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

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

OFFICE OF HEALTH CARE AFFORDABILITY
FINDING OF EMERGENCY OF PROPOSED EMERGENCY REGULATIONS

HEALTH CARE SECTORS – HOSPITAL SECTOR DEFINITION

SUBJECT MATTER OF PROPOSED REGULATIONS

The proposed regulation defines a hospital sector pursuant to Health and Safety Code section 127501 *et seq*.

SPECIFIC FACTS DEMONSTRATING THE NEED FOR IMMEDIATE ACTION

In enacting the California Health Care Quality and Affordability Act (Health and Safety Code, section 127500, *et seq*.) (Act), the Legislature found that health care affordability has reached a *crisis point.* (Health & Saf. Code, § 127500.5, subd. (a)(2).) The Office of Health Care Affordability (OHCA or Office) within the Department of Health Care Access and Information (HCAI) is responsible, *inter alia*, for analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs, creating a state strategy for controlling the cost of health care, and ensuring affordability. (Health & Saf. Code, § 127501, subd. (c)(12).)

OHCA is empowered to adopt and promulgate regulations for the purpose of carrying out the laws relating to the Act (Health & Saf. Code, § 127501, subd. (c)(16).) OHCA may adopt as an emergency regulation any necessary rules and regulations for the purpose of implementing the Act. (Health & Saf. Code, § 127501.2, subd. (a).) By statute, the adopted emergency regulations are deemed an *emergency* and necessary for the immediate preservation of the public peace, health and safety, or general welfare. (Health & Saf. Code, § 127501.2, subd. (a) [emphasis added].)

Accordingly, OHCA specifically finds the proposed emergency regulation an emergency and necessary for the immediate preservation of public health and safety, and general welfare of the citizens of California.

Health and Safety Code section 127504.2, subdivision (c), provides that any rule or regulation adopted pursuant to this section shall be discussed by the Health Care Affordability Board (Board) during at least one board meeting before the Office adopts the rule or regulation.

The Board discussed creation of sectors in general at the August and October 2024 board meetings. The Board discussed a hospital sector at the November 2024, December 2024, January 2025, and February 2025 board meetings. In November 2024, the Board discussed potential approaches to defining a hospital sector. At the December 2024 meeting, the Board continued discussions regarding potential approaches for the hospital sector. In January 2024, the Board voted unanimously (6-0 with one member absent) to define hospitals as a sector, prompting the obligation of OHCA to define the sector in regulation. At the February 2025 Board meeting, the Office presented to the Board the specific language of the proposed regulation.

AUTHORITY AND REFERENCE

Pursuant to Health and Safety Code section 127501, subdivision (c)(16), 127501.2, 127501.11, and 127502, the Office shall adopt, amend, or repeal, in accordance with the Administrative Procedure Act, rules and regulations as may be necessary to enable it to carry out the laws relating to the Act.

The proposed regulation implements, interprets, or makes specific Health and Safety Code sections 127501, subdivision (c)(3), 127501.11, subdivisions (a)(2) and (l)(2)(A), and 127502, subdivision (b)(1).

INFORMATIVE DIGEST

Existing Law

Existing law authorizes OHCA to adopt and promulgate regulations for the purpose of carrying out the laws relating to the Act (Health & Saf. Code, § 127501, subd. (c)(16).) Under the Act, the Board, after receiving input, including recommendations, from the Office, Advisory Committee, and public comment, shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate. (Health & Saf. Code §§ 127501.11, subd. (a)(2), 127502, subd. (b)(1).) The Board shall define health care sectors, and the Office shall promulgate regulations accordingly. (Health & Saf. Code §§ 127502, subd. (b)(1).)

Pursuant to Health and Safety Code section 127501.2, subdivision (a), OHCA may adopt as an emergency regulation any necessary rules and regulations for the purpose of implementing the Act. Before the adoption, the Board must discuss any rule or regulation during at least one board meeting. (Health & Saf. Code, § 127501.2, subd. (c).) The adoption of emergency regulations is deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. (Health & Saf. Code, § 127501.2, subd. (a).)

General Policy Statement

Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, OHCA's enabling statute emphasized the public's interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal. (Health & Saf. Code, § 127500.5, subds. (a)(1), (a)(2).) The Act established OHCA to, among other duties, develop a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. (Health & Saf. Code, § 127501, subd. (b).) To advance this mission, the Board has the authority to define health care sectors. (Health & Saf. Code §§ 127501.11, subd. (a)(2), 127502, subds. (b)(1), (l)(2)(A).)

In California, employers are increasingly shifting the cost of premiums and deductibles to employees as health care costs rise, which negatively impacts the potential for wage growth. (Health & Saf. Code, § 127500.5, subd. (a)(3).) While generally noting that wages in the state kept pace with inflation during a certain period, the Legislature found that families with job-based coverage experienced a 45 percent increase in premiums, or more than twice the rate of wage growth. (Health & Saf. Code, § 127500.5, subd. (a)(3).) During the same period for preferred provider organization (PPO) deductibles, families experienced a 70 percent increase, or nearly four times the rate of wage growth. (Health & Saf. Code, § 127500.5, subd. (a)(3).)

The Legislature declared that escalating health care costs are being driven primarily by high prices and the underlying factors or market conditions that drive prices. (Health & Saf. Code, § 127500.5, subd. (a)(4).) Of particular concern are escalating health care costs "in *geographic areas and sectors* where there is a lack of competition due to consolidation, market power, venture capital activity, the role of profit margins, and other market failures." (Health & Saf. Code, § 127500.5, subd. (a)(4) [emphasis added].)

Significantly, health care affordability is having a detrimental effect on the welfare of Californians. The Legislature expressly found:

> Surveys show that *people are delaying or going without care due to concerns about cost, or are getting care but struggling to pay the resulting bill*. In California, one in four people report problems paying or being unable to pay their medical bills, with two-thirds cutting back on basic household items like food and clothing to pay those bills. Concerns about affordability of coverage and care are expected to be exacerbated during the economic recession…. (Health & Saf. Code, § 127500.5, subd. (a)(9) [emphasis added].)

In enacting the Act, the Legislature declared California has a substantial public interest in the price and cost of health care coverage. (Health & Saf. Code, § 127500.5, subd. (a)(11).) The Legislature intends to have a comprehensive view of health care spending, cost trends, and variation to inform actions to reduce the overall rate of growth in health care costs while maintaining quality of care, with the goal of improving affordability, access, and equity of health care. (Health & Saf. Code, § 127500.5, subd. (b).)

In furtherance of the above, the Board held multiple meetings between November 2024 and January 2025, to discuss, among other topics, defining health care sectors pursuant to their statutory obligation, including a hospital sector. The Board chose to define the sector for various reasons. Hospitals are a significant source of health care spending. CMS data shows that nearly 40% of health care spending in California occurs in hospitals, making this a potentially high-impact area to improve efficiency and affordability for consumers.[1] Additionally, hospital prices vary widely across the state, with over five times price variation that is not attributed to higher quality care or better clinical outcomes, but is instead correlated with market concentration.[2] The high cost of hospital care is a reality corroborated by the extensive and regular testimony of public commenters at the Board meetings. Hospitals will be measured differently from other health care entities that rely upon an attributed total medical expense approach, establishing hospitals as their own sector aligns with measuring them differently. Further, this approach allows the Board to consider the unique attributes of hospitals. Finally, historical spending data is available through HCAI's Hospital Annual Disclosure Reports, such that trends and anomalies could be comprehensively examined for hospitals, whereas the Office has collected only two years of total medical expense data for other potential sectors. HCAI also has various other data points for hospitals.[3]

Based on input received from the Office, Advisory Committee, and public comment, the Board considered various approaches to defining the sector. Given the diversity of hospitals—ranging from large medical centers to community-based facilities in both urban and rural areas—the Board explored different approaches for defining the sector, such as focusing on metrics for high cost, high growth, or a combination of metrics. Additional consideration included hospital characteristics, such as critical access hospitals, psychiatric hospitals, academic medical centers, and hospitals that provide specialty care.

---

[1] Wilson, K. (2023, March 14). "*2023 Edition – California Health Care Spending*." California Health Care Foundation. https://www.chcf.org/publication/2023-edition-california-health-care-spending/#related-links-and-downloads.

[2] Data for patients with commercial insurance as well as other government programs are reported in the Other Third-Party category for HCAI Hospital Annual Disclosure Reporting.

[3] For example, hospitals submit annual financial data, which includes general hospital information, medical specialties, hospital services, number of beds, utilization data by payer, financial statements, revenues by payer, cost allocation statistics and calculations.

In January 2025, the Board voted unanimously (6-0 with one member absent) to define a hospital sector consisting of hospitals defined in Health and Safety Code section 1250 *et seq*. During previous meetings, the Board discussed at length the various considerations for defining a hospital sector. For example, in November 2024, the Board considered geographic regions, provider category, payer and/or provider by market category, and individual health care entities. In November 2024, December 2024 and January 2025, Board discussion touched upon the various types of hospitals, such as general acute care hospitals, acute psychiatric hospitals, and psychiatric health facilities. In January 2025, Board members emphasized that hospitals are clearly a health care sector and defining a hospital sector was the necessary first step to allow the Board to proceed with setting spending targets for high-cost hospitals within the sector. For example, in December 2024, OHCA presented data on key financial metrics for the top 30 hospitals without exclusions from 2018-2022, which showed that all of these hospitals had a Commercial to Medicare Payment to Cost Ratio at or above 300%, with approximately 5 hospitals surpassing 400%.

This emergency rulemaking creates a regulation section defining the hospital sector to implement the Board's vote. The sector includes general acute care hospitals, as used in Health and Safety Code section 1250, subdivision (a), acute psychiatric hospitals, as used in Health and Safety Code section 1250, subdivision (b), special hospitals, as used in Health and Safety Code section 1250, subdivision (f), chemical dependency recovery hospitals, as used in Health and Safety Code section 1250.3, subdivision (a)(1), and psychiatric health facilities, as used in Health and Safety Code section 1250.2, subdivision (a)(1).

SPECIFIC PURPOSE AND NECESSITY FOR EACH REGULATION

Section 97446 of Division 7 of Title 22, Health Care Sectors

The purpose of this section is to set in regulation the definition of health care sectors defined by the Board in accordance with Health and Safety Code sections 127502, subdivisions (b)(1), (l)(2)(A), and 127501.11, subdivision (a)(2). This section is necessary because Health and Safety Code section 127502, subdivision (b)(1), requires the Board to define health care sectors, with OHCA promulgating regulations accordingly. Specifically, Health and Safety Code section 127502, subdivision (b)(1), provides:

> (b)(1) The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as

appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.

Notably, Kaiser Permanente is presently the only health care organization that meets the statutory definition of a fully integrated delivery system. (*See* Health & Saf. Code, § 127500.2, subd. (h) [defining a fully integrated delivery system as "a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services."].)

Kaiser Permanente, as a fully integrated delivery system, includes distinct, but interdependent entities. Kaiser Foundation Health Plan is a Knox-Keene licensed health care service plan that provides benefits and coverage to enrollees. Kaiser Foundation Hospitals provide hospital services. The Permanente Medical Group is a medical group serving patients in Northern California. The Southern California Permanente Medical Group is a medical group serving patients in Southern California.

Currently, only one health care sector has been defined by the Board—the hospital sector. This section also establishes a framework for future health care sectors. Each sector will be set at the first subsection level, such as, (a) Hospital Sector, (b) [Second Named] Sector, (c) [Third Named] Sector, (d) [Fourth Named] Sector, and so forth.

Subsection (a)

This subsection defines the first health care sector: the hospital sector. The purpose of this subsection is to set in regulation the sector as defined pursuant to the Board's vote. This section is necessary because Health and Safety Code section 127502, subdivision (b)(1) mandates the Board to define health care sectors, with the Office promulgating regulations accordingly. As previously noted, the Board voted to define a health care sector that includes hospitals defined in Health and Safety Code section 1250 *et seq*.. It is necessary to specify each type of hospital because Health and Safety Code section 1250 *et seq.* is a wide-ranging set of statutes, with sections 1250.2 and 1250.3 using constructive incorporation language that might not be obvious to someone simply looking up "1250" online.

Although Kaiser is a fully integrated delivery system, Kaiser hospitals are not excluded from the hospital sector as the sector includes all hospitals under Health and Safety Code section 1250 *et seq*.. OHCA may report on spending by Kaiser hospitals as part of the hospital sector and can compare their spending growth with other hospitals in the sector. However, Kaiser hospitals would not be subject to any spending targets the Board sets for the hospital sector or adjusts for one or more hospitals within the hospital

sector. Instead, as a fully integrated delivery system, Kaiser would be subject to a spending target the Board may define for fully integrated delivery systems. (Health & Saf. Code, § 127502, subds. (b)(1), (i)(1)-(4), (l)(2)(B).)

Subsection (a)(1)

This subsection defines the first type of hospital included in the hospital sector: general acute care hospitals. This section is necessary to implement the Board's vote because a general acute care hospital is in Health and Safety Code section 1250. The text of the subsection does not modify the definition of a general acute care hospital. Instead, it uses the definition as established in California law. Specifically, the term "general acute care hospital" retains the meaning set forth in Health and Safety Code section 1250, subdivision (a), which is the following:

> "General acute care hospital" means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. A general acute care hospital may include more than one physical plant maintained and operated on separate premises as provided in Section 1250.8. A general acute care hospital that exclusively provides acute medical rehabilitation center services, including at least physical therapy, occupational therapy, and speech therapy, may provide for the required surgical and anesthesia services through a contract with another acute care hospital. In addition, a general acute care hospital that, on July 1, 1983, provided required surgical and anesthesia services through a contract or agreement with another acute care hospital may continue to provide these surgical and anesthesia services through a contract or agreement with an acute care hospital. The general acute care hospital operated by the State Department of Developmental Services at Agnews Developmental Center may, until June 30, 2007, provide surgery and anesthesia services through a contract or agreement with another acute care hospital. Notwithstanding the requirements of this subdivision, a general acute care hospital operated by the Department of Corrections and Rehabilitation or the Department of Veterans Affairs may provide surgery and anesthesia services during normal weekday working hours, and not provide these services during other hours of the

> weekday or on weekends or holidays, if the general acute care hospital otherwise meets the requirements of this section. A "general acute care hospital" includes a "rural general acute care hospital." However, a "rural general acute care hospital" shall not be required by the department to provide surgery and anesthesia services. A "rural general acute care hospital" shall meet either of the following conditions: (1) The hospital meets criteria for designation within peer group six or eight, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982. (2) The hospital meets the criteria for designation within peer group five or seven, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982, and has no more than 76 acute care beds and is located in a census dwelling place of 15,000 or less population according to the 1980 federal census.

Additionally, this subsection is necessary to provide clarity regarding which hospitals belong to the sector, helping to avoid public confusion regarding health care facilities subject to the sector. Health and Safety Code section 1250 *et seq*. lists various health care facilities. By explicitly including "general acute care hospitals," it ensures that general acute care hospitals are clearly identified as part of the sector.

Subsection (a)(2)

This subsection defines the second type of hospital included in the hospital sector: acute psychiatric hospitals. This section is necessary to implement the Board's vote because an acute psychiatric hospital is in Health and Safety Code section 1250. The text of the subsection does not modify the definition of an acute psychiatric hospital. Instead, it uses the definition as established in California law. Specifically, the term "acute psychiatric hospital" retains the meaning set forth in Health and Safety Code section 1250, subdivision (b), which is the following:

> "Acute psychiatric hospital" means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services."

Additionally, this subsection is necessary to provide clarity regarding which hospitals belong to the sector, helping to avoid public confusion regarding health care facilities subject to the sector. Health and Safety Code section 1250 *et seq*. lists various health care facilities. By explicitly including "acute psychiatric hospitals," it ensures that acute psychiatric hospitals are clearly identified as part of the sector.

Subsection (a)(3)

This subsection defines the third type of hospital included in the hospital sector: special hospitals. This section is necessary to implement the Board's vote because a special hospital is in Health and Safety Code section 1250. The text of the subsection does not modify the definition of a special hospital. Instead, it uses the definition as established in California law. Specifically, the term "special hospital" retains the meaning set forth in Health and Safety Code section 1250, subdivision (f), which is the following:

> "Special hospital" means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical or dental staff that provides inpatient or outpatient care in dentistry or maternity.

Additionally, this subsection is necessary to provide clarity regarding which hospitals belong to the sector, helping to avoid public confusion regarding health care facilities subject to the sector. As an initial matter, the Department is unaware of any special hospitals currently operating in California. However, the absence of such hospitals does not preclude their establishment in the future. The inclusion of special hospitals therefore ensures such hospitals fall within the sector. Furthermore, Health and Safety Code section 1250 *et seq*. lists various health care facilities. By explicitly including "special hospitals," it ensures that special hospitals are clearly identified as part of the sector.

Subsection (a)(4)

This subsection defines the fourth type of hospital included in the hospital sector: chemical dependency recovery hospitals. This section is necessary to implement the Board's vote because a chemical dependency recovery hospital is defined in Health and Safety Code section 1250 *et seq*.[4] The text of the subsection does not modify the definition of a chemical dependency recovery hospital. Instead, it uses the definition as established in California law. Specifically, the term "chemical dependency recovery

[4] A reference to Health and Safety Code section 1250 may be construed to reference section 1250.3. (*See* Health & Saf. Code, § 1250.3, subd. (h) [any reference in any statute to Section 1250 shall be deemed and construed to also be a reference to this section.].)

hospital" retains the meaning set forth in Health and Safety Code section 1250.3, subdivision (a)(1), which is the following:

> "Chemical dependency recovery hospital" means a health facility that provides 24-hour inpatient chemical dependency recovery services for persons who have a dependency on alcohol or other drugs, or both alcohol and other drugs. Each facility shall have a medical director who is a physician and surgeon licensed to practice in this state.

Generally, a chemical dependency recovery hospital may be intertwined with a general acute care hospital or acute psychiatric hospital. For example, a chemical dependency recovery hospital that "is not a part of a general acute care hospital *shall have agreements with one or more general acute care hospitals* providing for 24-hour emergency service" and certain other required services. (Health & Saf. Code, § 1250.3, subd. (c) [emphasis added].) A general acute care hospital or acute psychiatric hospital "may provide chemical dependency recovery services as a supplemental service *within the same building, or in a separate building on campus* that meets certain structural requirements of a freestanding chemical dependency recovery hospital. (Health & Saf. Code, § 1250.3, subd. (e)(1) [emphasis added].) Chemical dependency recovery services may be "co-located with other services of its *parent general acute care hospital or acute psychiatric hospital*." (Health & Saf. Code, § 1250.3, subd. (g) [emphasis added].)

Additionally, this subsection is necessary to provide clarity regarding which hospitals belong to the sector, helping to avoid public confusion regarding health care facilities subject to the sector. Health and Safety Code section 1250 *et seq*. lists various health care facilities. By explicitly including "chemical dependency recovery hospitals," it ensures that chemical dependency recovery hospitals are clearly identified as part of the sector.

Subsection (a)(5)

This subsection defines the fifth type of hospital included in the hospital sector: psychiatric health facilities. This section is necessary to implement the Board's vote because a psychiatric health facility is defined in Health and Safety Code section 1250 *et seq*.[5] The text of the subsection does not modify the definition of a psychiatric health facility. Instead, it uses the definition as established in California law. Specifically, the

[5] A reference to Health and Safety Code section 1250 may be construed to reference section 1250.2. (*See* Health & Saf. Code, § 1250.2, subd. (c) [a reference in any statute to Section 1250 of the Health and Safety Code shall be deemed and construed to also be a reference to this section.].)

term “psychiatric health facility” retains the meaning set forth in Health and Safety Code section 1250.2, subdivision (a)(1) which is the following:

> “As defined in Section 1250, “health facility” includes a “psychiatric health facility,” defined to mean a health facility, licensed by the State Department of Health Care Services, that provides 24-hour inpatient care for people with mental health disorders, severe substance use disorders, as defined in subdivision (o) of Section 5008 of the Welfare and Institutions Code, or cooccurring mental health and severe substance use disorders, or other persons described in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code. This care shall include, but not be limited to, the following basic services: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, food services, and substance use disorder services, as medically necessary and appropriate. Psychiatric health facilities shall only admit persons whose physical health needs can be met in an affiliated hospital or in outpatient settings and shall only admit people with stand-alone severe substance use disorders involuntarily pursuant to Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code.

Generally, psychiatric health facilities may be intertwined with a general acute care hospital or acute psychiatric hospital. (*See* Health & Saf. Code, § 1250.2, subd. (a)(1) [noting that “psychiatric health facilities shall only admit persons whose physical health needs can be met in an affiliated hospital or in outpatient settings….”].) Currently, there are thirty-four psychiatric health facilities in California, all licensed by the Department of Health Care Services. Like acute psychiatric hospitals, psychiatric health facilities provide 24-hour inpatient care for people with mental health disorders, or other persons described in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code. (*Compare* Health & Saf. Code, § 1250, subd. (b) *with* Health & Saf. Code, § 1250.2, subd. (a)(1).)

Additionally, this subsection is necessary to provide clarity regarding which hospitals belong to the sector, helping to avoid public confusion regarding health care facilities subject to the sector. Health and Safety Code section 1250 *et seq*. lists various health care facilities. By explicitly including “psychiatric health facilities”, it ensures that psychiatric health facilities are clearly identified as part of the sector.

ANTICIPATED BENEFITS OF THE PROPOSAL

The proposed emergency regulation sets the foundation and framework for future health care sectors, beginning with the hospital sector. These sectors will serve as the basis for the Board to set specific spending targets by sector. (See Health & Saf. Code, § 127502, subd. (b)(1).) Once fully implemented, health care sector spending targets will address the Legislature's concern of escalating health care costs "in *geographic areas and sectors* where there is a lack of competition due to consolidation, market power, venture capital activity, the role of profit margins, and other market failures." (Health & Saf. Code, § 127500.5, subd. (a)(4) [emphasis added].) By setting this foundation and framework, along with the initial hospital sector, OHCA can support the Board, through data collection, analysis, and recommendations, to establish specific costs targets by health care sector. This process will enable the Board and OHCA to fulfill the Legislature's intent in enacting the Act by providing a comprehensive view of health care spending, cost trends, and variations, ultimately guiding efforts to reduce the overall rate of growth in health care costs in California. (See Health & Saf. Code, § 127500.5, subd. (b).)

CONSIDERATION OF ALTERNATIVES:

No reasonable alternative to the regulatory proposal would be either more effective in carrying out the purpose, for which the action is proposed, or be as effective or less burdensome to affected private persons, and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the law being implemented or made specific. The Board considered the following alternatives:

Before choosing hospitals as a sector subject to a separate spending target, the Board considered other potential sectors: 1) geographic regions, 2) provider category (e.g. hospitals, physician's organizations), 3) payer and/ or provider by market category, and 4) individual health care entities. These options were ruled out because OHCA only began the collection of payer-level and regional total medical expenses in 2024. It would be more informative to have more than one year of spending growth trend before defining sectors based on geographic region, market, payer, physician organizations, and/or fully integrated delivery system.

In contrast, OHCA has historical data on hospital spending, and has developed a provisional measurement for hospitals using existing HCAI Hospital Annual Financial Data. In addition, based on 2020 CMS data, we know that nearly 40 percent of health care spending in California occurs in hospitals, making this a potentially high-impact

arena to improve affordability for consumers.[6] The high cost of hospital care is a reality corroborated by the extensive and regular testimony of public commenters at monthly Board meetings.

After choosing to focus on hospitals as an initial sector, the Board considered four alternatives for how to define the sector. One alternative would be to define specific high-cost hospitals as a sector and establish target(s) for those facilities. While this alternative directs attention at specific outlier hospitals, the health care landscape is dynamic and new high-cost hospitals could emerge. This alternative would limit the Board's flexibility in responding swiftly to an unpredictable environment.

A second alternative the Board considered was to define a sector based on facility attributes and financial measures. Many facility attributes that could be used to create a sector are self-reported or not defined in statute or regulation. For example, children's hospitals are not defined explicitly in state or federal statute or regulations, but there is an option in the annual financial disclosure reports that hospitals submit to HCAI that allows them to self-identify as a children's hospital. This is the data the Office is utilizing to examine California hospitals. The Board would need to operationalize specific attributes or financial measures, which may unintentionally include or exclude entities that may not warrant a spending target beyond the statewide target.

Thirdly, the Board considered waiting to define sector targets until performance year 2027 or later. Health and Safety Code section 127502, subdivision (l)(2)(A) provides that on or before October 1, 2027, the board shall define initial health care sectors. However, the option of waiting to define the first sector was rejected due to the pressing nature of the health care affordability crisis, and the impact of high-cost hospitals. As discussed above, the wide variation of hospital prices are not linked to quality or clinical outcomes[7], but are instead correlated with market concentration.[8] This dynamic was especially salient in the research and testimony presented about Monterey County at the Board meeting in August 2024 but is true throughout the state. For these reasons, the Board decided to act sooner on this issue rather than wait.

---

[6] Wilson, K. (2023, March 14). "*2023 Edition – California Health Care Spending*." California Health Care Foundation. https://www.chcf.org/publication/2023-edition-california-health-care-spending/#related-links-and-downloads ; Martin, A. B., Hartman, M., Washington, B., & Catlin, A. (2024). *National health expenditures in 2023: Faster growth as insurance coverage and utilization increased*. *Health Affairs*. Advance online publication. https://doi.org/10.1377/hlthaff.2024.01375

[7] Crespin and Whaley. 2022. "The Effect of Hospital Discharge Price Increases on Publicly Reported Measures of Quality." *Health Services Research*.

[8] Whaley et al. 2024. "*Prices Paid to Hospitals by Private Health Plans data.*" RAND Research Report. https://media.wmc.org/wp-content/uploads/2024/05/13170252/RAND_Hospital-Prices-2024.pdf

Finally, the Board considered defining all hospitals as a sector. This was the alternative approved by the Board in January 2025. With this option, all hospitals are subject to the statewide target unless and until the Board adjusts the target for all or a specified subset of hospitals within the sector.

TECHNICAL, THEORETICAL, AND/OR EMPIRICAL STUDY, REPORTS, OR DOCUMENT(S) RELIED UPON:

Reports / Articles / Other Resources:

- Crespin and Whaley. 2022. "*The Effect of Hospital Discharge Price Increases on Publicly Reported Measures of Quality*." *Health Services Research*. https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.14040?msockid=16772b21cb1867ab2f303e6bca546650
- Martin, A. B., Hartman, M., Washington, B., & Catlin, A. (2024). *National health expenditures in 2023: Faster growth as insurance coverage and utilization increased*. *Health Affairs*. Advance online publication. https://doi.org/10.1377/hlthaff.2024.01375
- Whaley *et al*. 2024. "*Prices Paid to Hospitals by Private Health Plans data.*" RAND Research Report. https://media.wmc.org/wp-content/uploads/2024/05/13170252/RAND_Hospital-Prices-2024.pdf
- Wilson, K. (2023, March 14). "*2023 Edition – California Health Care Spending*." California Health Care Foundation. https://www.chcf.org/publication/2023-edition-california-health-care-spending/#related-links-and-downloads

Public Meetings

- August 28, 2024 Board Meeting, Relevant Presentation Slides, Minutes
- October 14, 2024 Board Meeting, Relevant Presentation Slides, Minutes
- November 20, 2024 Board Meeting, Relevant Presentation Slides, Minutes
- December 16, 2024 Board Meeting, Relevant Presentation Slides, Minutes
- January 21, 2025 Advisory Committee Meeting, Relevant Presentation Slides, Minutes
- January 28, 2025 Board Meeting, Relevant Presentation Slides, Minutes
- February 25, 2025 Board Meeting, Relevant Presentation Slides, Minutes
- March 3, 2025 Hospital Sector Regulation Workshop, Relevant Presentation Slide, Transcript
- March 17, 2025 Advisory Committee Meeting, Relevant Presentation Slides
- March 25, 2025 Board Meeting, Relevant Presentation Slides, Minutes.

Written comments received and considered:

- August 23, 2024 Letter from Beth Capell and Amanda McAllister-Wallner, Health Access
- September 10, 2024 Letter from Ivana Krajcinovic, Unite Here Health
- September 24, 2024 Letter from Beth Capell and Amanda McAllister-Wallner, Health Access
- October 9, 2024 Letter from Ben Johnson, California Hospital Association
- October 10, 2024 Letter from Beth Capell and Amanda McAllister-Wallner, Health Access
- October 10, 2024 Letter from Steven Packer, Montage Health
- November 13, 2024 Letter from Alicia Metters, SEIU 521
- November 13, 2024 Letter from Mitch Stieger, CFT — A Union of Educators & Classified Professionals
- November 14, 2024 Letter from Kati Bassler, Salinas Valley Federation of Teachers
- November 15, 2024 Letter from Beth Capell and Amanda McAllister-Wallner, Health Access
- November 15, 2024 Letter from Ben Johnson, California Hospital Association
- November 18, 2024 Letter from Francisco Rodriguez, Monterey Bay Central Labor Council
- December 11, 2024 Letter from Ana Aguillon, Salinas Union High School District
- December 12, 2024 Letter from Beth Capell and Amanda McAllister-Wallner, Health Access
- December 4, 2024 Letter from Valarie Davis, California School Employees Association
- December 12, 2024 Letter from Ben Johnson, California Hospital Association
- December 16, 2024 Letter from Allen Radner, Salinas Valley Health
- December 17, 2024 Letter from Stephen Shortell
- January 16, 2025 Letter from Analis Downer
- January 17, 2025 Letter from Carla Adams, Barton Health
- January 17, 2025 Letter from Mark Behl, NorthBay Health
- January 17, 2025 Letter from Janelle Blanco, United Hospital Association
- January 17, 2025 Letter from Stephen DelRossi, Northern Inyo Healthcare District
- January 17, 2025 Letter from Elizabeth Stork, Barton Health
- January 17, 2025 Letter from Kelly Neiger, Barton Health
- January 17, 2025 Letter from Clint Purvance, Barton Health
- January 17, 2025 Letter from James Suver, Ridgecrest Regional Hospital
- January 17, 2025 Letter from David Young, Barton Health
- January 18, 2025 Letter from Mira Morton, California Children's Hospital Association

- January 18, 2025 Letter from Jody Roberts
- January 20, 2025 Letter from Keith Hobbs, Torrance Memorial
- January 20, 2025 Letter from Siri Nelson, Marshall
- January 21, 2025 Letter from Scott Thygerson, Kern Medical
- January 22, 2025 Letter from Andrea Constant
- January 22, 2025 Letter from Michele Lew, Stanford Medical Children's Health
- January 22, 2025 Letter from Sandra Mettler
- January 22, 2025 Letter from Michele Osorio
- January 23, 2025 Letter from Denise Bouillerce, Stanford Medicine
- January 23, 2025 Letter from Beth Capell and Amanda McAllister-Wallner, Health Access
- January 23, 2025 Letter from Lori Morgan, Huntington Health
- January 23, 2025 Letter from Allen Radner, Salinas Valley Health
- January 24, 2025 Letter from Jessica Anderson, San Diego Regional Chamber
- January 24, 2025 Letter from Jason Hill, Stanford Medicine
- February 21, 2025 Letter from Allen Radner, Saliva Valley Health
- March 5, 2025 Letter from Beth Capell and Katrina Walters-White, Health Access
- March 6, 2025 Letter from Anete Millers, California Association of Health Plans
- March 6, 2025 Letter from Ben Johnson, California Hospital Association
- March 17, 2025 Letter from Jim Wunderman, Bay Area Council
- March 18, 2025 Letter from Steven Packer, Montage Health
- March 20, 2025 Letter from Todd Suntrapak, Valley Children's Healthcare
- March 20, 2025 Letter from Kelly Ash, Dignity Health
- March 20, 2025 Letter from Ben Johnson, California Hospital Association
- March 20, 2025 Letter from Beth Capell and Amanda McAllister-Wallner, Health Access

CONSISTENCY AND COMPATIBILITY WITH EXISTING STATE REGULATIONS

During the process of developing this regulation, HCAI conducted a search of any similar regulations on this topic and concluded that these regulations are neither inconsistent nor incompatible with existing state regulations.

LOCAL MANDATE

No local mandate is imposed on a local agency or school district that requires reimbursement pursuant to Government Code section 17500 *et seq*.

DISCLOSURES REGARDING THE PROPOSED ACTION:

FISCAL IMPACT ESTIMATES

Cost or savings to any local agency or school district requiring reimbursement pursuant to Government Code section 17500 *et seq*.: None.

Cost or savings to any state agency:
OHCA does not anticipate any additional cost or savings from this proposal.

Cost to any local agency or school district which must be reimbursed in accordance with Government Code sections 17500 through 17630: None.

Other nondiscretionary cost or savings imposed on local agencies: None.

Cost or savings in federal funding to the state: None.