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Health Care Affordability Board
 August 2026
 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
8/21/2026	Associations of Northern California Oncologists and the Medical Oncology Association of Southern California	See Attachment #1
8/21/2026	Sharp HealthCare	See Attachment #2
9/12/2026	California Association of Health Insurance Professionals	See Attachments #3, 4, 5, 6, and 7 We wrote to you over a year ago and told you while we agree with you on making changes to curb Healthcare costs, we were not in agreement with your OCHA 3% mandate. We expressed our concern that this would only lead to LESS ACCESS TO CARE and LESS LEVEL OF CARE The hospitals have said just that – SEE SEPT Article Arbuckle ran Long Beach Memorial's spending data for 2022-23 through the state's penalty formula. Had the rules been in effect then, he estimated the hospital could have faced a \$27 million fine. "That's just beyond belief," he said. Industry groups also object to the amount of discretion the office has, calling the 0%-to-125% penalty range too broad. And they warn the caps could hurt patients. "Under the current growth targets, the primary way for hospitals to reduce costs is to reduce services and limit access," Angus Cochran, chief of community support services at Washington Health

Date	Name	Written Comment
		WHY can't you look at what the City of San Francisco is doing, and rightly so .. Brian Thompson United Healthcare, father of two young children was assassinated, That feels like 09/11 to us. It's completely biased and unfair to lay the Diabolical cost of Healthcare at our feet, while the UPF companies remain unscathed. We implore you to take a stance, <u>YOU CAN NOT CURB HEALTHCARE SPENDING WITHOUT CURBING CHRONIC ILLNESS, AND YOU CAN'T CURN CHRONIC ILLNESS WITHOUT CHANGING WHAT AMERICANS ARE EATING</u> San Francisco Sues Major Ultra-Processed Food Manufacturers San Francisco City Attorney David Chiu has filed a first-of-its-kind lawsuit in San Francisco Superior Court against 10 of the largest ultra-processed food (UPF) manufacturers in the U.S., including Kraft Heinz, Mondelez International, Post Holdings, Coca-Cola, PepsiCo, General Mills, Nestlé USA, Kellogg, Mars Incorporated, and ConAgra Brands What the Lawsuit Alleges The suit, filed on December 2, 2025, claims these companies engineered and marketed addictive, nutritionally poor foods for decades, knowing they contributed to serious health problems such as obesity, diabetes, heart disease, and other non-communicable diseases Key allegations include: • Public health crisis: UPFs are “former whole foods” chemically modified, reassembled with industrial techniques, and loaded with additives like artificial sweeteners, emulsifiers, and flavor enhancers • Addictive design: Similar to tobacco and drugs, UPFs are engineered to stimulate cravings and compulsive consumption • Deceptive marketing: Targeting children with harmful dyes and aggressive advertising, while concealing health risks • Unfair and deceptive acts: Violating California’s Unfair Competition Law and public nuisance statute Legal Goals The City seeks: • Restitution to help local governments offset “astronomical health care costs” linked to UPF consumption

Date	Name	Written Comment
		• Civil penalties. • A state order to stop deceptive marketing and require corrective actions to lessen the harm City Officials' Statements • David Chiu: "They took food and made it unrecognizable and harmful to the human body. We must be clear that this is not about consumers making better choices" • Mayor Daniel Lurie: "San Francisco families deserve to know what's in their food... We are going to stand up for public health and give parents the information they need to keep themselves and their kids safe and healthy" Context The lawsuit uses the Nova food classification system to define UPFs and draws parallels to tobacco litigation, arguing that the companies profited from a public health crisis they knowingly created This case could set a precedent for public health litigation against food industry giants, potentially influencing labeling, marketing, and product reform in California and beyond.
9/15/2026	California Hospital Association	See Attachment #8
9/17/2026	Health Access California	See Attachment #9
9/17/2026	California Association of Health Plans	See Attachment #10



August 20, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833

Sent via email to ohca@hcai.ca.gov

Re: Comments on Proposed Performance Improvement Plan Guidance and Spending Target Progressive Enforcement

Dear Secretary Johnson:

On behalf of the Association of Northern California Oncologists (ANCO) and the Medical Oncology Association of Southern California (MOASC), we appreciate the opportunity to comment on the California Office of Health Care Affordability's (OHCA's) proposed Performance Improvement Plan (PIP) Guidance and spending target progressive enforcement framework. Our organizations represent physicians and practices that provide cancer care across California, including community oncology practices that deliver the majority of outpatient cancer treatment in many regions of the state. We support the goal of improving affordability for California patients and purchasers. At the same time, any enforcement framework must recognize the unique realities of oncology care and avoid policies that would unintentionally reduce access to medically necessary, life-prolonging treatment.

Modern cancer care increasingly depends on uniquely expensive infused and injected drugs, oral oncolytics, precision diagnostics, biomarker testing, genomic profiling, advanced imaging, radiation planning, supportive care medications, and rapidly evolving evidence-based treatment protocols. These costs are driven by scientific innovation, FDA approvals, clinical guidelines, manufacturer pricing, hospital and payer contracting, and patient acuity - not by unnecessary utilization decisions made by community oncology practices in a static practice environment. We highlight the revolutionary advance represented by the upcoming FDA approval of the pancreas cancer drug daraxonrasib, which doubles survival in disease with limited options; however, appropriate adoption of this therapy will raise monthly drug prices from hundreds of dollars with traditional chemotherapy to tens of thousands.¹

¹ <https://www.nejm.org/doi/full/10.1056/NEJMoa2605555>

Even when standard-of-care practice doesn't change, oncology physicians often have little or no ability to negotiate the underlying acquisition price of infused, injected, or oral cancer therapies, nor do they control the price of advanced imaging, specialty diagnostics, hospital claims, or pharmacy benefit manager-administered drug claims that may be attributed to them. Same-drug oncology drug prices rise faster than general inflation. Holding oncology practices financially accountable for these costs would not reduce the true drivers of spending; it would only destabilize the practices that are actually delivering care and impair California patients' access to appropriate cancer care.

For that reason, ANCO and MOASC strongly urge OHCA to exclude high-cost oncology therapeutics and related oncology services from the calculation of spending target enforcement for physician organizations, or at a minimum to carve them out from any penalty calculation where the physician organization does not control the underlying cost. This should include infused cancer drugs, injectable therapies, oral oncolytics, companion diagnostics, molecular and genomic testing, advanced imaging, radiation-related planning and related oncology-supportive treatments. These are not discretionary cost centers. They are core components of standard-of-care cancer treatment. An enforcement methodology that treats these expenses as ordinary, controllable cost growth would penalize practices for delivering appropriate care to patients with serious and often life-threatening conditions.

This concern is especially acute under OHCA's proposed penalty structure. A dollar-for-dollar approach - and particularly a penalty range that could extend up to 125% of the amount by which an entity exceeds the spending target - would be devastating for community oncology. Community oncology practices operate on thin margins, face continual increases in staffing and drug acquisition costs, and do not have the reserves or affiliated entities that large health systems may rely upon to absorb regulatory penalties. In oncology, a penalty tied mechanically to attributed spending growth could easily exceed a practice's operating earnings, not because the practice acted irresponsibly, but because its patients needed high-cost treatment. In that circumstance, the likely result would not be better affordability. The likely result would be closure, acquisition, or consolidation of community oncology practices, pushing patients into more expensive hospital-based settings and worsening geographic and financial barriers to care.

ANCO and MOASC do recognize physicians can control some costs, for instance, by utilizing biosimilar agents instead of the branded reference, subject to manufacturer rebates. An alternative to evaluating practices by pure drug costs could be adherence to evidence-based clinical pathways endorsed by relevant national specialty societies. This would encourage the actual goal of rational prescribing based on the standard of care, as opposed to punishing physicians for the underlying price of drugs.²

² <https://ascopubs.org/doi/10.1200/JOP.2015.009134>

Community oncology is often the most accessible site of care for patients receiving chemotherapy, immunotherapy, hormonal therapy, and supportive treatment. If these practices close or are forced to consolidate into larger systems, patients may face longer travel times, treatment delays, higher site-of-service costs, and reduced continuity with their treating oncologists. A framework intended to address affordability should not accelerate the loss of lower-cost community cancer care infrastructure or drive patients into higher-cost settings. This is particularly important in rural, underserved, and safety-net communities, where even a single oncology practice closure can produce a serious access crisis.

ANCO and MOASC therefore urge OHCA to revise its framework in several ways.

- First, OHCA should explicitly recognize that physician organizations may not be penalized for categories of spending they do not negotiate, direct, or control.
- Second, OHCA should exempt oncology therapeutics, advanced oncology diagnostics, and advanced imaging from the calculation of physician organization spending-target penalties, or create a clear exclusion and adjustment methodology for these categories.
- Third, any PIP should focus only on spending drivers that a physician organization can meaningfully influence.
- Fourth, OHCA should adopt an initial penalty methodology far below the statutory maximum and preserve remediation as the true first step, especially during the early enforcement years.
- Finally, OHCA should account for the market reality that physician oncology practices do not exercise the type of market power that the enforcement framework appears designed to discipline.

Cancer care is expensive because cancer treatment is advanced, specialized, and lifesaving. The solution to rising oncology costs is not to punish the physicians and practices who care for patients with cancer for costs they cannot control. ANCO and MOASC respectfully ask OHCA to adopt an enforcement framework that distinguishes between unnecessary spending and medically necessary oncology care, protects access to community-based treatment, and avoids penalties that would destabilize the very practices California patients depend on. Thank you for your consideration of these comments.

Sincerely,



Millie Das
President, ANCO



Dr. Sumanta K. Pal
President, MOASC



August 21, 2026

Kim Johnson
Chair, Health Care Affordability Board
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833
(Submitted via email to ohca@hcai.ca.gov)

**SUBJECT: Sharp HealthCare Opposition to August 26, 2026, Agenda Items
4a and 4b: Spending Target Penalty Scope, Range and Justification Factors**

Dear Chair Johnson and Members of the Health Care Affordability Board:

Sharp HealthCare (“Sharp”) is a nonprofit, integrated health care delivery system based in San Diego, California, serving nearly one of every three San Diego County residents across five acute care hospitals, four specialty hospitals, three affiliated medical groups, and a regional nonprofit health plan. Sharp is San Diego’s largest health care provider, its largest private employer with nearly 22,000 team members, and the region’s largest Medi-Cal provider. Sharp shares the Office of Health Care Affordability’s (“OHCA”) goal of a more affordable, accessible, equitable, and high-quality health care system for all Californians.

Sharp is deeply concerned about multiple aspects of the frameworks and urges the Board to delay action on the spending target penalty scope, range and justification factors (Items 4a and 4b) until OHCA has completed and validated a comprehensive enforcement framework addressing unresolved technical, methodological, and adjustment-factor issues.

1. The Enforcement Framework Remains Incomplete

The proposed enforcement process sets hospitals up to fail: it relies on unclear measurement processes, unvalidated data, overly broad violation criteria, and disproportionate penalties. Sharp supports health care cost accountability, but cannot support a penalty framework that is premature, punitive, and likely to undermine patient access, workforce stability, and the financial viability of hospitals serving vulnerable communities. **The Board should not approve penalty ranges before establishing a fair, transparent, and reliable method for determining compliance.**

Key elements of the enforcement framework remain unresolved, including how compliance will be measured, how data will be validated, how adjustments will be applied, and how procedural penalties will be limited.

Sharp is similarly concerned that the proposed procedural penalty framework could undermine the progressive enforcement process established in statute. Procedural penalties should be narrowly limited to clearly documented, willful, egregious, or repeated noncompliance. They should not be used to penalize good-faith disagreements, challenges in developing or implementing a performance improvement plan, or circumstances in which an entity is actively working toward compliance.

2. OHCA Has Not Yet Addressed Industry Methodology Concerns Central to Enforcement

The penalty items before the Board depend on a measurement methodology that remains unresolved, unvalidated, and contested by the provider community. Public comments from hospitals, safety-net providers, physician groups, and medical associations have raised common concerns about data reliability, year-over-year volatility, payer and service-line measurement, outpatient data anomalies, patient mix, reimbursement structure, technical assistance, performance improvement plans, and factors outside provider control. These concerns must be resolved before enforcement consequences attach.

Sharp's recommended spending target adjustments are intended to address these methodological gaps in a concrete and administrable way. OHCA should account for baseline efficiency, Medi-Cal volume, alternative payment model participation, and labor costs before determining whether a hospital has exceeded the spending target or should be subject to penalties. Without these adjustments, the enforcement framework risks penalizing hospitals and providers for efficient operations, safety-net responsibilities, risk-based care models, workforce investments, and other circumstances that the methodology has not yet adequately distinguished from avoidable cost growth.

3. Premature Action Would Jeopardize Access and Undermine Due Process

The proposed spending target penalties could be large enough to affect hospitals' ability to sustain essential services, workforce investments, and community programs. As I shared with the Board in June, the framework would not make care more affordable if it ultimately makes care less available. Unlike the Massachusetts model OHCA has cited, OHCA's proposal could calculate penalties based on the full dollar difference between actual and allowed growth, creating potentially uncapped and escalating exposure. Penalties of that magnitude would reduce capacity to deliver care without addressing the underlying cost of care.

The risk is greatest for safety-net and community hospitals, where large penalties could force reductions in maternity care, cancer treatment, behavioral health, surgical care, emergency services, and other critical programs. Penalizing systems already absorbing substantial uncompensated care and serving high Medi-Cal populations is inconsistent with California's access, equity, and affordability goals.

OHCA has not yet established the clear, knowable standards needed to determine compliance, guide remediation, and support any penalty policy. Penalty policies should be considered only as part of a complete framework that explains how spending growth will be measured, how data will be validated, when adjustments or waivers will apply, what conduct will constitute a violation, and how remediation will occur. Approving penalties apart from those standards puts consequences ahead of the rules for assessment and compliance.

4. Requested Board Action

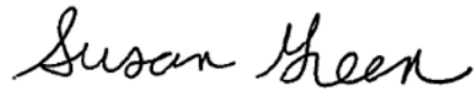
Before approving penalty policies that could affect hospital access, workforce stability, and essential services, the Board should require OHCA to complete and validate the enforcement framework as a whole. The unresolved technical, methodological, and adjustment-factor issues demonstrate why action on Items 4a and 4b is premature. Sharp respectfully urges the Board to:

- **Take no action on Items 4a and 4b**, including the proposed spending target and procedural penalty scope, range, and justification factors;
- **Direct OHCA staff to respond to public comments through written, published responses to public comments** submitted on Items 4a, 4b, and related items from previous Board meetings - rather than verbal summaries of public comments and responses during Board meetings - before those items are brought forward for Board action;

- Require OHCA to resolve the enforcement framework as a single, integrated package, not through piecemeal approvals, including validated measurement methodology, data reliability standards, limited violation criteria, necessary adjustment factors, and meaningful public review; and
- Require OHCA to validate that procedural penalties are narrowly limited to willful, egregious, or repeated noncompliance and cannot circumvent the statutory remediation process.

Sharp remains committed to working constructively with OHCA to advance affordability while protecting access, quality, equity, and workforce stability. The Board should not approve the proposed penalty policies until OHCA presents a complete, validated, and workable enforcement framework that incorporates appropriate adjustment factors and gives health care entities a meaningful opportunity to comply.

Respectfully submitted,

A handwritten signature in cursive script that reads "Susan Green".

Susan Green
Executive Vice President & Chief Financial Officer
Sharp HealthCare
Susan.Green@sharp.com

cc: Elizabeth Landsberg, Director, Office of Health Care Affordability
Megan Brubaker, OHCA Board Liaison
Chris Howard, President & CEO, Sharp HealthCare

Attachment #3

FOOD FOR THOUGHT

View of U.S. Healthcare Quality Declines to 24-Year Low

Americans' rating of U.S. healthcare coverage is below average; most say the system has major problems

BY MEGAN BRENNAN

UnitedHealth mounts full defense of its business in wake of Thompson's killing

UnitedHealthcare CEO Andrew Witty is expected to testify before a House subcommittee on Wednesday about the company's role in the death of a 19-year-old woman, a case that has sparked widespread outrage and calls for reform.



Stephen Mautner/Getty Images

“I do apologize for any strife or traumas but it had to be done. Frankly, these parasites simply had it coming.” Health insurers, he wrote, are “too powerful, and they continue to abuse our country for immense profit”.

-Luigi Mangione

Perspectives > Prescriptions for a Broken System

UnitedHealth CEO Andrew Witty Is Wrong. Just Plain Wrong.

— Everyone in healthcare bears some blame for our broken system

by N. Adam Brown, MD, MBA, Contributing Writer, MedPage Today
February 2, 2025



N. Adam Brown is a practicing emergency physician, entrepreneur, and healthcare executive. He is the founder of ABIG Health, a healthcare growth strategy firm, and a professor at the University of North Carolina's Kenan-Flagler Business School. [Follow](#) [Twitter](#)

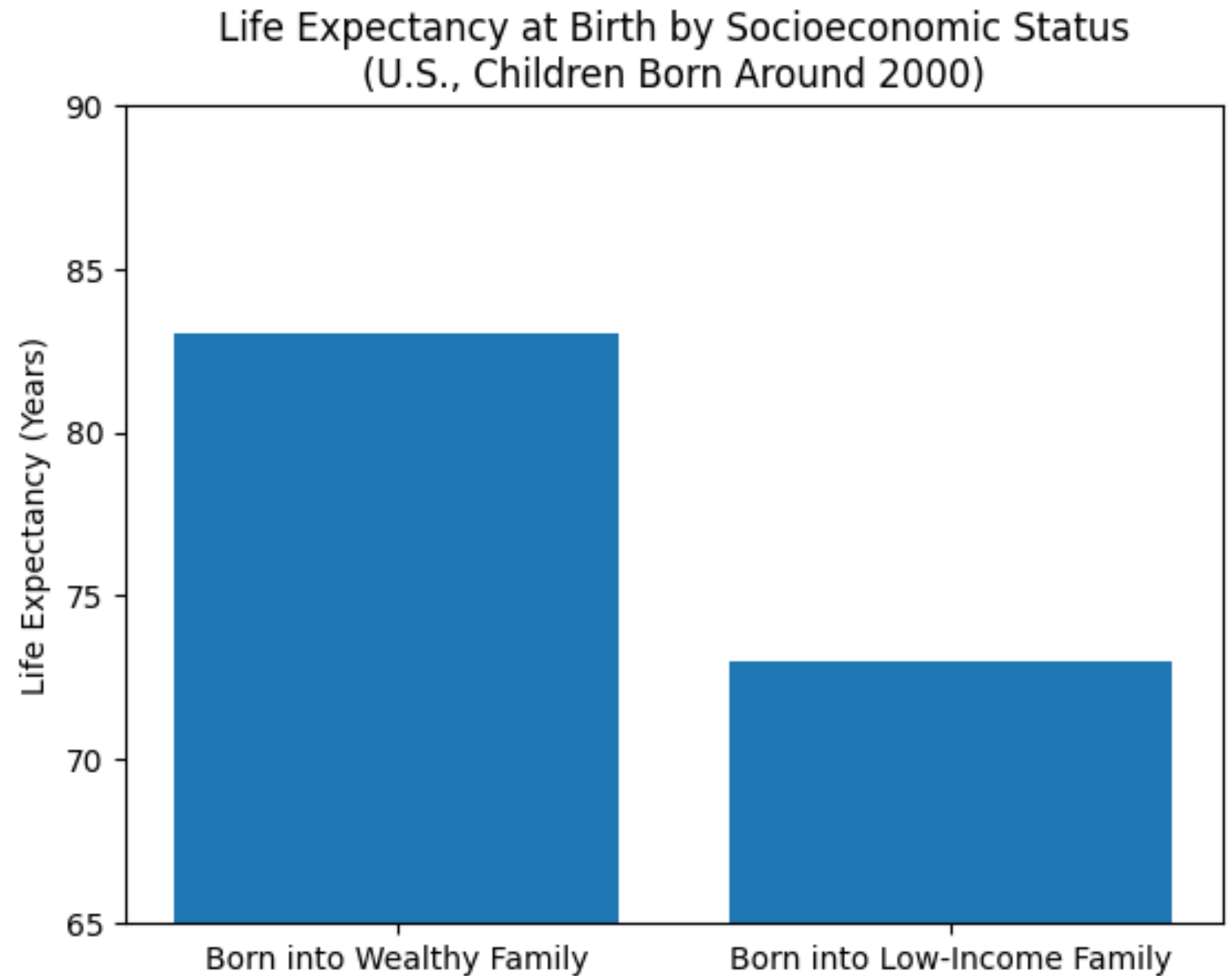


Witty blames “cost of care”;
2024 revenue \$400B, up 7.8% from 2023

Luigi Mangione wrote that **the United States has the most expensive healthcare system in the world, yet ranks relatively low in measures like life expectancy** compared to other wealthy nations.

- He attributed this disconnect — in broad terms — to **the power, corruption, and profit-driven nature of large healthcare/insurance companies**, suggesting they benefit financially while ordinary people suffer.
- Many of insurance agents have been working with our clients for over twenty even thirty years, I would think that gives us some perspective on this
- **Question-**
- **What would you say was the largest contributor to the fall in life expectancy is the US ?**

Life Expectancy by Socioeconomic Status

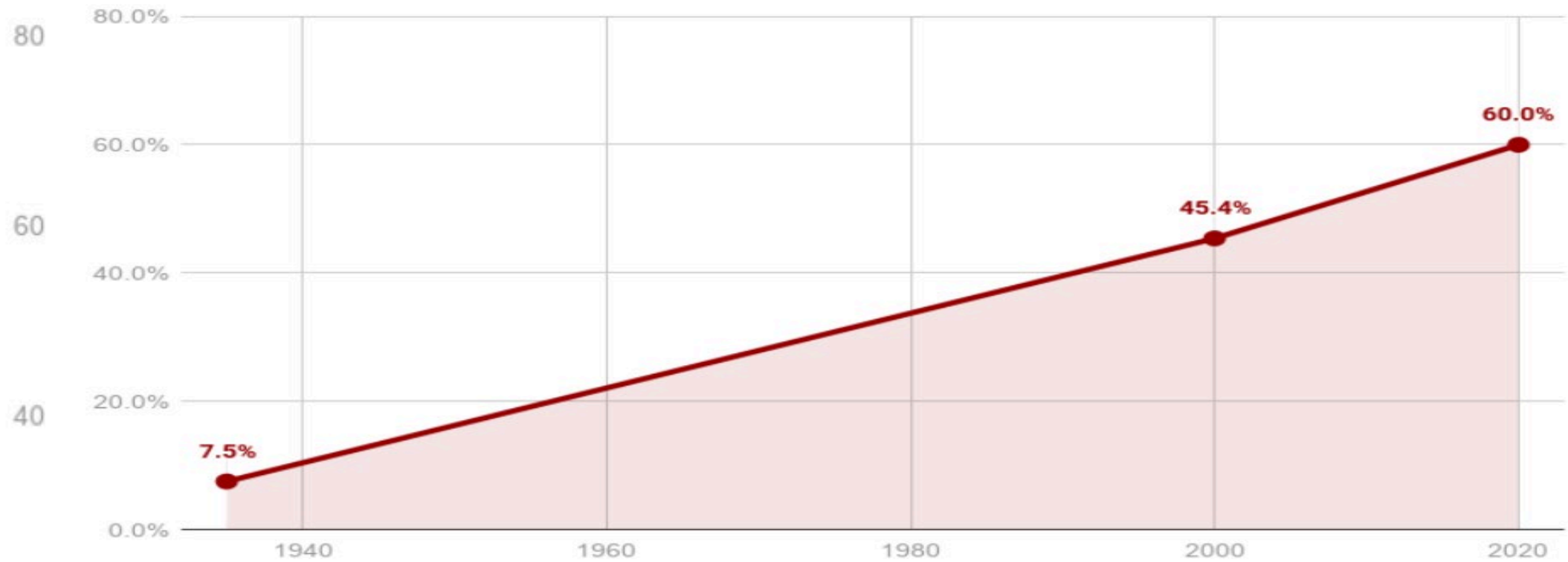


Food for Thought:

- Understanding How Modern Diets Impact Health
 - Chronic Disease
 - Ultra-Processed Foods (UPFs)
 - Nutrient Decline in Produce
 - Effects of Pesticides & Chemicals

Chronic Disease Prevalence in America

● % of population with chronic disease



10 Common Chronic Conditions for Adults 65+

Quick Facts



80%
have at least 1 chronic condition



68%
have 2 or more chronic conditions



Hypertension
(High Blood Pressure)
58%



High Cholesterol
47%



Arthritis
31%



Ischemic Heart Disease
(or Coronary Heart Disease)
29%



Diabetes
27%



Chronic Kidney Disease
18%



Heart Failure
14%



Depression
14%



Alzheimer's Disease and Dementia
11%



Chronic Obstructive Pulmonary Disease
11%

Source: Centers for Medicare & Medicaid Services, Chronic Conditions Prevalence State/County Table: All Fee-for-Service Beneficiaries, 2015

73% of Healthcare Spending is on chronic illnesses,
These Chronic Illnesses are caused by metabolic syndrome,
driven mostly by the consumption of ultra-processed foods.

- Question – What is Metabolic Syndrome ?
- Question – What are UPFs?

The rapid increase in **Non-Communicable Diseases (NCDs)** over the last 50 years closely parallels the rise in consumption of **Ultra-Processed Foods (UPFs)**.

Main Culprits: Ultra-Processed Foods

- **Common UPFs that drive chronic illness:**
 - Sugary drinks
 - Packaged snacks & chips
 - Ready-to-eat meals
 - Sweetened cereals
 - Processed meats
 - Refined baked goods
 - Fast food options
- These are high in sugar, sodium, unhealthy fats, and additives with low nutrient density.

Nutrition

'Ultra-processed' products now half of all UK family food purchases

Exclusive: health experts warn increasing popularity of industrially-made food will lead to negative effects such as obesity and poor health



▲ Some of the UK's best-selling ultra-processed foods. Photograph: Jill Mead for the Guardian

Sarah Boseley Health editor

Americans Are Eating More Ultra-Processed Foods: How to Cut Down on Them



Fast food such as hamburgers are among the ultra-processed foods that people are eating more often. Evrim Ertik/Getty Images

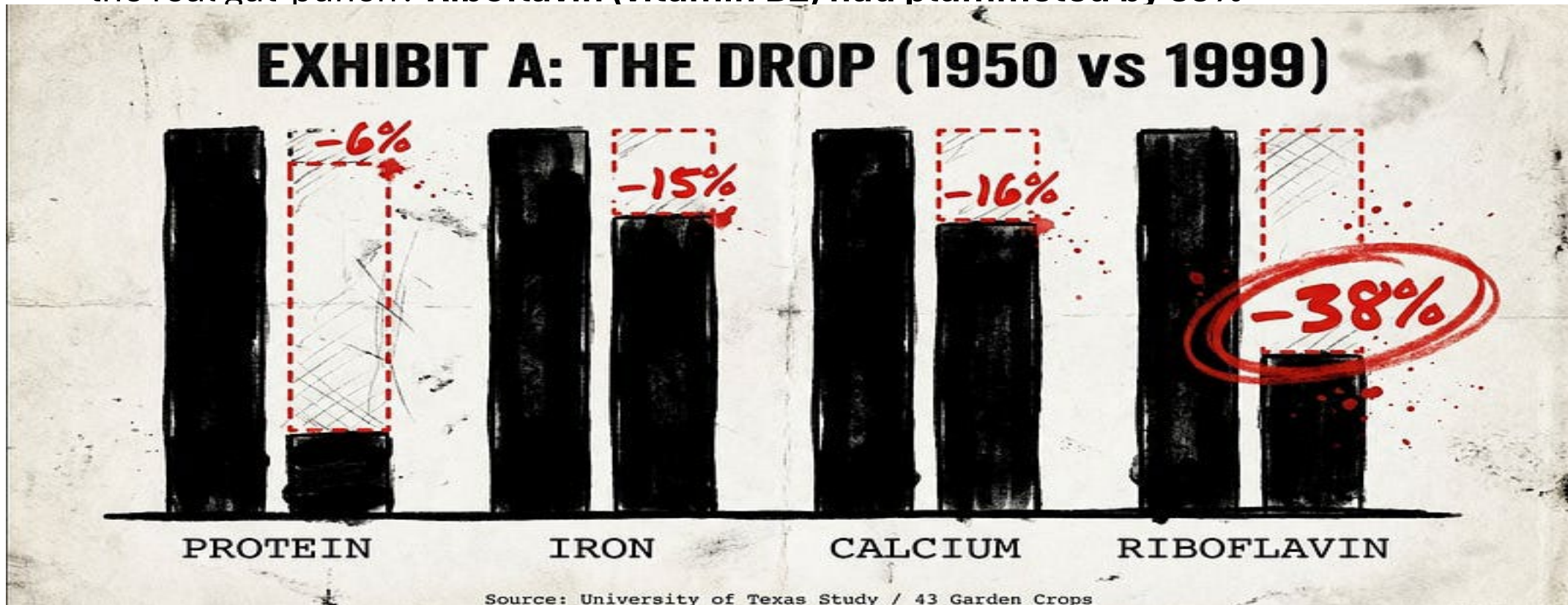
57% of US consumption
73% of the US food supply

UPF Consumption in the U.S.

- Ultra-processed foods make up approx.
 - **55% of daily calories** for Americans. ♦
 - Highest amongst children **~62%** of calories.
 - - ♦ UPFs are strongly linked to obesity, diabetes, cardiovascular disease and premature death in studies

Study: Since 1950 the Nutrient Content in 43 Different Food Crops has Declined up to 80%

- University of Texas analysis finds substantial nutrient losses in vegetables and grains between 1950 and 1999-
- the real gut-punch? Riboflavin (vitamin B2) had plummeted by 38%



Nutrition Loss in Vegetables & Fruits

Scientific analyses have documented declines in nutrient levels since the 1950s.

Nutrient	Vegetable/Fruit	% Decline*
Iron	Various vegetables	up to 50–80%
Vitamin A	Broccoli, parsley	30–60%
Calcium	Citrus varieties	~57–65%
Protein	Estimated across crops	~6% decline (historical data)

A man with dark, curly hair and a light beard, wearing an orange shirt, is looking directly at the camera. He is holding a large, round pizza in front of his chest. The pizza is topped with melted cheese, pepperoni, and mushrooms. The background is a simple indoor setting with a white wall and a brown door frame.

**luigi mangione
might go free
because of
pizza**

Overall Decline UHC stock

- **From ~\$610 (Dec 4, 2024) to ~\$280 (Early Feb 2026):**
- This is roughly a **54% decline** in share price over the period since Brian Thompson's death

US City Sues Ultra-Processed Food Companies, Seeking 'Restitution' for Health Costs

- The City of San Francisco has filed [a historic lawsuit](#) against 10 ultra-processed food (UPF) manufacturers, seeking “restitution and civil penalties” to help local governments to “offset astronomical health care costs associated with UPF consumption

Food for Thought: Who Is Really Responsible for America's Healthcare Crisis?

Anne T Kelly -Kelly & Kelly /Patrick & Patrick Insurance Services Inc

The assassination of UnitedHealthcare CEO Brian Thompson in December 2024 shocked the nation and triggered one of the most emotionally charged public reactions the healthcare industry has ever seen. Thompson was killed outside a Manhattan investor conference in what authorities described as a targeted attack. Soon afterward, alleged gunman Luigi Mangione released a two-page manifesto condemning the American healthcare system, accusing insurance companies of becoming “too powerful” and profiting while ordinary Americans suffered.

In his writings, Mangione posed a question that resonated with millions of frustrated Americans:

“How can the United States have the highest healthcare costs in the world, yet also experience some of the worst health outcomes and rising mortality among developed nations?”

It is a difficult question — and one that deserves an honest answer.

The media response that followed Thompson’s death was relentless. Within days, UnitedHealthcare became the symbol of everything Americans dislike about healthcare — denied claims, rising premiums, prior authorizations, administrative complexity, and corporate profits. Cable news panels, social media commentators, online activists, and political voices amplified a narrative portraying UnitedHealthcare as the primary villain behind America’s healthcare crisis.

But while public outrage focused almost entirely on insurers, the deeper causes of America's healthcare crisis received far less attention.

Because the uncomfortable truth may be this:

America does not merely have a healthcare problem. America has a chronic disease problem. And that distinction changes everything.

The Media “Assassination” of UnitedHealthcare

Following Brian Thompson's death December 4th 2024, UnitedHealth Group's stock price experienced a stunning collapse. Prior to the assassination, UnitedHealth traded near historic highs around \$610 per share. Over the following year, the stock fell dramatically to approximately \$280 per share in December 2025 — a decline exceeding 50%.

Yet something about this market reaction deserves closer examination.

Other major health insurers — including Cigna, CVS/Aetna, Elevance (formerly Anthem/Blue Cross affiliates), Centene/Health Net, and Humana — did not experience anything remotely close to the same level of destruction in shareholder value.

Cigna remained comparatively stable.

CVS/Aetna experienced volatility but avoided collapse.

Elevance and Centene fluctuated but did not suffer sustained investor panic.

If the healthcare industry itself were fundamentally collapsing, investors would likely have punished the entire sector equally. Instead, UnitedHealthcare became uniquely targeted — not only by public anger, but by a nonstop media narrative portraying the company as the face of America's healthcare failures.

In many ways, the financial destruction of UnitedHealth appeared driven not solely by business fundamentals, but by reputational damage amplified through relentless negative coverage. UnitedHealthcare became politically and culturally radioactive in a way that competitors did not.

The irony is that many of the forces driving healthcare costs are far larger than any single insurance company.

The Real Answer to Luigi Mangione's Question

Mangione's manifesto asked why America spends more on healthcare than any country in the world while experiencing worsening health outcomes and rising mortality.

The answer may be found not inside insurance companies — but inside the American food supply.

According to the course material from *Food for Thought* influenced by Dr Robert Lustig: *The Impact of Modern Diets on Healthcare Costs and Outcomes*, approximately 73% of healthcare spending is tied directly to chronic illness.

These illnesses include:

- Type 2 diabetes
- Obesity
- Cardiovascular disease
- Hypertension
- Fatty liver disease
- Metabolic syndrome

In his book *Metabolica*, Dr Lustig establishes metabolic syndrome as one of the primary drivers of escalating healthcare costs and poor health outcomes in the United States.

And what is driving metabolic syndrome?

Increasingly, scientific evidence points toward the modern American diet — particularly the explosion of ultra-processed foods (UPFs).

America's Diet May Be the Real Healthcare Crisis

The presentation highlights that approximately 55% of all daily calories consumed by Americans now come from ultra-processed foods. Among children, the number is even higher.

Ultra-processed foods include:

- sugary beverages
- packaged snacks
- fast food
- sweetened cereals
- processed meats
- refined baked goods
- ready-to-eat meals

These products are typically loaded with sugar, sodium, refined carbohydrates, unhealthy fats, preservatives, and chemical additives while containing very little nutritional value.

The result has been an explosion of:

- obesity
- insulin resistance
- chronic inflammation
- diabetes
- hypertension
- cardiovascular disease

At the same time, the nutritional quality of actual food has declined significantly. The presentation references a University of Texas analysis showing substantial nutrient losses

in fruits and vegetables since the 1950s, including a reported 38% decline in Riboflavin (Vitamin B2).

This may explain why the United States spends extraordinary amounts treating disease rather than preventing it.

America's healthcare system is remarkably advanced at expensive interventions:

- surgeries
- pharmaceuticals
- imaging
- hospital care
- specialty treatment

But it is far less effective at preventing chronic illness in the first place.

As a result, the country spends enormous sums managing diseases largely driven by lifestyle and nutrition while overall population health continues deteriorating.

That is the real answer to Mangione's question.

The Reality About Claim Denials

Media coverage following Thompson's assassination frequently highlighted stories suggesting insurers routinely deny care to maximize profits. Some reports implied that insurance companies deny overwhelming percentages of claims.

But the reality is far more complicated.

The vast majority of healthcare claims are ultimately paid. Many initial denials occur because of:

- incorrect billing codes
- incomplete documentation
- duplicate submissions
- provider office errors
- administrative processing issues

America's healthcare billing system is extraordinarily complex. Millions of claims are initially rejected each year simply because forms are filled out incorrectly or medical

coding requirements are not properly met by provider offices. After corrections and resubmissions, most claims are eventually approved and paid.

That does not mean unfair denials never happen — they absolutely do. But portraying insurers as intentionally refusing the majority of legitimate claims creates a distorted picture of a deeply complicated healthcare system involving hospitals, providers, pharmaceutical companies, government regulations, and administrative infrastructure.

The Legal Focus Is Now Shifting Toward Food Companies

Perhaps the most important development in the healthcare debate occurred quietly while public attention remained focused on insurers.

On December 2, 2025, the City of San Francisco filed a historic lawsuit against ten major ultra-processed food manufacturers seeking restitution for escalating healthcare costs associated with chronic disease.

The defendants included:

- Coca-Cola
- PepsiCo
- Kraft Heinz
- General Mills
- Nestlé
- Kellogg
- Mars
- Mondelez
- Post Holdings
- ConAgra Brands

San Francisco alleges that these companies knowingly engineered and aggressively marketed addictive ultra-processed foods despite mounting scientific evidence linking them to obesity, diabetes, cardiovascular disease, fatty liver disease, and metabolic illness.

Importantly, this was not the first lawsuit targeting ultra-processed foods.

In December 2024, law firm Morgan & Morgan filed a separate lawsuit on behalf of a Pennsylvania teenager alleging that ultra-processed foods caused him to develop Type 2 diabetes and non-alcoholic fatty liver disease. The suit accused food companies of intentionally designing addictive products and aggressively marketing them to children.

However, that case was dismissed in August 2025 because the court ruled that the plaintiff failed to sufficiently prove direct causation between specific food products and his illnesses. The judge also cited difficulty proving which ingredients allegedly created addictive effects and whether manufacturers intentionally engineered those effects in a legally actionable way.

Still, many legal analysts believe the Morgan & Morgan lawsuit opened the door for future litigation similar to the early tobacco lawsuits decades ago.

A National Conversation Long Overdue

The tragedy surrounding Brian Thompson exposed enormous anger toward America's healthcare system. But the public conversation that followed may have oversimplified the problem by focusing almost entirely on insurance companies.

The deeper issue may be that America is becoming progressively sicker.

If 73% of healthcare spending is tied to chronic disease, and if ultra-processed foods are major contributors to those illnesses, then America's healthcare crisis may have less to do with insurers denying claims and far more to do with the metabolic health of the population itself.

The media may have financially "assassinated" UnitedHealthcare after Brian Thompson's death, but the underlying drivers of healthcare inflation remain largely unchanged.

Until the nation seriously addresses:

- nutrition
- ultra-processed foods
- metabolic syndrome
- obesity
- chronic disease prevention

...healthcare costs will likely continue rising no matter which insurance company is blamed.

California's Healthcare Affordability Office Claims Power to Punish Overspending Hospitals

September 8, 2026 | Source: [CalMatters](#), by Ana B. Ibarra

"This story was originally published by [CalMatters](#). [Sign up](#) for their newsletters."

Year after year Californians watch their health bills increase faster than their wages — for some, to the point where care becomes unaffordable. Four years ago, the state created an office to curb that trend. Now, the California Office of Health Care Affordability is gaining new power to control costs.

Its board last week adopted penalties for hospitals, physician groups and insurers that exceed state spending caps — among the strictest in the country.

Under the approved framework, violators will pay up to 125% of the amount they spend over the limit. Currently the state caps annual spending growth at [3.5%](#), dropping to 3% in 2029. Certain hospitals deemed “high cost” face even stricter limits.

Over the last decade, [health spending grew](#) by an average of 6% a year.

The soonest hospitals can face **finest is 2028**. In **October, the state will release enforcement guidelines**.

State officials say the penalties are a last resort. Providers who miss spending targets will first get technical assistance and go through a performance improvement plan; fines apply only if they violate that plan. The framework gives the office discretion to set penalties anywhere from 0% to 125% of the overage, depending on individual circumstances.

“The hope is that by imposing these penalties... we’ll begin to reduce the rate of growth of spending on healthcare to make it more affordable for Californians,” said Stephen Shortell, professor emeritus at the UC Berkeley’s School of Public Health and a member of the office’s advisory committee.

Hospitals and others protest

Hospital executives are the most vocal critics. That’s because the Office of Health Care Affordability [narrowed in on hospitals](#) as “a high-impact area to improve efficiency and affordability.” Hospitals account for [about a third](#) of healthcare spending.

But hospitals say some of their spending is out of their hands. Barry Arbuckle, executive chairman at MemorialCare health system and a member of the office’s advisory

committee, says hospitals have little control over costs related to labor, [seismic related construction](#), and pharmaceuticals.

“I’ve got drugs in my children’s hospital that are over \$1 million a dose. Those are then passed through as hospital costs. So people think, ‘Oh, the hospital is really expensive.’ But the hospital has nothing to do with that drug cost,” Arbuckle told CalMatters.

Arbuckle **ran Long Beach Memorial’s spending data for 2022-23 through the state’s penalty formula. Had the rules been in effect then, he estimated the hospital could have faced a \$27 million fine.** “That’s just beyond belief,” he said.

Industry groups also object to the amount of discretion the office has, calling the 0%-to-125% penalty range too broad. And they warn the caps could hurt patients.

“Under the current growth targets, the primary way for hospitals to reduce costs is to reduce services and limit access,” Angus Cochran, chief of community support services at Washington Health, a hospital in Fremont, told board members last week.

Washington Health is one of [seven hospitals](#) deemed particularly “high cost” by the Office of Health Care Affordability. These hospitals have stricter annual growth limits – their spending growth is currently capped at 1.8%, dropping to 1.6% by 2029.

The **California Hospital Association** [sued last year to block the spending caps](#). The association argued that the office “only focused on capping hospital spending, without ensuring its cost targets would not harm patients or the availability of hospital services,” as required by statute. In the lawsuit, hospitals say that health insurers began negotiating reimbursement rates based on the office’s spending cap rather than the actual cost of care. That suit is still pending in the San Francisco County Superior Court.

Hospitals are also asking for more clarity on how the office will weigh outside cost pressures, including a likely rise in uncompensated care for **uninsured patients as federal healthcare cuts take effect. These cuts combined with state changes are projected to nearly double** [California’s uninsured rate](#) — a shift that could push more people into emergency rooms.

The California Association of Health Plans, which represents insurers, raised similar concerns in a statement, pointing to [recent changes in a tax](#) the state charges private health plans.

“For this framework to succeed, it must distinguish between spending growth that can be addressed and spending growth driven by broader market and policy realities,” the group said in a statement. “Unfortunately, many critical questions were not answered, leaving great uncertainty and significant work ahead.”

Getting serious about healthcare costs

Board members said the state’s affordability crisis demands urgent action.

Nearly 60% of Californians [report skipping or delaying care](#) because they can’t afford it, and four in 10 carry medical debt. Rising premiums are also pushing more people to [drop their health plans](#) altogether.

Eight other states have also adopted health spending benchmarks, but because most don’t enforce them, [research shows](#) that they have not made a difference in hospital prices or premiums.

“There has to be a penalty framework that is meaningful,” said Christine Eibner, a senior principal economist at the think tank RAND. “If it’s too small or if it’s not enforced, then it wouldn’t be enough motivation.”

Experts caution that relief will take time. Shortell said many hospitals likely won’t meet the state’s spending limits in the first year, with real progress emerging only when the state and industry adjust to work together.

“This is getting from home plate to first base,” he said. “I would look to three or four years from now to begin to see this having some impact.”

Consumers are hungry for relief. Claudia Garcia, a San Francisco hotel worker and mother of two, has gone on strike over health insurance because she can’t go without it – her son has severe asthma, and needs his inhaler and medication refills.

Garcia belongs to Unite Here, the hotel and restaurant workers’ union. Unions have been a forceful voice for controlling health spending because these costs, they argue, eat into potential wage increases. That’s backed up by [UC Berkeley Labor Center research](#), which shows that when employers spend more on premiums, they spend less on raises.

“We should not have to fight every year just for our healthcare,” Garcia said. She hopes that if the state can control health costs, maybe her union can pivot to fighting for higher pay.

Beth Capell, a lobbyist with the consumer advocacy group Health Access California, said the goal is not to punish struggling providers.

“It is not our goal to bankrupt a small rural hospital,” Capell told the board last week. “But we are interested in penalties that will help to convince large, wealthy health systems and insurers that the state of California is serious about slowing the growth of healthcare costs.”

California Weighs Penalties For Healthcare Providers That Don't Rein In Costs

August 25, 2026 | Source: [Fierce Healthcare](#), by Claudia Boyd-Barrett

California is weighing stiff penalties for hospitals and other healthcare entities that don't stay under state spending limits, potentially levying hundreds of millions of dollars in fines if these providers don't take steps to rein in rising healthcare costs.

If the state Office of Health Care Affordability adopts the fines next week, hospitals, medical groups, insurers, and others could face penalties that amount to as much as 125% of the total they spend above the state's annual growth targets.

The penalty proposal comes after healthcare entities in California were asked to limit growth by 3.5% last year and ramp down to 3% by 2029.

Seven hospitals that state officials consider particularly expensive face even smaller growth targets: 1.8% in 2026, dropping to 1.6% by 2029.

Consumer advocates argue that state financial deterrents are critical to bring relief to millions of Californians struggling with high insurance premiums and out-of-pocket expenses. **Hospitals accounted for [40% of the increase in U.S. health spending from 2022 to 2024](#), compared with 11% from retail prescription drugs.** But adding teeth to those targets sets up a fight with the powerful hospital industry, which has a [pending lawsuit](#) challenging the spending limits as unreasonable. Hospitals warned that they will cut back on vital services, including in emergency rooms, obstetrics, and behavioral health.

Healthcare industry representatives said the state affordability office hasn't accounted for year-to-year volatility or other factors beyond the industry's control, such as rising minimum wages, state earthquake retrofit requirements, and expensive new drugs.

"They're building the plane while flying it," said Ben Johnson, group vice president for financial policy at the California Hospital Association. "We know

improvements in affordability are needed, but we have serious questions about how and about **what the unintended consequences could be under OHCA's rather stringent approaches.**

When calculating penalties, California regulators would consider various factors, including a healthcare entity's financial situation, its market impact, and the gravity and number of offenses, according to a [board presentation](#) in June. Entities would first be given opportunities to implement performance improvement plans to bring their spending into line before penalties are imposed. For those that don't comply, the board is considering **penalties of \$10,000 a day or a flat \$500,000.**

The penalties, which the affordability office's eight-member board is required by [state law](#) to adopt, are slated for discussion and a potential vote at the board's [Aug. 26 meeting](#). **The soonest healthcare providers would be subject to penalties is 2028**, because it's expected it will take two years to collect and publicly report spending data to measure against the 2026 targets. The state is still collecting data on how entities performed against the 2025 targets, which aren't enforceable, according to Andrew DiLuccia, a spokesperson for the California Department of Health Care Access and Information.

States set targets

California is one of at least eight states that have set spending targets as part of an expanding effort to curb soaring healthcare spending across the nation. Connecticut, Massachusetts, Oregon, and Rhode Island have also authorized the use of some type of financial penalty. The specifics of each vary widely, although so far no state has applied them.

A [survey last year](#) by the California Health Care Foundation found that **4 out of 10 state residents said they had medical debt, and 6 in 10 reported that they or a family member had skipped or delayed medical care in the previous 12 months because of cost.** Nationwide, about [half of adults](#) say it is difficult to afford healthcare costs.

After Rosalyn Book got stitches on her chin, the elementary school teacher received a \$15,000 ER bill from a local hospital, despite having insurance. Many teachers in her district leave because they can't afford the cost of healthcare and insurance premiums, she said.

"The healthcare charges are just insanity, and what we get as patients for the care, it's not the best either," said Book, president of the Monterey Bay Teachers Association. "If you're a working, regular individual in terms of how much you make, the cost of living and especially the healthcare is just not doable."

Meanwhile, **hospitals are warning there's a risk of more closures.** According to Yale University's [Health Care Affordability Lab](#), **17 hospitals have closed in the state since 2016, compared with only six openings.**

Hospitals and other healthcare providers have said the proposed multimillion-dollar penalties are too steep and could destabilize their operations at a time **when they're facing funding challenges, including massive federal cuts to Medicaid, the end of enhanced federal subsidies for Affordable Care Act plans, and a sharp rise in uninsured patients. The One Big Beautiful Bill Act, passed by congressional Republicans and signed by President Donald Trump last summer, is expected to reduce federal Medicaid spending by more than \$900 billion—including by \$30 billion in California—and increase the rolls of the uninsured in the U.S. by 10 million people over a decade.**

Johnson said **hospitals raise prices on commercial payers to offset the expense of treating uninsured patients, as well as patients on Medicaid and Medicare**, which can reimburse care providers at rates that fall short of treatment costs.

In addition, said Anete Millers, vice president of legal and regulatory affairs at the California Association of Health Plans, tax increases on managed-care plans recently [approved by state legislators](#) to offset federal Medicaid cuts will force plans to increase their prices for consumers.

“Some spending pressures originate outside of the control of health plans and are the result of public policy decisions rather than underlying changes in healthcare utilization or efficiency,” she told the affordability office’s [board at the June meeting](#).

Kristof Stremikis, the director of market analysis and insight at the nonprofit California Health Care Foundation, acknowledged that external forces can drive costs but said that plenty of unnecessary spending is within the healthcare system’s control, such as administrative waste and duplicative tests and procedures. [Almost 25%](#) of U.S. healthcare spending is considered wasteful, according to [research published in JAMA](#).

Elizabeth Mitchell, a former Office of Health Care Affordability board member whose term ended in May, agreed.

“Every business has external challenges,” she said. “The hospital industry has not taken accountability to actually manage costs. I have heard those excuses for decades, and at some point, they have to make changes.”

First step to bring down costs

[An analysis](#) of five states with cost growth benchmarks, published in June, found that some have succeeded in modestly slowing healthcare spending, particularly those with enforcement mechanisms. However, **spending growth in most states has still [exceeded the targets set](#)**.

Jeremy Vandehey, a consultant with the Peterson-Milbank Program for Sustainable Health Care Costs, said setting benchmarks and collecting data to analyze which entities meet them is only a first step. Armed with information about what and who is driving up costs, states are more empowered to take additional action, such as imposing penalties or regulating prices, to bring down costs, he said.

“I don’t think anybody in any state is declaring victory on healthcare costs, but I wouldn’t say that that means the programs are a failure,” Vandehey said. “In all of these states, there’s much more robust conversations happening about, OK, we haven’t solved our cost crisis, so we need additional action.”

The Healthcare Cost Collision

Why California carriers, hospitals, employers and employees are all feeling the squeeze

By Anne Kelly

Thesis: California is trying to slow healthcare spending growth to 3.5% in 2025-2026 and 3.2% in 2027, while hospitals seek higher commercial reimbursement, carriers absorb pharmacy and utilization trend, federal coverage subsidies are shifting, and employers are receiving renewals that feel disconnected from the state affordability target.

At first glance, the 2026-2027 renewal cycle can look like another painful year of medical inflation. But the more carefully one looks, the more it appears that multiple pressure systems are colliding at once. The collision is especially visible in California, where the Office of Health Care Affordability (OHCA) has begun putting a public benchmark around what used to happen mostly behind closed doors: how fast healthcare spending should be allowed to grow.

This article argues that the current market friction is not simply a carrier-pricing story or a hospital-pricing story. It is a deeper affordability crisis in which provider reimbursement, pharmacy inflation, chronic disease, public-payer pressures, Covered California subsidy changes, Medi-Cal eligibility changes, and employer risk-pool dynamics are converging. The result is a market in which hospitals and carriers are increasingly “at each other’s throats” when contracts come up for renewal, while employers continue to receive Q4 2026 and Q1 2027 renewal increases that often exceed the state’s cost-growth target by a wide margin.

1. The OHCA benchmark: a new public yardstick

OHCA’s statewide spending target begins at 3.5% for performance years 2025 and 2026, drops to 3.2% for 2027 and 2028, and reaches 3.0% in 2029. The target is not a premium cap. It is a per-capita health spending growth target intended to signal that healthcare spending should not continue to grow faster than California household income.¹

That distinction matters. Employers buy premiums, not abstract medical trend. A carrier renewal can be driven by more than provider reimbursement: pharmacy costs, utilization, risk adjustment, population morbidity, reserves, administrative costs, benefit mix and product-specific experience all play a role. Still, the OHCA target changes the conversation. It creates a public affordability benchmark against which carriers, hospitals and large physician organizations can increasingly be judged.

Performance year	OHCA statewide target	Why it matters
2025	3.5%	First target year; public reporting begins.
2026	3.5%	Target remains at 3.5%; enforcement begins with 2026 performance.
2027	3.2%	Target tightens just as 2027 renewals and federal coverage changes hit the market.
2029	3.0%	Long-term affordability endpoint.

2. The baseline: carriers were already above the target

OHCA’s Baseline Report: Health Care Spending Trends in California, 2022-2023 established the pre-target landscape. Among major commercial carriers, medical expense growth was already generally above the later 2025 target. In simplified terms, the market was operating around 4% to 6.5% commercial total medical expense growth before the 3.5% target took effect.²

Carrier / plan	2022-2023 commercial TME PMPY growth	Gap vs. 3.5% target	Interpretation
Kaiser Permanente	4.3%	+0.8 pts	Closest among major carriers; vertically integrated model may matter.
Anthem Blue Cross	5.5%	+2.0 pts	Material gap before OHCA target period.
Blue Shield of CA	5.2%	+1.7 pts	Above target; active provider negotiations followed.
Health Net / Centene	3.9%	+0.4 pts	Closest traditional carrier in this comparison.
UnitedHealthcare	6.5%	+3.0 pts	Largest gap among the major carriers discussed.
Aetna	5.1%	+1.6 pts	Above target.

This does not mean those carriers “failed” OHCA in 2023. The target had not yet taken effect. It does mean California is asking the market to slow a trend that was already running meaningfully above the target before the measurement era began.

3. Why hospitals and carriers are fighting harder

The hospital-carrier conflict is driven by a simple arithmetic problem. Hospitals argue that labor, nurses, physicians, drugs, supplies, technology, capital costs, seismic and regulatory compliance, and public-payer reimbursement pressure are all rising. Carriers argue that they cannot accept provider price demands that would push employer premiums and consumer costs even higher, particularly while the state is measuring the system against a 3.5% or 3.2% target.

The contract table is where those pressures collide. If a hospital system seeks a large commercial reimbursement increase, a carrier has only a few options: accept the increase and eventually reflect it in premiums; reject the increase and risk network disruption; or accept part of it and try to recover savings elsewhere through utilization management, narrow or high-performance networks, prior authorization, site-of-care management, pharmacy management or value-based contracting.

4. Public California contract disputes show the pressure

The current contract friction did not suddenly appear with the 2025 OHCA target. Public negotiations were already escalating in 2023 and 2024, then continued across a wider group of major California systems in 2025 and 2026. The timeline below is not an exhaustive census of every confidential negotiation; it highlights well-documented disputes and threatened network terminations that show the trend.

Carrier	Hospital / provider system	Period	Publicly identified issue
Blue Shield of CA	Providence	2023-2024	Providence issued a termination notice in Oct. 2023; more than 110,000 members faced possible out-of-network status June 1, 2024. Blue Shield said the requested rates were not sustainably affordable; agreement followed in May 2024.

Carrier	Hospital / provider system	Period	Publicly identified issue
Blue Shield of CA	Stanford Medicine	2024	After extensive negotiations, a new agreement became effective Sept. 1, 2024 for commercial HMO/PPO. Some Individual/Family Plan and Covered California Stanford access remained out of network.
Anthem Blue Cross	Providence	2024 -> 2025	Providence said it sought fair and sustainable reimbursement rates; a Jan. 1, 2025 disruption was avoided when the parties reached agreement in Dec. 2024.
Anthem Blue Cross	Sutter Health	2024 -> 2025	A Jan. 1, 2025 network termination was threatened during negotiations; the parties reached terms and later announced a multi-year agreement.
Anthem Blue Cross	Stanford Medicine	2025	A Sept. 1, 2025 termination was threatened. A multi-year agreement was reached Aug. 25, preserving HMO, EPO and PPO access.
Blue Shield of CA	UC Health / UCSF	2025	UC Health threatened termination while seeking higher reimbursement. Negotiations were extended and an agreement was reached in July 2025.
Blue Shield of CA	Hoag	2025	A June/July 2025 commercial termination was possible during negotiations. Blue Shield publicly cited affordability and Hoag facility costs; a new agreement preserved commercial access.
Blue Shield of CA	Sutter Health	2025	A major statewide renewal was completed early, before year-end expiration. It is included as a contrast: a large negotiation that did not escalate into the same public standoff.
Blue Shield of CA	Community Medical Centers / CHP	2026	The system went out of network Feb. 1, 2026 after negotiations failed. Blue Shield cited unreasonable rate demands and warned of premium effects on Covered California, CalPERS and employer plans.
Anthem Blue Cross	Scripps Health	2026	A major 2026 negotiation carried an Oct. 1 termination risk. Anthem publicly said Scripps sought 15%-20% annual price increases.
Blue Shield of CA	Providence	2026	A new statewide agreement announced July 31, 2026 maintained commercial HMO/PPO and Medi-Cal access across Providence hospitals and physician organizations.

The trend is the important point. The 2023-2024 Providence-Blue Shield confrontation predates OHCA enforcement, so OHCA cannot fairly be described as the cause of these disputes. But by 2025-2026, multiple large California systems were simultaneously pressing Anthem and Blue Shield over reimbursement and network terms just as the state began measuring spending growth against 3.5% targets. The Scripps-Anthem dispute makes the arithmetic particularly visible: a publicly alleged 15%-20% annual provider price request is not directly comparable with OHCA total expenditure growth, but it demonstrates the gap carriers may be trying to reconcile at the negotiating table.

Timeline sources: *Blue Shield of California and Providence (2024, 2026); Providence and Anthem (2024); Blue Shield and Stanford Medicine (2024); Stanford Medicine and Anthem (2025); Blue Shield and UC Health, Hoag and Sutter (2025); Blue Shield and Community Medical Centers (2026); Anthem and Scripps (2026).*

5. Kaiser's vertical model: not immune, but structurally different

Kaiser Permanente is not exempt from cost pressures. It faces labor, drug, technology and utilization pressures like every other healthcare organization. But its model is structurally different. Kaiser describes itself as combining health coverage and care delivery into one coordinated experience, with the health plan financing care delivered through Permanente physicians, hospitals and medical facilities. It also describes its physicians as salaried and the model as aligning incentives around coordinated care rather than volume.⁷

That difference matters. A traditional carrier must negotiate rates with independent hospital systems and physician groups for access to its network. Kaiser's core delivery system is more vertically integrated. That does not automatically make Kaiser cheaper in every market or every product, but it may help explain why Kaiser often appears to have somewhat lower trend in certain public comparisons. The larger point is that cost containment may increasingly depend not only on negotiated discounts, but on care model design.

6. Q4 2026 and Q1 2027 renewals: what is weighing on small and large group

For Q4 2026 and Q1 2027, brokers should be prepared to explain that renewal increases are not being driven by one factor. They are being driven by a stack of pressures.

Pressure	Small group impact	Large group impact
Hospital/provider reimbursement	Directly affects fully insured rates; smaller employers have less negotiating leverage.	Large employers can use plan design, network strategy and purchasing leverage, but still face hospital system pricing.
Pharmacy and specialty drugs	High-cost claims can materially affect community-rated or pooled trend; GLP-1 and specialty utilization is a visible concern.	Large employers increasingly scrutinize GLP-1 coverage, specialty management, PBM terms and formulary strategy.
Utilization and acuity	Sicker pooled populations drive higher rates; preventive gaps can become claims.	Large employers see chronic disease and high-cost claims in experience reporting.
Level-funded migration	Healthier small groups may leave fully insured pools, worsening morbidity for those who remain.	Less direct; many large employers are already self-funded.
Federal coverage changes	Covered CA subsidy loss and Medi-Cal churn can shift employee decisions and potentially payer mix.	Employers with hourly or lower-wage populations may see more enrollment pressure or coverage gaps.
OHCA pressure	Not a premium cap; may intensify carrier-provider contracting friction.	May increase transparency and pressure around hospitals, carriers and provider organizations.

National small-group filings show the same pattern. KFF's review of 2027 filings found a median proposed small-group premium increase of about 14%, with insurers citing rising medical prices and utilization, high-cost specialty drugs, GLP-1 utilization, behavioral health utilization, declining enrollment and worsening risk-pool morbidity; some filings specifically attribute the worsening fully insured risk pool to the rise of level-funded arrangements among healthier small employers.⁸

Aon's 2027 employer forecast points in the same direction for the broader employer market: U.S. employer healthcare costs are projected to rise 9.5%, with utilization, chronic conditions, high-cost claims, specialty medications, GLP-1 therapies and even provider coding/documentation technology contributing to cost pressure.⁹

7. Covered California and Medi-Cal changes add another layer

The individual market and public coverage changes are not the same thing as employer renewal trend, but they are part of the same healthcare financing ecosystem. Covered California announced a preliminary weighted average rate increase of 9.9% for 2027, with Anthem at 13.0%, Blue Shield at 12.5%, Health Net at 13.2%, Kaiser at 6.7%, and the overall marketplace at 9.9%. Covered California attributed the increase to rising healthcare costs, pharmacy expenditures, broader industry challenges, and federal actions including the failure to extend enhanced federal tax credits.¹⁰

Covered California had already reported the impact of the subsidy change in 2026: new enrollment was down 32%, middle-income renewals that lost all enhanced premium tax credits had a 22% cancellation rate, and more than 130,000 renewing Californians switched to Bronze plans.¹¹

At the same time, DHCS states that H.R. 1 Medi-Cal changes are expected to affect up to two million Medi-Cal members. Beginning January 1, 2027, certain expansion adults face work or community-engagement rules unless exempt, and some members must renew Medi-Cal every six months rather than annually.¹²

These changes may affect employer markets indirectly. Some lower-wage employees who lose or churn off Medi-Cal may look to employer coverage. Others may remain uninsured. Hospitals may experience payer-mix pressure and uncompensated-care concerns, while carriers and employers may see enrollment behavior change. These are emerging risks rather than fully proven causes of current employer premium increases, but they are important to watch.

8. The underbelly: chronic disease and the American diet

The financing conversation can miss the deeper utilization question: why are so many Americans consuming so much healthcare in the first place? CDC states that 90% of the nation's \$5.3 trillion in annual healthcare expenditures are for people with chronic and mental health conditions.¹³ That means any serious affordability conversation must include chronic disease, not merely unit prices.

The post-World War II and especially post-1970 food environment changed dramatically. USDA data show that between 1970 and 2003, food available for consumption increased 16%, calories increased by 523 calories per person per day, added fats and oils rose 63%, grain consumption rose 43%, sugars and sweeteners rose 19%, and corn sweetener consumption increased 400%.¹⁴ A later USDA review noted that about two-thirds of U.S. adults were overweight or obese in 2003-2004 compared with 47% in 1976-1980, and that the adult obesity rate more than doubled from 15% to 32%.¹⁵

It would be too simple to say the American diet is the only cause of the healthcare cost crisis. Aging, smoking history, inactivity, alcohol use, environmental exposure, socioeconomic conditions, administrative complexity, medical prices, provider consolidation, technology and drug innovation all matter. But it is reasonable to argue that population health is the upstream cost driver that makes every downstream financing problem harder.

9. The broker's message: premium is the symptom, disease burden is the cause

For employers, the renewal conversation often begins and ends with the percentage increase. But brokers can add value by explaining the chain underneath the number:

Poor population health and chronic disease -> higher utilization -> higher medical and pharmacy claims -> hospital revenue pressure and carrier claims pressure -> more contentious provider negotiations -> higher employer premiums and employee cost sharing.

If the market only negotiates lower prices after people are already chronically ill, it may slow trend but it will not cure the affordability problem. Long-term healthcare cost containment must include primary care, nutrition, metabolic health, obesity prevention, diabetes reversal and prevention, behavioral health, musculoskeletal health, medication adherence, early cancer detection and better site-of-care decisions.

Conclusion: California is entering a healthcare affordability stress test

OHCA did not create the healthcare cost problem. Hospital consolidation, drug costs, chronic disease, utilization, public-payer shortfalls, employer risk-pool erosion and administrative complexity were already present. But OHCA may be forcing the conflict into the open by placing a public target on spending growth at the same time carriers, hospitals, employers and consumers are all under stress.

The question for California is not simply whether the state can impose a 3% cost-growth trajectory. The question is whether the healthcare system can change enough to live within that trajectory. That requires more than rate negotiation. It requires care-model redesign, pharmacy strategy, primary-care investment, administrative simplification, better use of technology, and a far more serious commitment to improving the metabolic and chronic-disease profile of the population.

For brokers and consultants, this is the story behind the renewal: premiums are the visible number, but the battle underneath is over who absorbs healthcare inflation that remains far above the affordability target. The broker who can explain that larger system collision will be better equipped to guide employers through the difficult 2026-2027 renewal cycle.

About the Author



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Anne T. Kelly is President of Kelly & Kelly Insurance Services/Patrick & Patrick Insurance Services. Her formal education as a Cost Accountant gives her a distinctive framework for interpreting the financial and compliance implications of employee benefits, including the Affordable Care Act's Employer Shared Responsibility rules. She has more than 25 years of experience in the sales and administration of employee benefit programs, with particular expertise in eligibility, employer reporting and ACA compliance.

Anne is a frequent speaker and educator for CAHIP and ADOMA, presenting on topics including Healthcare Affordability and the forces driving medical premiums; the Affordable Care Act and employer reporting requirements; tax write-offs and the tax treatment of benefits through payroll versus individual tax returns; and California Pay Transparency requirements. She is also an approved California Department of Insurance instructor on Disability Insurance and Section 125 plans, as well as Healthcare Cost crisis and has spoken to insurance-industry and employer groups throughout California.

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September 15, 2026

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

Subject: CHA Comments for the September 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 September 2026 board meeting.

In August, the board approved the most egregious spending target penalty structure in the country. It did so before telling hospitals how their spending will be measured, what constitutes a violation, what compliance with a performance improvement plan (PIP) looks like, or how corrected financial data will be handled.

The August board discussion nevertheless illuminated two key facts about the purpose of those penalties: that they are reserved for entities that both exceed the target and fail to cooperate, and that a good-faith attempt to improve performance that falls short of the projected savings is an entirely different matter from a refusal to participate. **CHA asks the board to meaningfully codify those sentiments into regulation, and to resolve the measurement and data questions that remain open despite the fact that the first enforcement year is already complete for hundreds of hospitals;** this letter details six key areas where the board has still failed to provide clear direction.

Payments Set Too Low Produce Service and Staffing Cuts, Not More Efficient Care

At the August 26 board meeting, one board member pointed to 2008 MedPAC evidence that hospitals responded to Medicare payment reductions by changing their cost structures, and framed the underlying question as whether hospital cost structures are exogenous or are instead, to a meaningful degree, within hospital control, noting that OHCA's work takes the latter view. Director Landsberg added that the office will rely on entities to come forward and quantify the effects of federal and state policy changes, like those

stemming from enactment and ongoing implementation of the One Big Beautiful Bill Act (OBBBA; Public Law 119-21).

Hospitals do adapt to financial pressure; that is not in dispute, and California hospitals have been adapting for years. The question is which costs they can adapt to, how quickly, and at what point those reductions begin to affect access, quality, and outcomes. **Given the aggressiveness of both the previously promulgated targets and the penalty structure approved by the board in August, many California hospitals will exhaust the reductions they can absorb without affecting patient care in the first year of progressive enforcement.**

The same body whose evidence was cited in the board discussion has spoken to the other side of this question. In its June 2026 Report to Congress, MedPAC warns that payments set too low threaten provider participation and reduce beneficiaries' access to care, and that inadequate payment rates can contribute to lower-quality care and worse outcomes.¹ Peer-reviewed literature is consistent with that warning: a report analyzing impacts from the Balanced Budget Act of 1997 found that Medicare payment reductions had long-term effects on patient outcomes and may widen quality disparities across hospitals.²

[CHA's August letter](#) supplied the real-world illustration of what “adjusting the cost structure” looked like in Rhode Island, which also pursued aggressive price regulation. Rhode Island's affordability standards produced an 18.4% reduction in registered nurse staffing per bed and a 22.4% reduction in all non-physician staffing per bed by 2022, accompanied by wage reductions of 6.9% and 9.4%, respectively.³ That is what the best available evidence tells us adaptation to revenue restrictions looks like.

California hospitals cannot adapt the same way. Nurse-to-patient ratios and the state's health care worker minimum wage prevent the staffing and wage reductions Rhode Island hospitals used to absorb the pressure. When those levers are unavailable, the adjustment falls on services — and on the access on which Californians across the state rely. That is the exact outcome the Legislature directed this office to avoid, and it is why the enforcement regulations must sufficiently define, in advance, the factors and adjustments that separate spending growth a hospital can control from spending growth it cannot.

Hospitals Still Do Not Know What Triggers Enforcement

Following the board's votes on penalty scope and range, the discussion of PIP guidance exposed both a sequencing and a volume problem. In response to one board member's questions on whether every entity that exceeds the target would be required to submit additional information, staff indicated that statute affords every entity a 45-day opportunity to submit additional information and data and that OHCA will notify every entity of an initial determination that it exceeded the target. The office has now set penalties before it has told hospitals how this exceedance will be determined.

Earlier in the meeting, board discussion had raised a related problem — whether an entity could be penalized for exceeding the target on a single line of business. Measuring and enforcing separately by market, one board member observed, places entities in “triple jeopardy” — assessed on the same underlying performance across

¹ Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy (June 2026), p. 12.

² Wu VY, Shen YC, Health Services Research 49, no. 5 (2014): 1596. <https://doi.org/10.1111/1475-6773.12185>

³ Whaley, Arnold, et al., Health Affairs (June 2026). <https://doi.org/10.1377/hlthaff.2025.01548>

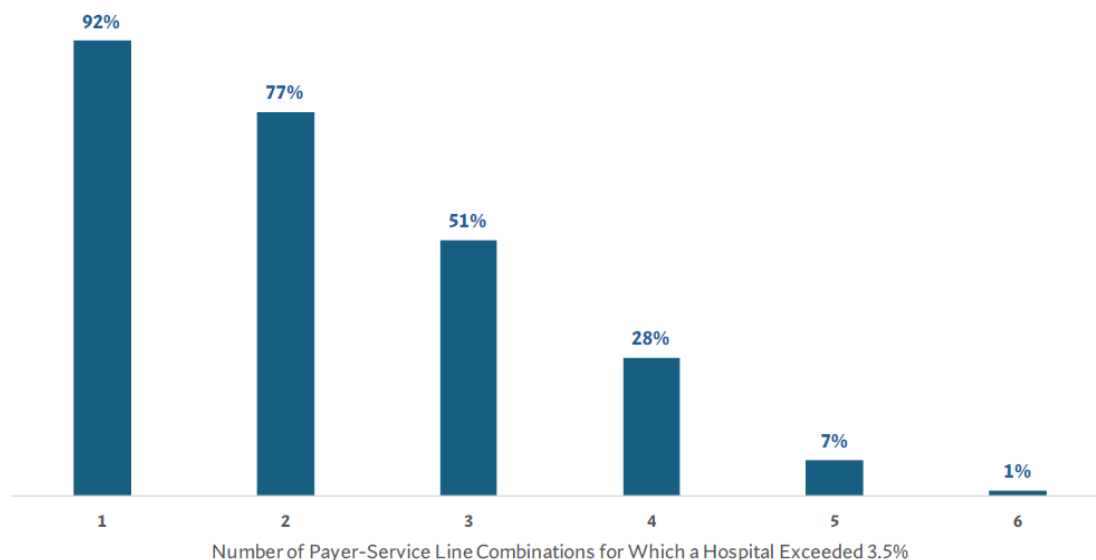
three payer markets. For hospitals, the exposure is not triple; instead, they could be found in violation on up to six different payer-service line combinations, a result of OHCA's intention to measure hospitals separately for inpatient and outpatient services in addition to the three payer markets.

The practical result is that nearly any adjustment a hospital makes in response to the targets creates penalty exposure somewhere else — including adjustments this board should want to encourage. **For example, a hospital that shifts care from the inpatient setting into lower-cost outpatient settings mechanically increases its measured outpatient spending growth, and could be found in violation on that line even as its total spending growth falls below the target.**

The scale of that exposure is not hypothetical. For hospitals, using OHCA's own 2022-23 data, if the target were applied separately to each payer and service line combination, 326 of 356 hospitals— 92% — would have triggered enforcement. Rather than a functioning enforcement program, OHCA has created a program that will have to exempt nearly every hospital through unwritten discretion, exercised after the fact.

Nearly Every Hospital Would Exceed the Spending Target for at Least One Payer-Service Line

Percent of Hospitals That Would Have Exceeded 3.5% for One, Two..., and Up to All Six Payer-Service Lines



Data from 2022-23. Payer-service lines reflect all possible combinations of payers and service lines. Examples: Medicare outpatient and commercial inpatient.

Hospitals are in the first enforcement year now (it has already concluded for the more than 150 hospitals whose fiscal year ended on or before June 30, 2026) and they cannot answer, let alone begin to plan for, any of the following questions:

- How performance will be measured across payer and service lines, and whether inpatient and outpatient spending will be assessed separately or together
- What constitutes a violation of the spending target
- How resubmitted and updated financial data will be incorporated into a measurement year

- Which entities would move from the pool of entities that exceeded the target into technical assistance, and which would move from technical assistance into a PIP
- What compliance with a PIP requires, and what constitutes failure of a PIP
- How the enforcement considerations and penalty justification factors would be applied
- Whether performance will be judged on a single year or across multiple years

[CHA's July 31 letter](#) set out three potential structural fixes that would reduce enforcement to a narrower and thus more workable population. The first is on this month's agenda. Hospitals ask that all three be addressed:

- **Conjoin inpatient and outpatient spending into a single measure.** Averaging the two growth rates, weighted by service line patient revenue, would reduce the number of hospitals exceeding a hypothetical 3.5% target on their commercial line in 2023 from 354 to 167. Enforcing only where both service lines exceed the target would reduce it to 90.
- **Enforce only against entities that exceed on both their commercial and all-payer lines**, so that enforcement reflects payer mix, cross-subsidization, and the coverage losses from OBBBA already underway.
- **Assess compliance on a multiyear basis**, so that hospitals do not cycle in and out of compliance on measured volatility that bears no relationship to their efforts to meet the target.

Hospitals also ask the office to promulgate objective criteria for the two selection decisions that matter most: which entities would move from the exceedance pool into technical assistance, and which would move from technical assistance into a PIP. Board members made the same request in August, asking the office to set out guidelines and standards in advance so that broadly similar situations are handled in a consistent manner and entities know what to expect. As that discussion noted, uncertainty carries a cost of its own: Penalty exposure of unknown scope affects an entity's ability to secure financing for the very investments that expand services and lower costs.

The office responded that it will address this through the enforcement considerations and the penalty justification factors, which allow OHCA to account for changes in federal and state law; staff also noted an entity must proactively document the effects. Hospitals urge OHCA to consider the following steps to make it clear **how** these important contextual factors will be incorporated and meaningfully considered during progressive enforcement:

- **Enumerate the enforcement considerations in the regulations.** OHCA has considered various factors as enforcement considerations; CHA urges OHCA to also consider additional factors that drive hospital spending growth for reasons outside hospital control, detailed in the Table below. Hospitals ask that each factor be specified in the forthcoming regulations, alongside a provision requiring other relevant factors to be considered as appropriate.
- **State how those considerations and the penalty justification factors will be applied.** Board members asked for principles the office could use so that similarly situated entities receive equivalent treatment. Hospitals ask that the principles be written into the regulations.

Factors for Enforcement Considerations
Factors OHCA Has Previously Considered
• Population characteristics • High-cost patient outliers • High-cost drugs • Entity baseline costs • Historical spending growth • Impact on consumer access and affordability • Investments in primary and preventative care • Changes in state and federal law • Acts of God or catastrophic events
Additional Factors Hospitals Ask OHCA to Include
• Macroeconomic trends, including as applicable on a regional basis • All labor costs • Payer mix • Investments in specialty care • Provider financial distress • Changes in service offerings • Payment settlements and other factors driving revenue volatility • Any other reasonable cause

Good-Faith Compliance — and PIP Failure — Must Be Defined in Regulation, Not Left to Discretion

Before the vote on the spending target penalty structure, one board member pressed for a distinction between entities that refuse to cooperate and entities making good-faith efforts, and asked that the board be clear that an entity working in good faith with the office is not the target of these penalties. Director Landsberg and staff responded that penalties are reached only after every other step of progressive enforcement has been exhausted and staff confirmed that, under statute, an entity that has fully complied with its PIP by the deadline established in the PIP shall not be assessed a penalty. Staff further confirmed that interim milestones are not hard targets, and that a good-faith effort in which a strategy did not pan out is a different situation than an entity that does not implement one at all.

The board and the office have therefore made clear that the spending target penalty is aimed at non-cooperation rather than at exceedance alone. The penalty motions the board adopted in August say nothing about PIP compliance. **The enforcement regulations should sufficiently incorporate what board members and staff expressed:**

- **Define what constitutes compliance with a PIP**, and state affirmatively that full compliance by the office's deadline bars a spending target penalty, thereby effectuating the Legislature's clear command at Health and Safety Code (HSC) § 127502.5(d)(1).
- **Codify staff's August statement that interim milestones are not hard targets**, and that a good-faith attempt to implement a strategy that did not produce the projected savings is treated differently from entities that willfully abstain from the process.

- **Confirm that the spending target is an annual measure.** As CHA explained in July, an entity cannot fail an annual target on a sub-annual basis, and PIP compliance therefore cannot be assessed sub-annually for purposes of a spending target penalty.⁴

The framework still does not define what it means to fail a PIP — or which penalty a failure triggers.

Statute establishes two distinct tracks. A spending target penalty under HSC § 127502.5(d)(1) requires both that an entity is not compliant with an approved PIP and that it does not meet the cost target. Procedural penalties under HSC § 127502.5(h)(1) are assessed directly, for enumerated acts that include repeatedly failing to file an acceptable PIP or repeatedly failing to implement one. Statute is clear that an entity that has fully complied with its PIP by the office's deadline is not subject to penalty, whatever its measured spending growth.

What remains undefined is everything short of full compliance, where two very different situations are currently captured by the same term:

- A hospital makes a documented good-faith effort but is unable to execute every provision of its PIP.
Neither penalty should apply.
- A hospital does not meaningfully engage or cooperate with the office on its PIP at all.

Only the second describes the conduct the Legislature had in mind with respect to procedural penalties, and only the second is consistent with what board members and staff described in August as not meeting “good-faith” compliance.

Finally, hospitals reiterate the request in CHA's July 31 letter: **Penalties should apply only to the portion of spending growth determined to be unreasonable** through the 45-day information submission period — the mandatory step in OHCA's progressive enforcement process at which an entity submits additional information and data for OHCA's review — and the technical assistance that follows. Because the board did not adopt that approach as the starting penalty amount, the office should establish an explicit downward adjustment at step two of the penalty framework, under the “nature of the offense” justification factor, for spending growth an entity has documented as reasonable.

A penalty calculated on the full amount by which a hospital exceeded its target assumes that every dollar above the target was wasteful, an assumption that will very often be wrong. The same dollars may reflect patient acuity, high-cost drugs, uncompensated care, or investments in primary and behavioral health care that improve access and quality — the very spending the enforcement considerations are meant to recognize and moreover promote. Removing documented, reasonable growth from the penalty base would align the penalty with the purpose board members described in August.

⁴ See, e.g., HSC § 127500.2(j).

High-Cost Designations Rely on Data That Does Not Reflect Known Corrections

The measurement questions above are not confined to the generally applicable hospital spending target. The same underlying data drive the high-cost hospital designation, which carries a target starting at 1.8%, roughly half the statewide rate for the hospitals it captures.

A hospital is designated high-cost if it exceeds the 85th percentile on both the commercial-to-Medicare payment-to-cost ratio (PTCR) and inpatient commercial net patient revenue per case-mix adjusted discharge (IP commercial NPR per CMAD) in at least three of the five years from 2018 through 2022. The designation is calculated entirely from the Department of Health Care Access and Information's (HCAI's) Hospital Annual Financial Disclosure Report (AFDR) Complete Data Set — data that were never collected, validated, or previously used for this purpose. That file is frozen once posted and is not updated to reflect the resubmissions hospitals regularly file with HCAI.

Because the 85th percentile threshold is relative rather than absolute, a correction to data anywhere in the distribution moves the cut point. Data that are not updated to reflect corrections do not merely misclassify the hospital whose report contained the correction; it changes which hospitals fall above and below the line. Every hospital in the distribution has a stake in the accuracy of every other hospital's report.

Corrections are not rare. An expert from HCAI's AFDR team told the board in March 2026 that the department **receives more than 100 resubmissions each year**; that these are complex reports containing more than 18,000 data elements; and that mistakes and updates happen, a common one being revenues allocated differently by payer. This is precisely the type of correction that has consequential implications for both the high-cost designation and spending target measurement.

These corrections by hospitals often reflect a healthy and necessary update as more information becomes available. Hospital revenue can take years to recognize fully after care is provided, given the long window in which payers may pay claims, the data lag inherent in quality incentive payment calculations, and the multi-year processes built into Medi-Cal financing mechanisms. A data set frozen at the moment of posting therefore does not always capture a hospital's finances as they were; it often captures an early and incomplete view of them. That was a tolerable limitation when the AFDR primarily served as a public reporting resource. It is a different matter now that the data are being used to set a spending target half as low for the hospitals they capture and feed a penalty framework reaching into the hundreds of millions of dollars.

The board has already recognized this problem. What has not followed is a timeline for hospitals to submit corrections.

- **January 2026.** Two board members raised the need for a timeline establishing when resubmissions would and would not be accepted. The board's clear sense was that resubmissions — particularly for the earlier years, filed before OHCA existed — should be reconsidered, precisely because hospitals filed those reports without knowing they would be used this way.
- **March 2026.** OHCA committed to presenting the board with options comparing its original approach against a revised approach using other data sources, including HCAI's System for Integrated Electronic Reporting and Auditing (SIERA), to incorporate individual resubmissions. Staff noted that if there were hundreds of resubmissions, they were not certain all could be processed.

- **April 2026.** One board member raised concerns about volatility in the hospital spending measures, observing that “going forward some more attention on what’s causing these patterns is probably needed.”
- **Through the summer.** Hospitals resubmitted corrected data in reliance on what they heard from the board. OHCA has never announced a deadline or timeline for considering resubmissions.
- **August 2026.** A board member asked that the data questions be agendized for a future board meeting, with a staff presentation and an opportunity to hear from the entities raising the concerns. The office responded that it should be as transparent as possible, offered a presentation on its data methodology, and committed to continued work with entities to ensure they can replicate its calculations.

Before any high-cost designations are finalized for the 2028 enforcement year, hospitals ask that the office:

1. **Publish a resubmission cutoff date now.** To ensure OHCA does not inadvertently limit how many corrections arrive, hospitals must know the deadline in advance.
2. **Change the data source for the reassessment** so that accepted resubmissions are reflected — SIERA, refreshed AFDR extracts, or any source that is not frozen at the moment of posting.
3. **Apply corrections to all years in the lookback window**, not only the most recent one. The high-cost designation reaches back to 2018; the corrections must reach back with it.
4. **Re-run the full distribution on corrected data** before designations are finalized, because the threshold is relative and the cut point moves.
5. **Fulfill the March commitment** to share with the board the comparison of the original approach against a revised approach that incorporates resubmissions.
6. **Hold the same standard in the enforcement regulations.** High-cost designations and spending target enforcement run on the same data. The forthcoming regulations must adequately state how corrected data flow into a measurement year, and the deadline after which resubmissions are no longer accepted.

An Adjustment That Only Covers One Segment of the Workforce Does Not Promote Workforce Stability

OHCA’s decision to collect total nonsupervisory organized labor expenses — inclusive of all unions and agreements— rather than data reported agreement by agreement is a real and useful simplification that materially reduces hospital reporting burden.

The central problem detailed in [CHA’s non-supervisory organized labor adjustment \(NOLA\) letter](#) is nevertheless unresolved. Labor is 56% of hospital operating costs. An adjustment available only for collectively bargained labor protects one subset of health care workers and leaves out hundreds of thousands of others. When one hospital raises wages under a bargaining agreement, its neighbors have no choice but to follow in order to compete for the same staff — and those hospitals receive no adjustment. **Rural hospitals, where union penetration is lower, are disadvantaged most.**

Statute directs the office to promote the stability of the health care workforce — not one segment of it.⁵ The 26 bicameral, bipartisan legislators who wrote to the board in August asked this office the same question: How does the office plan to protect job stability for workers not covered by a collective bargaining agreement?

These questions are critical, and forthcoming progressive enforcement regulations must specify that all nonsupervisory labor cost growth, whether or not collectively bargained, is a justifiable reason for exceeding the spending target — and that it will be evaluated at the enforcement stage even where no prospective NOLA request was filed. An entity should not lose the ability to document actual labor expenses because it did not submit a projection two years in advance, particularly since agreements, staffing needs, classifications, and operating conditions change during the intervening years.

Hospitals also ask for transparency on the mechanics. OHCA has stated that labor costs outside a collective bargaining agreement will be accounted for on the “back end,” through the progressive enforcement process, and that actual expenditures will be verified against any preliminary adjusted target. Hospitals need certainty as to whether that will occur and how it will work; for example, what documentation the office will accept, how the adjustment will be quantified, at which step of enforcement it will be applied, and how the result will be communicated to the entity. A protection that exists only in the office’s internal practice is not one hospitals can plan around and is destined to result in uneven treatment.

The Most Timely and Best-Informed Input OHCA Received Never Reached the Board

On July 7, OHCA held a hospital-focused workshop on the progressive enforcement process with participants representing more than 100 hospitals. The office answered questions at that workshop and asked for written comment on the progressive enforcement process by July 31. Forty-three hospitals and health systems submitted letters by that date, with one clear uniting theme: severe concerns about the volatility and accuracy of the data used for hospital spending target enforcement. In fact, multiple hospitals reported that double-digit changes in commercial and government payer price measures were not only inaccurate but impossible.

None of these letters were summarized for the board ahead of the votes on spending target penalties and procedural penalties. The workshop feedback surfaced only after those votes, during the discussion of PIP guidance, where a summary table recorded the concerns in a single line about reconsidering or clarifying how OHCA measures hospital spending and calculates penalties. The July 7 workshop and the July 31 letters were the most timely and most technically informed input the office has received from the entities this framework will be enforced against, and the board voted without the benefit of that information.

The same gap appeared in the evidence before the board. CHA’s August letter detailed recent *Health Affairs* research bearing directly on the August decisions, including Professor Keith Marzilli Ericson’s finding that meeting 2022-23 targets across six benchmark states would have required real per capita spending to decline by an average of 1.6% per year, largely due to the lack of adjustments for inflation. A further item⁶ not included

⁵ See, e.g., HSC § 127502(c)(6).

⁶ Keith Marzilli Ericson, *Health Affairs* (August 2026): <https://www.healthaffairs.org/content/forefront/could-california-s-health-care-spending-benchmark-become-global-budget>

was an August 19 commentary by the same author addressing OHCA and its proposed penalty structure directly, which concludes that California has adopted a spending cap without the protections needed to safeguard access and quality, and that "the penalty should not exceed the harm caused." Professor Ericson submitted written public comment to this board on August 14 as well. The board voted without hearing this highly relevant perspective.

Hospitals therefore ask the office to do three things as it moves into rulemaking:

- Create a standing mechanism for provider technical and data concerns to reach the board before it votes on the issues those concerns bear on, rather than after.
- Summarize the 43 July 31 comment letters in full for the board in advance of the board's consideration of the forthcoming progressive enforcement regulations, and respond directly to the data volatility concerns those letters raise.
- Present to the board the published research bearing on the design choices before it, including research that cuts against the office's approach.

The board itself signaled in August that a substantive response is expected. One board member observed that commenters had raised legitimate and valid concerns and asked the office to respond to them going forward. Another asked that the data questions be agendaized for a future meeting, with a staff presentation and an opportunity to hear from the entities raising them; the office agreed. Hospitals are encouraged to see both on this month's agenda — follow-up on the enforcement workshop feedback, and a session on volatility in the hospital spending measures. For that discussion to close the gap, it should address the volatility documented in the July 31 letters directly, identify its sources, and state how the office will distinguish real growth above the target from measured growth that is an artifact of the methodology. Now that the penalty structure has been adopted, this discussion matters more, not less. The regulations that follow will determine whether penalties of this magnitude fall on real spending growth or on artifacts of measurement.

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,



Victoria Valencia
Vice President, Data Analytics

cc: Members of the Health Care Affordability Board:
David Chase

Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, PhD
Dr. Mikah Owen
Dr. Richard Pan

Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability



September 17, 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

2020 W. El Camino Ave., Ste. 1200
Sacramento, CA 95833

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

Health Access California, the statewide consumer coalition committed to quality, affordable health care for all Californians, commends the Health Care Affordability Board, the Department of Health Care Access and Information, and the Office of Health Care Affordability for taking action to penalize health plans, insurers, hospitals, large physician organizations, and other health care entities that exceed the cost growth target set by the Health Care Affordability Board in 2024.

Executive Summary

Health Access:

- Thanks the Health Care Affordability Board for its unanimous vote to support commensurate penalties to slow the worsening of health care affordability. Today a majority of Californians skip or delay care because of health care costs.
- Thanks the Board for its vote to approve procedural penalties and cautions that \$500,000 may not be enough to deter some large wealthy health insurers or health systems.
- Supports SB 1037 by Senator Weber Pierson to further link the OHCA cost targets to rate review by Department of Managed Health Care and the California Department of Insurance as well as to report on the lack of affordability of premiums and deductibles.
- Discusses possible adjustments to statewide growth target, opposes use of GDP as reflecting the wealth of the economy rather than ability of consumers to afford care and opposes use of higher consumer price index because higher general inflation means consumers are even less able to afford care. We also continue to support a twenty-year lookback to improve predictability and reduce volatility.

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Michael Young
California Teachers Association

Sonya Young
California Black Women's Health Project

Amanda McAllister-Wallner
Executive Director

Organizations listed for
identification purposes

- Seeks transparency of enforcement throughout the enforcement process and more public notice in the early stages of enforcement.
- Appreciates many aspects of proposed performance improvement plan guidance and process.
- Offers comments on hospital spending, including the possibility of a single measure that combines both inpatient and outpatient spending, the validity of the outpatient intensity measure, volatility of hospital revenues in the context of year to year target enforcement, and provisions of existing law recognizing county funding of the nonfederal share of the Medi-Cal match for public hospitals (county and UC) while private hospitals' QAF reporting is both voluntary and uneven.
- Continues to support measuring target compliance for health plans, hospitals, large physician organizations and other health care entities separately by market segment (Medicare, Medi-Cal and commercial) supports further work to develop a behavioral health benchmark.

High Health Care Costs and Affordability of Care: Strong Penalties Consistent with California Law

Health Access supports the unanimous vote by the Health Care Affordability Board in favor of commensurate spending target penalties consistent with California law and anchored in median household income. Penalties based on California law are strong enough to deter spending in excess of the target, an action that remains firmly anchored in the need to slow the worsening affordability for consumers and other purchasers.

Almost six of ten Californians cannot afford to get the health care they need, and many get sicker as a result. For low-income Californians, seven out of ten skip or delay health care because of costs¹. That is wrong.

It is clinically wrong:

- People avoid preventive care because they cannot afford the follow up visit, the next test, the diagnostic mammogram.
- People do not manage their chronic conditions because they cannot afford their insulin or the asthma inhaler or even the \$11 Lisinopril to manage their hypertension—despite what this Administration has done with CalRx to make insulin, albuterol and naloxone more affordable
- And the Board has heard from those with serious conditions like multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS), or blood cancer about the astonishing costs they face.

It is wrong in terms of health equity because it makes access less equitable and deepens already-entrenched disparities resulting from differing abilities to pay for care. It worsens income inequality and cements generational wealth inequities.

¹ <https://www.chcf.org/resource/2026/02/25/2026-california-health-policy-survey/>

It is economically wrong, contributing to labor disputes and undermining small business owners who want to do the right thing by providing health benefits to their employees. Skyrocketing healthcare premiums have kept wages low and reduced the ability of labor unions to negotiate livable wages for their workers.

In one example among many, a Santa Cruz teacher and member of the California Federation of Teachers shared that educators in Santa Cruz saw premium increases of 19% last year and another 22.6% this year. “We cannot afford this,” they said. At that pace, by 2030 a new teacher in Santa Cruz City Schools could be paying 39.1% of their salary toward health insurance premiums².

In any other wealthy country, what consumers pay for their care would be limited and scaled to their income. California can do better and that is why this Board voted to base the target on growth in household income. Median household income was the best available measure of the ability of consumers to afford care.

The unanimous Board action to approve a penalty structure that is commensurate with the amount an entity spent above the target comes after more than a year of discussion, including input from the Advisory Committee and extensive input from a broad range of stakeholders. Health care affordability is the difference between income available for health care and income available for housing, groceries, gasoline, childcare, and everything else a household needs³.

Commensurate penalties also protect the integrity of the program. Other states offer cautionary examples. In Massachusetts, the Mass General Brigham hospital system exceeded the target by \$300 million, but the law only allowed a \$500,000 penalty. With consequences this small, overspending can be treated as just another cost of doing business.⁴ Penalties lose the power to deter behavior when the financial consequences are cheaper than continuing the behavior, leaving consumers and other purchasers of coverage to bear the burden of rising health care costs while health care systems retain the financial benefit.

Health Access also supports using those penalty adjustment factors specified in law, including an entity’s individual financial circumstances as well as the nature, gravity and number of offenses, the market impact of the entity and the federal Medi-Cal match. It is not our intent to bankrupt small, rural hospitals without any system affiliation. It is our hope that meaningful penalties will send a message to large, wealthy health systems and insurers with ample reserves that the State of California is serious about health care affordability.

² Health Access townhall, Gilroy, August 2026.

³ <https://hcai.ca.gov/affordability/ohca/slow-spending-growth/>

⁴ <https://masshpc.gov/news/press-release/hpc-finds-mass-general-brigham-cost-trends-and-expansions-threaten-state-health>. The penalty was not imposed because Mass General successfully implemented its performance improvement plan: <https://masshpc.gov/publications/market-oversight-report/performance-improvement-plan-final-evaluation-mass-general>

Procedural Penalties: Safeguards against Delay and Noncompliance

Health Access supports the Board action to adopt penalties of up to \$10,000 per day for knowingly failing to provide information, such as an audited financial statement from a large physician organization or repeatedly failing to file a performance improvement plan. For other state agencies, per day penalties have proven effective in encouraging compliance. We also support the “justification factors” consistent with the law, including both the nature and gravity of the offense, the fiscal condition of the entity, and Medi-Cal match. Again, we are not interested in bankrupting a small, rural hospital or a physician group with no statutory requirement for reserves.

Health Access still has doubts about whether a one-time \$500,000 penalty is sufficient to change behavior, particularly for large, wealthy entities such as health systems or multi-state insurers and plans. We recognize that the one-time fines apply when an entity knowingly falsifies information, a high legal standard, or repeatedly fails to implement a performance improvement plan. We remain concerned that given the scale of some of the entities involved, a penalty of \$500,000 may amount to the cost of doing business.

We encourage recognition that a single entity can have multiple violations of procedural requirements and may incur multiple procedural penalties.

Cost of Coverage: Linking OHCA's Work to Insurer Rate Review

For California employers, family coverage is projected to be \$30,000 next year⁵. Family share of premiums will be \$9,000 and deductibles about \$4,800, if the worker share of premium and deductibles continue to be the same proportion as in recent years⁶. Employer coverage premiums are expected to increase 9% next year, the biggest jump in 16 years.⁷ Rate increases for the small group and individual markets ranged from 9.2-10% for this year, which is nearly triple the cost growth target. CalPERS also experienced a 9% jump last year.⁸ Premiums and cost sharing, including deductibles, copays and co-insurance, have grown 8.5%-10.7% and 6.5%-8.0% for state-regulated coverage for 2024 and 2025⁹, respectively.

Health Access supports SB 1037 (Weber Pierson), now pending on the Governor's desk, which would take the next step in linking the work of the Office to rate review by the two regulators, the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI). While rate review is prospective, assessing rate increases for the next year, and the OHCA process is

⁵ [California employer health premiums will cost as much as a new car in 2027 - Los Angeles Times](#)

⁶ Estimate based on https://laborcenter.berkeley.edu/wp-content/uploads/2024/02/Measuring-Consumer-Affordability_revisedFeb82024.pdf

⁷ [California Employer Health Premiums Will Cost as Much as a New Car in 2027 \(Los Angeles Times, July 2026\)](#)

⁸ [Health Plan Aggregate Premium Rate Report \(Department of Managed Health Care, 2026\)](#)

⁹ <https://www.dmhc.ca.gov/Portals/0/Docs/DO/HealthPlanAggregatePremiumRateReport2024.pdf>; https://www.dmhc.ca.gov/Portals/0/Docs/DO/SFPublicMeeting/2026/PublicMeetingonHealthCarePremiumRatesandPrescriptionDrugCostsPresentation_1.pdf

retrospective, reporting on cost growth in prior years, the rate review process can serve as an early warning system about whether the OHCA targets are being met.

SB 1037 requires plans and insurers to explain what steps they are taking to meet the cost growth targets. SB 1037 will also require the regulators to document how unaffordable coverage is by reporting annually on what income an individual consumer or family must earn in order to meet the threshold of 7.97% of income for coverage to be affordable under California's individual mandate¹⁰. Put another way, for family coverage with a premium of \$30,000 and deductible at \$4,800, the family would need an annual income of about \$440,000 to meet the affordability standard of the individual mandate¹¹. This is more than four times the California median family income of about \$100,000¹². Even if only the family share of premium at an estimated \$9,000 and the family deductible of \$4,800 is considered, the family would need to make \$170,000 a year. SB 1037 looks at "gross total premium" as well as deductible because the employer share of the premium counts as part of employee compensation in classic economics.

SB 1037, if signed by the Governor, would be another step forward on the long path to stop the worsening of the lack of health care affordability.

Adjusting the Growth Target?

The law says the following about the basis for setting the growth target:

(c) The health care cost targets shall meet all of the following requirements:

(1) Promote a predictable and sustainable rate of change in per capita total health care expenditures.

(2) (A) Be based on a target percentage, with consideration of economic indicators or population-based 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 aging¹³.

Nowhere does the law mention basing the cost growth target on the cost of providing health care.

Median Family Income vs. State Gross Domestic Product

Health Access strongly supported setting the growth target based on median family income as a measure of the ability of California families to afford health care. We equally opposed using

¹⁰ [Health Care Minimum Essential Coverage Individual Mandate Report, 2026](#)

¹¹ SB 1037 uses gross premium because employee compensation includes both the employer share of premium and the worker share of premium.

¹² <https://data.census.gov/profile/California?g=040XX00US06>

¹³ Health and Safety Code 127502 (c).

state gross domestic product which measures the wealth of the economy as the basis for setting the target rather than a measure of the ability of consumers to afford care. The wealth of Google, Open AI, or Meta as reflected in our state's GDP does not help the six of ten Californians who skip or delay health care because of costs.

Family Income and Inflation

We relooked at “What Can We Afford?”, a policy brief from the UC Berkeley Labor Center.¹⁴ For the twenty years 2001-2021, inflation was lower than growth in wages or income. It will be helpful to see the trend lines extended through 2025. At the December 2025 Board meeting, OHCA staff presented updated data on household income, consumer price index, gross state product per capita and per capita health care spending.

One piece of research that seems to us methodologically flawed is a piece on cost growth targets in other states and the impact of inflation¹⁵. This piece uses only two years of inflation data, 2022 and 2023. But inflation in 2022 was an outlier at almost 8%. Conversely, inflation in 2021 was less than 1%. Does a single outlier year, 2022, justify rebasing the target or using inflation as an enforcement consideration? No.

In contrast, a recent piece found that:

Whereas premiums grew 78.4% between 2011 to 2024, health spending grew by \$2844 (84.2%) during the same period. For context, if premiums had grown at the pace of general inflation, they would have only grown by \$1582 (39.5%)¹⁶.

“Health spending” in this sentence refers to the costs of doctors, hospitals, and prescription drugs paid for by insurance premiums.

In the last five years, wages grew more slowly than increases in general inflation as measured by the consumer price index. This means California consumers are even less able to afford their health care, all while growth in health care spending far outstrips inflation.

We look forward to further data on wages, income and inflation to help inform the Board's thinking, and ours.

Volatility of Economic Measures

In adopting the growth target, the Board in 2023 and 2024 settled on median family income as the appropriate basis for the growth target but engaged in a lively debate about what look-back period was appropriate, debating five years, ten years or twenty years. Weighing heavily on our thinking was the volatility of broad economic measures over shorter periods and the consequent lack of predictability of the target from year to year. An analysis by the UC Berkeley Labor Center, in a letter to the Board dated March 11, 2024, said:

¹⁴ <https://laborcenter.berkeley.edu/wp-content/uploads/2023/09/What-can-we-afford.pdf>

¹⁵ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2026.00046>

¹⁶ https://jamanetwork.com/journals/jama-health-forum/fullarticle/2853324#google_vignette

If California had set a spending target over the last few decades using median household income growth, the target value would have ranged from 2.4% to 3.4% using a 20-year average, 1.3% to 4.4% using a 10-year average, and 0% to 5.5% using a 5-year average. A 20-year average promotes the most “predictable” rate of change, a methodological consideration in statute¹⁷.

Because of this volatility combined with the statutory direction to provide predictability to the entities subject to the target, Health Access supported a twenty-year lookback period for the statewide growth target that applies to health plans and insurers as well hospitals and large physician organizations.

Again, we look forward to further analysis and data to inform the discussion.

Enforcement Transparency: From Beginning to End

Health Access supports transparency throughout the enforcement process. The public should be able to follow an entity's progress from when it first exceeds the spending target through technical assistance, PIP implementation, and final resolution. This includes understanding when an entity enters or exits enforcement and the basis for OHCA decisions.

Our review of the transparency proposed by staff raises troubling questions about timely notice and opportunities for both Board oversight and public comment in the earlier stages of the enforcement process.

The first public notice will not occur when the entity is informed that it has exceeded the target but at some time after “the end of the 45-day period for the submission of additional information” when the staff has had additional time to “finalize performance determinations”. Nothing in the law prohibits informing the Board and the public from the start, when the entity is informed it has exceeded the target, rather than after the entity has weeks to pile up reasons and excuses and the OHCA staff takes weeks longer to determine whether to proceed. We are also concerned that the 45-day period will extend longer first by mutual agreement between the entity and the OHCA staff with no public notice during that period and second while OHCA staff is finalizing its determination. In other states and with other departments, enforcement often goes “dark” for extended periods of time, cutting out the oversight of the Board and the input of other stakeholders.

This means that for months and perhaps longer, entities that have exceeded the target will be able to share with other health care entities how they are attempting to avoid enforcement, but the Board and other stakeholders will have no notice of which entities exceeded the target. Whether it is hospitals or health plans or large physician organizations, they will be able to share information among themselves, with their trade associations, and to advocate with individual Board members while the Board as a whole will have no official notice and other

¹⁷ https://hcai.ca.gov/wp-content/uploads/2024/04/Spending-target-public-comments-part-5_Final_Redacted.pdf. P.62.

non-industry stakeholders will have no opportunity for input. That lack of transparency advantages those who exceed the target and disadvantages those who pay the costs of high health care costs.

This Board and stakeholders, including Health Access, would also like to know whether the information from the entity provided during the period after the entity receives notice it exceeded the target consists simply of data corrections or if it is enforcement considerations and if so, what enforcement considerations were advanced by the entity. Again, both the Board and the OHCA staff might benefit from input by stakeholders on possible enforcement considerations. We have already observed that some entities have literally asked to point to newspaper clips and other generalized data, rather than quantified, documented entity-specific data.

Will all entities that exceed the target receive “template TA”? If not, then we, and we assume the Board, would like to know which entities do and which receive more extensive technical assistance. Presumably the Board as well as stakeholders would like to know which entities proceed to further stages of enforcement.

We appreciate the attention to public notice surrounding each performance improvement plan. In Massachusetts, only one entity in a decade has proceeded to this stage and in Oregon, it appears that only two or three will. If this stage is similarly infrequent in California, this means few entities will get to the enforcement stage involving a performance improvement plan. While we appreciate the transparency surrounding this stage of enforcement, transparency at earlier stages is also important. By allowing the initial stage of enforcement to play out behind closed doors, the Board and other stakeholders will miss out on valuable information on patterns of entities exceeding the target, OHCA's response, and the leveraging of enforcement considerations.

As the staff presentation says, Board meetings, the Advisory Committee and the webpage provide opportunities for public updates. But if transparency occurs only 45 days or longer after an entity gets notice and during the PIP process, that can leave a big gap in enforcement transparency.

In prior letters, we have requested public notice:

- At the time notice is provided to the entity that it has exceeded the target.
- Of any enforcement considerations asserted by the entity as well as any data errors or corrections made by the entity after the 45-day period for the entity to respond
- If the Office determines that either the data changes or enforcement considerations “meet the burden” established by the Office
- When the entity receives notice that enforcement will proceed

We again ask that the Board and stakeholders have public notice of these important steps in the early stages of the enforcement process. Nothing in the law prohibits any of this. Secretive enforcement does not benefit consumers or other purchasers.

With respect to confidential information, Health Access acknowledges that there may be nonpublic information in the enforcement process and that this may include what lawyers call “business confidential” information. We worked closely on the law to ensure that information that is otherwise public shall remain public while that which is nonpublic remains confidential. Too often, we have observed blanket assertions of confidentiality even about information that is public in other forums such as federal regulatory agencies or through other avenues such as shareholder materials.

Enforcement Process: Performance Improvement Plans

Health Access, like other organizations, appreciated the opportunity to join a workgroup to discuss performance improvement plans, required by law to correct spending in excess of the target for entities that proceed to the near-final stage of enforcement.

- First, we again ask that the reasons asserted by an entity as reasons for exceeding the target be documented and quantified. To the extent possible, independent analyses such as CHBRP are preferred. News clips or general assertions are not enough justification. We have presented numerous examples of why such general assertions do not stand scrutiny, in this and prior letters:
 - High-cost drugs are frequently a revenue source benefitting the hospital or health system, rather than a net cost.
 - Inflation measured by the consumer price index likely bears little or no direct relationship to increases in the cost of operating a large physician organization, hospital or health plan.
- We very much support the requirement that the entity itself describe how the steps of its plan of correction are expected to improve affordability for consumers and other purchasers. Too often any reduction in savings gets lost in the black box of health organizations and does not translate into slower cost growth for those of us who pay the bill.
- We also support the requirement that the assessment plan includes specific metrics and data sources to be used to measure progress. Clear, objective measures are essential to determine whether a performance improvement plan is achieving its intended results.
- Health Access strongly supports putting the burden on each entity itself to describe how its performance improvement plan will not erode access, quality, equity or workforce stability. It is up to each entity to meet the growth target and to explain how it will accomplish that in a manner consistent with the law. Consistent with the law¹⁸, this approach puts the burden on the offending entity rather than the Office.
- We also appreciate that OHCA staff may request revisions to the performance improvement plan if it is not proceeding as expected.

¹⁸ Health and Safety Code 127502.5 (a)

- Proposed timeline: we note much comment about the need for time to implement performance improvement plan: this gives each entity the opportunity to say how much time they need to get the changes done.
- In this approach, cost drivers are largely self-identified by the entity that exceeds the target. An entity may highlight the causes that are easiest to explain or defend may receive the most attention while other cost drivers are overlooked.
- If the entity has taken other steps to mitigate cost growth, the entity should include this information though it should not excuse the need to correct spending over the target. It may also be helpful to track areas of spending growth other than those targeted in the performance improvement plan so that the other areas do not drive cost growth over the target.

We look forward to continued development of performance improvement plan requirements as the agency gains more experience.

Hospital Revenues

In the aggregate, hospital revenues are about 40% of premiums, with inpatient hospital revenues and outpatient hospital revenues roughly equal shares of health care costs, about 20% each.

Single Measure Combining Inpatient and Outpatient Hospital Spending

Health Access served as part of the hospital measurement workgroup. In that context and in the months since, we have been willing to consider a single measure that combined both inpatient and outpatient hospital spending so long as the Office continues examining hospital inpatient and outpatient spending separately as it did in a recent report¹⁹.

Health Access has looked at a simple average, a weighted average which could be weighted by revenue or other readily available metrics, and other arithmetic solutions to create a single measure. We are not proposing a particular measure because there are a variety of policy and statistical issues to be worked through. For example, the mix of inpatient and outpatient services can vary widely by hospital. Some hospitals provide chemotherapy and infusion services, others do not. Some have emergency rooms, some do not. Some hospitals have little more than the eight basic inpatient services required under California regulation²⁰, others have a wide range of both inpatient and outpatient care.

We note that other health care entities have a single measure for each of the three market segments. For health plans and insurers, the measure is based on “total health care

¹⁹ <https://hcai.ca.gov/wp-content/uploads/2026/05/Examining-Hospital-Inpatient-and-Outpatient-Spending-in-California-2022-2023.pdf>

²⁰ [Browse > Title 22. Social Security > Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies > Chapter 1. General Acute Care Hospitals > Article 3. Basic Services - California Code of Regulations](#) Sections 70201-70279.

expenditures” (THCE) which include both claims and nonclaims payments as well as profits and administrative costs. For large physician organizations, it is proposed to be attributed total medical expense, that subset of THCE that includes claims paid by health insurers for professional services, hospital care, outpatient drugs and other medical care but that excludes insurer overhead and insurer profits²¹.

Health Access supports continued reporting on the separate trends in inpatient and outpatient hospital spending. Transparency of the mix of inpatient and outpatient services should continue to be maintained by continuing HCAI and now OHCA’s tradition of making public the elements that are measured and the methodology.

Transparency of inpatient hospital spending as well as outpatient hospital spending involves many aspects of OHCA’s work. Growth in inpatient spending may raise questions about whether there are gaps in access to primary care or behavioral health services, or whether preventable hospitalizations are increasing. Research from the Milbank Memorial Fund has found an association between greater investment in primary care and few emergency department visits and hospitalizations, suggesting that inpatient spending trends can reflect broader patterns of access, prevention, and investments.²²

Rising outpatient spending raises other questions. Is the decades-long shift of care to the outpatient setting occurring in hospital outpatient departments or locations that most consumers perceive as doctors’ offices or clinics? Does it involve facility fees for physician offices or implicate site neutrality? Are negotiated outpatient prices increasing? Has provider consolidation changed market dynamics and pricing power? Scheffler, Arnold, and Fulton in “The Sky’s the Limit” and earlier research to support the Sutter litigation found that outpatient prices rise with market concentration and that hospital-physician integration can increase pricing power, particularly when providers already hold significant market share. In that context, outpatient spending growth may be signaling changes in prices or market structure rather than changes in patient need.²³

OHCA’s own data demonstrates why this visibility matters. In its analysis of California hospital spending from 2022 to 2023, after adjusting for volume and intensity, median commercial inpatient spending increased 7.1% while commercial outpatient spending increased 4.2%. In Medicare, inpatient spending decreased 1.4% while outpatient spending increased 8.9%.²⁴ In Medi-Cal, inpatient spending decreased 1.2% while outpatient spending increased 2.5%.

Measuring Intensity of Outpatient Services

²¹ <https://hcai.ca.gov/wp-content/uploads/2026/07/June-2026-OHCA-Board-Meeting-Presentation.pdf> Slides 42-44.

²² <https://www.milbank.org/publications/investing-in-primary-care-a-state-level-analysis>

²³ <https://www.chcf.org/resource/2019/10/03/the-skys-the-limit/>

²⁴ <https://hcai.ca.gov/wp-content/uploads/2026/05/Examining-Hospital-Inpatient-and-Outpatient-Spending-in-California-2022-2023.pdf>

Health Access appreciates the extensive analysis regarding hospital outpatient services to validate the use of the Medicare measures of “average visit intensity”. While we were initially troubled by the small sample for commercial coverage in the Health Payments Database and the likely unrepresentative nature of that small sample, we were reassured by the further analysis presented at the December 2025 Board meeting. This analysis found a correlation of over 90% between all payer and commercial claims for visit intensity for both inpatient and outpatient care, a strikingly strong correlation²⁵. Correlations of 0.93 and 0.94 have far greater explanatory power than most statistical relationships. That analysis also found a pattern of high intensity outpatient visits at the types of hospitals most likely to have high intensity outpatient care such as cancer treatment centers. We also note that the staff laid out additional steps to further validate the data.

Examining Hospital Year to Year Spending Growth in Light of Multi-Year Data

Complying with the statewide cost target is based on year over year spending growth. But it is appropriate to examine that spending growth in light of multi-year data because some revenue to hospitals and other providers can be “lumpy.” For example, legal settlements that may cover multiple years may be paid in a single year or over a few years. Similarly, it is our understanding that some Medi-Cal payments can come in chunks. Other revenue, whether inpatient or outpatient, may also come in irregular chunks.

In the work to develop the lower targets for very high-cost hospitals, OHCA looked at five years of data. In doing so, one hospital (NorthBay) fell off the list because several years prior, it had recategorized Medicare Advantage as Medicare revenue rather than commercial revenue. While the HCAI hospital financial data reporting was originally developed for cost containment purposes by state government, it has been some years since it was used for that purpose. As HCAI begins again to use that data to control health care costs, inevitably closer inspection will lead to the discovery of data errors in the self-reported data by other hospitals.

Health Access does not propose that multi-year enforcement but rather when a hospital or other entity exceeds the target for a particular year reviewing multiple years of hospital revenue data indicates a pattern of exceeding the target or there is something odd with a particular year’s data.

Public Hospitals, Private Hospitals: IGTs/CPEs, QAF

Health Access encourages OHCA to use its authority to “help ensure that full federal financial participation is available” to evaluate the nonfederal share of match for county and UC hospitals and encourages greater transparency and accuracy of reporting of the hospital provider tax, known as the Quality Assure Fee (QAF).²⁶ Health and Safety Code Section 127502

²⁵ <https://hcai.ca.gov/wp-content/uploads/2025/12/December-2025-OHCA-Board-Meeting-Presentation-1.pdf> - slide 22

²⁶ Health and Safety Code 127502 (d) (5) (C).

(d)(5) expressly directs OHCA to consider the provision of the nonfederal share associated with Medi-Cal payments and provides flexibility to account for supplemental payments, provider contributions, and health care-related taxes and fees.

Public hospitals, including both county hospitals and the UC hospitals but not district hospitals, put up the nonfederal share of Medi-Cal funding through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). Other hospitals, particularly private hospitals, benefit from the Medi-Cal hospital provider tax, referred to as the Quality Assurance Fee (QAF). These differences can affect how Medi-Cal revenue and spending appear in hospital financial data and should be considered when evaluating spending performance. The law anticipated this.

Health Access has long supported policies that maximize federal Medicaid funding for California's county hospitals. The spending target methodology should not inadvertently penalize county hospitals for financing arrangements that allow California to draw down federal funds to support care for Medi-Cal beneficiaries and uninsured Californians. Unfortunately, the UC hospitals for many years have failed to provide care to the uninsured and the Medi-Cal population commensurate with the needs of the Medi-Cal population. For example, only 16% of UCLA's patients are on Medi-Cal even though 40% of the population of Los Angeles depends on Medi-Cal²⁷.

While the public hospitals, including both county hospitals and the UC hospitals, report the county funding through IGTs and CPEs that make up the nonfederal share of Medicaid financing, unfortunately the reporting by private and district hospitals on the QAF is both voluntary and uneven. The HCAI financial data requirements should be updated to require full public transparency of hospital revenues from the QAF. This would allow OHCA to distinguish spending growth attributable to Medi-Cal financing mechanisms from growth attributable to underlying drivers such as higher prices, increased utilization, or other changes in spending.

Spending Target Measurement and Enforcement: By Market Segment

Health Access continues to support measuring spending target performance and enforcing against the spending target separately for each of the three market segments, specifically across the commercial, Medicare, and Medi-Cal markets. Evaluating performance separately across these three market segments provides a more accurate understanding of health care cost growth and ensures accountability for cost growth in each market segment. These markets serve different populations, operate under different financing and payment rules, and raise different affordability concerns.

Affordability challenges do not disappear when market segments are averaged together. The growth of spending in the commercial market segment remains substantial for the majority of

²⁷ <https://www.latimes.com/business/story/2026-09-05/low-income-patients-at-ucla-health-scramble-to-find-new-doctors-as-contract-ends>

consumers who rely on employer-sponsored insurance as well as for their employers who pay most of the cost. If commercial spending grows rapidly while Medicare or Medi-Cal spending grows less quickly, an aggregate measure could mask the very affordability concern that OHCA is intending to address. Combining all three markets would allow excessive spending growth in one segment to be offset by lower growth in another.

OHCA's own baseline data demonstrates why market-specific measurement matters. From 2022 to 2023, commercial spending grew by 6.4%, compared with 5.4% in Medicare and 2.9% in Medi-Cal.²⁸ Those differences matter because they reflect distinct market dynamics and different drivers of spending growth. Combining the segments would make it harder to identify where affordability pressures are emerging and where intervention may be necessary.

The differences are not accidental. Medicare and Medi-Cal payment rates are largely determined through government financing and rate-setting rules. Commercial payment rates, by contrast, are often influenced by relative market power of insurers and providers as well as the ability of both payers and providers to pass on costs to consumers and purchasers. Most individual consumers and employers are mandated by state and federal law to purchase health insurance, so insurers are better able to pass on cost increases in the components of commercial coverage, including physician professional services, hospital costs, and outpatient prescription drugs as well as insurer profits and overhead. This structural difference in market segments makes OHCA's role especially important for the commercial market segment.

Experience from other states illustrates why this distinction is important. Connecticut has found substantial variation in spending growth across its commercial, Medicare, and Medicaid markets. From 2020 to 2021, commercial per-capita spending grew by 18.8%, while Medicare spending grew by 1.4% and Medicaid spending grew by 0.8%.²⁹ While California's recent differences have been smaller, the lesson is the same: divergence across markets can become significant, and policymakers need visibility into those differences rather than a single blended number.

The goal of the spending target is not simply to produce a favorable average. It is to identify where health care costs are growing fastest, further worsening consumer affordability and to ensure accountability for addressing the cost of commercial coverage. Separate measurement of market segments is pivotal to achieving OHCA's statutory goals.

²⁸ HCAI, Office of Health Care Affordability, *Health Care Spending Growth Trends in California, 2022–2023* (June 5, 2025)

²⁹ <https://portal.ct.gov/-/media/ohs/cost-growth-benchmark/2020-2021-benchmark-report/benchmark-initiative---final-report-upd.pdf>

Behavioral Health Spending Measurement and Benchmark

Health Access appreciates OHCA's continued work to develop a behavioral health investment benchmark and supports taking the additional time necessary before determining the appropriate benchmark. We discuss why additional time is needed.

The law requires OHCA to measure spending on behavioral health as a percentage of "total" health care expenditures. This made sense for primary care because almost all primary care spending, probably well in excess of 98% of primary care, is health plans and insurers paying for primary care physicians and other health professionals. This approach makes far less sense for behavioral health when major sources of spending are not covered benefits paid by health plans and insurers provided by in-network health professionals and facilities. Two major sources of behavioral health spending fall outside so-called "total" health care expenditures: first, cash pay by middle class and affluent consumers unable to readily obtain in-network care and second, and importantly for California, county behavioral health. In addition, too often those facing mental health, substance abuse, or both end up in correctional facilities. County jails and hospital emergency rooms are not a substitute for timely and appropriate early intervention.

We commend OHCA staff and their counterparts at the Department of Health Care Services for attempting to sort through county behavioral health spending, given the many decades of contentious relationships between the counties and the state over this responsibility. OHCA obtained some information about county behavioral health spending but has been advised that it is most useful for measuring utilization rather than spending. The job of OHCA is to measure spending so that is an unsatisfactory answer, but it is the answer we have at the moment.

As yet, the question of how to address cash pay for out of network care has no satisfactory answer either, despite the best efforts of OHCA staff and others. While we encourage continued investigation, we recognize the data limitations we face at the moment.

OHCA's August findings highlight significant variation in behavioral health spending across market segments. In 2024, behavioral health accounted for approximately 8% of total claims spending in the commercial market, compared with less than 3% in Medicare Advantage.³⁰ These differences support OHCA's preliminary recommendation to develop market-specific benchmarks that reflect the distinct populations, benefit designs, and delivery systems operating within each market.

As OHCA moves forward, the benchmark should remain closely aligned with its core policy objective: improving access to behavioral health care. Health Access has consistently emphasized that consumers should obtain timely and appropriate care, through access to in-network services at in-network cost sharing, while advancing health outcomes and equity and reducing reliance on costly crisis interventions. We have joined with others in prioritizing earlier

³⁰ <https://hcai.ca.gov/public-meetings/august-ohca-investment-and-payment-workgroup-4/>

interventions and community-based care. For that reason, higher spending should not, by itself, be viewed as a measure of success and the precise level of spending that is optimal for behavioral health remains unclear to us at the moment. Again, this is in sharp contrast to primary care where the answer from extensive research in this country and comparison with other wealthy nations encourages prioritizing spending on primary care.

Conclusion

Health Access appreciates the action by Health Care Affordability Board to adopt spending target penalties consistent with California law rather than the law of other states. We look forward to continuing to work with the Board and the Office on the continuing work of implementing California law to slow the worsening affordability crisis for California consumers and other purchasers.

Sincerely,



Katrina Walters-White
Regulatory Advocate

CC: Members, Health Care Affordability Board
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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
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September 17, 2026

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Sent via email:
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Re: Implementation of OHCA's Spending Target Enforcement Framework and Related Rulemaking Activities

Dear Chair Johnson, Director Landsberg, Deputy Director Pegany, and OHCA Board Members:

On behalf of the California Association of Health Plans (CAHP), we appreciate the opportunity to provide comments following the Board's recent approval of the spending target penalty framework and related enforcement concepts. We also recognize that many of the framework's operational details remain under development and will be addressed through forthcoming regulations and guidance.

CAHP and its member plans share OHCA's goal of improving affordability for California consumers. However, the August Board discussion reinforced many of the concerns that plans, providers, purchasers, Board and Advisory Committee members, and other stakeholders have raised throughout the enforcement development process. While the Board has now approved key policy direction, substantial questions remain regarding how the framework will function in practice. As OHCA moves into the rulemaking stage, we respectfully encourage the Board and staff to focus on the following issues.

I. The Board Has Approved a Framework, but Critical Implementation Questions Remain Unresolved

The August Board vote represented a significant milestone, but it did not resolve many of the practical questions that stakeholders have raised over the past year.

To date, stakeholders have had to assemble OHCA's proposed framework through a series of Board meetings, Advisory Committee meetings, workshops, presentations, draft guidance documents, and public comment periods. While those discussions have been valuable, many important implementation details remain unclear. Stakeholders still lack a complete understanding of how enforcement considerations will be applied, how entities will move through the progressive enforcement process, how performance improvement plans (PIPs) will be evaluated, and which of the Board-approved concepts will ultimately be codified in regulation.

CAHP respectfully encourages OHCA to publish a consolidated explanation of the enforcement framework with a meaningful opportunity for feedback before regulations become effective. OHCA should identify which elements of the enforcement framework will be codified in regulation and provide stakeholders a complete and integrated proposal with sufficient time for meaningful review and comment. Stakeholders should not be required to reconstruct policy through a patchwork of presentations and discussions.

The consolidated framework should also explain how OHCA intends to treat confidential information throughout technical assistance, PIP implementation, compliance reporting, and enforcement proceedings. Stakeholders need clarity regarding how proprietary, trade secret, and competitively sensitive information will be protected, what process will be available to request confidential treatment, and whether entities will receive notice and an opportunity to address any disagreement before requested confidential information is publicly disclosed.

II. Annual Enforcement and Multiple Concurrent Performance Improvement Plans (PIPs) Raise Significant Practical Concerns

CAHP remains concerned about OHCA's proposed approach of treating each performance year separately for enforcement purposes.

As discussed during recent Board meetings, the current structure appears likely to require an entity to manage multiple overlapping PIPs tied to different performance years. While annual accountability may seem straightforward conceptually, health care spending patterns are often volatile, influenced by multi-year initiatives, and affected by factors that unfold over time. The prospect of separate enforcement tracks for overlapping years introduces undue complexity, administrative burden, and uncertainty without clear evidence that it will improve affordability outcomes.

OHCA should pursue a multi-year evaluation framework or coordinated corrective action process that would better support sustainable improvement as compared to treating each year as a discrete enforcement event.

In addition, overlapping PIPs may not provide sufficient time for entities to implement and evaluate corrective actions before subsequent enforcement obligations arise. Many affordability initiatives require operational changes, regulatory review, provider negotiations, or other implementation steps that can take considerable time to complete and even longer to demonstrate measurable results. This is particularly true where implementation depends in part on actions or approvals by other regulators, including DMHC and CDI. As OHCA develops its framework, it should further clarify how it will coordinate with other agencies whose decisions may directly affect an entity's ability to achieve affordability goals and comply with a PIP.

III. The Framework Should Prevent Duplicative Accountability for the Same Spending

The health care delivery system is highly interconnected, and the same underlying health care expenditures may be reflected in the performance of multiple entities subject to the spending target. As OHCA implements the enforcement framework, it should ensure that the same spending growth does not result in duplicative enforcement actions or monetary penalties against multiple entities without consideration of each entity's respective role in driving that spending.

This concern is particularly important where a health plan reports expenditures associated with provider prices or utilization patterns that are also reflected in the performance of a provider organization subject to the spending target. In these circumstances, imposing penalties on multiple entities based on the same underlying spending growth could result in aggregate penalties that appear disproportionate to the conduct or circumstances giving rise to the target exceedance.

OHCA should establish clear principles for addressing overlapping accountability, including how responsibility will be evaluated when the same spending is attributed to more than one entity. The framework should ensure that enforcement reflects each entity's actual ability to influence the spending at issue and avoids duplicative penalties for the same underlying cost growth.

IV. Flexibility and Transparency Are Not Mutually Exclusive

We continue to support OHCA's desire to maintain flexibility when evaluating individual circumstances. However, OHCA can preserve flexibility while still providing stakeholders with clear standards regarding how enforcement considerations and penalty justification factors will be applied.

Clear standards are particularly important where an agency's determinations may result in significant monetary penalties. Regulated entities must have adequate notice of the conduct and performance standards against which they will be evaluated, as well as the evidence and methodology OHCA will use in applying those standards.

CAHP and other stakeholders consistently expressed concern that terms such as "market impact," "nature and gravity of the offense," "acceptable" PIP performance, and other penalty justification concepts remain undefined. Without additional clear standards, similarly situated entities could face materially different outcomes depending on how discretion is exercised.

CAHP is not suggesting that OHCA eliminate discretion. Rather, stakeholders need enough clarity to understand how major decisions will be made while preserving OHCA's ability to address unique circumstances when appropriate.

V. Entities Should Have a Meaningful Opportunity to Review and Respond to Enforcement Determinations

Transparency should extend not only to the standards OHCA will apply, but also to the data, calculations, and factual assumptions underlying individual enforcement decisions. Before an entity advances through progressive enforcement, OHCA should provide sufficient information for the entity to understand the basis for the determination and a meaningful opportunity to identify data discrepancies, attribution issues, methodological concerns, or other factual circumstances that may materially affect the analysis.

This is particularly important given the significant consequences that may follow an initial determination that an entity has exceeded the spending target. Enforcement may ultimately involve public proceedings, a PIP, and monetary penalties. An entity should not progress through that process based on data or assumptions that have not first been subject to appropriate validation and reconciliation.

CAHP therefore encourages OHCA to establish a transparent process through which entities receive notice of material enforcement determinations, the data and methodology supporting those determinations, and a reasonable opportunity to respond before further enforcement action or public disclosure occurs. OHCA should also establish a process for addressing material factual or methodological errors identified after an initial determination.

VI. Accountability and Penalty Exposure Must Be Aligned With an Entity's Ability to Influence Spending Outcomes

One of the strongest recurring themes throughout recent stakeholder discussions is that accountability, enforcement actions, and potential penalties should be aligned with factors that entities can reasonably influence and control. Stakeholders should not be subject to monetary penalties for spending growth driven by decisions made by other parties that ultimately determine the underlying cost of care.

Health plans continue to operate in an environment shaped by:

- State and federal benefit mandates.
- The Managed Care Organization Tax.
- Workforce and labor cost pressures.
- Pharmaceutical inflation.
- New technologies and therapies.
- Regulatory and reporting obligations.
- Market-wide inflationary pressures.

Many of these factors are outside the direct control of any individual health plan, provider organization, or hospital, yet they materially affect spending growth. As CAHP has stated previously, a successful affordability framework must distinguish between avoidable, internally driven spending growth and external cost increases driven by public policy decisions, market dynamics, or broader health system trends.

To accomplish this, OHCA should establish a common baseline or objective methodology for excluding or adjusting for material spending increases attributable to external cost drivers that are outside of the entity's control. This includes providing stakeholders with clear guidance on which existing measurement methodologies, reporting standards, or data sources will be used when evaluating spending growth tied to mandates, labor costs, taxes, high-cost pharmaceuticals, catastrophic cases, or other external pressures. Without a common framework, entities cannot reasonably predict how spending growth will be interpreted or how enforcement considerations will be applied.

OHCA has indicated that actual labor costs may be evaluated as part of performance assessment and progressive enforcement. To ensure consistent application across entities, OHCA should clearly state in both the nonsupervisory organized labor adjustment (NOLA) regulations and forthcoming enforcement regulations that actual labor costs will be considered during enforcement regardless of whether an entity initially sought a prospective labor adjustment.

Accountability should also reflect the distinction between reporting expenditures and controlling the underlying drivers of those expenditures. Health plans may report spending that reflects decisions made by self-funded employers, provider organizations, pharmaceutical manufacturers, or other parties over whom the reporting entity has limited authority. OHCA should establish a transparent process through which entities can demonstrate when excess spending growth was primarily driven by factors outside their reasonable control and clarify how those circumstances will affect both enforcement considerations and penalty determinations.

Recent national research published in *JAMA Health Forum* further underscores this point, finding that underlying health care spending accounted for 91% of premium growth between 2011 and 2024 while insurer markups declined as a share of premiums. These findings reinforce the importance of accurately identifying the drivers of spending growth before assigning accountability or imposing penalties.

As rulemaking proceeds, CAHP urges OHCA to define how each enforcement consideration will be evaluated, how those considerations will affect decisions to advance an entity through progressive enforcement, and what evidence will be required for stakeholders to demonstrate that costs were attributable to factors outside their control. This would support greater predictability while preserving OHCA's ability to exercise appropriate discretion when warranted.

CAHP also encourages OHCA to provide greater clarity regarding how penalty justification factors will be applied during the later stages of enforcement. While stakeholders have spent considerable time discussing enforcement considerations, the framework provides far less detail regarding how concepts such as the “nature, number, and gravity” of an offense or an entity's market impact will influence final penalty determinations. Market conditions are not static. The factors that contribute to spending growth may evolve significantly between the initial assessment of performance, implementation of a PIP, and any eventual penalty determination. Accordingly, OHCA should clarify how changing circumstances—including state and federal policy changes, new mandates, labor pressures, pharmaceutical trends, and other external drivers—will be evaluated when determining whether penalties are warranted and, if so, the appropriate amount.

VII. Penalties Should Improve Affordability, Not Simply Generate Revenue

Additional discussion is warranted regarding the disposition and purpose of spending target penalties.

The current framework emphasizes accountability and deterrence, but there remains limited discussion regarding how collected penalties will ultimately improve affordability for consumers and purchasers. While significant attention has been devoted to the size and calculation of potential penalties, considerably less attention has been given to how those penalties advance the affordability goals of the spending target program. During recent stakeholder discussions, several participants expressed concern that significant penalty amounts could create uncertainty regarding how funds would be used and whether they would meaningfully improve affordability outcomes.

OHCA should assess whether and under what circumstances a penalty could increase the costs ultimately borne by consumers, purchasers, providers, or the health care workforce. A penalty structure intended to improve affordability should not itself create additional cost pressures without a clear and measurable consumer benefit. In addition, OHCA should consider whether significant penalties could inadvertently

divert resources from value-based care initiatives, primary and behavioral health investments, quality improvement efforts, or other strategies intended to support long-term affordability. A penalty framework that discourages those investments could ultimately work against the program's underlying objectives.

Before finalizing the framework, OHCA should clearly articulate how any collected penalty funds would support affordability, maintain the financial integrity of California's health care system, and avoid increasing health care costs for consumers. The framework should also ensure that penalties are proportionate to the circumstances and do not inadvertently undermine corrective actions or affordability initiatives that are intended to reduce spending over the long term.

VIII. Performance Improvement Plans (PIPs) Should Encourage Constructive Affordability Solutions

Throughout stakeholder discussions, OHCA has described Performance Improvement Plans as a central component of the affordability framework. CAHP encourages OHCA to view PIPs not merely as compliance tools, but as opportunities to identify the actual causes of spending growth and develop practical, sustainable solutions. Such a view is consistent with the overall approach under the authorizing statute.

To achieve this objective, OHCA should clearly articulate what constitutes a successful PIP, how progress will be evaluated, and how entities can demonstrate good-faith efforts to improve affordability. PIPs should encourage collaboration around shared cost drivers where appropriate and help stakeholders address the root causes of cost growth rather than simply assigning responsibility after spending has occurred.

OHCA should also distinguish between an entity that fails to meaningfully participate in or implement a PIP and an entity that implements its PIP in good faith but does not achieve every anticipated outcome or interim milestone. Spending patterns may evolve during a multi-year PIP, and even well-designed interventions may not produce results on a precise timeline. A missed milestone should not, by itself, establish noncompliance or automatically trigger additional enforcement.

As OHCA develops regulations and guidance, we encourage the agency to identify reasonable opportunities where corrective actions can improve affordability while maintaining access, quality, workforce stability, and long-term sustainability.

In addition, CAHP is concerned by suggestions that OHCA may impose interim monetary penalties based on an entity's failure to satisfy individual milestones during the term of a PIP. Before codifying or implementing such a mechanism, OHCA should identify the statutory authority supporting penalties tied to interim milestones, separate from the enforcement terms expressly authorized by statute. PIP milestones should be used to evaluate progress and guide corrective action, not to create additional penalty triggers that the Legislature did not authorize. OHCA should also clarify how procedural penalties associated with PIP implementation interact with penalties tied to spending target performance and ensure that the same circumstances do not result in duplicative or disproportionate penalties.

IX. Continued Concerns Regarding Palomar and UC System Transactions

Finally, we continue to believe that the recent budget trailer bill language relating to the Palomar Health–University of California Joint Powers Authority transaction underscores the importance of transparent and predictable affordability oversight.

While the transaction ultimately proceeded without a full CMIR review, the broader concerns raised by plans regarding affordability impacts, pricing dynamics, and future UC-related restructurings remain relevant. The trailer bill language addresses certain legal issues surrounding the transaction, but it also serves as a reminder of the importance of clear oversight principles for large health system restructurings that may affect affordability, access, and competition.

CAHP looks forward to continuing to engage with OHCA staff and the Board as the next phase of implementation begins. We remain committed to working collaboratively to ensure that California’s affordability framework achieves its intended goals while preserving access, promoting innovation, and ensuring fair and consistent treatment across the health care system.

Sincerely,

A handwritten signature in black ink, reading "Charles Bacchi". The signature is written in a cursive, flowing style.

Charles Bacchi
President & CEO