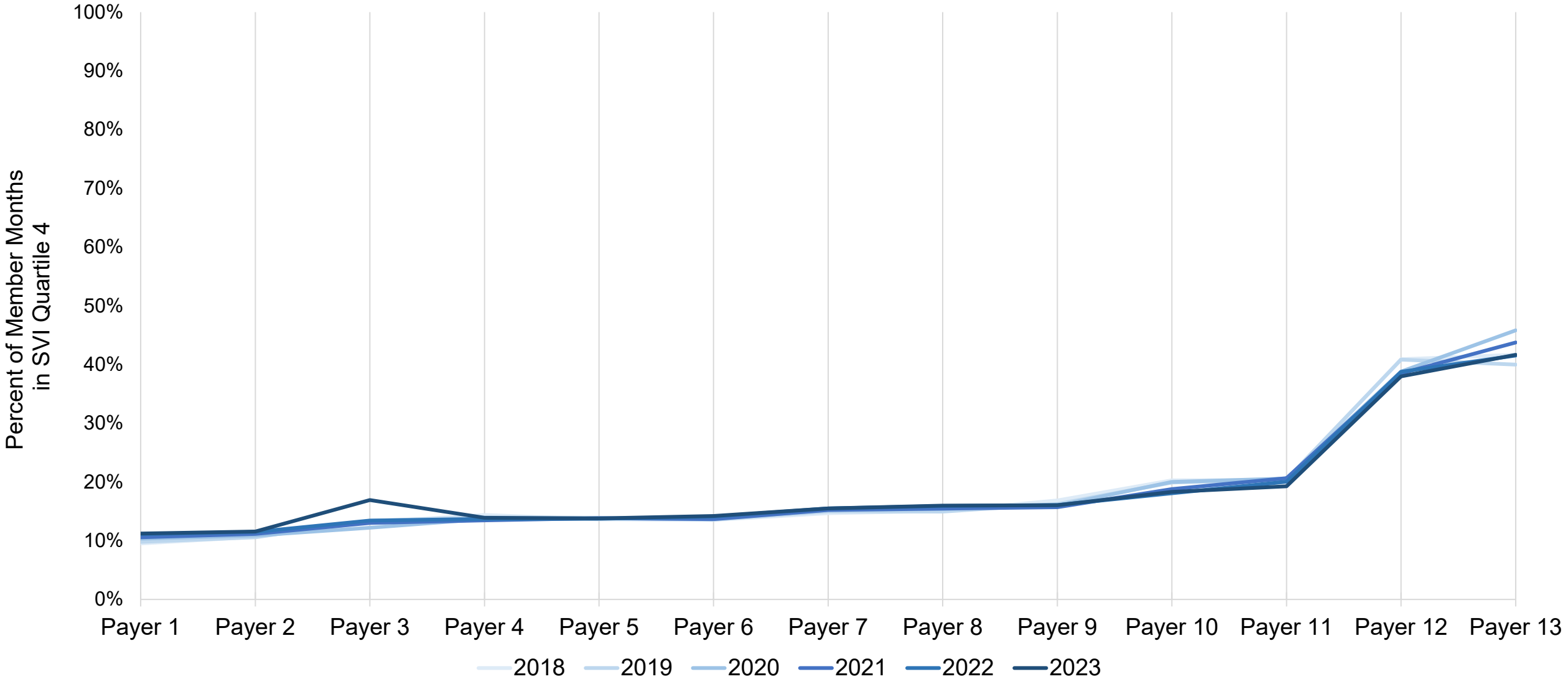
- Information provided to health care entities to provide resources and general guidance for compliance with spending targets.
- All entities that exceed the spending target will receive technical assistance.
- May include research studies, literature, cost-reducing strategies, etc.

Public Testimony

- An opportunity to hear from health care entities that have exceeded the spending target. This may take various forms, including in-person or written testimony.
- An optional step taken at the discretion of the director.

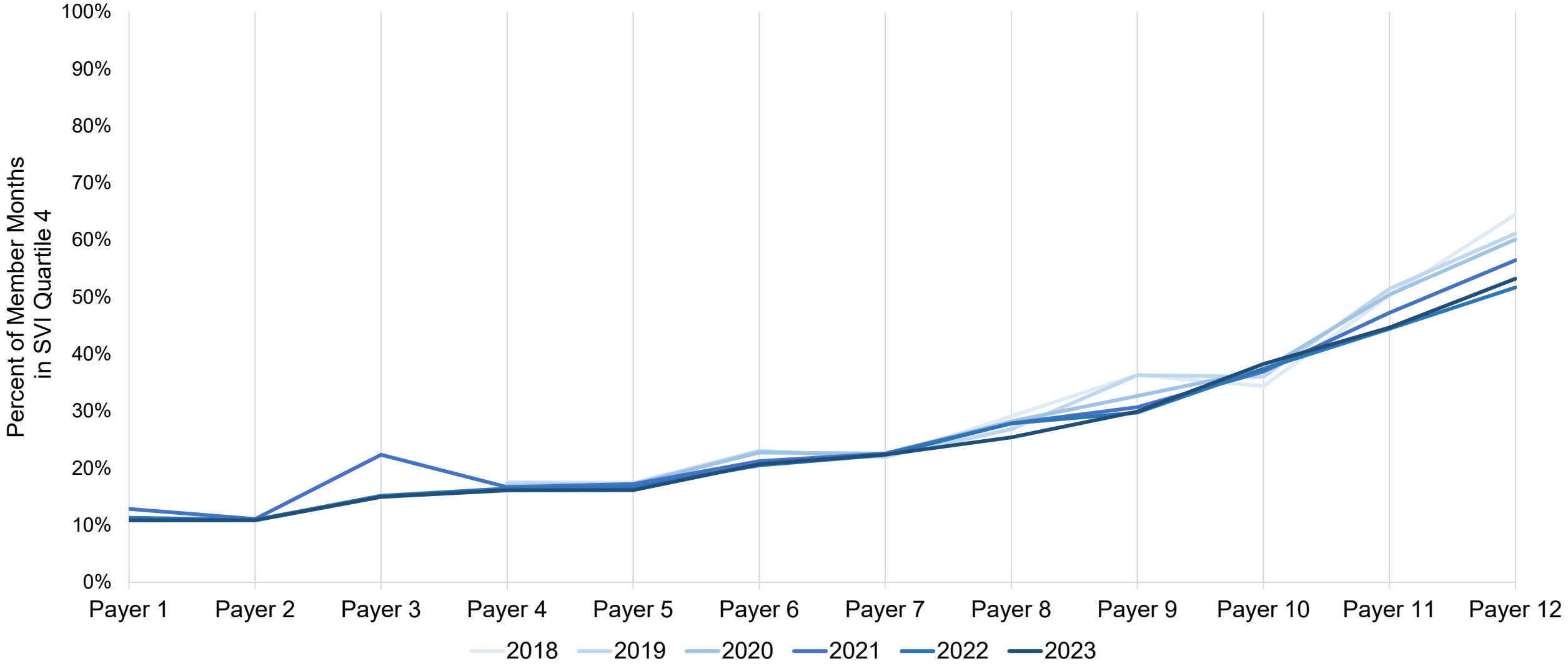
Assessment of Social Risk Distribution Among Payers Appendix

Chart 1: Percentage of Commercial Members with the Highest Social Risk (SVI Quartile 4), 2018-2023



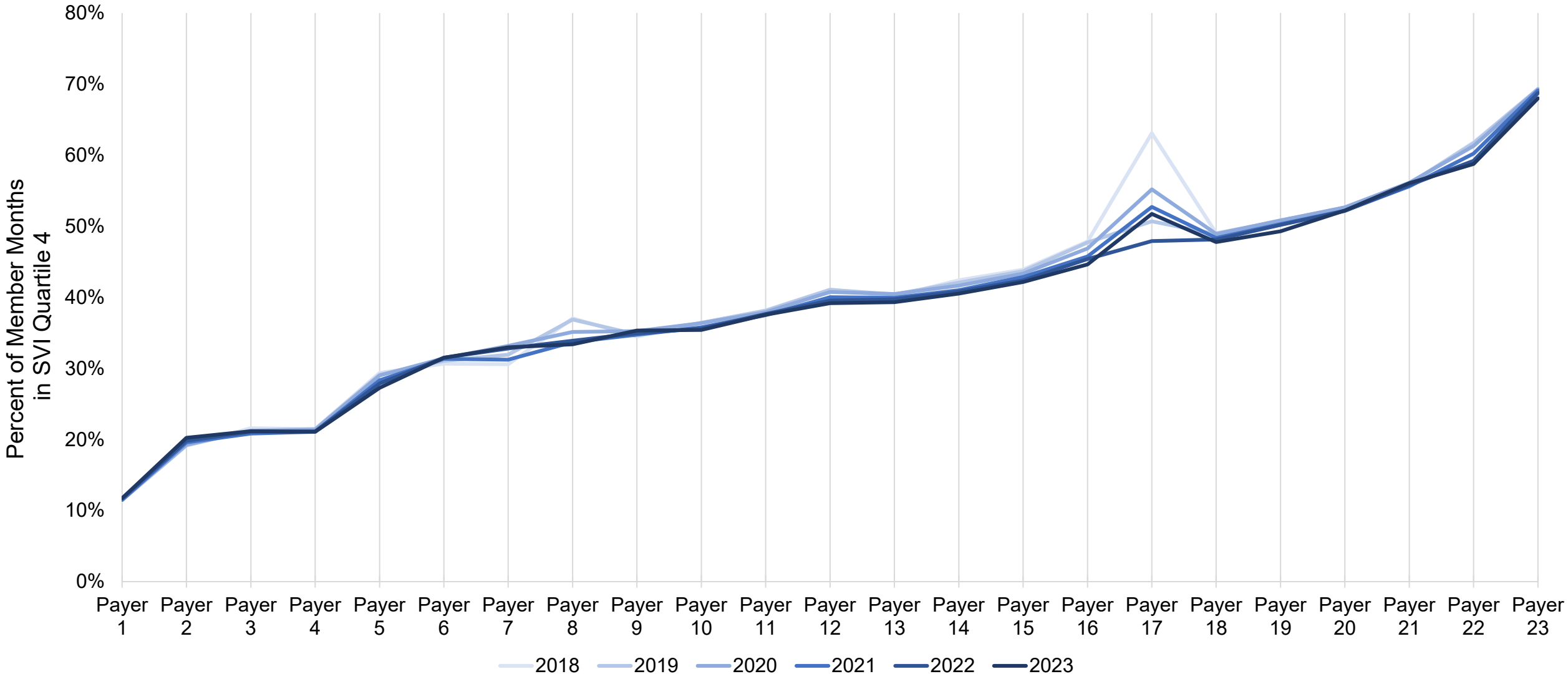
Only payers with data in the HPD for all 6 years are included.

Chart 2: Percentage of Medicare Advantage Members with the Highest Social Risk (SVI Quartile 4), 2018-2023



Some payers do not have data in the HPD for all 6 years.

Chart 3: Percentage of Medi-Cal Managed Care Members with the Highest Social Risk (SVI Quartile 4), 2018-2023



Only payers with data in the HPD for all 6 years are included.

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information