



2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov



Health Care Affordability Board
August 26, 2025
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
9/26/2025	Eunice Kohara	I started a private community based pediatric ophthalmologist with the intention to be sustainable and provide high level care. Unfortunately the insurance payor payments due not reflect the level of care provided, is completely under compensated in comparison to my UCLA colleagues, and do not allow me to continue practicing without burning out. Insurances take your statements and in turn interpret that as the need to under pay the physicians who are actually on the front line caring for people. How to make healthcare affordable is not by limiting the physician's payments so they are forced to see more patients in less amount of time, and therefore leading to less quality care. limiting the profits of healthcare insurances, and their executive pay, investing these dollars directly to caregivers and pediatric population, will long term benefit us and reduce the need for costs on psychiatric medication. Supporting caregivers, physicians and the support system for pediatric population is the most cost effective way to target this affordability problem. When investing in our children will mean less incarceration, less suicides, less drug overdoses and less dependence on costly psychiatric medication that suppress the problem and not treating the root cause. Will you consider having me be a voice that represents are physicians who work hard to keep our people out of chronic care and hospitals and in turn improving healthcare affordability? I propose for example using a science and evidence based approach to tackling this issue. Thank you.

Date	Name	Written Comment
10/10/2025	Local Health Plans of California	See Attachment #1.
10/22/2025	California Hospital Association	See Attachment #2.
10/22/2025	Barton Health	See Attachment #3.
10/23/2025	Health Access California	See Attachment #4.



October 10, 2025

Elizabeth Landsberg, Director
Department of Health Care Access and Information
2020 W El Camino Ave.
Sacramento, CA 95833

Re: LHPC Data Submission Enforcement Penalties Comments

Dear Director Landsberg,

On behalf of the 17 local health plans that collectively serve over 70% of Medi-Cal managed care enrollees statewide, the Local Health Plans of California (LHPC) appreciates the opportunity to provide comments in advance of the Office of Health Care Affordability's (OHCA) October 2025 Board Meeting. LHPC and our member plans value OHCA's ongoing efforts to develop thoughtful policies and procedures that support compliance with data submission requirements. We recognize the importance of timely and accurate data in achieving OHCA's mission to promote health care affordability. **However, we respectfully request that OHCA consider key refinements to its enforcement approach to ensure fairness and workability for Medi-Cal managed care plans (MCPs).**

Incorporate a Corrective Action Plan (CAP) Process Prior to Financial Penalties

As currently proposed, OHCA would permit two 15-day extensions before initiating financial penalties in the subsequent months. **We respectfully request OHCA to build in a formal Corrective Action Plan (CAP) process before imposing financial penalties for late or failed data submissions.** Other state departments working with MCPs, including the Department of Health Care Services (DHCS), routinely implement CAPs that provide MCPs the opportunity to document how they will resolve submission issues and prevent future occurrences.

While local plans understand the importance of timely data submission requirements, there may be unforeseen challenges that hinder timely submission, even as plans communicate proactively and act in good faith. One key example is the submission of Medi-Cal managed care data through the Rate Development Template (RDT), which is the single most critical data source used by the Department of Health Care Services (DHCS) to develop capitation rates for MCPs. Given its impact on managed care capitation rates, completing the RDT is a top priority for MCPs. Typically, DHCS distributes the RDT to MCPs in early fall, with plans working diligently to complete and submit the data by the new calendar year. However, this timeframe does not account for subsequent resubmission cycles or the need to respond to supplemental data requests from DHCS, which often extend well into the summer months. Establishing a CAP process would provide OHCA with a structured, yet flexible, mechanism

to address instances of delayed data submission, while fostering a more collaborative approach to compliance.

Extend the Resubmission Period from 5 to 10 Business Days

In addition, we request that OHCA extend the current 5-day resubmission window to 10 business days. The current timeframe often coincides with other critical deadlines, most notably, the submission of RDTs to DHCS. As previously mentioned, the RDT process requires MCPs to dedicate significant attention and resources, given its direct impact on Medi-Cal capitation rate development. As a result, while MCPs are working to fulfill OHCA's annual data submission requirements, they are simultaneously focused on ensuring the accuracy and completeness of their RDT submissions, placing additional strain on already limited resources.

A 10-business-day window would offer a more practical and achievable timeframe for resubmission, while still supporting OHCA's data quality and timeliness goals.

Apply Discretion When Imposing Financial Penalties

LHPC urges OHCA to exercise discretion in imposing penalties, both for untimely data submission and failure to submit data, particularly when plans are actively communicating and demonstrating good-faith efforts to comply. If a plan encounters legitimate challenges during the two 15-day extension periods and remains engaged with OHCA, we believe it is reasonable to agree upon an adjusted timeline without incurring financial penalties.

Should recurring issues persist, that would be an appropriate juncture for implementing a CAP prior to financial penalties. This approach would support constructive resolution while maintaining accountability.

Consider Unique Characteristics of Medi-Cal in Spending Target Enforcement

In light of ongoing discussions around spending target enforcement, prior to developing an enforcement construct, it is important for OHCA to acknowledge the unique structure and challenges of the Medi-Cal program. Additionally, it's important to consider that local health plans play a critical role in supporting the safety net and may face increased costs due to higher levels of indigent care and/or reductions in hospital supplemental payments. While we appreciated OHCA's presentation on potential enforcement considerations related to spending targets, **we respectfully request that OHCA take into account Medi-Cal's distinct characteristics when evaluating compliance with these targets.**

Services such as long-term care (LTC) and Enhanced Care Management (ECM), introduce cost dynamics not seen in other health care markets. For instance, California's aging population is expected to drive continued growth in LTC costs, already one of the most expensive Medi-Cal benefits.

Given these complexities, LHPC requests that OHCA convene a separate forum with Medi-Cal plans to further explore how these distinct characteristics should be considered in the spending target enforcement policies and evaluations.

We thank OHCA and the Board for considering these requests and for your continued partnership. LHPC and local plans remain committed to working collaboratively to advance the shared goal of a more affordable and equitable health care system

Sincerely,



Beau Bouchard
Director of Health Plan Financing
Local Health Plans of California

Cc: Kim Johnson, Chair, Health Care Affordability Board; Secretary, California Health and Human Services

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

Vishaal Pegany, Deputy Director, Office of Health Care Affordability



October 22, 2025

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

Subject: OHCA Must Protect Access to Care and Hold Health Insurers Accountable
(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.

OHCA Must Prevent Payers from Leveraging OHCA Policies to the Detriment of Rural Health Care

Hospitals throughout the state are struggling to make ends meet. This is especially true for small, independent, and rural hospitals. Now, large, national health insurance companies are leveraging OHCA's spending targets against these vulnerable hospitals. In the past month, Anthem sent communications to several rural and independent hospitals in California threatening contract termination if rate increases were not reduced to OHCA's spending targets.

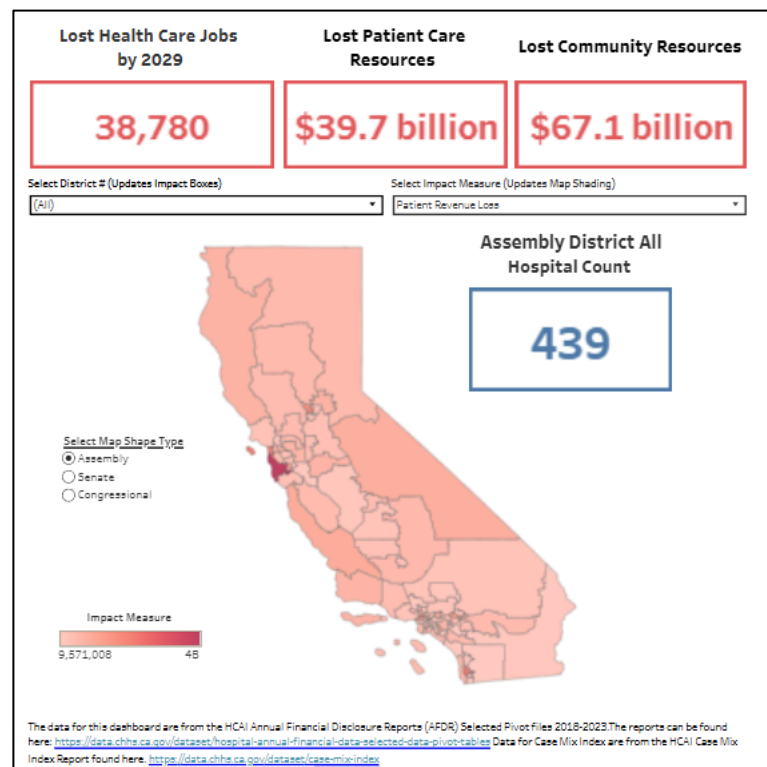
While affordability is a real challenge requiring real solutions, solving it on the backs of distressed rural health care providers is not the right path forward. Of the hospitals targeted by Anthem, the majority are critical access hospitals, have 25 or fewer general acute beds, and have lower commercial reimbursement rates than 70% of California's hospitals. Affected hospitals have Medi-Cal and Medicare payer mixes around 90% or higher and operating margins less than -20% as of 2024. While Anthem seeks to limit its reimbursement adjustments to 3.5% or less, the hospitals being squeezed experienced average annual operating expense growth of 11% (after accounting for volume) for the years 2019-2023. The new limits come just as Anthem is raising its premiums by more than 10%, raising major questions about the relationship between its actions and the purported goal of improving consumer affordability.

The threat places these small hospitals in an impossible position: lose their largest commercial contract and a huge portion of the patients they serve, or accept ongoing contractual adjustments far below sustainable levels. Either would bring staffing and service level reductions, and potentially even closure for hospitals already on the brink. In addition to harming the hospitals' patients, workers, and communities, the outcomes would contravene OHCA's legislative mandate to promote affordability *without sacrificing access, quality, equity, and workforce stability*.

California's hospitals urge OHCA to clearly state that these threats from insurance companies, and their assured consequences, run counter to OHCA's intent and purpose. Before it's too late, OHCA must immediately clarify that actions taken by regulated payers and providers to sustain access to already threatened health services — including exceeding spending targets due to necessary contracted rate adjustments — will not be penalized retroactively under OHCA's enforcement powers. Without such a commitment, these tactics will spread throughout the state, to the detriment of patients and health care workers across California.

OHCA's Spending Targets Will Drastically Curtail Resources for Patient Care

Unfortunately, OHCA's spending targets fall far short of covering the cost of providing hospital care. Statewide, operating expenses are growing at 5.2% annually based on volume and resource intensity. With 2030 seismic requirements, a \$25 health care worker minimum wage, and economic shocks from tariffs on medical supplies and other essential inputs, this high rate of expense growth will not subside any time soon. As the figure at the right shows, by instituting targets at so much less than the rate of cost growth, OHCA is poised to reduce the amount of resources hospitals have for patient care by nearly \$40 billion statewide over the next four years. This number is not dissimilar from the health care cuts that California will see from the One Big Beautiful Bill Act, so the state and federal governments are chopping health care resources for Californians at similar and dangerous levels. Hospitals will have no choice but to shed clinical and non-clinical workers, causing further economic damage in communities across the state. California's hospitals urge OHCA to consider



the magnitude of its prior decisions on spending targets and course-correct to protect access to life-saving hospital care.

Greater Consideration of Factors is Needed for the Enforcement Process

At the September OHCA advisory committee (AC) meeting, OHCA staff reviewed a list of potential enforcement considerations to assess which entities exceeding the spending target would be subject to progressive enforcement and sought the AC's feedback. This prompted a fruitful discussion where members raised important questions and comments that merit additional consideration from the OHCA Board and staff:

- Identify and directly adjust the spending target for factors outside of an entity's control – AC members were supportive of OHCA considering factors beyond health care entities' control as justifiable reasons for exceeding the spending targets. Some went further, advising OHCA staff to explicitly adjust the spending target for such factors when they have industry-wide effects. This would be in place of requiring hundreds of entities having to explain identical reasons for exceeding the targets after the fact. It would also help entities plan ahead and focus on factors they can control and allow OHCA to appropriately focus its limited enforcement resources on issues that do not have field-wide effects.
- Plan for impacts of looming coverage losses – In discussing "population characteristics" as an enforcement consideration, AC members noted that it will be critical to incorporate the impacts of the One Big Beautiful Bill Act's eligibility changes, which will make it harder for individuals to maintain their health care coverage. For hospitals, coverage losses will mean more uncompensated care, straining finances and requiring that the losses be made up elsewhere. For other entities, if healthier individuals disproportionately fall off coverage, (for example, within the individual marketplace) the risk pool will shift to being relatively sicker, increasing per capita spending within that line of business.¹ This must be monitored closely, with an eye toward risk adjustment and other changes to how the spending targets are measured and enforced.
- Account for spending growth that supports patient care – AC members voiced support for having "investments in primary and preventative care" as an enforcement consideration, noting that health care entities should not be penalized for increased spending that aims to improve Californians' health. Additionally, members noted that investments that expand and increase access to care, such as opening a mobile access clinic or rural health clinic, should be appropriately accounted for.
- Caution on reputational impacts of identifying all entities that exceed the target – OHCA has stated that it intends to publish the names of all entities that exceed the spending target in a given year. An AC member warned OHCA about the unwarranted reputational harms of doing so when the media will be likely to name entities that exceed the spending target but not

¹ <https://www.kff.org/health-costs/health-policy-101-health-care-costs-and-affordability/?entry=table-of-contents-how-does-health-care-spending-vary-across-the-population>

retract or contextualize the report following a determination by the office that the higher growth was in fact justified. While OHCA staff noted that they will be providing appropriate context and framing for interested parties on OHCA’s work, including why some spending growth is warranted, this does not provide assurance that the media will do the same. OHCA should reevaluate its intended approach and consider only reporting entities determined to have unjustifiably exceeded the spending target.

OHCA Must Consider and Incorporate Additional Reasonable Enforcement Considerations to Maintain Health Care Access and Quality

While OHCA’s initial proposed list of enforcement considerations provides a reasonable starting point for assessing enforcement on entities, CHA asks that the OHCA Board and staff consider additional relevant factors that have not been proposed to date. These additional factors (shown in the figure to the right) represent valid and justifiable reasons for why a health care entity may exceed the spending growth cap. Several are entirely absent from the proposed factors, while others should be explicitly enumerated in regulation as key components of factors that have been proposed. Without additional consideration and incorporation of these factors, entities like hospitals will be unable to maintain or improve access, quality, equity, and workforce stability while making care more affordable. Ultimately, hospitals will be forced to make changes that will negatively impact patients’ access to quality care and will struggle to sustainably operate in their communities.

OHCA's Proposed List of Enforcement Considerations
Factors that OHCA Has Considered
Population Characteristics
High-Cost Patient Outliers
Historical Spending Growth
Impact on Consumer Access and Affordability
Investments in Primary and Preventive Care
Entity Baseline Costs
High-Cost Drugs
Changes in State and Federal Law
Acts of God or Catastrophic Events
Additional Factors
Changes in insurance coverage, payer mix and uncompensated care
Changes in service offerings
Factors that drive revenue volatility
Macroeconomic trends, incl. inflation & as applicable on a regional basis
Overall labor cost growth
Regulatory changes affecting health care costs
Medical supplies and capital facility cost growth
Tariffs and other supply chain shocks

Scrutiny of Health Insurance Companies’ Non-Medical Expenses Needed for Patient Affordability

While OHCA has applied focused scrutiny on hospitals, insurers have received little by comparison. At the August 2025 OHCA Board meeting, a health plan representative noted that “health plans already operate under some of the tightest cost control frameworks in the country,” citing public reporting requirements and state and federal Medical Loss Ratios (MLR) as proof that their revenues are already constrained. But mounting evidence shows that the MLR, designed to ensure most consumer premium dollars go directly to patient care and quality improvement, has become a highly flexible accounting tool that allows insurers to bolster their profits and minimize refunds to consumers.

Recent analysis from the Center for American Progress² and industry experts³ detail how insurer vertical integration – in which insurers own or control the providers and vendors they pay – allows large insurers to mask profits as “medical spending.” A September 2025 *Health Affairs Forefront* commentary⁴ by Michael Bailit, a former OHCA advisor, further explains that this vertically integrated structure among large insurers enables conglomerates like UnitedHealth and CVS Health to book payments from their insurer to their provider arms as care costs, masking the true level of retained earnings. Evidence of this practice can be found in steadily increasing inter-company revenue transfers and extensive acquisitions of large physician groups and other health entities. For example, UnitedHealth Group consists of nearly 3,000 distinct entities⁴ including OptumHealth, which employs 90,000 physicians, 10% of all physicians in the U.S.⁵, all while more than doubling inter-company revenue 2018-2023.³

Academic and regulatory analyses from the *Journal of Insurance Regulation*⁶ show an additional tactic for gaming the MLR: manipulating year-end claim reserves. Plans that do not meet their MLR overstate year-end outstanding claims, which allows them to avoid paying rebates to consumers, then release these excess reserves the following year as profit. The amounts are significant: across 1,951 health plans nationwide between 2011 and 2013, overstated claims reduced rebates by \$190–\$325 million over the three years (10%–17% of rebates actually paid), while understated claims accounted for 14%–34% of health plan pre-tax profits. In other words, insurers used these over/underestimates to directly pad profits and avoid paying consumers back. Other tactics to increase “medical spending” include reclassifying administrative activities as “quality improvement,” and exploiting state-to-state MLR rule differences in what counts as medical versus administrative expense.

Together, these studies make clear that MLR compliance does not guarantee appropriate spending of consumer premium dollars. Without further scrutiny of how insurers calculate medical spending, reserves, and intercompany transfers, the MLR provides an illusion of regulation rather than a safeguard of patient affordability. This is particularly unfortunate since MLR filings are OHCA’s chosen mechanism for regulating payers’ non-medical expenditures. With health care premiums expected to increase by double digits in the coming year (for example, by [10.3%](#) in Covered California), OHCA must consider alternative accountability mechanisms for payers to ensure that its efforts translate into improved affordability for Californians.

Conclusion

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

² <https://www.americanprogress.org/article/medical-loss-ratio-reform-can-help-curb-corporate-power-and-lower-health-care-costs/>

³ <https://healthcareuncovered.substack.com/p/gaming-the-system-medical-loss-ratios>

⁴ <https://www.healthaffairs.org/content/forefront/insurers-own-providers-can-game-medical-loss-ratio-rules>

⁵ <https://www.statnews.com/2023/11/29/unitedhealth-doctors-workforce/>

⁶ https://content.naic.org/sites/default/files/JIR-ZA-40-01-EL_0.pdf

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, 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



2170 South Avenue
South Lake Tahoe
CA 96150

530.541.3420 TEL
bartonhealth.org

October 22, 2025

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

Subject: Anthem Negotiations Undermine Patient Care (Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

Months before the statewide enforceable target is set to take effect, Barton Memorial Hospital is beginning to see the ill-conceived consequences of the spending cap established by the Office of Health Care Affordability.

Barton Memorial Hospital has been notified that Anthem will limit its payment for our services, commensurate with the spending cap, in 2026 and beyond. If we do not accept these terms, Anthem has threatened to terminate our contract — jeopardizing access and continuity of care for 26% of the commercial patients our hospital treats each year.

Barton Memorial Hospital is the only health care delivery system in our rural community. Each year, we incur over 200,000 patient encounters, 65% of whom are covered by Medicare or Medi-Cal. Further, due to Barton's remote, mountainous location, Barton provides maternity and pediatric care when other small hospitals have ended these costly services. As a resort town, not only do we provide safe, high-quality care to our community, we additionally ensure that we are equipped to care for the many visitors that come to our community annually.

A hospital does not collect what it charges due to uncompensated care, contractual adjustments, claim denials, etc. For example, Barton typically collects only 28% of gross charges. By implementing a CDM adjustment cap, this will further erode our revenue that is already not keeping pace with cost growth. Our operating costs have grown by 8% in recent years primarily due to increased labor, physician services and supply costs straining our financial sustainability and placing our services, workforces, and whole community at risk. With the closest California hospital 40 miles away (assuming no winter road closures), financial sustainability is necessary to ensure that we are available to care for those in need.



Consistently Exceptional Care

Anthem's threats place us in an impossible situation: Either we lose our largest commercial contract, or we acquiesce to the demands of a payer far more powerful than a small, rural hospital such as us. Either way, our patients and communities will suffer.

If we are forced to agree to Anthem's terms:

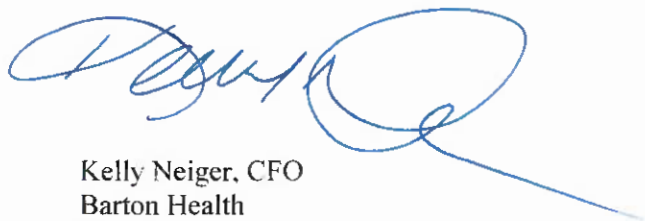
- It would open the door for additional payers to follow suit.
- We would need to assess the reduction of service lines decreasing access. This will result in patients being forced to travel 40-50 miles over mountainous roads for their health needs or forgo care altogether creating sicker patients at a higher cost.
- Decreased services also means decreased staff. Barton is the largest employer in South Lake Tahoe. A reduced workforce will have a ripple down negative effect on the local economy.
- Investments such as expansion of our rural health center, expanded mental health and substance abuse services could be paused or cancelled. These services are at the top of the list every year on our Community Health Needs Assessment.
- We would not have the financial resources necessary to make the several hundred-million-dollar investment in our facilities to meet the state's 2030 seismic compliance goals.

The Legislature was clear: "OHCA's work to improve health care affordability must promote, rather than come at the expense of, health care access, equity, and quality, and the stability of the health care workforce."

Attempting to solve the state's real and important affordability challenges on the backs of small, rural, and vulnerable health care providers isn't just wrong — it flies in the face of OHCA's mandate to protect access and quality. "Working together" to improve affordability must be a collaborative effort — not a negotiating tactic against providers that cannot push back.

This is not the path toward affordability the Legislature intended. **Barton Memorial Hospital asks OHCA to clearly state that Anthem's actions are inconsistent with OHCA's intent and purpose and jeopardize access to health care in communities like ours.**

Sincerely,



Kelly Neiger, CFO
Barton Health
Barton Memorial Hospital



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Executive Director

Organizations listed for
identification purposes

October 21, 2025

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
Health Care Access and Information Department

2020 W. El Camino Ave, Ste. 1200
Sacramento, CA

Re: October 2025 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 comments on the growth targets, the proposed data submission penalty, spending target enforcement, and hospital spending measurement.

Health Access:

- Commends Governor Newsom for his action to “crush” health care costs, including through the creation of the Office of Health Care Affordability.
- Recognizes that the enabling statute for the Office requires that the growth target be based on consumer affordability with consideration of broad economic and demographic indicators and does not permit the growth target to be based solely on the current cost of care.
- Respects the role of the Department of Managed Health Care and the California Department of Insurance in reviewing rates, including premiums and cost sharing, for state-regulated health insurance, not OHCA.

- Offers recommendations on the data submission penalty, including:
 - Consistent with the law, having the penalty reflect the financial condition of the entity, including any affiliates or subsidiaries as well as any larger system or national presence of which the entity is a part.
 - Per member per year penalties for health plans and insurers, with similar scaling to size for other entities.
 - Escalating penalties month by month from December until July or August of the reporting period and then year by year until in year 3, the penalty is commensurate with incentive to avoid data submission, as estimated from other data sources.
 - Not basing a penalty on profits or administrative costs, in part because of the lack of publicly available data on profits and administrative costs for most hospital systems and physician organizations.
- Discussion of the differential impact of enforcement considerations by type of entity, such as insurers, hospitals and large physician organizations.
- Notes continued discussion of hospital spending measurement, particularly the intensity of outpatient services.

I. **Health Care Costs: Growth Target: Statute**

“No Californian should ever have to ration insulin or go into debt to stay alive — and I won’t stop until health care costs are crushed for everyone.”
Governor Gavin Newsom¹, Oct. 16, 2025

Health Access congratulates Governor Newsom, and HCAI, on lowering the cost of insulin by manufacturing California’s own insulin, thus breaking the Pharma oligopoly, and commends the Governor for signing SB 40 (Wiener) which caps cost sharing for insulin at \$35 for commercial coverage as well as signing SB 41 (Wiener) which licenses pharmacy benefit managers and bans “spread pricing”. These actions are consistent with the Governor’s support for universal health care, which has included the creation of the Office of Health Care Affordability to “crush” health care costs for all Californians.

As the OHCA Board and staff think about whether to reconsider the high-cost hospital growth targets as well as, perhaps, the overall growth targets, Health Access notes the enabling legislation does not allow the Office to base those targets on the cost of providing care by providers such as hospitals and large physician organizations. Here are relevant operative sections of the OHCA enabling statute:

¹ [In shot across Big Pharma's bow, California will sell its own insulin - POLITICO](#)

(c) The health care cost targets shall meet all of the following requirements:
(2) (A) Be based on a target percentage, with consideration of economic indicators or population-based measures, and be developed based on a methodology that is available and transparent to the public.
(B) Economic indicators may include established *measures reflecting the broader economy, the labor markets, and consumer cost trends*.
(C) Population-based measures may include *changes in the state's demographic factors that may influence demand for health care services, such as aging*.

(5) Promote the goal of *improved affordability for consumers and purchasers of health care*, while maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness.

(d) (4) The methodology shall review potential factors to adjust future cost targets, including, but not limited to, *the health care employment cost index, labor costs, the consumer price index for urban wage earners and clerical workers, impacts due to known emerging diseases, trends in the price of health care technologies, provider payer mix, state or local mandates such as required capital improvement projects, and any relevant state and federal policy changes* impacting covered benefits, provider reimbursement, and costs.

(e) The methodology for setting a sector target for an individual health care entity shall be developed taking into account the following:

(1) *Allow for the setting of cost targets based on the entity's status as a high-cost outlier*². (emphasis added.)

Nowhere does the statute speak to basing the growth target on the cost of providing care. The growth target may be adjusted for factors that may influence the cost of care, but the targets are not based on the cost of care but rather broad economic and demographic factors as well as consumer affordability. Basing the growth target on the current cost of care, an arbitrary amount determined by those who benefit from getting paid more, rather than broad economic factors such as the overall labor market or demographic factors such as the diversity of California, is contrary to the statute.

Basing the growth target on consumer affordability as well as broad economic and demographic factors is in line with both the vision and the letter of the law. The Office is intended to transform the delivery of care by working toward the triple aim

² Relevant sections of Health and Safety Code 127502

of lower costs, higher quality and improved equity through promoting primary care and behavioral health while encouraging hospitals, physician organizations, integrated care delivery systems and other providers to meet a growth target that will lower premiums and cost sharing for consumers and other purchasers.

II. Growth Targets and Rate Review: OHCA and DMHC/CDI

OHCA is charged with setting growth targets that apply to health plans and insurers as well as hospitals, large physician organizations and other health providers. That is the responsibility of HCAI and OHCA. Health plans and insurers are subject to the same overall growth target of 3.5% of “total” health care expenditures, diminishing to 3% over time, as other health care entities, including hospitals and physician organizations. Additionally, the target applies separately to the profits and administrative costs of the health plan or insurer “to deter growth in administrative costs and profits” and the law also limits growth in administrative costs and profits if the costs of total medical expenditures exceed the growth target.³ These limits on administrative costs and profits apply only to health plans and insurers as payers, not to other entities which are providers such as hospitals and large physician organizations.

It is not the responsibility of HCAI or OHCA to regulate premiums and cost sharing, the rates paid by consumers and other purchasers. That is the job of the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) through health plan rate review for the state-regulated coverage for almost 14 million Californians⁴. The same law that created the Office also added two sections of law to the existing laws governing rate review by DMHC and CDI, one applying to DMHC and the other to CDI.

Health and Safety Code 1385.035. (a) It is the intent of the Legislature in enacting this section to ensure that enrollees and subscribers benefit from reductions in the rate of growth in health care costs as a result of the establishment of the Office of Health Care Affordability.

(b) In submitting rates for review consistent with this article, a health care service plan shall demonstrate the impact of any changes in the rate of growth in health care costs resulting from the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107.

³ Health and Safety Code 127502 (h)

⁴ <https://dmhc.ca.gov/Portals/0/Docs/OFR/FSSB/Aug25/HealthPlanQuarterlyUpdate.pdf>.

(c) In determining whether a rate is unreasonable or not justified, the director shall consider the impact on changes in health care costs as a result of the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107⁵.

Comprehensive rate review has been in place in California since 2010. Over the fifteen years of reviewing rates, the largest single component of the cost of health insurance has been hospital inpatient and hospital outpatient care amounting to 35%-40% of the rate while insurer profits and overhead range from 5% (for Kaiser Permanente) to 20% in the individual market. This is similar to what the OHCA baseline report found which was that insurer profits and overhead in the commercial market were 7%-8% while spending on hospitals amounted to 41% of claims⁶.

It is not OHCA's responsibility to review rates to determine whether those rates are unreasonable or unjustified. That is the responsibility of DMHC and CDI which respectively regulate health plans and insurers⁷. The Governor and the Legislature recognized the basic division of labor between HCAI and OHCA on the one hand and DMHC and CDI on the other hand.

III. Data Submission Penalty Considerations

Health Access strongly recommends that the amount of the data submission penalty is in some way or degree related to the incentive to avoid compliance with timely, complete, and accurate reporting of data. Other available data sources can provide insight into the degree by which a health care entity is likely to exceed the target. We recommend a commensurate penalty for protracted failure to knowingly or willfully fail to provide the data timely, completely and accurately. The ability to monitor and enforce the growth targets rests on timely annual submission of complete and accurate data.

A. Data Penalty Amount Sufficient to Deter Noncompliance: Scale of Entity, Scale of Missed Growth Target

⁵ Health and Safety Code 1385.035 and Insurance Code 10181.35

⁶ <https://hcai.ca.gov/wp-content/uploads/2025/06/Baseline-Report-Health-Care-Spending-Growth-Trends-in-California-3.pdf>

⁷ For self-insured coverage provided through employment which covers 4-5 million Californians, state law relies on employers and trust funds to negotiate lower rates on their own behalf and on behalf of the working families who rely on such coverage.

The initial data submission penalties will apply to health plans and insurers that fail to report timely, complete and accurate information on “total” health care expenditures, that is what the plan or insurer spends money on, including not only profit and overhead but also payments to doctors, hospitals, and other providers as well as for outpatient prescription drugs.

The OHCA law requires the Director to look at the financial solvency of not only the entity but also affiliates and subsidiaries controlled by the entity as well as any larger system the entity is part of:

The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity⁸.

Some of the health plans submitting data are very large enterprises, some of them parts of even larger enterprises, whether in California or nationally. The top five health plans all have a presence outside California. The law requires the HCAI Director to look at the larger picture, not just the revenues to the California subsidiary that is licensed as a health plan or insurer.

Health Plan Top Five 2022	<i>California Enrollment: Medicare, Medi-Cal, Commercial, 2022⁹</i>	<i>California Plan Premium Revenue 2022</i>	<i>National Revenue: 2024</i>	Staff proposal: \$5/member Penalty	Estimated Commensurate Penalty if Growth Target Exceeded by 1%: estimate
Kaiser Permanente	8.5 million	\$67.7 billion	\$115.8 billion ¹⁰	\$42.5 million	\$677 million
Elevance (Anthem)	5.9 million	\$23.7 billion	\$175.2 billion ¹¹	\$29.5 million	\$237 million

⁸ Health and Safety Code 127502.5 (d) (6) (B).

⁹ Slides 20 and 4: <https://www.chcf.org/wp-content/uploads/2024/10/HealthInsurersAlmanac2024.pdf>

¹⁰ <https://about.kaiserpermanente.org/news/press-release-archive/kaiser-foundation-health-plan-hospitals-risant-health-report-2024-financial-results>

¹¹ <https://www.elevancehealth.com/newsroom/elv-quarterly-earnings-q4-2024>

Blue Shield	3.2 million	\$23.5 billion	\$27.4 billion ¹²	\$16 million	\$235 million
Centene (HealthNet)	2.6 million	\$20.2 billion	\$163.1 billion ¹³	\$13 million	\$202 million
United	2.0 million	\$20.0 billion	\$298.2 billion ¹⁴	\$10 million	\$200 million

If Health Access can do this arithmetic, so can health plan actuaries, lawyers and executives.

The amount of a data submission penalty should be sufficient to encourage entities to comply with requirements to submit information timely, completely and accurately. Here are a few examples of the failure of a \$5 per member penalty to be in any way commensurate with the incentive to delay or avoid data submission:

- If the per member per year amount of private health insurance is \$7,500 and a health plan or insurer has THCE that grows at 4.5% instead of 3.5%, then the incentive is \$75 per member per year¹⁵.
- If the health plan or insurer has THCE that grows at 10.5%¹⁶, then the incentive is avoidance of reporting that the plan exceeded the growth target by \$525 per member per year.

These are not idle examples. According to a prior presentation by staff, private health insurance is currently \$7,600 per member per year. Covered California rates are estimated to grow by 10.3% in 2026 (if the enhanced subsidies are continued). In the context of these real-life cases, \$5 per member per year may not be sufficient to incentivize compliance.

B. Per Member Per Year Penalty Scales to Size of Entity

Health Access supports an amount that is per member per year for health plans and insurers because it scales to the size of the affected entity.

If additional data is needed from hospitals, large physician organizations or other-non-insurer entities, another metric may be needed but the same principle of scaling to size should apply. A 25-bed hospital is a different entity than Cedars Sinai

¹² <https://news.blueshieldca.com/mission-report-2024-financials>

¹³ <https://investors.centene.com/2025-02-04-CENTENE-CORPORATION-REPORTS-2024-RESULTS>

¹⁴ <https://investors.centene.com/2025-02-04-CENTENE-CORPORATION-REPORTS-2024-RESULTS>

¹⁵ \$7,600 is the amount per member per year for private health insurance cited by OHCA staff in , rounded down for ease of computation. The current growth target is 3.5%.

¹⁶ Covered California rates will increase 10.3% if the enhanced subsidies continue.

with 915 beds in West LA and another 544 beds at Huntington in Pasadena. Similarly, a single specialty physician group with 30 physicians has a different scale than Hill Physicians with more than 600 doctors¹⁷ or Optum with almost 3,000 physicians in California.¹⁸

As we noted, the law requires consideration of the financial solvency of the entity: the purpose of the penalty is not to bankrupt financially unstable entities but to create a strong incentive for entities, including those with ample reserves, to comply. Even a large organization may face financial challenges under some circumstances. Small entities are less likely to have reserves or administrative capacity sufficient to weather downturns. Fortunately, HCAI has experience dealing with financially distressed hospitals just as Department of Managed Health Care has experience dealing with financially stressed health plans and risk-bearing medical groups.

C. Month One, Month Two, Month Three and Year One, Year Two

Health Access supports escalating penalties for failure to comply. Penalties should escalate on a monthly basis from December through July or August of each year with data submissions due on September 1. For year two of failure to submit data, penalties should be even higher. And for year three, penalties should approximate the incentive to avoid data submission.

How will OHCA know what the incentive is for avoiding data submission? For most types of health care entities, there are other sources of data:

- For health plans and insurers, rate review filings for the relevant year with either DMHC or CDI can provide insight into both the magnitude of rate increases and the reasons for those increases, such as excessive reserves as well as medical trend and utilization for hospital inpatient and outpatient costs, physician and other professional services as well as outpatient prescription drugs¹⁹.
- For hospitals, OHCA is already using HCAI hospital financial filings and in the future, the Health Payments Database (HPD) will prove helpful.
- For physician organizations, data sources will vary but again both DMHC financial filings and the HPD as well as other sources of information in the

¹⁷ <https://www.westernhealth.com/hill/>

¹⁸ <https://www.nammcal.com/>

¹⁹ Health and Safety Code 1385.03, DMHC rate filings: <https://wpso.dmhc.ca.gov/premiumratereview/>

OHCA enabling statute such as audited financial statements or the equivalent can provide a cross-check.

D. Profits and Administrative Costs Not a Good Measure of Incentives for Noncompliance

The initial data submission penalty discussion focuses on health plans and insurers. OHCA also has the authority to compel data submission by other health care entities, including hospitals and physician organizations. For any of these entities, grounding the data submission penalty in “profits” and administrative costs is problematic for a number of reasons. Some reasons vary by the type of entity. Others are common across all entities.

First, most health care entities are part of larger health care entities. Health plans are often multi-state entities, and some health plans include other entities such as pharmacy benefit managers or physician organizations. Most hospitals, even standalone hospitals such as North Bay or Community Hospital of the Monterey Peninsula (CHOMP), are part of some sort of hospital system comprised of multiple entities. The same is true of many physician organizations. It is routine for profits and administrative costs to get buried in the web of entities: basing a penalty amount on profits, administrative costs or both only encourages hiding money.

Second, many health care entities have reserves that consist of accumulated profits. Indeed, state law requires health plans and insurers to hold sufficient reserves so that claims can be paid, even in tough times like a global pandemic. Hospital systems similarly hold reserves: CHOMP has \$1 billion in reserves, Sutter made almost a billion dollars from investment income last year alone, far more than it made from net operations, and for Stanford health systems in 2024, its investment income was \$2.2 billion²⁰.

Physician organizations often have limited reserves but only because they pay out the income to the participating physicians and for operations rather than holding reserves²¹.

²⁰ We recognize that for tax purposes, many of these entities are categorized as non-profits. But revenues in excess of expenditures, including investment earnings, constitute profits, just as a rose is a rose. <https://www.sutterhealth.org/about-us/financials> and https://bondholder-information.stanford.edu/sites/g/files/sbiybj21416/files/media/file/fy24-annual-financial-report_0.pdf

²¹ This appears to be true even for state-regulated risk-bearing organizations.

Third, all of these entities have administrative costs that may not show in the top lines of the reporting to state agencies. For example, a hospital system like Adventist or Providence has an administrative structure so the system, as a system, can negotiate with insurers and other payers over rates. This creates layers of administrative costs that may not be reported in the HCAI hospital financials.

Recent research²² points to the inadequacy of medical loss ratio reporting in the context of such administrative complexity: it goes hand in hand with decades of research demonstrating the inefficiency of the American health care system with its layers of administrative costs, at the plan and provider level²³.

E. Past Performance is No Guarantee of Future Compliance

Past compliance by health plans with data reporting requirements when the cost targets were unenforceable is no guarantee of future compliance when such targets are enforceable. Once real money is on the line for failure to meet the growth target, behavior may well change.

Also, OHCA is adding Medi-Cal managed care plans this year: these entities in the past have not submitted this information to OHCA. Health Access strongly supports the addition of Medi-Cal managed care organizations. Given recent questions about several Medi-Cal managed care plans²⁴, there is no surety that Medi-Cal managed care organizations will necessarily be routinely compliant with data reporting requirements.

Even once a record of compliance is established for each entity, those organizations will face the same temptation to point to system malfunctions, data issues or other reasons bordering on excuses rather than face penalties for the cost growth target.

F. Past Performance Does Not Establish Knowing or Willful Failure to Comply

The fact that a health plan previously filed THCE data even for several years may not be sufficient to meet the legal standards for “knowingly” or “willfully” failing to comply with data filing requirements for a subsequent reporting year. Whether it is the legal standard for “knowingly” fail to comply or the even higher legal standard

²² Bailit

²³ JG Kahn

²⁴ <https://information.auditor.ca.gov/pdfs/reports/2022-112.pdf>. Also, Inland Empire Health Plan: <https://www.justice.gov/opa/pr/united-states-files-suit-against-california-based-health-plan-alleged-false-claims>

for “willful” failure, HCAI will not be able to hand out fines unless it can meet those legal standards. Our primary interest in the sufficiency of penalties is to ensure compliance with the data submission requirements. While we appreciate OHCA’s optimism that future behavior will match the past, the Office must be prepared to adapt if compliance worsens in response to the changing incentives.

G. So what does Health Access recommend for data submission penalties?

Health Access recommends the following for data submission penalties:

- Consistent with the law, the penalty should reflect the financial condition of the entity, including any affiliates or subsidiaries as well as any larger system or national presence of which the entity is a part.
- Penalties that take into account the size of the entity.
- Per member per year penalties for health plans and insurers, with similar scaling to size for other entities.
- Escalating penalties month by month from December until July or August of the reporting period and then year by year until in year 3, the penalty is commensurate with incentive to avoid data submission, as estimated from other data sources.
- Not basing a penalty on profits or administrative costs, in part because of the lack of publicly available data on profits and administrative costs for most hospital systems and physician organizations.

IV. Growth Target Enforcement Considerations

The discussion to date on growth target enforcement has focused on “enforcement considerations” and “enforcement process flow”.

The process of enforcement began in April 2024 when the Health Care Affordability Board set the initial targets for the five years of 2025, 2026, 2027, 2028 and 2029. The next step in enforcement is the collection of the data on compliance with the targets: the data for 2025 will be collected in 2026 and analyzed and reported in 2027. Setting the target was the first step in determining compliance.

With respect to enforcement considerations, the discussion to date has focused on types of considerations without distinguishing differential impacts across sectors such as health plans, hospitals and health systems, physician organizations and

more. But each enforcement consideration plays somewhat differently by sector. As the discussion of enforcement moves forward, it will be helpful to consider how different factors affect different parts of the health care system differently.

V. Hospital Spending Measurement

Health Access has been represented on the hospital spending measurement workgroup. We have devoted time to this effort because of the limitations inherent in attributing patient care to hospitals through primary care providers, especially given the complexity of the delivery system in California. HCAI has been collecting hospital financial and discharge data for 50 years: part of the reason OHCA is at HCAI, in our view, is because HCAI was intended to be the central hub for health data as well as health planning from its inception. This data collection role has been enhanced by the HPD and other data efforts.

Health Access is pleased that general agreement has been reached for inpatient hospital revenue on the use of “net patient revenue” and “case mix adjusted discharge”. Net patient revenue refers to revenues for patient care, net of contractual adjustments and discounts to payers. “Case mix adjusted discharge” reflects the reality that care for some patients is more complex and more resource intensive than for other patients: a patient who spends a month in an intensive care unit is different than a patient held overnight for observation because of a concussion. There remain various complications with inpatient revenue, particularly the alphabet soup of federal programs that affect Medi-Cal funding, such as QAF, IGTs, and various waiver funding streams, further complicated by the pending changes due to H.R.1.

For purposes of determining compliance with the cost growth target for commercial coverage, “net patient revenue” and “case mix adjusted discharge” seem likely to capture compliance with the target. This is especially important now because some health care entities have suggested deliberately cost shifting to commercial coverage, even though historically hospitals and physicians provide little care to the uninsured, those most likely to suffer from H.R.1. Prior to the ACA, hospitals spent on average less than 2% of revenue on the uninsured. Now it is closer to 1% of revenue. If H.R.1 plus the cruel cuts in the state budget for the undocumented falls somewhere in-between the pre-ACA world and the current near universal health coverage, then hospitals are likely to spend on average

something like 1.5% of revenue on the uninsured. That modest increase in no way justifies undoing the cost growth targets, much less cost shifting the entire amount of lost revenues to commercial coverage, as proposed by some.

We look forward to further discussions on measuring intensity in hospital outpatient care. We note that in earlier work, OHCA has used both inpatient net patient revenue (adjusted by case mix of discharges) and a commercial to Medicare payment to cost ratio, which includes both inpatient and outpatient hospital care, despite some erroneous assertions to the contrary.

Summary

Health Access made concrete recommendations on data submission penalties and offers further comments on growth target enforcement considerations as well as hospital spending measurement. We look forward to further discussion at the Board meeting.

Sincerely,



Beth Capell, Ph.D.
Policy Consultant



Amanda McAllister Wallner
Executive Director

CC:

Members, Health Care Affordability Board

Richard Figueroa, Deputy Cabinet Secretary, Office of the Governor

Christine Aurre, Legislative Affairs, Office of the Governor, Attn.:

Paula Villescaz

Robert Rivas, Speaker, California Assembly, Attn.: Rosielyn Pulmano

Mike McGuire, President Pro Tempore, California State Senate, Attn.: Marjorie Swartz

Mary Watanabe, Director, Department of Managed Health Care

Michelle Baass, Director, Department of Health Care Service

Assemblymember Mia Bonta, Chair, Assembly Health Committee, Attn.:

Lisa Murawski
Senator Caroline Menjivar, Chair, Senate Health Committee, Attn.:
Teri Boughton
Brendan McCarthy, 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 Figueroa, Deputy Commissioner, California Department of Insurance