HCAi Department of Health Care Access and Information
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Health Care Affordability Board
December 16, 2025
Public Comment

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

Date	Name	Written Comment
12/15/2025	Salinas Valley Health	See Attachment #1
01/22/2025	California Hospital Association	See Attachment #2.
01/22/2025	Health Access California	See Attachment #3

December 15, 2025

VIA EMAIL
Members of the Office of Health Care Affordability Board
2020 W. El Camino Avenue
Sacramento, CA 95833

Dear OHCA Leadership,

The OHCA-commissioned "Investigative Study of Hospital Market Competition in Monterey County" dated November 13, 2025, aims to analyze market competition and affordability in Monterey County. However, the report contains significant factual inaccuracies, critical omissions, unsupported conclusions, and conflicts of interest that undermine its credibility and distort the reality of healthcare delivery in the region.

The conclusions and recommendations contained in the report are likely to cause considerable harm to the people of Monterey County by constraining and reducing the availability of critical services.

Particularly concerning issues include:

- Major factual inaccuracy regarding the alleged ownership of Montage Health by Salinas Valley Health (SVH)
- Selective quality reporting
- Rejection of the concept of cost shifting despite conflicting peer-reviewed evidence
- Failure to account for underpayment by Medicare and Medi-Cal
- Superficial analysis of market competition
- Misinterpretation of operating margins and exclusion of consolidated system financials
- Mischaracterization of physician practice integration
- Failure to acknowledge Salinas Valley Health investments in lower-cost outpatient care
- Heavy reliance on commercial insurers, which have financial incentives and no requirement to pass savings on to employers

This document provides a corrected, evidence-based interpretation of Monterey County's healthcare landscape.

Factual Error: SVH Does Not Own 49 Percent of Montage Health
The report inaccurately implies that CHOMP and SVH are partners through Montage Health. It claims that "market power is amplified by significant physician consolidation, particularly the alignment of the county's largest medical groups with CHOMP and SVMHC through Montage Health …."

Additionally, one of the OHCA board members explicitly stated in the most recent November 19, 2025 meeting that SVH owns 49% of Montage Health. This claim is false. SVH holds no equity stake, partial ownership, or governance authority in Montage Health.

While there has been a partnership principally devoted to providing a Medicare Advantage Plan through Aspire Health, this venture has incurred losses in excess of $100 million and is supported by the independent parent organizations as a community benefit. These figures can be readily validated.

The statement in the report, as well as the verbal assertion by the OHCA board member, incorrectly inflates the perception of consolidation and distorts the study's assessment of market power.

Failure to Account for Payer Mix, Government Funding, and Cost Shifting
The report asserts that cost-shifting is "generally rejected by economists."
This statement is inaccurate. A substantial body of research demonstrates that cost-shifting does occur when hospitals serve a high proportion of Medicare and Medi-Cal patients and face persistent below-cost reimbursement. Peer-reviewed research supporting cost-shifting includes, but is not limited to:

- Chernew, M., He, H., Mintz, H., & Beaulieu, N. *Public Payment Rates for Hospitals and the Potential for Consolidation-Inducing Cost Shifting.* **Health Affairs.** August 2021.
- Zwanziger, J., PhD, & Bamezai, A., PhD. *Evidence of Cost Shifting in California Hospitals.* **Health Affairs.** 2006;25(1):197–203.
- Priselac, T. M. *The Cost Shift, the Health Care Ecosystem, and Commercial Prices.* **Health Affairs.** September 25, 2023.
- Meyer, J., & Johnson, W. *Cost Shifting in Health Care: An Economic Analysis.* **Health Affairs.** Summer 1983.

Monterey County exhibits all conditions associated with cost-shifting:
• SVH: approximately 70 percent Medicare and Medi-Cal (currently closer to 75–78 percent)
• Medi-Cal reimbursement among the lowest in the United States – for SVH ~50% of cost
• Medicare reimburses below cost, typically 84–90 percent of hospital cost

Margin Misinterpretation and Use of Hospital-Only Financials
SVH is an integrated system that includes an inpatient hospital, hospital-based outpatient services, a clinic system off the hospital license, and joint ventures with lower-cost community healthcare entities.

Despite repeated requests for OHCA to evaluate SVH as a consolidated system using audited consolidated financial statements, the agency relied solely on hospital-only margins. This approach overstates system financial performance, disregards integrated care delivery models, and distorts affordability conclusions. Consolidated margins are the appropriate basis for regulatory review and are significantly lower than hospital-only margins.

Mischaracterization of Physician Practice Integration
The report states that Monterey County hospitals consolidated the market by acquiring physician practices. This characterization is misleading. In reality, at SVH, physicians sought affiliation because private practice had become financially unsustainable. Clinics were not purchased

beyond limited tangible assets, such as medical equipment. This could have been confirmed through interviews with providers and a review of public documents.

Additionally, at SVH, the commercial contracts held by practices prior to joining the SVH clinic system were reimbursed at higher rates than the global SVH Clinics contracts, thereby reducing costs to payers. Instead, the report relies on nonfactual generalizations about what may have occurred in other markets. Why was this not confirmed and discussed in the report?

While the report acknowledges that professional contracts in Monterey were lower than the state average, this was not accurately defined. Non-hospital contracts included provider reimbursement, lower-cost imaging, clinic services, and laboratory studies. Oddly, the OHCA board generated an unfounded conclusion that providers in Monterey County were being underpaid. This assertion could easily have been shown to be false through a review of our physician reimbursement.

Incorrect conclusions about competition

The report asserts that there is limited competition in Monterey County. In reality, five independent hospital systems operate in the county: Salinas Valley Health, CHOMP, Natividad, Mee Memorial, and Watsonville Community Hospital (which serves as the principal Monterey County hospital for Kaiser Permanente). By what established measure is this level of competition deemed insufficient?

The report further claims that competition is restricted by geographic barriers, suggesting that "mountainous terrain" limits travel between Monterey and Salinas. This description is inaccurate and overstates actual travel difficulty. State Route 68 and other major roadways provide direct access between the two cities. The route includes a limited number of rolling hills rather than mountainous passes. Commuting between Monterey and Salinas is routine for hospital staff, physicians, patients, and residents.

By representing this route as a substantial geographic barrier, the report misleads readers and inaccurately portrays Monterey and Salinas as separate markets. These communities are closely connected, with regular cross-travel for healthcare, employment, education, and daily activities. This description functions as rhetorical exaggeration rather than a factual assessment of market dynamics.

OHCA Ignores SVH's Investments in Lower-Cost Outpatient Care

Salinas Valley Health has expanded access to lower-cost alternatives to hospital-based care through targeted investments, including urgent care clinics that divert patients from the emergency department, as well as an independent ambulatory surgery center, an outpatient endoscopy center, and an outpatient radiation oncology center.

Mischaracterization of Quality Performance

The report states that Monterey hospitals generally perform at levels similar to statewide averages, using a combination of traditional and OHCA "constructed" metrics. Well-established industry metrics present a different picture:

Salinas Valley Health holds a four- to five-star CMS Overall Quality Rating, a distinction achieved by approximately 10 percent of hospitals nationally. Salinas Valley Health consistently receives a Leapfrog Hospital Safety Grade of "A," reflecting strong performance in preventing

harm and ensuring patient safety. Salinas Valley Health has earned designation through the American Nurses Credentialing Center Magnet Recognition Program, a distinction achieved by approximately 10 percent of health systems nationwide.

The omission of these recognized quality measures undermines the objectivity of the report's quality analysis.

Conflict of Interest
The report relies heavily on interviews with commercial insurers, who have clear financial incentives to attribute cost trends to hospitals. Insurers are not required to:
• Reduce premiums when hospital rates decrease
• Pass savings to employers
• Lower patient out-of-pocket costs

This reliance introduces a significant conflict of interest, as lower hospital payments may increase insurer profits without improving affordability for patients or employers.

Conclusions
The OHCA-commissioned study contains factual inaccuracies, inapplicable or unsupported generalizations, unbalanced sourcing, misinterpretations, and unsupported conclusions.

A scientifically and economically sound analysis would require accurate representation of ownership structures, inclusion of complete and recognized quality metrics, consideration of peer-reviewed research on cost shifting, acknowledgment of reimbursement realities, use of consolidated system financials, accurate characterization of physician practice dynamics, recognition of outpatient investments that improve affordability, and reduced reliance on commercial insurers.

SVH shares OHCA's concerns regarding affordable health care. Our primary service area is overwhelmingly Latino/Hispanic, with many residents having uncertain immigration status and a payer mix that is predominantly Medi-Cal. We have made deliberate efforts to reduce costs while maintaining access to care for everyone in our community.

To that end, we have developed low-cost clinics and imaging services, urgent care centers, and have partnered with a community ambulatory surgery center, an endoscopy center, and a radiation oncology center. We have developed a clinic system to recruit and retain providers at considerable cost to SVH, while simultaneously decreasing expenses to payers. In addition, we have supported, at considerable financial loss, a Medicare Advantage program for our community.

OHCA's unilateral focus on hospital commercial payer mix, without appropriate consideration of the broader context of the services we provide, clearly endangers our ability to continue offering these essential services. This concern is compounded by an overemphasis on a narrative of geographic collusion, which does not reflect the realities or needs of our community.

Questions for OHCA

1. Why did the report imply, and an OHCA board member state, that Salinas Valley Health has an ownership interest in Montage Health when no such ownership exists? What fact-checking process allowed this error?
2. Why did this report rely on commercial insurer interviews, given that these entities have clear financial conflicts of interest? If insurers are not required to pass savings on to employers, how would reducing hospital reimbursement improve affordability rather than simply increase insurer profits?
3. Why does the report claim that cost shifting is "generally rejected," despite substantial peer-reviewed research documenting cost shifting in markets with high public-payer mix and chronic under-reimbursement?
4. Why did the report generalize hospital quality as "similar" statewide while omitting Salinas Valley Health Medical Center's consistent Leapfrog "A" safety grades, Magnet nursing designation, and above-average CMS ratings? Where did OHCA obtain its rubric for quality analysis? Was it developed to align with preconceived conclusions?
5. Why does OHCA focus solely on hospital operating margins and ignore consolidated system margins that include significantly lower professional reimbursement, including clinics, outpatient radiology, and laboratory services?
6. By what criteria was it determined that five independent hospitals in Monterey County do not create a competitive environment?
7. Did the report verify whether physician practices joined Salinas Valley Health voluntarily due to financial instability? Did the analysis evaluate any adverse change in payer expense after practices joined the health system? Was there an analysis of physician compensation under this model, or did the report rely on generalizations?
8. Why did the study claim that system consolidation increased professional prices when professional rates, including provider-based services and outpatient radiology, laboratory, and clinic services, generally declined under clinic-wide contracts?
9. How does OHCA reconcile its narrative with Salinas Valley Health investments in lower-cost outpatient care, including urgent care, an ambulatory surgery center, an ambulatory endoscopy center, and outpatient radiation oncology?
10. Did anyone from the commission visit Monterey County and drive State Route 68 to evaluate whether the purported "mountainous terrain" dividing the county affects access or competition?
11. Given the multiple factual errors, omissions, and unbalanced sourcing, will OHCA revise or correct the report to ensure accuracy before using it to inform policy?

Sincerely,

Allen Radner, MD
President/Chief Executive Officer
Salinas Valley Health

cc: Members of the Office of Health Care Affordability Board:
David Carlisle, MD, PhD
Sandra Hernandez, MD
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Richard Pan, MD, MPH
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Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom

California Hospital Association

January 22, 2026

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

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

Dear Chair Johnson:

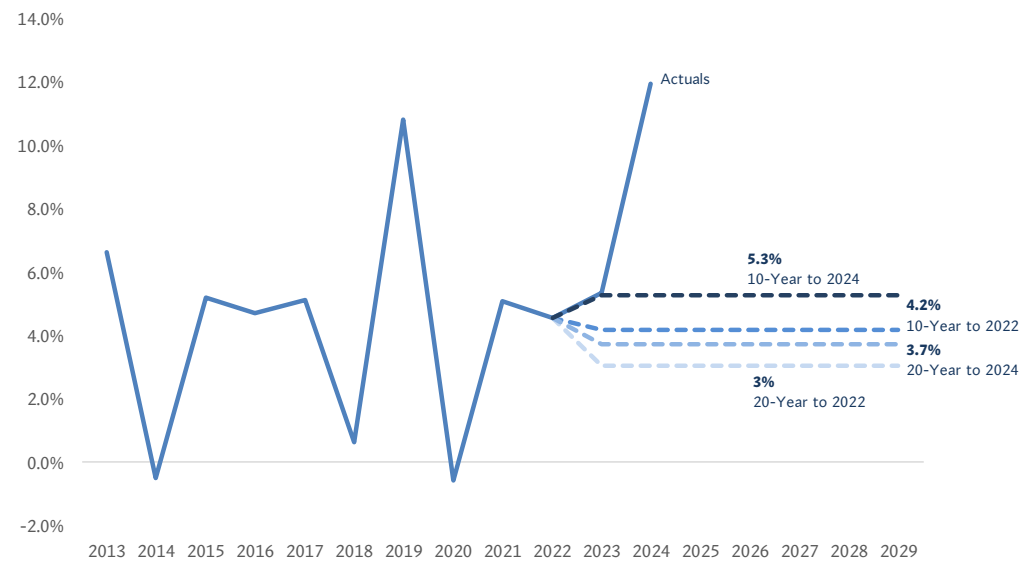
California's hospitals share the Office of Health Care Affordability's (OHCA's) goal to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of nearly 400 hospitals, the California Hospital Association (CHA) appreciates the opportunity to comment.

OHCA Must Update Spending Targets to Reflect Current Economic Trends

The December board meeting included an update and helpful discussion of recent economic and health care spending trends. The conversation revealed a deep disconnect between the 3% statewide spending target and the trends illustrated by more recent data — as well as with the rationale on which OHCA based that 3% spending target. In selecting median household income growth as the basis of the spending target, OHCA declared its intent that per capita health care spending should not grow faster than Californians' incomes. However, since the target was set in early 2024, two additional years of data have become available, revealing that **a typical California household's income has grown at nearly 3 times the rate assumed by OHCA (8.6% versus 3%).** The figure on the next page further illustrates the divergence between OHCA's selected value and alternative approaches to establishing expectations for current and future median household income growth. As shown, the 10-year average growth rate (updated to include the last two years of available data) is closest to the actual values, while the 20-year historical period based on outdated data diverges farthest from the actuals. In fact, in 9 out of the 12 years included in this snapshot, the 20-year average undershot actual growth (in each of these years, by

more than 1 percentage point). Technical analysis also reveals the superiority of using shorter time windows to predict future values.[1]

OHCA's 20-Year Historical Average of Median Household Income Growth Is Out of Alignment with the Last 10 Years' Trends



Furthermore, the state's most recent economic outlook projections in the Governor's proposed January 2026-27 budget anticipate elevated growth of economic indicators similar to median household income to persist, forecasting average wages and personal income to grow by 4.3% and 4.6%, respectively, between 2025 and 2029 on average (in the long term, median household income typically grows at a rate between these two economic indicators). Data for the past 10 years of growth for per capita health care spending, inflation, and per capita gross state product similarly all point in the same direction — that the spending target is far too low.

An inadequate spending target undermines OHCA's mission in a plethora of ways:

- It sows doubt among health care entities as to whether meeting the target is within their control, and whether undertaking challenging and uncertain efforts to reduce their spending would even allow them to successfully avoid missing the target and penalization.
- It will likely result in hundreds of entities violating the target in a given year, overwhelming OHCA's ability to properly carry out its compliance activities and provide individual attention to those progressing through the enforcement process as statutorily required.
- Statewide health care spending that continues to grow far beyond the target will ultimately give lawmakers, providers, and other stakeholders the impression that the office is not effectively pursuing its goals.

[1] Using pseudo out-of-sample techniques, CHA tested whether 10- or 20-year windows generated median household income growth predictions closer to actuals since 1984. The 10-year average performed better in terms of both mean absolute errors and bias reduction. While both windows systematically underestimate growth (likely due to the Great Recession period), the bias for 20-year average was far higher.

For these reasons, the OHCA board should update the spending target to ensure it is realistic, attainable, and responsive to recent trends. While incorporating drivers of health care spending directly into the calculation of the target would be the best approach, tying the target to more recent economic conditions would be a step in the right direction.

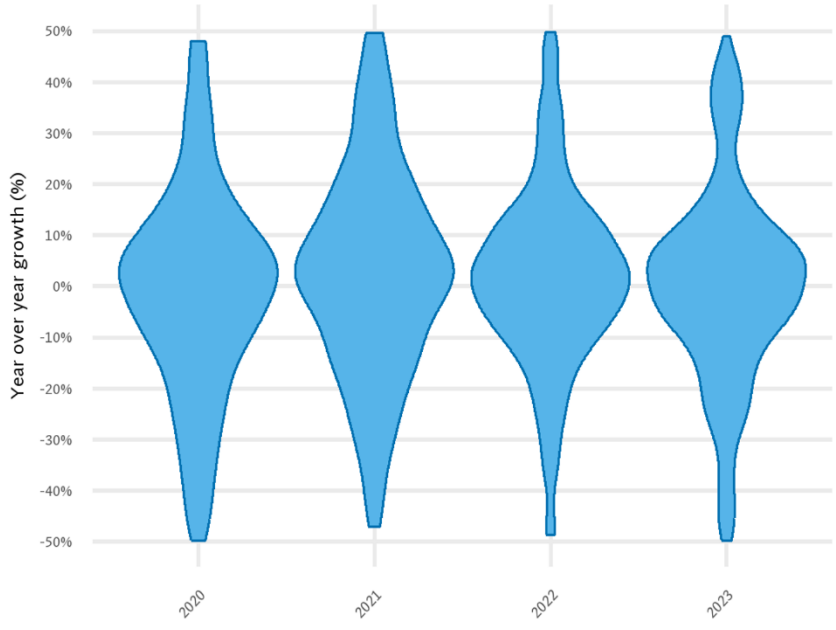
Performance Improvement Plans Are a Mandatory and Important Step in Collaboration Toward Shared Goals

OHCA's spending targets do not reflect many of the economic, policy, and public health realities that health care entities face. These conditions drive up the cost of care, increase uncompensated care, and result in patients being sicker by the time they visit the hospital. A reasonable and collaborative enforcement process is essential if OHCA is to pursue its full mission: promoting affordability while maintaining and improving health care access, quality, equity, and workforce stability.

As part of the enforcement process, after completing prior steps, OHCA has authority to direct entities that exceed the target to undertake performance improvement plans (PIPs). These would be developed by the entity and ultimately approved by OHCA. This progressive enforcement step provides entities with an opportunity to work toward improved affordability in collaboration with OHCA.

Yet, at the December 2025 board meeting where OHCA staff presented its initial proposed PIP process, some board members questioned whether the process was even necessary. They noted that PIPs are simply a deferral of enforcement, and suggested that OHCA should bypass the PIP process to directly levy fiscal penalties on these entities. OHCA staff correctly clarified to the board that the PIP process is a required component of the progressive enforcement process, providing entities the opportunity to develop and implement meaningful improvement to improve their spending trends. As OHCA staff continue to develop and define the PIP process, California's hospitals urge staff and the board to incorporate the following considerations.

Commercial Inpatient Spending Growth is Highly Volatile Across Hospitals and Years



Commercial spending defined as Commercial Inpatient Net Patient Revenue per Case-Mix Adjusted Discharge. Half of hospital measurements across observation years are within 2.1 percentage points of the 3.5% spending target.

PIP Implementation Should Be Based on Multiyear Performance and Statistical Confidence

Hospital spending growth, as OHCA intends to measure it, is anything but stable. Every year, hospitals'

inpatient revenues on a volume- and service intensity-adjusted basis regularly explode or crash, alternating between these cycles year-to-year. This enormous variation is vividly apparent in the figure on the prior page, which illustrates that in any single year-to-year period, huge numbers of hospitals will grow above the target, **despite the fact that their multiyear trajectory is closer in line with OHCA's targets.** Ultimately, this makes it absolutely necessary for OHCA to base enforcement decisions, including which entities are subject to a PIP, on a multiyear evaluation of entities' performance against the spending targets. For example, OHCA could initiate the PIP process for entities that miss the target in 3 out of 5 years. OHCA should further consider using statistical testing techniques to determine whether measured growth rates differ from the targets with statistical confidence, as is done in Oregon.

Entities Must Be Given an Appropriate Timeline for PIP Submission and Implementation
OHCA has proposed providing entities with 45 days to submit a PIP, along with the opportunity to request an extension of up to 30 days; the PIP itself would last up to three years. To ensure entities have adequate time to weigh strategies and actions to come into target compliance, and to develop meaningful plans which will involve coordination and extensive analysis with a number of departments, OHCA should extend its proposed PIP submission time frame. For example, Oregon's PIP process for its spending target program allows entities 90 days and an extension of up to 45 days for their PIP submission. Additionally, entities should be afforded adequate time to implement and make progress on their PIPs, while collaboratively engaging with OHCA as they take effect.

Entities Must Be Given Appropriate Flexibility to Tailor Their PIPs
OHCA has noted that entities will need to include specific goals, strategies, adjustments, and action steps in the development of their PIPs. While OHCA staff, with input from the board, will approve each entity's PIP, it is vital that entities have latitude to develop and carry out individually tailored cost-saving strategies that **they** identify as appropriate for their own organizations. This flexibility would allow entities to implement strategies within their administrative and operational functions, while striving to maintain health care access, quality, equity, and workforce stability.

Confidentiality Must Be Protected During PIP Implementation and Assessment
The PIP process will result in entities sharing sensitive information and documents with OHCA — not just so that OHCA can approve the PIP, but also so it can adequately assess the entity's performance and completion of the PIP. Pursuant to statutory protections, it is critical that OHCA does not disclose confidential information or documents shared during this process. Efforts to publicize this confidential information would not only jeopardize the entity's administration and operations, but also lead to faulty misconceptions and conclusions by those outside the process.

PIP Rules Must Be Clearly Articulated in Regulation – Lastly, as OHCA finalizes steps in the PIP process, California's hospitals urge OHCA to clearly enumerate these steps and rules in the regulations it plans to promulgate this year so the entire enforcement process is clear and transparent for all regulated entities.

OHCA Must Consider Using Payer-Specific Case Mix Indices When Estimating Annual Spending Growth Rates

At the December board meeting, OHCA proposed using all-payer case mix index (CMI) in the calculation of outpatient commercial net patient revenue (NPR) per case-mix adjusted discharge (CMAD), citing the high overall correlation between all-payer and commercial CMI from both outpatient and inpatient data. While correlation at a point in time may appear strong in the aggregate, this framing does not address how the substitution of all-payer CMI for payer-specific CMI behaves at the hospital level over time, nor the consequences it may have in determining whether an entity has met the 3.5% spending target.

Because CMI scales the denominator in the calculation of CMADS, even modest differences between all-payer and payer-specific CMI can translate into meaningful differences in measured year-over-year growth rates.

To evaluate the policy implications of this choice, CHA calculated year-over-year commercial inpatient NPR per CMAD growth from the Annual Financial Disclosure Reports (AFDR) and HCAI Patient Discharge Data (PDD) from 2019-23 using 1) commercial CMI and 2) all-payer CMI, restricting the analysis to hospitals with meaningful commercial activity and valid year-over-year comparisons. This isolates the effect of the CMI choice itself, holding all other factors, including utilization, NPR, and payer mix constant.

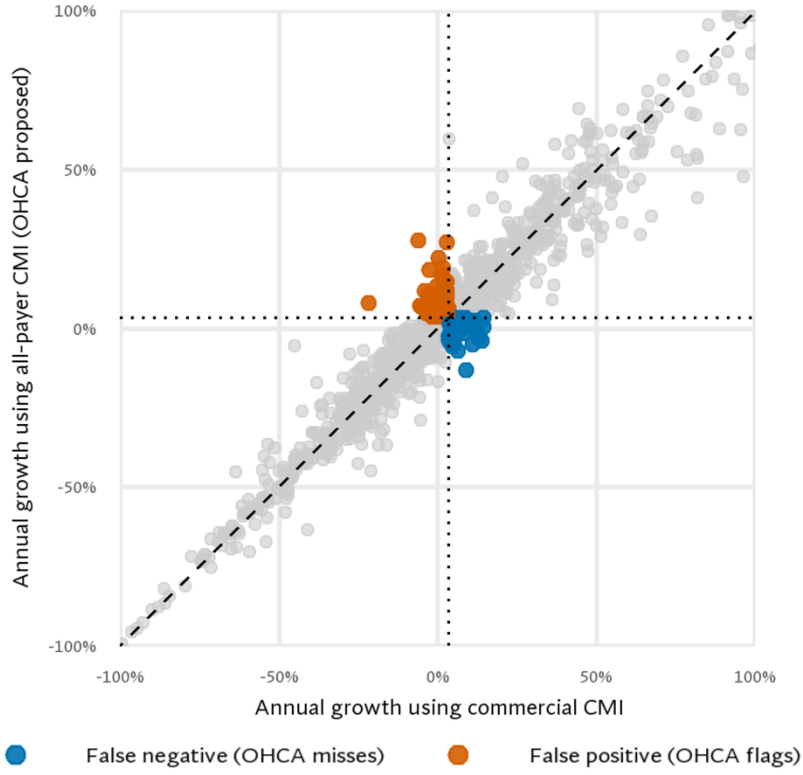
This analysis raises major questions about the appropriateness of proxying payer category-specific CMIs using all-payer CMI. Specifically, it shows:

- **Hospital level growth rates are materially distorted under OHCA proposed inpatient spending measurement approach**. About 75% of hospital spending growth measurements across observation years experience a greater than or equal to 1 percentage point change in the measured growth rate solely due to the choice of CMI.
- Half of hospitals are **within roughly two percentage points of the threshold**, making measured growth highly sensitive to this methodological choice.
- **The choice of CMI materially affects measurement against the spending target.** Approximately 8% of hospital measurements across observation years are misclassified as above or below the 3.5% target depending solely on the use of all-payer versus payer-specific CMIs. Roughly 15-20 hospitals (3-5% of all hospitals) per year are falsely flagged as exceeding the target
- **Cumulative exposure to misclassification is substantial.** Over the full observation period from 2019 to 2023, 13.6% of **hospitals — more than 1 in 8 — are falsely identified as having exceeded a hypothetical spending-growth target for these years of 3.5% at least once** due solely to the use of all-payer rather than commercial CMI.

False positives and false negatives are roughly balanced in the aggregate (see figure on the next page), indicating that the issue does not reflect a systematic bias but does generates arbitrary enforcement risk. Because this reclassification arises from a methodological choice rather than any true underlying

Using All-Payer CMI Changes Which Hospitals Are Flagged as Over the 3.5% Target

Commercial Spending Growth: Payer-Specific vs All-Payer CMI



Axes limited to –100% to +100%. Each point is a hospital-year. Dotted line represents 3.5%

spending behavior, it is a wholly avoidable risk. In OHCA's proposed threshold-based spending target enforcement program, methodological precision at the hospital level is essential. **OHCA must reconsider using payer-category-specific CMIs in place of all-payer CMIs for growth calculations in the inpatient setting.**

Furthermore, **this analysis calls into serious question whether an all-payer outpatient average visit intensity adjustment can be used as a proxy for a commercial average visit intensity adjustment**, as proposed at the December board meeting, as a means for overcoming the major data limitations in the Healthcare Payments Database.

High-Cost Hospital Determinations Do Not Appropriately Reflect Updated Data

OHCA has designated hospitals as "high cost" and intends to assess hospital compliance with the spending targets based on hospitals' AFDR. While hospitals have filed these reports annually for decades, they have never been used for regulatory compliance purposes similar to OHCA's. As a result, hospitals have identified errors in prior years' submitted data, which they are now working to correct. The data submission system for hospitals' AFDR allows hospitals to refile data should they discover errors or problems with past submissions. To date, several hospitals have submitted refiled financial statements that have to materially affected the measures used to assess the high-cost designation, including corrections that change their calculated commercial NPR per CMAD and commercial-to-Medicare payment-to-cost ratio. These refilings may alter not just whether an individual hospital is designated as high cost, but also the value of the 85th percentile threshold that demarcates that group of hospitals.

However, data presented at the December board meeting on these high-cost hospital measures for the designated seven high-cost hospitals indicate that refiled hospital data have not been incorporated into the analysis. (In addition, for the commercial NPR per CMAD measures, the values presented differed

slightly — without explanation —from figures OHCA previously shared. While the difference is small, unexplained changes raise questions about version control and methodological consistency.

To ensure OHCA is using the best possible data, OHCA must incorporate refiled data and reassess which hospitals should be designated as high-cost. Given the significant regulatory consequences associated with being a high-cost hospital, data accuracy and reliability are essential.

Evidence Gaps in the Oregon Hospital Payment Cap Study

The December board meeting's executive updates included a discussion of a *Health Affairs* study of Oregon's hospital payment cap program. Notably, the study does not assess patient affordability outcomes such as premiums, out-of-pocket costs, or access, and therefore does not demonstrate meaningful affordability gains for patients. Instead, the analysis focuses on hospital finances, operations, and patient experience, and finds largely no statistically significant changes after implementation of the hospital payment cap.

Critically, the cap applied to only about 15% of the Oregon commercial market, a limitation the authors explicitly acknowledge; they go on to explain that this limits the degree to which the report may be generalized to broader markets. The authors also note that potential hospital responses to the cap such as cost shifting cannot be ruled out, as several estimates are directionally consistent with such behavior. In addition, the study relies on the National Academy for State Health Policy Hospital Cost Tool and Medicare cost report data, which the authors recognize have known reporting and auditing limitations. As one board member discerningly noted, it is unclear how a hospital payment cap program can successfully promote the affordability of hospital services without any measurable impact on any relevant hospital financial measure, including revenues and operating margins. Clearly, something is missing from this story.

Conclusion

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

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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

HEALTH ACCESS CALIFORNIA

January 21, 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
Health Care Access and Information Department

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

Re: January 2026 Health Care Affordability Board Meeting

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

Health Access, the statewide health care consumer advocacy coalition committed to quality, affordable care for all Californians, seeks public transparency and accountability for enforcement processes as well as penalties consistent with state law.

Executive Summary

Health Access recommends:

- Public notice at each step of the enforcement process to further transparency of slowing health care cost growth and public accountability
- Recognition that performance improvement plans are not required for all administrative penalties, including not only the modest data submission penalties already approved by the Board but also other penalties for knowingly or willfully failing to submit information or a performance improvement plan
- The best penalty is a penalty that is never needed because health care entities slow the rate of growth
- No waivers of enforcement at this time
- Enforcement considerations only for factors documented to be beyond the control of the entity, and not for revenue sources masquerading as alleged costs
- Continued reliance on established data sets

Enforcement: Transparency and Accountability

Health insurance premiums for coverage bought by individuals and employers for working families are five times as expensive as twenty years ago. Prior to the

creation of OHCA, purchasers had literally no place to hold accountable the entire health care industry. Today Californians face an individual mandate to purchase health insurance no matter how much costs have grown: this makes the need for transparency and accountability of health insurance costs even greater.

The Health Care Affordability Board creates a public forum for transparency and accountability for health care costs in California's multi-payer health care system with multiple sources of coverage, including not only Medicare and Medi-Cal but also employer coverage and individual coverage, whether purchased directly or through Covered California. Purchasers of commercial coverage including both employer coverage and individual coverage are a diffuse group consisting of large employers, small businesses and individual consumers, unable to act collectively to control the cost of health insurance. Without the public forum of OHCA, every element of the health care industry has been able to increase costs with little or no effective accountability.

The enabling statute for OHCA requires public transparency of the enforcement and accountability for the industry elements responsible for health care costs. Transparency and public accountability are foundational to shifting the longstanding health care industry culture of ever-increasing costs to slower growth. The baseline report on 2022-23 spending found that more than 90% of commercial coverage is spent on hospital care, both inpatient and outpatient, professional services by physicians and others, outpatient prescription drugs, labs and imaging while less than 10% is spent on the administrative overhead and profits of health plans and insurers.

At each of the steps of accountability for health care costs in this multi-payer system, public transparency is foundational:

- Step One: setting the growth target
    - The law requires that the Board publicly vote on the growth targets. After months of public input and public Board deliberations, the Board did so two years ago.
    - After further months of public debate, the Board acted to set a lower target for very high-cost hospitals, hospitals that start from a higher relative and absolute cost than 98% of California hospitals.
    - Because of the growth targets set by the OHCA Board, for the first time ever, hospitals, large physician organizations, and other health care entities as well as health plans and insurers are subject to publicly knowable growth targets.
- Step Two: determine whether an entity exceeded the target: public notice at the time the entity initially receives notice of exceeding the target.
    - Notice that the entity has exceeded the target should be made public in writing at the time the initial notice is given to the entity.
- Step Three: public notice of office's determination of whether to proceed with enforcement, including any enforcement considerations.
    - After an entity receives notice that it has exceeded the target, the entity then has 45 days to provide additional information. If the entity provides additional information "that meets the burden established by the office[1]" and is determined by the director on the basis of this information not to have exceeded the target, then that determination and a brief summary of the basis for it should be made public in writing.

[1] 127502.5 (b) (3)

    - This 45-day window also provides the opportunity for public input but only if the public has notice when it commences.
    - Whether to proceed with enforcement, including any enforcement considerations, should be made public, at least in summary fashion.
- Step Four: the office provides public notice of the extent to which the target was exceeded[2]. If general technical assistance is provided to the entity, the fact that it has been should also be subject to public notice.
    - This provision for public notice assures that policy makers and other stakeholders can determine whether the entity only exceeded the target slightly or missed by a mile.
        - This step can assist in enforcement: is there widespread compliance as we hope? Or specific geographic regions or categories of entities that disproportionately driving up costs? Is there a pattern such as "must-have" providers?
        - The office will provide general technical assistance, not detailed consulting, and the public should be informed when and to what extent technical assistance is provided.
- Step Five: Public Testimony Written or Verbal:
    - The law gives the director discretion to compel such testimony, either verbal or written. This provision is part of progressive enforcement. At a minimum, each entity that exceeds the target should be required to provide a written explanation of the reasons for exceeding the target.
- Step Six: "Performance Improvement Plan":
    - If the entity fails to meet the target after the first several steps of enforcement, then the director may require the entity to develop an entity-specific plan of corrective action to bring the entity into compliance over time. This plan needs agreement from the OHCA staff. Public notice is required by law and that law requires a "detailed summary to the entity's compliance with" the plan[3]. The law requires Board discussion of any performance improvement plan.
    - Health Access also recommends that ongoing monitoring of a "performance improvement" plan should be subject to periodic public reporting.
    - A performance improvement plan may last up to three years, or a much shorter period depending on what is required for an entity to meet the target. Tracking progress toward coming into compliance will be a matter of public interest.
- Step Seven: administrative penalties for exceeding the target:
    - Health Access recommends that any administrative penalty be publicly announced on the OHCA website and disseminated to local media, as a deterrent for future violations.

Although the law allows the Board to go into executive session to discuss specific aspects of enforcement[4], the law also specifies that only information that has been confidentially maintained is confidential. Information that is in the public domain, as reported to shareholders or subject to other federal or state laws, is not confidential and should be publicly disclosed. The provisions of law are similar to those for other state agencies which have now long track records of extensive public disclosure, such as the Department of Managed Health Care.

[2] 127502.5 (c) (1)
[3] Health and Safety Code 127502.5 (c) (2)
[4] Health and Safety Code 127501.10 (e) (2)

Health Access recommends that OHCA develop a page of its website for making public the progress of "progressive" enforcement, from the growth target to which entities exceeded it and by how much to each of the steps of enforcement. While transparency alone has not been sufficient to fully control costs in other states, transparency is the beginning of public accountability for uncontrolled cost growth.

Penalties and "Performance Improvement Plans"

Not all penalties require a "performance improvement plan".

Contrary to the discussion at the December 2025 Board meeting, it is factually inaccurate to state that all penalties require a "performance improvement plan", a plan to allow the entity time and opportunity to correct its failures to comply.

Indeed, the modest data submission penalties already adopted by this Board do not require a formal "performance improvement" plan or other formal progressive enforcement steps such as public testimony prior to the penalty being imposed. Instead, the focus is on timely submission of data to support the work of the Office and the Board, with a short time interval allowed for late submissions prior to the imposition of penalties. As the Board considers additional penalty types, it should ensure that performance improvement plans do not become a way to delay accountability for gross non-compliance with state law.

Penalties: Triggers and Types

The law provides for several types of administrative penalties, including penalties for:

- Willfully, knowingly, or repeatedly failing to provide complete and accurate information or
- failing to file or implement a performance improvement plan acceptable to the Office.

These penalties are in addition to, and different than, the penalties for exceeding the growth target. These penalties were intended to ensure that the Office can collect necessary information and conduct progressive enforcement steps. Aside from the modest penalties for late or inaccurate data submission by payers, the Board has yet to set the scope and range of the administrative penalties for other transgressions.

Another type of administrative penalty is a penalty which may trigger, after other enforcement steps, when an entity exceeds the growth target. The law states that this penalty is "commensurate" with the failure to comply with the growth target and the penalty escalates from there for continuing or repeated violations. The commensurate penalty was intended as a dollar-for-dollar penalty for the amount the entity exceeds the target.

The Best Penalty: The Penalty that is Not Needed

Health Access has supported substantial penalties for an entity that exceeds the growth target as well as other penalties in the hopes that the threat of such penalties would be sufficient to create incentives for compliance with the growth targets, and the information requirements. Many health care entities subject to the targets and requirements are multi-billion entities with hundreds of millions of dollars in revenues. The magnitude of penalties needed to dam this river of health care

spending is recognized in the provisions of the law that provides for penalties commensurate with the amount the target is exceeded.

The only question in our minds is whether health care entities subject to the targets take seriously the affordability needs of consumers and working families in order to create a sustainable system. Premature and ill-founded litigation indicates a failure to understand the damage done to consumers and workers year after year by high and escalating health care costs. That is why the law includes penalties for violating the growth target that are dollar-for-dollar commensurate with the violation and escalate from there.

Waivers, Enforcement Considerations, What Constitutes Exceeding the Target?

Health Access has previously written, at length, about waivers of enforcement, enforcement considerations and what constitutes exceeding the target. Here we reiterate:

- Health Access supports the staff recommendation not to rely on waivers of enforcement at this time.
    - We note that there are a few instances in which such a blanket waiver might be appropriate, such as the early months of a global pandemic or re-opening of a needed hospital.
    - But there are other instances, such as a major quake, that are on further examination are more appropriate for "enforcement considerations" since even hospitals located in the affected geographic region may vary greatly in impacts, from permanent, near-instant closure to overcrowding due to injuries.
    - We agree that the existing framework of enforcement considerations is sufficient to address factors outside of an entity's control and that implementing waivers would create unnecessary redundancies.
- With respect to "enforcement considerations", Health Access recommends:
    - Careful consideration of which factors are in practice beyond the control of the entity because some, like prescription drug costs, may be revenue sources under the 340B program rather than uncontrollable cost growth.
    - Skepticism about which factors are outside the control of the entity.
    - Estimates of the contribution of the "consideration" to the inability of the entity to meet the cost target in terms of the overall spending by the entity.
    - A requirement that the entity document the specific impact of the enforcement consideration on the entity, presenting internal financial and other relevant data, rather than general market statistics or newspaper clips. What is the concrete, documented impact whether it is unorganized labor costs or general inflation?
    - Public discussion of possible enforcement considerations to receive broad input prior to recognition of such "considerations".
- With respect to measuring target performance, Health Access recommends:
    - Notice that an entity has exceeded the target and summary supporting information should be made public at the time notice is provided to the entity. If or when an entity provides additional information that demonstrates the entity meets the target, then OHCA should make that public at that time.
    - Previously submitted data, whether it is plan THCE data submissions to OHCA, rate review data provided by DMHC or CDI, or hospital financial reporting has been

attested to as valid and truthful and should be treated as entity-provided data throughout the process. An entity which seeks to cook the data after the fact to alter the appearance of compliance with a target should be subject to penalties for "knowingly" failing to provide information or "knowingly" falsifying information. Either the entity submitted bad data the first time or it is polishing the data post-hoc. Most of the data sets used to date are established data sets. This is particularly true of hospital financial data which hospitals have submitted for 50 years, long enough to get it right. Plans have been submitting rate review data for almost 15 years. Even THCE data has now been submitted by plans for almost five years of data.

Summary

The OHCA Board and staff have done important work over the last few years in setting growth targets tied to consumer affordability, as measured by median family income. The work of enforcement, starting with public accountability, measurement of compliance with the targets, and progressing through other enforcement steps is the task ahead.

Sincerely,

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