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Health Care Affordability Board
April 2026 Board Meeting
Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox.

Date	Name	Written Comment
5/21/2026	California Association of Public Hospitals and Health Systems	See Attachment #1
5/21/2026	Health Access California	See Attachment #2
5/21/2026	California Hospital Association	See Attachment #3
5/21/2026	Greg Perkins	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. My household includes a septuagenarian stroke survivor who is gravely disabled and is on a fixed income. Her health care requires an inhome health aide paid out of pocket. We have great difficulty meeting expenses outside of her care. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/21/2026	Emily Bender	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, my spouse stayed in a job that was negatively impacting their well-being for way too long. I was forced to abandon a successful independent business because I could no longer afford the health insurance costs for my family. Insurance for the 3 of us

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		topped 24,000 per year WITH an ACA subsidy. This system is depressing wages, forcing families to make decisions they shouldn't have to make between healthcare and groceries, and killing people when they can't access the care they need. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/21/2026	James Mundy	Almost all Californians like me face high costs of living, and very many Californians often cannot afford the ever-escalating price of health care. Because of these expenses, people have to delay or ration life-improving, life-extending or even in some cases life-saving care or make difficult decisions about what to prioritize financially. This is unacceptable for the richest nation in the history of the world. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/21/2026	Peter Warner	The exorbitant and yet-rising costs of living have rendered the price of health care unaffordable for tens of millions of Americans. Today, after years of paying for insurance, and being annually abandoned by insurers in the black hole for medical care of Humboldt County, I am apparently not covered for essential healthcare costs. This despite paying my monthly Medicare fees from my Social Security account. I'll say here that Medicare is a highly overrated and extremely disappointing resort for those of us who cannot afford actual health care when it's needed. Yet now that system, instead of providing full services to all those in need, is further threatened by government corruption and personal greed. That is a crime against humanity. I have severe obstructive sleep apnea, and have used a continuous positive airway pressure (CPAP) machine every night since my original diagnosis in 2018. About 7 months ago, the machine motor indicated failure, and ever since, I've been pursuing getting a replacement machine. To date, between my primary care provider, the contract CPAP equipment company, and Medicare, I have been denied coverage. I've provided the results from my original sleep study, as well as the resulting diagnosis and prescription, all to no avail. Because of this condition, I cannot sleep well, and stand to develop further health complications (dementia, cardiopulmonary disease, among others) as a result of this loss of reliable sleep therapy. Up until two years ago, I was able to replenish non-durable sleep therapy components and supplies, but now in a time of dire need,

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		all parties have failed to respond with the materials, or even provide any assistance in resolving -- instead, all I've gotten is a constant barrage of excuses, and passing off of accountability. In addition, I have additional health concerns that my primary care provider is "not budgeted" to cover or to provide counsel or further diagnostic care. At this point, I don't know where to turn but to investigate my legal rights and to pursue action on behalf of my health. Should those fail, I won't promise not to take matters with those "care" providers into my own hands. I'm furious and not going to suffer in silence! This denial of health care and personal dignity should not be happening in this wealthy nation! Consumers can’t wait, we need the Board to enforce cost-growth targets with real penalties!
5/21/2026	John Oda	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. A recent op-ed highlights what so many families are already feeling: When health care costs go up, workers fall behind. Employer-sponsored family coverage in California jumped 24% in just three years, far outpacing wage growth. Employers pay more for premiums, and that leaves less for wages. For working Californians, rising health costs are a hidden pay cut. At the same time, costs keep climbing. This is exactly why California created the Office of Health Care Affordability (OHCA): to bring transparency to pricing, set cost growth targets, and hold the system accountable so patients aren’t left footing the bill. Consumers can’t wait, we need the Board to enforce cost-growth targets with real penalties!
5/21/2026	Marilyn Duke	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. This administration does not even consider the hardships of the middle class people! The backbone of our country! The Trump administration has distributed our hard earned money to his pockets, the pockets of his family and big business! Will there be a working class left if he is allowed to continue and serve his term?! Something needs to be

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		done, sooner rather than later, if we are to survive as a FREE COUNTRY and not one run by the rich only!! Please!!! Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/21/2026	Patricia Marlatt	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/21/2026	Lily Leung	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/21/2026	SG	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. We shouldn't have to choose between health and survival. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/14/2026	UC San Diego Health	See Attachment #4
5/10/2026	Lily Mejia	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/7/2026	Steve Wendt	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!

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5/5/2026	Rich C	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/5/2026	John Curtiss	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. MY MEDICARE COST THIS YEAR INCREASED 53 PER CENT PER MONTH! **********| HAVE BEEN ON MEDICARE 13 YEARS NOW! ********** MY AGE IS 78 NOW! ********** I LIVE ON SOCIAL SECURITY AND MEDICARE! ********** MY IBM PENSION IS $183.07 CENTS PER MONTH! ********** I NEVER QUALIFIED TO BE A HOME OWNER, THERE FORE I RENT FOR 57 YEARS! ********** Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/5/2026	Barrie Avis	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. My husband and I are in our late 60s, and my husband is disabled. We live in fear of losing our healthcare. Our adult children do not work in fields that provide insurance, so we worry that they are not receiving preventive care. Even trying to cover our dental and vision care means that we are struggling to still cover groceries and gas, and if the car needs repairs, then we don't buy groceries. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/5/2026	Grace Silva	It is self-evident that our present system of health care is imploding on itself and is not sustainable. We need to face the facts and change the system to benefit people, not insurance companies. We need single payer and

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		universal coverage. Our present system enriches insurers and then dumps patients into Medicaid or Medicare, while profiting all the way. Cut out the profiteers. Run health care as a nonprofit public trust. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Gabriele Wampfler	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Eugene Sanchez	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Linda Oeth	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Charles Abele	Californians like myself face high costs of living, and the increasing price of health care far outpaces wage growth. More and more Californians have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties! Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Sherrill Futrell	Stop letting us sicken and die for your friends' profit. We'll see you in jail. Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!

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5/4/2026	Chris Loo	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Ann Wasgatt	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. I am a senior citizen reliant on Medicare, but the cost of that keeps going up yearly, as do the utility bills, the cost of gas and groceries. Social Security doesn't grow quickly enough to cover these increasing costs. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Judith Borcz	Californians like myself need reasonably priced healthcare coverage, and whenever possible, detailed cost transparency which can then be managed appropriately. Understandably, emergency situations are different than chronic and known conditions which are managed with regular appointments and/or medication. Insurers in the state must give patients easily accessible, detailed coverage information, including coverage maximums and percentages to help consumers manage costs. Insurers like Blue Shield, do not provide this information as I have experienced with regard to mental health coverage. Insurers should be required to provide coverage tables by procedure code by geography as Medicare does. Insurers can easily use Medicare rates which are publicly available if these rates are the limits of their coverage, or provide patients which similar detailed information for coverage. Along with transparency on costs, the Board needs to closely investigate premium increases alongside these costs. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Timothy Conger	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Dear Sirs and Ms.,

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		Actually right now I have MediCal and MediCare insurance. I have a neurodivergent diagnosis (mental health) and also COPD. These pay for my medical appointments, prescriptions, and also hospitalizations if I need them.The copays for my medicines are not too bad thanks to MediCal and MediCare. I would hate to see the system cut any more than it already is. Helping health care helps people the most, particularly workers but also retired people like me. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Lill D	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, Many Californians have to delay or ration care, or make difficult decisions about what to prioritize financially. Rising health care costs rank among the top financial concerns for California families. A recent survey by the California Health Care Foundation found 7 in 10 Californians say health care expenses strain their household budgets, with nearly 2 in 3 worried about unexpected medical bills — more than those worried about rent or groceries. Many report they already are skipping or delaying health care as a result. Soaring out-of-pocket health care costs are only part of the troubling financial picture for families. Millions of working Californians receive health insurance as part of the compensation paid by their employers, but it is far from free. In California, the cost of employer-sponsored family health coverage has risen sharply — from $22,818 in 2022 to $28,397 in 2025 — a 24% jump in just three years. That far outpaces general inflation (12%) and wage growth (14%). California's premiums are growing faster than the 6% national average. When employers spend more on health insurance, there is less money available for wages. Rising premiums are, in effect, a hidden pay cut for working families. This sad story — stagnant or reduced wages due to rising health care costs — has been documented by economists at the UC Berkeley Labor Center and the Federal Reserve. California established the Office of Health Care Affordability to monitor and limit health spending growth. But hospital industry groups have pushed back against its targets, arguing they will starve patient care and jeopardize patient access. The California Hospital Association has filed a lawsuit challenging the affordability agency's actions.

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		Hospitals have real operational pressures, and those concerns deserve a hearing. But the core argument against the Office of Health Care Affordability's targets does not hold up. First, the affordability agency's policy does not impose budget cuts. It is designed to slow health spending growth, not make actual cost reductions. California family premiums have been growing at 7% per year — well above the Office of Health Care Affordability's approved spending growth limits of 3.5% in 2025, declining to 3% by 2029. Even that modest deceleration could meaningfully free up employer budgets for worker wages. It makes sense for the affordability agency to target hospital spending first. It is the largest driver of health insurance premium costs. Payments to hospitals make up more than one-third of total premiums. Data reported by hospitals to the state show operating costs across all California general, acute care hospitals in 2024 totaled $148 billion, of which 40% ($59.4 billion) went to overhead — including administration, fiscal services and other non-patient care functions. That represents a significant opportunity for efficiency gains and cost savings that need not touch direct patient care. Add to this the rapidly expanding role of artificial intelligence in streamlining administrative functions, and hospitals have more tools than ever to meet a modest growth target without sacrificing a single bed or a single nurse. California's workers have waited long enough for relief. The Office of Health Care Affordability's spending targets are a reasonable, overdue course correction. The time to let them work is now. Every year of delay means thousands more California workers will go without a raise — not because their employers won't give one, but because rising premiums driven by rising health care prices already took it. CONSUMERS CANNOT WAIT! LOWER PRICES NOW! Offer CALIFORNIANS A SINGLE PAYER OPTION: VOTE CALCARE!!THE TIME IS NOW ! Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	William Jackson	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

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		Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Thomas Antorietto	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. 1) I am a senior with Medicare and Anthem Blue Cross PPO. My wife and I live off SS and Univ of Cal retirement. I got my prescriptions from Rite Aid/co-pays $125 a month until they closed. I transferred to Costco in early July 2025 from July 2025 to December my co-pays were $0. The BBB came along and in January 2026 I had to pay $225 in co-pays for three months of medication. 2) My sister-in-law who lives with us had a Humana HMO policy 2025. Very little co-pays if any. UCSD decided not to accept any Medicare Advantage or Supplemental policies for primary care in 2026 (UCSD sucks). My sister-in-law is being charged $30 in co-pays a visit for primary care and Neurology. Two weeks ago she had to go to Ophthalmology because she had retina problem. She has been charged with $450+ in co-pays and has another appointment Friday May 9 where they will charge her another $140. Her only income is SS. 3) My son, 53 years old cannot work and is on Medical. Under the BBB he could lose his Medical any day. He has a medical condition that requires continual care. We cannot afford to pay for his health care so do not have any GD ideal what to do!! The Republican Congress people in the State of California have sold us out and need to be kicked out!! Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Angela Gardner	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Suzanne Graves	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

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		I am a member of Kaiser Permanente and due to climbing prices i can no longer attend to my medical needs. I can barely afford my medications now. Worse yet my daughter(31) had to go to urgent care over the weekend for a UTI. It cost her $300+ to get out the doo to go home due to a recent temporary lapse in her medical insurance. This was followed by a broken ankle on Saturday which required a trip to the local ER. She has no idea what shes going to do now that rent and utilities are due! I feel horrible for her and i wish i could help her out financially, I'm on a very small($700/mo) fixed income. Neither one of us don't know what to do. Not only can we not afford medical/dental care, we can't afford groceries or gas either due the fascist clown show in D.C. we don't know what to do anymore! We, the American people need help to get through this trying time. We need a show of compassion rather than greed. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Camille Gilbert	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Christine Borje	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	AJ Cho	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Sue E	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care,

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5/4/2026	Walter Beech	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. 1) I am 80. When I was younger and my income was lower, I sometimes did not buy drugs that doctors prescribed because I could not afford them. 2) I have a larger income now that I am retired. I and my wife were able to save for retirement, unlike many Californians who cannot save anything because of low wages and the high cost of living. My current income is fixed, however. We have to budget our monthly expenses. During retirement, I have occasionally not taken certain tests that doctors prescribe because I cannot afford them. For example, a U.C. Davis allergist recommended a skin test. I did not take it because the estimated cost was too high. 3) Sometimes, my primary care physician or a specialist orders a test similar to a test that another doctor orders. I am careful not to take duplicate tests 1) to avoid unnecessarily paying more and 2) to prevent getting the same results from similar tests. 4) While I was younger with less income and now, while retired with a higher but fixed income, I have been and still am careful to get a pre-authorization from my health insurance company before going ahead with an elective, nonemergency operation or test. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Marc Silverman	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care; mine doubled in the past year which only gets me in the door but does not cover all my medical until after hitting a high deductable. its insane and most people cannot afford it. Because of these expenses, I have to consider delayed or rationing any care, or make difficult decisions about what to prioritize financially. We need a single payer system like Medicare For All! Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!

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5/4/2026	Phallon Davis	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Lisa Hammermeister	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. No one should go bankrupt because of healthcare. I had stage three cancer in 94. Surgery, Chemo and radiation. Even with good insurance we couldn't pay our hospital bills. We were forgiven for our outstanding balance by a good and charitable hospital. We would have lost our house and car. We were lucky not to be on the street. We are a rich country but invest in bombs and war over the greater good. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Warren Gold	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Our patients in California cannot receive good care if all our funds go to support the wars of Israel. Enforce cost-growth targets but with real penalties! Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	JL Angell	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. For example, EPI Pens increased from $100 to $600. CT sued and got that $500 from the company for each patient in CT to keep costs down. What have you done? Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Jane Devine	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care,

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5/4/2026	Virginia Hoyt	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Personally I am fortunate to be healthy. Personal health care is something that ought to be taught in school With knowledge we can keep costs down. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Alex Zukas	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Diana Kliche	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Martin Horwitz	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care,

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5/4/2026	Jennifer Alonso	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Donna Laba	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. The sad truth is that the insurance companies drive up prices and add deductibles and co-payments so that people can't afford to get the health care they need. They are reluctant to pay high prices for doctors and testing. Those who cannot afford to pay for services they authorized can go into debt or pay higher interest elsewhere because of low credit ratings. The hospitals don't get the payments they rely upon to cover their costs. Everyone suffers while insurance and pharmaceutical companies rake in record profits. They have been protected by corrupt politicians who vote against Medicare for all. Yet Medicare for all is the only way to provide necessary coverage. It doesn't rely on employers or waiting periods. It would provide care for all Americans regardless of economic status. The wealthy can choose their own private doctors if they wish. I am fortunate to have MediCal which is wonderful in my retirement. I waited a year and a half waiting for hernia surgery, waiting for a new employers insurance to kick in. They played games over number of hours worked. However, it is still difficult if not impossible to get dental work. I do my own fillings, but without a drill, they are temporary at best. We spend billions of dollars on vanity projects, endless wars and conflicts and subsidizing billionaires and corporations. Trickle Down doesn't work. More and more people are living paycheck to paycheck and the numbers of homeless are growing. It's not the poor or the immigrants that are the problem. It's the greed on top and the lack of representation.

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		There is a solution. In CA, we have the opportunity to show the rest of the country what is possible and humane. All it takes is putting people before profits. It's time. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Alan Yamamoto	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Eugene Barber	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Gloria Thompson	Alaskans like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Miguel Barraza	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.My only option is to get up early on Monday morning and try and get a appointment for my mother,she needs more options. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Philip Simon	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Lizzie Lyles	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care.

Date	Name	Written Comment
		Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. My medicine is also being denied keeping me as health as a Senion Citizen should. Why should we at my age have to worry about can I go to a doctor when I have worked in this country all my life. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Justin Truong	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/4/2026	Margaret Park	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/2/2026	Patty Harvey	OHCA: this organization was formed in excess and outside of the CA Commission's recommendation for a unified healthcare financing program. The collection and analysis of data had already been going on for decades in California, so your efforts are not only unwarranted but duplicative and inefficient. OHCA is also apparently incapable of effecting change in that it has no real clout except for wrist slapping the egregious waste and profiteering of health care in California. Watching hours of OHCA board deliberations only cements the view that this organization is just another pointless drain on California resources. It would do better to direct its efforts to realizing the goal set out by the CA Commission conclusions instead of the fruitless and endless hours it spends spinning its wheels.
4/27/2026	Daryl Gale	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!

CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

May 21, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
2020 West El Camino Avenue, Suite 1016
Sacramento, CA 95833

Re: CAPH Comments for the May 2026 Health Care Affordability Board Meeting

Dear Chair Johnson,

On behalf of the California Association of Public Hospitals and Health Systems (CAPH), I am writing to provide comments ahead of the May 2026 Health Care Affordability Board Meeting on the Office of Health Care Affordability's (OHCA's) proposal on financial penalties for spending target performance and its proposal to adjust spending targets for organized labor costs.

California's 17 public health care systems, which include county-operated and affiliated facilities and the five University of California health systems, are the core of the state's health care safety net. County public health care systems have a mission and mandate to deliver high-quality care to all, regardless of ability to pay or insurance status, across a comprehensive range of services. Despite representing only 6% of all hospitals statewide, public health care systems provide 35% of all Medi-Cal and uninsured hospital care. They contribute over $4 billion annually to the Medi-Cal program, in place of the state's share, with many of their payments uniquely tied to quality and performance improvements. Additionally, these systems train a diverse and inclusive workforce, including nearly half of all new doctors in hospitals across the state.

We share OHCA's and the Health Care Affordability Board's goals to improve affordability for patients and slow the growth of health care spending. However, we urge careful consideration of the policies being developed to achieve these goals and potential for negative impacts for the health care safety net. This is critically important at a time when $30 billion per year in federal funding is expected to be taken out of the Medi-Cal program.[1] Cuts like this will already push safety net providers to the brink and jeopardize services for our Medi-Cal and uninsured patients. As OHCA and the Board seek to adopt new policies regulating health care spending in California, the historic changes to health coverage and funding in California that we are facing must be at top of mind. It is with this lens that we offer comments to inform policy development on the following issues:

1. **Proposed Spending Target Penalties Concerns**
   During the April 2026 Board Meeting, OHCA proposed a penalty structure for health care entities that fail to meet performance on the spending target and a performance improvement plan. OHCA proposed the penalty amount to be the difference between an

[1] Joyce, D. (2025). How massive federal cuts will create unprecedented challenges for Medi-Cal patients and providers. *California Health Care Foundation*. Available at: https://www.chcf.org/resource/how-massive-federal-cuts-will-create-unprecedented-challenges-medi-cal-patients-providers/

entity's actual revenue growth and what the growth would have been had the entity met the target. Public health care systems have significant concerns with this proposal and fear financial penalties of this extreme magnitude could lead to significant instability in the health care safety net, risking service line and facility closure for entities that are already facing historic payment cuts and destabilization. We strongly encourage OHCA and the Board to reconsider the proposed penalty structure, especially this early in the implementation of the spending target.

In addition, it must be acknowledged that we are nearly halfway through the first enforceable performance year and hospitals and health systems still have many outstanding questions about how their performance would be assessed, including:

- *Performance Measurement:* Hospital spending measurement metrics have not yet been finalized, and it is unclear how performance would be determined for hospitals. For example, we are uncertain about:
    - If both the inpatient and outpatient metrics will be used to determine performance and if these will be combined or looked at separately;
    - If performance would be determined across an all-payer metric, commercial, and/or if Medi-Cal and Medicare would also be assessed separately;
    - If more than one metric is looked at, how would performance be reconciled if an entity meets the target for some but not all metrics; and
    - Given that there is significant volatility in growth rates (both negative and positive) between years, how would this be accounted for in year-over-year performance measurement and how is the subsequent year's baseline adjusted if there is large negative growth in a year? Will OHCA seek to create a rolling average or method to smooth this?

- *Enforcement Considerations:* While we appreciate OHCA and the Board's discussions around potential factors OHCA may consider during the enforcement process, there is no clarity for health care entities with how this would be implemented or when needed investments would be permissible above the spending target.

  Of priority for public health care systems are the looming financial pressures created by cuts to Medi-Cal under HR 1 and state budget decisions made recently and that are currently being contemplated, which could result in nearly $4 billion in additional annual losses for these systems. As one potential strategy to stabilize revenues and prevent facility and service closures, some systems may seek Medi-Cal managed care base rate increases and/or commercial rate increases. Without these sources of revenue, some members could be forced to significantly scale back the care they provide or potentially close sites altogether.

  Depending on how these changes flow through the hospital spending measurement metrics, strategies like this could result in a system's performance being above the spending target. As just one example, we are concerned that it remains unclear how needed revenue growth like this would be accounted for during the enforcement process.

With many unknowns around performance measurement and enforcement considerations remaining, it is impossible for our health systems to plan and make adjustments at the local level to ensure they can continue to provide critical access to the populations they serve while at the same time not be penalized under OHCA's policies in the current and upcoming performance years. If OHCA were to apply financial penalties as aggressively as it has proposed, there could be widespread unintended negative consequences to the health care delivery systems, resulting in a loss of access for California's populations that are most at risk.

We strongly recommend that OHCA and its Board consider alternative approaches to the penalty structure, such as what was developed in Oregon for its cost growth target program. The Oregon Health Authority (OHA), which oversees the program, is phasing in financial penalties for entities that "unreasonably exceed" its spending targets. The structure created by OHA does not assess penalties against health care entities unless they exceed the state's spending target with statistical confidence and without a valid reason for three of five years.[2] Further, the initial penalty amount is limited to only 5% of the entity's net total cost above the cost growth target over a five-year period.[3] This can progressively increase by five percentage points for additional instances of an entity failing to meet the performance requirements.[4]

We encourage OHCA to consider incorporating features like this to create a reasonable starting place for financial penalties, while avoiding further financial distress and potential closures of safety net facilities and providers. In addition, we recommend OHCA adopt safeguards to limit the instances of health care entities being unduly penalized, such as by defining performance failure as failure to meet the spending target across a number of metrics. For hospitals, a framework could consider if the hospital failed to meet performance requirements on both the inpatient and outpatient metrics under consideration, for both commercial and all-payer metrics.

2. **Spending Target Adjustments for Organized Labor Costs**
CAPH appreciates there is recognition in the authorizing statute and by OHCA that labor costs are a significant driver of health care spending and that workforce-related expenditures may warrant careful consideration in the spending target framework. Public hospitals and health systems operate in a challenging labor market, face persistent workforce shortages, and must compete for clinical and non-clinical staff while continuing to provide essential services to high-need communities. Some members have reported that labor costs represent at least 65-75% of their total expenses and the ability to control labor cost growth can sometimes be limited, with contracts being negotiated at the county level or multi-system level.

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[2] Flaherty, G., & Angeles, J. (2025). Beyond public reporting: Strengthening accountability to states' cost growth targets and leveraging targets in health care oversight. *Peterson-Milbank Program for Sustainable Health Care Costs.* Available at: https://www.milbank.org/wp-content/uploads/2025/06/State-Cost-Growth-Target-Accountability_final.pdf

[3] Ibid.

[4] Ibid.

We support incorporating adjustments to the spending target for labor cost growth. As the methodology is developed, CAPH recommends OHCA and the Board:

- *Ensure Adjustment Reflects Total Labor Costs Impact*: Wage increases may represent only part of the total cost impacts for health care entities and if looked at narrowly, would underestimate the impact to the entity. Any methodology should capture the full costs for the employer, including changes to salaries and wages, bonuses, overtime, shift differentials, pension contributions, changes to benefit packages, paid leave accruals, premium-pay holidays, education/training obligations, contractually required staffing premiums, and family medical leave.

  We also recommend that OHCA incorporate retiree benefit costs, such as pensions and other post-employment benefits. For many public health care systems, these make up a significant portion of labor costs and present challenges in predicting year-to-year fluctuations. These variations are often driven by macro-level factors like market performance, which are generally outside the control of the health care entity.

- *Consider Operational Feasibility and Potential Administrative Burdens for Reporting:* While health care entities can provide reasonable estimates, consistently accurate projections sufficient to support binding regulatory adjustments is not realistic. There is often uncertainty around collective bargaining outcomes and the length of negotiations with labor unions, making cost projections a best estimate. Many labor agreements may also be finalized outside the target-setting process and timeline, which may limit how useful front-end adjustments can be.

  Further, depending on the type and amount of data needed for the projections and the reconciliation process, requesting and truing up adjustments may add a significant level of new administrative processes and workload. We would encourage OHCA to consider this as it develops policies around spending target adjustments and look for opportunities to streamline processes.

- *Base Adjustments on Recent Historical Experience, With Flexibilities:* Given that there is significant uncertainty around projections, we recommend OHCA consider using historical organized labor cost trends as a starting point for adjustments. These adjustments could be changed when there are projected deviations supported by executed labor agreements, board-approved staffing changes, or other binding obligations. True-ups could be incorporated retrospectively when labor cost growth surpasses previous history.

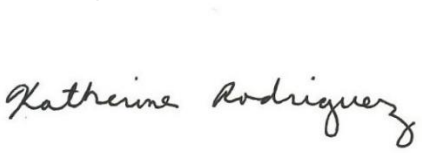
- *Recognize Structural Differences in Labor Composition:* As large safety net systems, public health care systems often have higher union density, more complex patient populations, greater psychiatric and emergency utilization, and higher mandated staffing intensities. We recommend that any methodology that is developed recognize that there may be structural differences in labor composition amongst providers, particularly those with higher levels of behavioral health, emergency psychiatric, trauma, and essential access responsibilities and services.

- *Include Represented Staff That Are Also Supervisors:* Some staff that are also supervisors are represented by labor unions. We recommend these organized labor costs also be incorporated into the adjustment.

- *Develop Transparent Process for Adjustments for Organized Labor Costs for 2026 and 2027 Performance Years:* We appreciate OHCA is creating a framework for future organized labor adjustments and see this as a critical step to creating more realistic and attainable spending targets. We understand OHCA and the Board must follow certain statutory timelines around setting the health care spending targets and any adjustments. However, OHCA must also incorporate adjustments for the 2026 and 2027 spending target performance years. Health care entities will be held accountable for performance in these years and in alignment with the statute, should not be penalized for growth of organized labor costs above the spending targets. We urge OHCA to create a transparent policy for how organized labor cost growth will be considered in assessing health care entities' performance in the years prior to the formal adjustment process.

Thank you for the opportunity to comment on these important issues. CAPH appreciates OHCA's engagement with stakeholders and urges the Office and Board to adopt policies that advance affordability without compromising access to care in the health care safety net. We would welcome the opportunity to continue working with OHCA as these proposals are refined.

Sincerely,



Katie Rodriguez
Interim CEO & President
California Association of Public Hospitals and Health Systems

Cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency

HEALTH ACCESS CALIFORNIA

May 20, 2026

The Honorable Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

California Department of Health Care Access and Information
2020 W. El Camino Ave, Ste. 1200
Sacramento, CA

Re: May 2026 Health Care Affordability Board Meeting

Dear Ms. Johnson, Ms. Landsberg, and Mr. Pegany,

Health Access, the statewide health care consumer advocacy coalition committed to quality, affordable care for all Californians, offers recommendations and comments on overall enforcement, the scope and range of cost growth target penalties, and possible equity and quality adjustments to the spending target methodology.

Executive Summary:

Health Access offers comments and recommendations on affordability targets:

- Enforcement should align entity spending with consumer affordability
- Providing transparency and accountability of the enforcement process
- Support for commensurate, dollar-for-dollar penalties for entities that exceed the cost growth target
- Adjust penalties based on the magnitude of spending above the target, progress toward compliance with the target, and other factors:

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    - Evaluating financial capacity to ensure meaningful penalties, including consideration of have and have-not entities
    - Investments such as primary care and behavioral health that reduce long-run spending.

- Supports the staff recommendation on not making adjustments to the spending target methodology at this time, including:
    - No equity adjustment for payers such as health plans and insurers.
    - No adjustment for low-cost, high-quality care as well as high-cost, low-quality care.

Part One: Overall Enforcement of the Growth Target: Affordability and Transparency

Enforcement Should Improve Alignment with Consumer Affordability

Consumer affordability must remain the central guiding goal through the design and implementation of the cost growth target, including enforcement of it. Growth target enforcement exists to bring health care spending into closer alignment with what Californians can afford, as measured by the growth in median household income. When an entity exceeds the growth target, the excess growth ultimately translates into even higher premiums, deductibles, and other out-of-pocket costs for consumers and other purchasers, including public programs.

While some adjustments or enforcement considerations for factors outside the control of the entity may be appropriate, such enforcement considerations should not diminish the underlying accountability for exceeding the target. Instead, any adjustments or enforcement considerations should consider how the entity comes into compliance over time. Enforcement considerations should frame the structure, timing, and pacing of enforcement, while maintaining a clear expectation that entities should demonstrate progress toward meeting the spending target that applied at the time the entity exceeded the target.

The overarching goal of this framework is to ensure that over time, entities' spending comes into alignment with the growth in family incomes over time. Weakening accountability would undermine that objective and delay meaningful cost containment. Consumers and other purchasers need an enforcement system that is strong enough to change cost-increasing behavior, and that advances long-term affordability goals.

Growth Target Enforcement: Transparency and Accountability

Growth target enforcement process should include transparency and public accountability throughout the process, ensuring a broad range of stakeholders may weigh in, not just the affected entity. Consumers, workers, local elected officials, and other affected entities should have the opportunity to contribute to the public discussion.

Health Access recommends the following steps to encourage public accountability and transparency of the enforcement process.

Phase 1: Target Setting – Establishing and Adjusting Growth Targets:

- Public process at the Health Care Affordability Board with an extensive public comment period as provided in law.

Phase 2: Transparency When Entity Receives Notice of Non-Compliance

- Public notice should happen simultaneously as an entity receiving initial notice that it has exceeded the target
- This avoids secret negotiations between the entity and the cost commission as seen in other states.
- For most types of entities, particularly health plans or insurers and hospitals, should know in advance whether they exceeded the target because these entities are the source for each entity's own data used to determine whether they exceeded the target and if so, by a little or a lot. This applies to THCE submitted by each health plan and insurer, as well as hospital financial data submitted by each hospital.
- Further discussion is needed on physician organizations because of the use of data attribution for these entities.

Phase 3: Notice that the Entity has provided additional information that resolved the issue.

- The law gives an entity up to 45 days to provide additional data and information to the Office. For both health plans and hospitals, which are the sources of data on whether each type of entity exceeded the target, this 45-day period comes long after the entity is likely to be aware that it has exceeded the target.

- The office may then modify its findings "as appropriate".
- Because public notice was given that the entity had exceeded the target, public notice should also be given if the entity is able to provide additional information that "meets the burden established by the office".[1]

Phase 4: Office's Enforcement Determination

- Public notice should be provided of the office's determination on whether to proceed with enforcement.

Phase 5: Public Notice of Findings and Technical Assistance

- Public notice of "the extent to which the health care entity exceeded the target"[2] and;
- Any technical assistance provided by the office.

Phase 6: Written or Verbal Public Testimony.

- Public testimony is required by law for those entities that exceed the target.

Phase 7: Public Disclosure of "Performance Improvement Plan"

- Public disclosure of draft "performance improvement plan" followed by;
- Public disclosure of approved plan as well as public reporting of monitoring of progress, if any, in addressing that plan by the entity to slow the growth of spending.

Phase 8: Spending Growth Target Penalties:

- Public notice of any administrative penalties for exceeding the target, including the amount of the penalty, to be publicized to local and statewide media.
- Growth target penalties are the final step in a lengthy enforcement process.

Part Two: Spending Target Penalties

Spending Target Penalties Commensurate with the Dollar-for-Dollar Amount in Excess of the Target

Health Access supports the OHCA staff proposal for dollar-for-dollar penalties, that is, penalties in the amount by which an entity exceeded the target. The proposed

[1] Health and Safety Code 127502.5 (b) 2) and (3)
[2] Health and Safety Code 127502.5 (c) (1)

approach is proportional to the impact that rising costs have had on consumers and other purchasers. It is consistent with the statutory requirement to ensure that the penalties are commensurate. [3] This approach strengthens the accountability that entities must take for contributions towards creating unaffordable premiums and cost sharing.

We recognize that the Director may consider adjustments to account for factors such as the fiscal condition of the entity, including the financial solvency of a health plan or insurer, or the financial distress of a hospital or large physician organization, as well as the nature, number, and gravity of the offenses. This provision of the law also provides that penalties should account for meaningful differences among entities, such as the magnitude of excess spending, progress toward compliance, financial capacity, and investments that reduce long-term spending[4].

Adjusting Penalties for Magnitude and Progress Toward Compliance

Entities that exceed the spending target by a substantial margin should be treated differently from those that moderately or slightly exceed the spending target. For example, an entity with spending growth of 14% compared to an entity with 7% growth has significantly different deviations from the 3.5% spending target or a third entity that comes in at 3.6% or 3.7%, just slightly over the target. Entities with substantially high spending growth should face correspondingly stronger consequences, given the greater impact on consumers and other purchasers. The proposed dollar-for-dollar approach provides a strong baseline that is consistent with the statute and that captures the magnitude of excessive spending. For substantial exceeders, additional escalation beyond the base penalty may be warranted.

Progress toward slowing the rate of growth should also be considered by the Director. Entities that exceed the spending target but show sustained meaningful improvement in their performance over time, particularly entities subject to and making measurable progress towards their performance improvement plan (PIP) objectives, should be distinguished from those entities where spending growth continually increases or remains egregiously high. Improvement over time, or the lack of it. Such progress, or lack of it, should inform how the Director adjusts the penalty.

[3] Health and Safety Code, Division 107, 127502.5 (d)(1)
[4] Health and Safety Code 127502.5 (d) (6)

While the statute does not explicitly reference an entity's performance improvement over time, it does provide flexibility for the Director to account for both the magnitude and pattern of noncompliance. Factors such as the "nature, number, and gravity of the offense" and escalating penalties for repeated or continuing failure support a principle that how far an entity exceeds the target and whether it is moving toward or away from compliance warrant consideration.[5]

Evaluating Financial Capacity to Ensure Meaningful Penalties

The statute provides the Director with the authority to adjust penalties based on the entity's fiscal condition, such as revenues, reserves, profits, and assets of affiliates, subsidiaries, and controlling entities.[6] This authority ensures that penalties reflect the total financial capacity available to an entity, rather than a narrow view of the specific entity that exceeded the target. Evaluation of financial capacity should account for the full range of resources available across an entity's organizational structure. These resources may exist not only within a parent organization, but also across affiliated entities, clinics, and other related or controlled entities.

Applying this statutory authority is critical to ensure that penalties serve as a meaningful deterrent. Penalties that are too small relative to available resources risk being absorbed as a cost of doing business rather than driving corrective action. In contrast, penalties that do not account for limited financial capacity may be destabilizing for smaller or financially vulnerable entities.

Financial capacity can be reflected in many ways, depending on how an entity is structured. For example, a hospital such as Community Hospital of the Monterey Peninsula (CHOMP), while not part of a large hospital system, maintain substantial resources through an affiliated foundation and associated provider networks.[7] Similarly, an entity such as Washington Hospital Healthcare System operates with public system-level structures and access to broader financial resources.[8] Because both entities have access to resources beyond the single licensed entity, they may be better positioned to absorb penalties.

Both entities demonstrate that assessment of financial capacity requires looking both up to any system level and down the organization chart to affiliated or controlled entities, and across related structures such as foundations and

[5] Health and Safety Code 127502.5(d)(6))
[6] Health and Safety Code127502.5 (d)(6)(B)
[7] Montage Health, IRS Form 990 (2024)
[8] https://www.washingtonhealth.com/news/2025/january/washington-health-rebrands-as-washington-health

associated organizations. Similarly, a large national insurer or health plan, perhaps one that is merged with a pharmacy benefit manager or controls physician organizations or both, has considerable financial capacity that a small, California-based health plan likely lacks.

At the other end of the financial spectrum of have and have-not entities, financially distressed hospitals often operate with limited margins and reduced reserves, making them more vulnerable to financial shocks. For example, the Legislature is today considering early budget action on grants for public or non-profit hospitals that are not part of a system and have less than 10 days' cash on hand, meaning a hospital that literally lacks the money to make payroll in two weeks[9]. This underscores the need to evaluate financial capacity based on the full range of resources reasonably available to the entity.

HCAI's existing data provides some of the tools needed to make distinctions. The Department houses extensive financial data that can inform a health facility's financial capacity. Through annual disclosure reports and quarterly financial reports, hospitals and other health facilities submit detailed information, including balance sheets, statements of cash flows, revenues by payer, expenses, financial ratios, labor information, and trend data. [10] Unfortunately, this data and similar data on financial solvency maintained by the Department of Managed Health Care (DMHC) on health plans are limited to the licensed entity and do not provide information on the larger system or controlled and related entities such as United and Optum or pharmacy benefit managers merged with health plans.

HCAI's distressed hospital program shows that the state has used indicators such as days' cash on hand, current ratio, access to working capital, operating margin, and cash runway to distinguish facilities at acute risk of failure from those with greater resources. Those same concepts can be adapted to support a consistent penalty framework, and whether a penalty would be easily absorbed versus when it could create a destabilizing financial strain.[11] Again, this has been limited to standalone hospitals, rather than hospitals that are part of systems.

Fortunately, the existing law gives the HCAI director broad authority to obtain additional financial information on systems as well as controlled and related entities if the health care entity is part of a system, a national carrier, or has controlled or related affiliates and subsidiaries. Again, the intent is to ensure that

[9] AB 108 (Gabriel), amended May 4, 2026
[10] https://hcai.ca.gov/data/cost-transparency/hospital-financials/
[11] https://hcai.ca.gov/facilities/health-facility-financing/distressed-hospital-loan-program/

the scale of the penalty is sufficient to change behavior and not an easily absorbed cost of doing business.

Health Access recommends that the Office draw on these existing sources when distinguishing the "haves" from the "have-nots". For example, a small rural or safety-net hospital with fewer than 30 days of cash on hand should be distinguished from a hospital that reports losses but is supported by a larger system with high reserves. Again, the Department should be transparent about the information used to determine whether an entity is a "have" or a "have-not", using information that is otherwise publicly available in any forum (including investor calls) but not disclosing information that is otherwise in the public domain.

Investments That Reduce Long-Run Spending Should Inform Penalty Adjustments

The statute recognizes that some spending can be justified when it reflects planned investments that reduce future costs and expand access, such as primary care and preventive services, as well as behavioral health.[12] That provides the basis to treat certain care investments as important factors when adjusting penalties. To quote the law:

> The office shall measure and promote a sustained systemwide investment in primary care and behavioral health[13].

California needs more investment in primary care, not less. Primary care was explicitly identified in statute as a cost-reducing investment, and evidence shows that stronger primary care leads to lower total spending over time.[14] Increased primary care reduces emergency department use, avoidable hospitalizations, and total spending growth over time.

Behavioral health, which is also explicitly named in the statute in the same article as primary care plays a similar role in reducing costly downstream care, including for physical health as well as behavioral health. Underinvestment in behavioral health drives significant health care costs, including emergency department visits and crisis stabilization, all too often without improving outcomes or equity.

For these reasons, it is reasonable to adjust enforcement generally and penalties for exceeding the spending target when entities make additional investments in

[12] Health and Safety Code127502.5 (i)
[13] Health and Safety Code Section 127505.
[14] https://www.milbank.org/publications/the-health-of-us-primary-care-2025-scorecard-report-the-cost-of-neglect/i-financing-declining-investment-and-fee-for-service-payment-are-hindering-primary-care-clinicians-ability-to-meet-growing-patient-needs

primary care and behavioral health that expand access to these services and strengthen prevention through earlier intervention. Penalizing these investments risks discouraging the very changes needed to improve affordability in the long run. But the provisions of the OHCA law with respect to hospitals in particular complicates the application of these broad principles.

Hospitals and health plans are differently situated with respect to the law on the spending targets. The spending target applies to the hospital, not the hospital system or affiliated entities such as primary care clinics or community-oriented behavioral health. In an earlier letter, Health Access proposed that it would be appropriate for OHCA to look at efforts by the hospital to improve access to primary care and behavioral health through affiliates and subsidiaries, but that the hospital itself must be held to the spending target, under the current law[15]. Health Access supports the broader look as consistent with the broader vision of OHCA but recognizes that enforcement of the target must be consistent with existing law.

Conversely, health plans pay for a broad range of services, including primary care and community-based behavioral health, as well as care delivered in health facilities. In the instance of health plans, consideration of investments in greater access to primary care and behavioral health, as reflected in plan spending, is an appropriate element for consideration and well within the ambit of existing law.

Part Three: Adjustments to Spending Target Methodology: Equity and Quality

Equity Adjustment to Spending Target Methodology

The law states that the methodology for the spending target shall be adjusted for equity to the extent data is available and methodology has been developed and validated:

> (g) 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[16].

Consistent with this direction in the law, the OHCA staff reviewed with the Advisory Committee the possibility of adopting an "equity adjustment" for the spending target methodology for payers such as insurers and health plans. Health Access

[15] Health Access attempted to look at hospital systems more broadly defined in the initial version of AB1415 (Bonta) as introduced in 2025. Unfortunately, because of the opposition of the California Hospital Association, these provisions were removed. OHCA must operate within the constraints of the existing law.

[16] Health and Safety Code 127502 (g)

supports OHCA's decision not to apply equity adjustment for payers at this time. The data show that payers' social-risk mix is stable year over year, the relationship between social risk and cost is inconclusive, and an adjustment would add administrative burden without clear benefit to consumers. However, further analysis is needed for hospitals and large physician organizations, where social-risk patterns may differ. Any future equity adjustment must advance equity without undermining affordability: affordability of commercial coverage, Medicare cost sharing, and Medi-Cal is central to improving equity. That is why we oppose premiums and cost sharing in Medi-Cal and fight for lower premiums and cost sharing in commercial coverage and Medicare.

Health Access supports the recommendation of OHCA staff not to apply an equity adjustment to the spending target methodology for payers at this time. The staff's recommendation not to do an equity adjustment reflects three factors: the stability of year-over-year social risk trends of the enrollment of each plan or insurer, the inconclusive relationship between social risk and cost in each market segment, and the significant administrative burden associated with implementing such an adjustment.[17] Adjusting the target might not produce meaningful results in terms of payer behavior. An equity adjustment could result in the consumer or other purchasers of commercial coverage paying more without seeing a better outcome.

We also note, as we did in our public testimony at the Advisory Committee, that the determination to measure the spending target by market segment (Medi-Cal, Medicare Advantage, and commercial) is in itself an equity adjustment because of the differences in the populations served by different insurance market segments. Most notable is the contrast between Medi-Cal and the commercial market. In contrast, Medicare Advantage enrollment is spread evenly across the quartiles of the equity dimensions. Medi-Cal managed care rates have been significantly revised by this Administration and, in some senses have begun to reflect social determinants of health, whether it is in the Cal-AIM efforts or other program changes.

However, we note that an equity adjustment may have different implications for the spending target methodology for providers such as hospitals and large physician organizations. Hospital and physician organizations may have different patterns of social-risk variation than payers. As OHCA evaluates whether equity adjustments should be considered for providers, an equity adjustment should be

[17] https://hcai.ca.gov/wp-content/uploads/2026/04/April-2026-OHCA-Advisory-Committee-Meeting-Presentation-Updated-slide-29.pdf

considered only if it improves care without worsening affordability for those patients it intends to benefit.

Quality Adjustment to Spending Target Methodology

The law asks that the Board and staff consider the possibility that there is low-cost, high-quality care as well as high-cost, low-quality care when looking at the methodology for the spending target:

> (6) (A) The methodology shall allow the board to adjust cost targets downward, when warranted, for health care entities that deliver high-cost care that is not commensurate with improvements in quality, and upward, when warranted, for health care entities that deliver low cost, high quality care[18].

We support the recommendation of OHCA staff not to apply a quality adjustment at this time. The evidence shows that higher spending does not reliably translate into higher quality, and raising the spending target for quality could make care more expensive for consumers without improving outcomes. Entities delivering high-cost, low-quality care are already likely to exceed the target and will be addressed through enforcement, making a downward adjustment unnecessary.

As the framework develops, it will be important to understand which measures are being considered for adjusting the spending target methodology and how the adjustment to the spending target methodology will avoid unintentionally disadvantaging plans that serve higher-risk populations.

Finally, we appreciate OHCA's ongoing work to explore a quality adjustment and look forward to reviewing the detailed recommendations. As this work progresses, it will be important to ensure that quality adjustments do not inadvertently disadvantage plans or providers serving higher-risk populations.

Conclusion

Californians need an enforcement system that meaningfully addresses rising costs with a spending target methodology that supports equity and quality. We appreciate the Department's continued engagement with stakeholders and look forward to working together as OHCA finalizes its recommendations on enforcement, penalties, equity, and quality adjustments.

[18] Health and Safety Code 127502 (d) (6) (A)

Thank you for your consideration of these comments,

Sincerely,

Katrina Walters-White
Regulatory Advocate

CC: Members, Health Care Affordability Board
Richard Figueroa, Deputy Cabinet Secretary, Office of the Governor
Christine Aurre, Legislative Affairs Secretary, Office of the Governor, Attn.: Paula Villescaz
Robert Rivas, Speaker, California Assembly, Attn.: Rosielyn Pulmano
Monique Limón, President Pro Tempore, California State Senate, Attn.: Marjorie Swartz
Mary Watanabe, Director, Department of Managed Health Care
Michelle Baass, Director, Department of Health Care Services
Assemblymember Mia Bonta, Chair, Assembly Health Committee, Attn.: Lisa Murawski
Dr. Akilah Weber Pierson, Chair, Senate Health Committee, Attn.: Teri Boughton
Brent Houser, Deputy Secretary, California Health and Human Services Agency, Attn.: Darci Delgado
Dr. Akilah Weber Pierson, Chair Senate Budget Subcommittee 3 on Health and Human Services, Attn.: Scott Ogus
Dawn Addis, Chair, Assembly Budget Subcommittee 1 on Health, attn.: Patrick Le
Josephine Figuroa, Deputy Commissioner, California Department of Insurance

California Hospital Association

May 21, 2026

Kim Johnson
Chair, Health Care Affordability Board
2020 W. El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments for the May 2026 OHCA Board Meeting**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

California's hospitals share the Office of Health Care Affordability's (OHCA's) goal to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of nearly 400 hospitals, the California Hospital Association (CHA) appreciates the opportunity to comment ahead of OHCA's May 2026 board meeting. Of paramount concern to hospitals ahead of this meeting:

- How OHCA will measure performance against the spending targets **currently in effect** remains unclear.
- OHCA risks undercutting legislative protections that ensure entities have meaningful opportunities to improve their spending performance prior to the imposition of monetary penalties.
- Penalties at the astronomical levels recommended by OHCA would undermine hospital care and endanger patients' access to care — the exact opposite of OHCA's stated goals.

Further detail on each of these concerns is provided below.

Clarity Needed on How Performance Against the Spending Targets Will Be Measured

The first enforceable spending target is now in effect (in fact, it has already concluded for any hospital whose fiscal year ended on March 31).[1] For the more than 150 hospitals with fiscal years ending on June 30, the first enforceable spending target year will end in less than six weeks. And yet, hospitals still do not know how their spending growth will be assessed against the targets, nor do they have confidence that OHCA's methodologies will accurately reflect year-over-year changes in the components of spending that are within their control. While OHCA's approach has positive and essential features, it has yet to be validated. Many

[1] OHCA has indicated it will assess hospital spending growth on a hospital fiscal, rather than calendar year, basis due to data reporting schedules.

outstanding questions must be addressed to assure hospitals that their efforts to comply with OHCA's spending limits will be successful; absent that clarity, hospitals making good faith efforts to comply may still find themselves caught in the enforcement process. **To firmly resolve these outstanding ambiguities, the enforcement regulations promulgated this year must clearly specify how OHCA will measure hospitals against the spending targets.**

Volume and Intensity Adjustments Are Essential

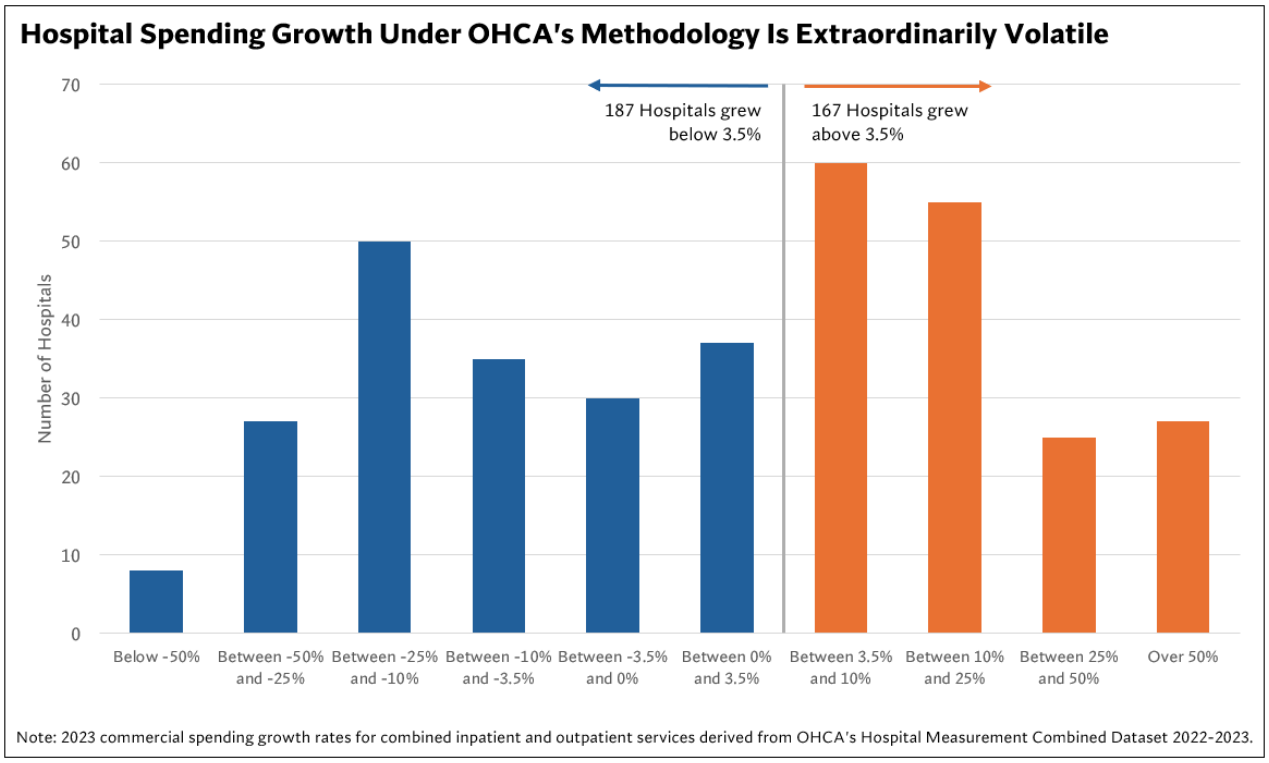
OHCA has spent more than a year developing its approach for measuring hospital spending growth with the help of a dedicated workgroup. The resulting methodology has essential features that aim to prevent fluctuations in volume and service intensity from biasing determinations of whether hospitals exceeded their target. Without such volume and intensity adjustments, OHCA would discourage hospitals from serving more patients, sicker patients, and offering resource-intensive services. The 2022-23 hospital spending growth data presented by OHCA aptly demonstrate the importance of these adjustments: Median commercial outpatient spending growth flipped from negative 7% when only volume was accounted for, to positive 4.2% when both volume and intensity were considered. Conversely, median Medi-Cal inpatient spending flipped from 1.5% to negative 1.2% when an intensity adjustment was included. **Without an intensity adjustment, around 15% of hospitals would have mistakenly been identified as having growth above or below a 3.5% target had it applied in 2023.** We urge OHCA to retain both the volume and intensity adjustments in its final methodology.

Further Testing of Hospital Spending Methodology Is Needed

While conceptually promising, more work is needed to validate OHCA's approach for measuring hospital spending, particularly with respect to how OHCA plans to estimate intensity for outpatient services. Its approach utilizes a new and incomplete data source — the Healthcare Payments Database — that only covers 20% of hospital-reported commercial outpatient visits statewide. For many hospitals, the coverage is likely even lower. Although OHCA has shown that there are strong correlations between a hospital's commercial and all-payer intensity scores, the deviations between these two values can be very large, regularly above 30%. Without a fix, OHCA will routinely mismeasure true spending growth and take enforcement action against hospitals based on these mismeasurements. Before this approach is used to hold hospitals accountable against the spending targets, further testing is needed. Even with improvements, the approach will not fully capture annual fluctuations in patient needs. OHCA will have to work closely with hospitals that exceed their target to determine whether unmeasured changes in service intensity are a driving factor that provides a reasonable basis for that excess growth. However, solidifying the measurement approach up front will save OHCA from having to engage dozens of hospitals within the enforcement process on justifiable reasons they exceeded their target.

Assess Hospital Compliance Against the Spending Targets on a Multiyear Basis

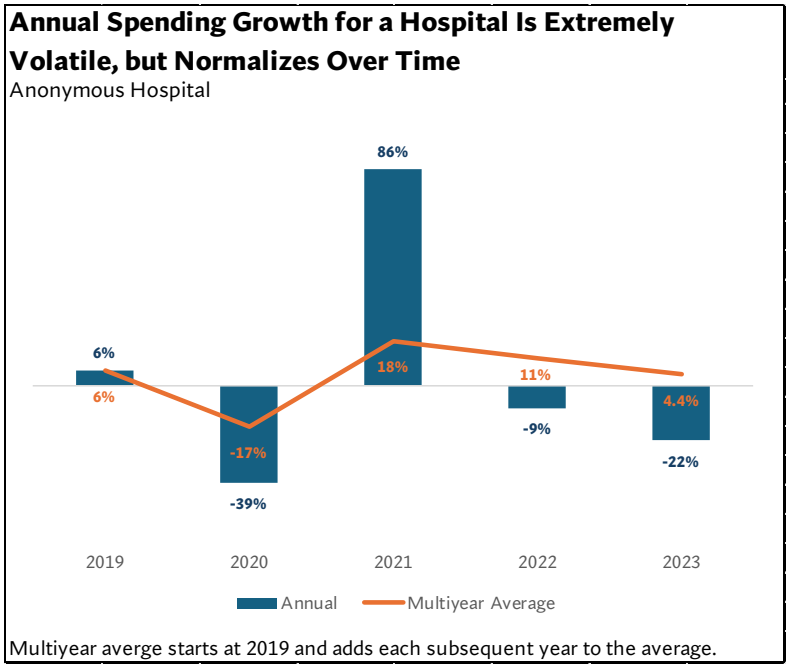
OHCA's 2022-23 hospital spending data reveal incredible volatility in individual hospitals' measured spending growth. As the first figure on the next page shows, 35 (nearly 10% of) hospitals saw annual commercial spending growth of greater than 50% or less than negative 50% between 2022 and 2023. A further 52 hospitals had growth between 25% and 50% or negative 25% and negative 50%. This volatility extends to government payers as well. Undoubtedly, these annual growth rates are not reflective, over a two-year period, of what OHCA aims to measure — the annual change in unit price. Hospitals did not receive 25% year-over-year rate increases or decreases from Medicare.



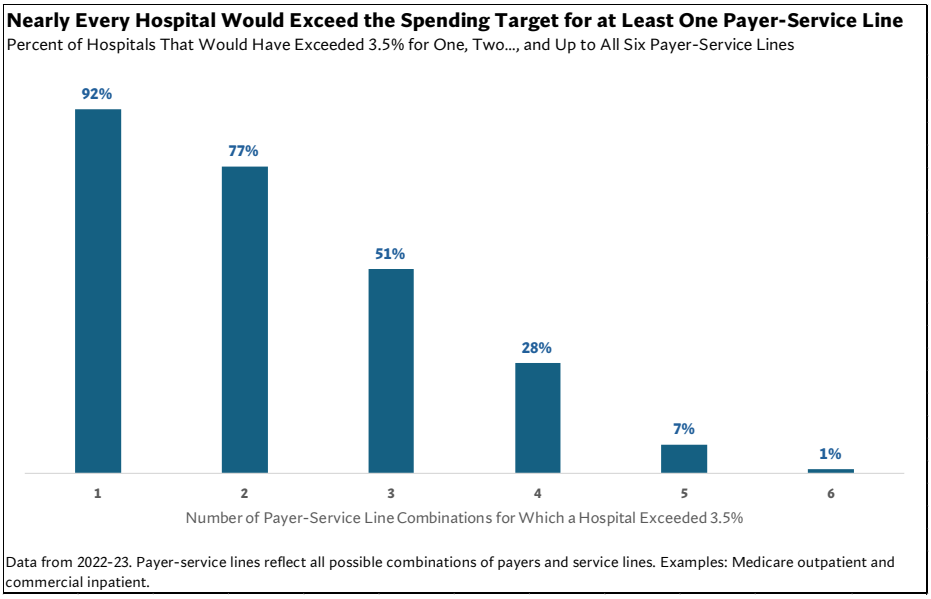
The figure below shows inpatient spending growth over a longer period for an individual hospital. It reveals that high growth rates over a single annual growth period are **not** indicative of a sustained trend of either explosive price growth or radical price cutting. Instead, the figure shows that on a multi-year basis, the average annual growth rate normalizes to something OHCA could compare against the spending target. Ultimately, these data demonstrate that OHCA must measure hospital spending growth on a multiyear basis to avoid arbitrary punishment of hospitals that just happen to be in the boom cycle of their measured, but not actual, price growth.

Clarify What It Means to Be Accountable Against the Spending Targets

While there has been progress in developing the hospital spending measurement methodologies (despite more testing being needed), there remains a complete lack of clarity in what will actually constitute a violation of the spending target, given that OHCA has stated it will compare multiple spending growth trends against the targets to determine compliance. Relatedly, uncertainty remains around what it means to "contextualize" spending growth in Medicare and Medi-Cal, how self-financed spending growth (defined on page 5) will be treated, and how the



coming spike in uncompensated care due to the One Big Beautiful Bill Act (OBBBA) and related state policy changes will be considered.



OHCA has stated an intent to measure spending growth against the targets separately for each payer category (i.e., commercial, Medicare, and Medi-Cal) and, for hospitals, separately for each service category (i.e., inpatient and outpatient). Adopting this approach would yield six distinct ways for which a hospital could be found in violation of the spending targets. As the figure on the left shows, had the target been in place in 2023, almost no hospital would have been safe. OHCA would have had to commence enforcement actions against **326 (92%) of the 356 hospitals that reported data**. It would have had to issue technical assistance to and investigate the reasons why each of these 326 hospitals exceeded the target, and 326 hospitals would have had to supply extensive information justifying why, for example, their Medi-Cal inpatient spending grew above the target — even if their overall spending growth was within the state's limits.

This would not be a prudent use of attention and resources — for OHCA or the hospitals themselves. Moreover, this approach would discourage hospitals from taking concrete and proactive steps to comply with the targets because they would have a high likelihood of violating the target for one payer-service line or another for reasons beyond their control. To address barriers to efficient, fair, and appropriately targeted enforcement — and to properly inform hospitals, and other entities where applicable, of how the targets will be enforced — OHCA should codify the following policies in its forthcoming enforcement regulation package.

Conjoin Inpatient and Outpatient into A Single Measure

A hospital whose inpatient, outpatient, and total spending grows by 1%, 5%, and 3% respectively should not be determined to have violated a 3.5% spending target. OHCA must remedy this problem by either:

- **Averaging the inpatient and outpatient growth rates to estimate a single measurement of growth for each hospital.** (OHCA could weight the inpatient and outpatient growth rates by service line total patient revenues to account for hospitals' differing mixes of services.) Using 2023 data and considering only commercial spending growth, this would limit the scope of enforcement from 354 to 167 hospitals.
- **Only enforcing when hospitals exceed the targets for both their inpatient and outpatient service lines.** Again, using 2023 data and considering only commercial spending growth, this would limit the scope of enforcement from 354 to 90 hospitals.

Only Enforce Against Entities That Exceed Both Their Commercial and All-Payer Spending Targets

Since its inception, OHCA has focused on commercial health care spending growth as its key area of concern. In keeping, OHCA could simply disregard Medicare and Medi-Cal spending growth and only enforce the targets based on commercial spending growth. However, this would ignore more than 70% of the services a hospital provides, and therefore more than 70% of the payments hospitals rely upon. Payer mix and cross subsidization, where commercial payments make up for large and growing shortfalls in payments from public payers, are fundamental features of hospital finance that cannot be ignored.

These patterns of hospitals' finance were present in OHCA's reporting on hospital spending trends in 2022 and 2023. For example, the data showed that statewide median Medicare and Medi-Cal inpatient payments were respectively 57% and 39% lower than commercial payments, and that statewide median reimbursement fell year-over-year for both Medicare and Medi-Cal. When the three payers are combined, the result is 0.5% annual growth in median reimbursement — far lower than all of the 7% growth reported for commercial payers, the state's first spending target of 3.5%, and overall inflation of 3.9% in California in 2023.

Furthermore, shifts in coverage are coming because of OBBBA and other federal and state policy changes. Hundreds of thousands of people have already dropped their Covered California coverage due to the expiration of the enhanced subsidies, and millions are expected to fall off Medi-Cal coverage. These coverage losses will place further downward pressure on overall hospital reimbursement, increase uncompensated care, and leave hospitals with no good options for sustaining services and jobs. To protect access to hospital care in the face of OBBBA's cuts, OHCA can **and must** account for the law's impacts through its quantitative assessments of which hospitals exceeded their target. To achieve this, **OHCA should designate a hospital as exceeding its target only if it exceeds the target on both its all-payer and commercial lines.** Moreover, the all-payer line should account for all payments — not only those from commercial, Medicare, and Medi-Cal — to properly capture the effects on overall reimbursement from the increase in the ranks of uninsured patients and uncompensated care.

Account for Complexity of Medi-Cal Financing

Medi-Cal financing of hospital services is bewilderingly complex, which makes determining actual reimbursement growth extremely difficult. Faced with state reimbursement rates that fall far short of covering the cost of care, hospitals have turned to "self-financing" to ensure they can continue caring for their communities. Self-financing comes in the form of provider taxes, intergovernmental transfers, and certified public expenditures that hospitals pay to the state or incur which, in turn, are used to "draw down" federal Medicaid funding for allowable expenditures. Because hospitals incur the nonfederal share of cost, their net reimbursement equals only the federal funding. However, HCAI reports of hospital revenues include both the federal and self-financed nonfederal shares of this funding, overstating the net reimbursement hospitals receive.

Managed care is Medi-Cal's predominant delivery system that covers 94% of all Medi-Cal enrollees. In 2024, nearly half (48%) of total Medi-Cal managed care reimbursement for hospitals was self-financed — causing **total reimbursement in Medi-Cal managed care to be overstated by 20% that year**. Between 2022 and 2024, self-financed hospital reimbursement grew by more than $5 billion, while state-financed reimbursement grew by less than $1 billion. As a result, while payments in Medi-Cal managed care appear to have grown by 2.5% annually over this period, in truth, they grew by just 0.4% — far below the cost of caring for this population. To

meet its statutory obligations under provisions such as Health and Safety Code (HSC) § 127502(d)(5) and appropriately reflect the realities of Medi-Cal finance, OHCA must account for self-financing in its measurement of hospital spending growth against the targets.

Performance Improvement Plans Must Reflect a Meaningful Opportunity to Comply with Spending Targets

OHCA's April 2026 board meeting included extensive discussion of PIPs and how they relate to the monetary penalties that OHCA may impose as the final step in the progressive enforcement process. **As OHCA discusses, develops, and promulgates formal enforcement regulations, it must conform with and expound upon the protections and processes established in state law.**

Health Care Entities Must Have an Opportunity to Improve Spending Trends Under a PIP

The enforcement provisions of the California Health Care Quality and Affordability Act are unambiguous: Health care entities must have opportunities for remediation of their spending trends prior to the imposition of any monetary penalties. HSC § 127502.5(a)) mandates that the office "enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, **allows each health care entity opportunities for remediation**, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability" (emphasis added).[2] State law further outlines a progressive enforcement process that starts with technical assistance, moves to (optional) public testimony, then mandatory performance improvement plans, and finally, as a last resort, monetary penalties.[3]

The Legislature did not intend the early steps of enforcement to be a check-the-box exercise. Rather, the process must include meaningful opportunities and adequate time for health care entities to implement cost-reducing strategies to meet the state's spending growth goals. First, this plainly requires that PIPs must be forward-looking; health care entities cannot go back in time to alter prior policies, practices, or service offerings. Therefore, PIPs should apply starting in the first annual measurement period following their approval. Second, entities must be given a reasonable amount of time to implement their PIPs. The returns on many cost-reducing strategies, like primary care investments, regularly lag the upfront investments. To balance the urgency of improving affordability and the time and work involved in system improvement, the Legislature thoughtfully established that PIPs may be imposed for a period up to three years.[4] Third, the PIPs must be self-directed. OHCA's role is to approve, not develop the PIPs. Health care entities must have a meaningful opportunity to develop and implement their own strategies, like investing in community-based care or adopting alternative payment methodologies, to comply with their target. OHCA's role is oversight to ensure the improvement plans' goals are reached and do not have negative unintended consequences.

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[2] Also see the Legislature's findings and declarations in HSC § 127500.5(m): "It is the intent of the Legislature in enacting this chapter that enforcement actions to address growth in per capita total health care expenditures are implemented in a progressive manner, such that health care entities are assisted to come into compliance with cost targets, including through technical assistance and performance improvement plans, before assessing administrative penalties unless there are egregious violations as specified in Section 127502.5."

[3] See HSC § 127502.5(a) and (d)(1).

[4] See HSC § 127502.5(c).

Monetary Penalties May Only Be Levied After an Entity Has Failed Both Its PIP and Lawfully Established Target

California law states that, except in narrow circumstances specified in HSC § 127502.5(h)(1) for willful, egregious, or repeated noncompliance, a monetary penalty may only be imposed "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" (emphasis added).[5] This provision, among others, establishes multiple protections that require clarification following the April board discussion and, ultimately, incorporation in the promulgated framework.

OHCA May Not Fine Entities Based on Midyear Compliance with a PIP

The spending target is a "target percentage for the maximum **annual** increase in per capita total health care expenditures" (emphasis added).[6] This means that that a monetary penalty may only be imposed after the office has determined that, in addition to being noncompliant with the PIP, the entity violated the corresponding year's spending target. **An entity cannot fail an annual target on sub-annual basis.** Accordingly, pursuant to OHCA's underlying regulatory framework, fining an entity for noncompliance with its target based on midyear benchmarks, monitoring, and deliverables is plainly impermissible. OHCA must give entities a year, at minimum, to comply with their PIP and associated spending target.

PIPs May Not Impose Cuts Beyond the Spending Targets

OHCA's authority to impose a PIP exclusively derives from its authority to enforce the spending targets; it does not have authority to enforce health care spending reduction goals that go beyond the spending targets OHCA establishes.[7] The Legislature's intent language (see in footnote 2) further affirms this limitation — PIPs may only be imposed to assist entities in coming into compliance with the spending targets. Imposing deeper cuts beyond the relevant spending target, as discussed at the April board meeting, would plainly violate the intent and letter of state law.

Additionally, PIPs may not be used to establish distinct spending targets. State law closely defines the process by which spending targets may be adopted and imposed;[8] nowhere does the law establish an opportunity to revise the spending targets via the PIP process. The target-setting process must include an initial recommendation from the office, discussion of the recommendation at a board meeting by March 1 of the year prior to the target taking effect, a 45-day public comment period, and adoption by the board by June 1 before the target takes effect. The PIP process is wholly distinct. Critically, the authority to make these decisions is partitioned — while the board sets spending targets, OHCA's director approves the PIPs. Clearly under the law, changes to an entity's spending target must occur through the formal spending target process, not through approval of a PIP that imposes cost reductions at any level beyond the spending targets that the director decides.

PIPs That Jeopardize Access to High-Quality and Equitable Care May Not Be Imposed

To avoid unintended consequences and reinforce a holistic approach to improving affordability, the Legislature tasked OHCA with ensuring that PIPs are not implemented "in ways that are likely to erode access, quality,

[5] See HSC § 127502.5(d)(1).
[6] See HSC § 127500.2(j).
[7] See HSC § 127502.5(a).
[8] See HSC § 127502(m).

equity, or workforce stability" (see HSC § 127502.5(a)). This important constraint ties the hands of both the office and entities in terms of what cost-reducing strategies may be employed. For hospitals, cutting revenues means cutting costs — costs that are concentrated in workforce recruitment and retention, facility upgrades (including those necessary to comply with state laws), and drugs and medical supplies used in patient care. Reducing hospital spending to the levels established by the spending targets may require service reductions that impair access to services, reduced ability to invest in quality-assurance activities, workforce reductions, and cuts to discretionary programs that address community needs. This is not what the Legislature envisioned. Flexibility will be needed for hospitals and other entities to implement cost-reducing strategies that avoid these negative impacts.

Monetary Penalties Must Not Endanger Access to High-Quality and Equitable Care

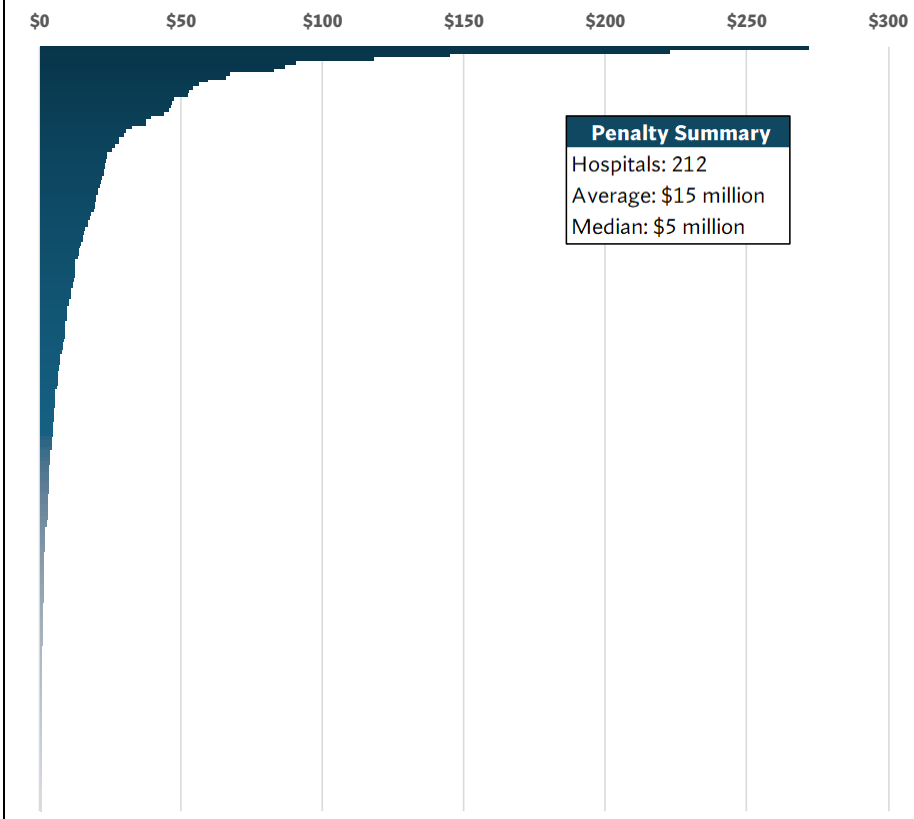
At the April board meeting, OHCA presented a two-step framework for determining the scope and range of monetary penalties for entities that failed their PIP and exceeded their spending target. First, the office would set an initial amount equal to the amount by which the entity exceeded its allowable growth under its target. Then, the office would adjust that amount to account for various factors, including the nature, number, and gravity of the offenses; the entity's fiscal condition; the entity's market impact; penalty justification factors; and input from other state agencies.

OHCA's Recommended Penalty Structure Could Result in Enormous Penalties

OHCA's charge is to promote affordability without jeopardizing access to high-quality, equitable care and the stability of jobs. Unfortunately, monetary penalties at the levels contemplated in OHCA's proposal would do just that and reflect the type of punitive approach to affordability the Legislature expressly disavowed. As the figure on the right shows, absent significant downward adjustments under step 2 of the framework, entities that

OHCA Penalty Structure Could Impose Penalties in the Hundreds of Millions of Dollars

Penalty Amount (in Millions) per Hospital Under Step 1 of Recommended Framework



Note: Penalties calculated based on difference between actual spending growth and allowable growth under a 3.5% target assumed applicable in 2023. Analysis only includes hospitals with fines over $1,000.

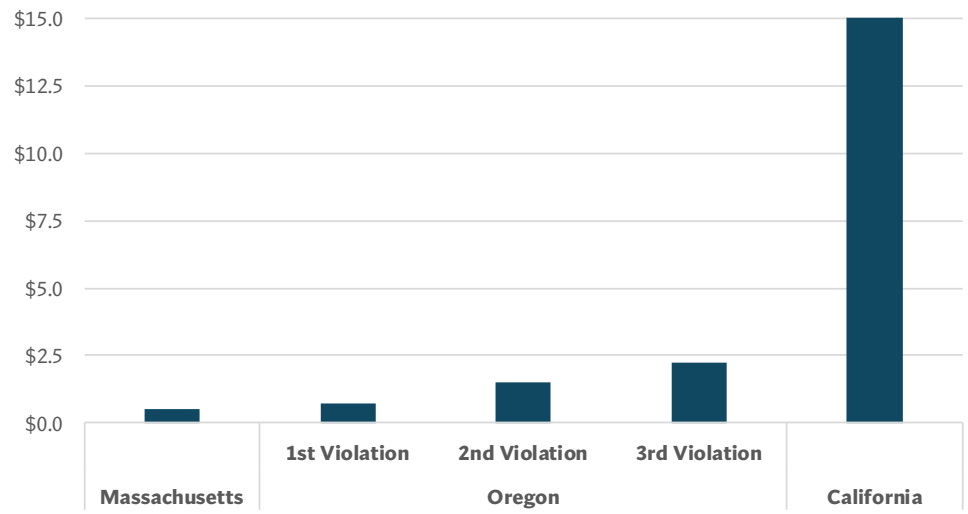
exceed their spending target for even a single year could potentially be subject to fines in the hundreds of millions of dollars. Had the 3.5% target been in place in 2023, 131 hospitals would have received penalties exceeding their entire operating earnings for the year. For 117 hospitals, the penalties would exceed their prior three-year cumulative total of operating earnings. Fines of these magnitudes would threaten the very viability of penalized hospitals, placing access to care and health care jobs at serious risk. Enormous downward adjustments would be needed to reduce the penalties to practicable levels, rendering the process unpredictable, inscrutable, and capricious.

Other States Provide a Model for a More Reasonable Penalty Structure

OHCA is closely modeled after spending target programs in Massachusetts and Oregon, both of which rely on PIPs and financial penalties as their principal means of enforcement. However, the monetary penalties in these other states vary significantly from OHCA's recommendation. In Massachusetts, the maximum financial penalty for failing to implement a PIP is $500,000. In Oregon, the financial penalty for failing to meet the state spending target starts at 5% of an entity's spending above the target (after the entity has been found to have exceeded the target with statistical significance and without good cause in three out of five years). The penalty then increases by 5 percentage points for every additional instance of an entity exceeding the target (using the same multiyear formula). The figure on the left shows what a true outlier OHCA's recommended penalty structure could be compared to its peers, with OHCA's penalties starting at 20 times those in Oregon. OHCA should align with its peer states' penalty structures and modify its recommended framework accordingly.

California's Recommended Penalty Structure Would Be a Major Outlier

Average Monetary Penalty (In Millions) Per Hospital Under Each State's Penalty Framework



Note: Penalties are applied to California and calculated based on the difference between actual spending growth and allowable growth for hospitals under a 3.5% target assumed applicable in 2023. Analysis only includes hospitals with fines over $1,000.

Adjustments to Initial Penalty Amounts Are Critical to Protect Access to Care

OHCA has recommended applying various adjustments to consider an individual entity's circumstances when determining final penalty amounts. Such adjustments are essential, particularly if step 1 of OHCA's penalty-setting framework is adopted, but also under a more restrained approach such as that in Oregon. These adjustments must account for the following circumstances:

- Hospital financial status — To protect access to care, penalties must not undermine a hospital's ability to sustain services and remain viable. **OHCA should cap the penalty amount at a hospital's patient care earnings.**

- Factors beyond a hospital's control — New mandates that raise costs, inflationary pressures, and changes in patient needs all influence a hospital's spending, despite their best attempts to remain under the spending limit. **OHCA should deduct the costs associated with such factors from the penalty.**
- Efforts to improve access to high-quality, patient centered care — Investments in primary and behavioral health care, for example, cost more at the outset but result in long-term savings and better health for Californians. **OHCA should deduct the costs associated with such factors from the penalty.**
- Success in reducing spending trends up until the imposition of the penalty — **OHCA should credit an entity for any improvement in its spending performance.**

Without these adjustments, OHCA's penalties would be unduly punitive and ultimately undermine its statutory responsibility to improve affordability while maintaining equitable access to care.

Conclusion

California's hospitals appreciate the opportunity to comment and look forward to continued engagement toward our shared goals of promoting affordability, access, quality, equity, and workforce stability in California's health care system.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

Attachment #4

UC San Diego Health

UC San Diego Health
9300 Campus Point Drive, #7970
La Jolla, CA 92037
T: 858.249.5534

Patricia S. Maysent

Chief Executive Officer

May 15, 2026

Kim Johnson
Chair, Health Care Affordability Board
Secretary, California Health and Human Services Agency
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: Correction for the Record Regarding Statements Made at the Health Care Affordability Board meeting on April 22, 2026
(Submitted via email to ohca@hcai.ca.gov)

Dear Secretary Johnson:

Please accept this letter as a correction to the record for comments said during the Health Care Affordability Board meeting on April 22, 2026, regarding the Joint Powers Agreement (JPA) between UC San Diego Health (UCSDH) and the Palomar Healthcare District (Palomar). This strategic collaboration is intended to stabilize and expand access to specialty care for the communities Palomar serves in North San Diego County, optimize inpatient capacity across both health systems, and advance a shared growth strategy that will benefit patients, team members, and the communities we serve.

During the public comment period at the April 22 board meeting, it was suggested the new JPA would not be subject to the *Brown Act,* California's open meetings law. That assertion is incorrect. The JPA is subject to the *Brown Act,* which expressly applies to local bodies created by state or federal statute (Government Code §54952(a)). In addition, the governing board of a JPA is subject to the *Brown Act* as both the governing body of a local agency and a body created according to procedures established by state law (Government Code §6500 et seq.). JPA meetings will be duly noticed and meeting materials will be publicly posted online.

UCSDH takes seriously its commitment to transparency and its responsibility to maintain a public and open process as it moves forward with this new and exciting partnership with Palomar. Should you have any additional questions, please do not hesitate to contact Kaitlin Chell, Executive Director of State and Local Government and Community Relations for UCSDH at kchell@ucsd.edu.

Sincerley,

Patricia S. Maysent
CEO
UC San Diego Health