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Health Care Affordability Board
July 22, 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
08/20/2025	California Hospital Association	See Attachment #1.
8/21/2025	California Association of Public Hospitals and Health Systems	See Attachment #2.
8/22/2025	Health Access California	See Attachment #3.

August 20, 2025

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

Subject: **Comments on the July 2025 Health Care Affordability 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 hospital members, the California Hospital Association (CHA) appreciates the opportunity to provide feedback on the most recent board meeting, which raised significant concerns with both the enforcement process and the data OHCA are relying on to support and inform affordability discussions.

Enforcement Process Must Be Fair and Considered to Avoid Unintended Consequences

Hospitals Are Deeply Concerned by Board Discussion of Enforcement Process

At the July OHCA board meeting, OHCA staff began focused discussion of the spending target enforcement process, noting that these discussions will continue into the next year and culminate in the promulgation of related regulations. While the discussion was intended to be preliminary, several board members made many troubling remarks about what they would consider reasonable factors for exceeding the spending cap — essentially, there are none. For example:

- Following the largest health care cuts in the nation's history, passed under the One Big Beautiful Bill Act, hospitals will have no choice but to increase payments from other sources to sustain access to care or be forced to curtail services — but this was disregarded as a compelling reason.
- Cost pressures from new blockbuster drugs like Ozempic and Wegovy — drugs with life-changing impacts and for which patients are clamoring — were not deemed appropriate reasons for exceeding the spending cap.
- One board member stated that only "acts of God" should be justifiable, but even that was curtailed by other board members' opinions that such exceptions should be very narrow to avoid a "slippery slope."

This early reluctance to consider valid reasons a hospital may exceed the spending growth cap — reasons that are often driven by pharmaceutical companies, patient needs, or other forces outside of hospitals' control — is troubling, particularly given that programs in other states **did** account for these realities. Without a means to compensate for these pressures through a waiver process, hospitals would be forced to take drastic actions to curtail costs that run counter to OHCA's legislatively-mandated mission of promoting access to high quality and equitable care — for example, by limiting access to costly services or drugs. As OHCA continues its work to define the enforcement process, the discussion and resulting rules must carefully balance the office's imperative to improve affordability **without sacrificing** health care access and quality.

OHCA Must Account for Health Care Spending Growth that Supports Patient Care

In its pursuit of improving health care affordability, OHCA is also required to maintain and improve quality, equity, access, workforce stability, and the value of health care service delivery. Consequently, as OHCA assesses entities' compliance with the spending target, OHCA must appropriately account for factors that reasonably explain why entities' health care spending has increased — especially increased spending that is in service of improving Californians' health. Hospitals and health systems that invest in and expand services, technology, and programs that provide equitable, high-value, and high-quality care in their communities should not be penalized for increased spending. Reasonable factors outside of an entity's control should also be considered, such as statutory and regulatory changes affecting health care costs and macroeconomic trends, like rising inflation. Without a prudent approach that accounts for these important investments and uncontrollable influences, hospitals would be forced to make changes that will negatively impact patients' access to care and affect their ability to sustainably operate in their communities.

State Law Mandates Implementation of a Meaningful Waiver Process

OHCA staff's presentation at the July board meeting left an impression that the establishment of a meaningful enforcement waiver process is optional. However, this interpretation runs counter to both the letter and spirit of state law. Per statute, prior to any enforcement action, OHCA is **required** to give an entity that exceeds the target a reasonable opportunity "to respond and provide additional data, including information in support of a waiver" and to determine whether that submission "meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target…" (HSC § 127502.5 (b)(2) and (3)). State law only provides discretion in this context for establishing the procedural requirements for filing such waiver requests and the evidentiary burden to be met in considering those reasonable factors outside of an entity's control, such as changes in state or federal law, investments to improve care and reduce future costs, and acts of God or catastrophic events (HSC § 127502.5(i)). So, while OHCA has discretion to promulgate regulations governing the filing of such requests and technical specifications for how those requests will be evaluated, establishing the waiver process itself and providing regulated entities a meaningful opportunity to justify reasons for exceeding a spending target is legally required. The Legislature's reasoning behind this is clear and similar to other states' approach: That there are indeed instances when entities have a reasonable cause for exceeding the target, and therefore should be waived from the enforcement process upon a sufficient showing by the subject entity. OHCA and its board must follow the Legislature's clear direction and the example of other states.

OHCA Must Revisit the Spending Cap and Implement a Reasonable Waiver Process

Under the spending target framework, OHCA has two mechanisms by which it can account for justifiable spending growth:

- **Up-front Quantitative Adjustments to the Spending Target** – OHCA could determine factors that drive health care spending and directly incorporate them when setting spending targets, so that the targets reflect appropriate or unavoidable cost growth within the health care delivery system. For example, the statewide spending target is based on average median household income growth between 2003-2022, a measure that is — at best — only tangentially related to the growth of health care spending. Economy-wide inflation, by contrast, more accurately captures trends in health care spending because it reflects broader economic conditions. When setting the initial spending growth targets, OHCA could have incorporated relevant inflationary data into the spending target to ensure health care entities' ability to sustain levels of access to care to meet their communities' needs.
- **Back-end Waivers of Enforcement** – Alternatively, OHCA may choose to provide waivers after the fact, to account for reasonable factors that caused a health care entity to exceed the spending target. OHCA would obtain from the entities additional information that could help explain the drivers behind their spending and, with this information, determine whether spending growth in excess of the target was worthy of a waiver that would forestall enforcement. This mechanism, however, makes it challenging for hospitals to plan for the future as they will lack clarity on how they will be judged against the targets until after an enforcement period has ended.

OHCA Risks Failing to Account for Any Reasonable Growth Factors

In setting both the statewide spending target and the hospital sector spending target, OHCA did not make up-front adjustments to account for key drivers of health care spending that were needed to balance access, quality, equity, and workforce stability with affordability. These drivers include, but are not limited to, federal and state policy changes and mandates, inflation, coverage and demographic changes, high drug costs, increasing supply and labor costs, payer mix, and cost of living variation. **OHCA must revisit the spending targets for future years to ensure they account for key drivers. Otherwise, the spending target will force health care entities to cut back on the care and services they provide or face penalties for delivering the care their patients need.**

It Is Too Late to Revisit Spending Targets for 2026 — A Reasonable Waiver Process is Necessary

While hospitals encourage OHCA to revisit future targets, the deadline for changing the 2026 spending target has passed and cannot be adjusted. Therefore, incorporating enforcement waivers based on reasonable factors is the only mechanism left for OHCA to account for either uncontrollable or desirable growth above the target. Moreover, not all factors for reasonable but excessive growth can be predicted in advance. For example, changes in payer mix or an increased number of patients with costly medical needs could cause a provider's spending to jump significantly from year to year; these could only be addressed through a meaningful waiver process.

Yet, at the July 2025 OHCA board meeting, OHCA signaled its intent to backtrack on prior commitments to "contextualize" higher spending growth even if it was for reasons articulated in statute or those previously acknowledged publicly — such as when Director Elizabeth Landsberg testified (during the May 1, 2025, Senate

Budget Subcommittee #3 on Health and Human Services) that "there will be an ability to adjust the targets for reasonable considerations." This means that investments to improve access to preventive care or revenue increases to keep pace with the health care worker minimum wage would result in penalties from OHCA.

Given that OHCA failed to account for key drivers of health care spending in the established 2026 statewide and hospital sector spending caps, and that some justifiable factors cannot be anticipated, it is imperative that OHCA establish a meaningful waiver process.

Hospitals Are Committed to Helping Establish a Reasonable Enforcement Process

As OHCA develops and defines each component of the enforcement process, it must do so with transparency, adopt an approach that appropriately assesses compliance, reflect the challenges and constraints that health care entities face, and allow for input and engagement from all stakeholders so that the path toward affordable health care is achieved fairly and collaboratively. In carrying out progressive enforcement actions, OHCA must give entities the opportunity to provide information, allow for the conditions or factors that give reasonable cause for entities' exceeding the target, incorporate a waiver process, and give entities flexibility in carrying out its critical functions — particularly if they are required to implement a performance improvement plan. These guiding principles should be paramount as OHCA develops the enforcement process.

OHCA's Reliance on Selected Reports and Tools Undermines the Affordability Narrative

Hospital Cost Tool Manipulates Data to Reach Misleading Conclusions

At the July OHCA board meeting, OHCA provided an overview of its engagement with stakeholders on high-cost drugs in relation to the spending target. One suggestion to OHCA from these discussions was to use the NASHP Hospital Cost Tool to examine hospital cost-to-charge ratios and drug pricing, with a potential goal of identifying variation across hospitals and understanding whether drug prices might justify a hospital exceeding its spending growth target.

While the tool attempts to make complex Medicare data from the Healthcare Cost Report Information System more accessible, the methodology contains structural biases that make it inappropriate for evaluating hospital pricing or supporting decisions around hospital expenses. A key example: The tool calculates operating margin based on operating costs using only Medicare-allowable expenses, excluding numerous legitimate and unavoidable expenses such as physician recruitment, research, innovation and technology upgrades, intern and resident physician training programs, and portions of many community benefit programs. These costs are essential to delivering care in hospitals, promoting innovation and quality, and training future generations of providers, but because they are not "Medicare-allowable," they are removed from the cost calculation. Problematically, the tool does not make a corresponding adjustment to hospital revenue to exclude associated revenues from the aforementioned costs, meaning the margin calculation compares full revenue against a partial, artificially reduced cost base. Ultimately, this methodology systematically inflates operating margins and gives the appearance that hospitals retain more from patient care than they actually do.

CHA's analysis of the NASHP tool and other data sets for California hospitals illustrates the magnitude of this distortion. When comparing the NASHP tool's 2023 hospital-level net patient revenue and hospital operating costs data to the HCAI Annual Financial Disclosure Report Selected Pivot file for 2023, focusing on the net patient revenue and total operating expense columns, CHA found that hospital revenues in NASHP's dataset matched HCAI's to within 1% on average — but **reported expenses were, on average, 15% lower in the NASHP tool.** This is clear evidence that NASHP is not adjusting revenue appropriately when excluding costs and points to a methodology that is unsound and misleading.

This flawed approach to calculating operating margins raises serious questions about the validity of the tool's other reported measures, including drug costs and cost-to-charge ratio; CHA has similarly found those metrics to be inflated by understated costs. This lack of transparency and systematic exclusion of legitimate expenses produces a one-sided narrative that misleads more than it illuminates. It is especially problematic when the tool is used for purposes it was never designed for — such as informing spending growth targets or determining allowable exceptions for entities exceeding the target.

Conversation on Market Concentration Skips Major Features of the Health Care Market

At the July OHCA Board meeting, OHCA staff presented a 2024 JAMA Health Forum analysis that reported higher insurer concentration is associated with lower commercial-to-Medicare hospital price ratios. Unfortunately, this finding offers an incomplete view of "affordability" and risks misrepresenting the broader patient impact.

Peer-reviewed literature shows that dominant insurers' ability to negotiate lower reimbursement rates from providers can reduce provider prices in markets with high insurer concentration. **However, those lower prices do not translate into lower premiums for consumers.** For example, Trish & Herring (2015)[1] analyzed national employer-sponsored insurance markets and found that higher insurer concentration was indeed associated with **lower hospital payment rates** — but it was also correlated with **higher premiums for patients**. This reflects the exercise of monopoly power on the consumer side: big insurers increase premiums and bank the revenue rather than passing on savings to consumers.

In further evidence of this relationship, Dafny and colleagues (2012[2], 2015[3]), analyzing real-world changes from major insurer mergers and insurers exiting certain markets, found that increased insurer concentration led to significant premium growth — 5% to 7% higher than without the increase in insurer concentration. In their California-specific analysis, Scheffler and colleagues (2018)[4] found that higher insurer concentration was

[1] Trish, E. E., & Herring, B. J. (2015). How do health insurer market concentration and bargaining power with hospitals affect health insurance premiums?. Journal of health economics, 42, 104–114. https://doi.org/10.1016/j.jhealeco.2015.03.009
[2] Dafny, L., Duggan, M., & Ramanarayanan, S. (2012). Paying a premium on your premium? Consolidation in the U.S. health insurance industry. American Economic Review, 102(2), 1161–1185. https://doi.org/10.1257/aer.102.2.1161
[3] Dafny, L., Gruber, J., & Ody, C. (2015). More insurers lower premiums: Evidence from initial pricing in the health insurance marketplaces. American Journal of Health Economics, 1(1), 53–81. https://doi.org/10.1162/AJHE_a_00003
[4] Scheffler, R. M., Arnold, D., & Whaley, C. M. (2018). Consolidation trends in California's health care system: Impacts on ACA premiums and outpatient visit prices. Health Affairs, 37(9), 1409–1416. https://doi.org/10.1377/hlthaff.2018.0472

linked to higher premiums; a 10% increase in insurer concentration was associated with a 2% increase in premiums for patients.

By focusing solely on commercial-to-Medicare hospital price ratios, the *JAMA Health Forum* analysis presented to the board stops at what insurers pay hospitals and does not follow through to what patients ultimately pay. Lower hospital price ratios in concentrated insurance markets do not guarantee improved affordability for patients. In making decisions that will impact the lives and health care of millions of Californians, OHCA must rely on a full affordability analysis that includes the end prices patients pay, not just the prices insurers negotiate. Without this, OHCA risks creating policies that reduce provider revenue while leaving patients facing higher, not lower, health care costs. It is unfortunate that OHCA has chosen to present only one side of this story. Greater balance is needed if the office is to truly achieve its mission of promoting affordability for California residents.

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

Sincerely,

Jenny Nguyen
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

CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

August 21, 2025

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

Subject: Comments on the July 2025 Health Care Affordability Board Meeting

Dear Chair Johnson,

On behalf of the members of the California Association of Public Hospitals and Health Systems (CAPH), I am writing to provide feedback on the Office of Health Care Affordability's (OHCA's) and the Board's discussion of the key impacts of HR 1 on California's health care delivery system and considerations for spending targets, as well as OHCA staff's presentation to the Board on defining the spending target enforcement process.

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

Fundamentally, we share the goals of OHCA and the Health Care Affordability Board to improve affordability and slow the growth of health care spending while working together to provide access to high quality and equitable health care for all Californians. However, as PHS face unprecedented funding cuts from HR 1 and other federal actions, we are concerned that enforcement actions by the board could accelerate service reductions and closures. We ask the Board to address these concerns by including justifiable reasons for growth beyond the spending cap, as outlined below.

HR 1 Impacts and Considerations for Spending Targets

At the July 2025 meeting, OHCA staff presented the key impacts of HR 1 to California's health care delivery system, including the unprecedented cuts to Medi-Cal and other government programs. According to Department of Health Care Services (DHCS) estimates, roughly 3.4 million of Medi-Cal's approximate 15 million beneficiaries may lose their health care coverage due to HR 1. OHCA staff reminded the Board that they will report and enforce spending targets by market category, allowing for the consideration of changes in state and federal policy that could affect spending performance.

PHS provide care for a disproportionate share of the Medi-Cal population, and we anticipate nearly $4 billion in annual funding losses when HR 1 is fully implemented. These federal policy changes will increase the number of uninsured Californians, drive up uncompensated care costs, and increase demand in PHS emergency departments as Medi-Cal beneficiaries lose coverage and delay needed primary care services. At the same time, other hospitals may be forced to adjust their payer mix or close due to financial straining, further shifting the burden to PHS.

Key provisions of HR 1 affecting our public health care systems are already underway, with additional provision scheduled to take effect through 2028. These include:

2025

- New state directed payments (SDPs) submitted after July 2025 will be capped at 100% of Medicare for expansion states. Our current SDPs are grandfathered until 2028, when they begin to phase down 10% per year until total payment reaches 100% of Medicare. This will result in more than $2 billion net losses to PHS.
- DSH cuts are expected to go into effect October 1, 2025, unless further legislation is enacted to delay the cuts. This will result in more than $800 million annual losses for PHS.

2026

- Beginning October 2026, HR 1 reduces the Federal Medical Assistance Percentage (FMAP) for emergency services provided to childless adults with unsatisfactory immigration status from 90% to the state's FMAP floor of 50%. PHS are disproportionately impacted by the FMAP reduction because they serve higher numbers of the UIS population. This reduction will likely result in losses of $120 to $300 million annually as UIS patients are shifted to Medi-Cal fee-for-service (FFS), which our PHS self-finance, directly impacting our net revenue. For some of our members, the UIS population represents up to 30% of their total Medi-Cal enrollees

2027

- Starting in January 2027, new Medi-Cal eligibility requirements take effect, including work requirements for adults ages 19-64, eligibility redeterminations for expansion adults every six months, and retroactive coverage limitations reduced to one month for expansion enrollees. PHS serve a large percentage of Medi-Cal patients, and we anticipate significant losses to our Medi-Cal enrollment, with most of these patients becoming uninsured.

2028

- In January 2028 the SDP phase-down begins for grandfathered directed payments.

The compounding impacts of HR 1, combined with OHCA's statewide enforceable spending target of 3.5% taking effect in 2026, will have devastating consequences for the financial viability and stability of PHS. OHCA staff have indicated they will be enforcing targets separately for Medi-Cal, which will allow them to evaluate the impact of federal and state policy decisions on spending performance. As OHCA considers proposals on defining the spending target enforcement process along with considerations for exceeding the target, **we urge the Board to include federal and state policy changes as justifiable reasons for exceeding the target.**

Spending Target Enforcement Process and Considerations for Exceeding the Target

As OHCA provides guidance on how health care entities' spending performance will be judged against the targets, **it is imperative that the enforcement regulations include reasonable and justifiable factors for exceeding the target.**

OHCA is obligated to balance the spending target goal of affordability with factors that are instrumental in maintaining access, quality patient care and workforce stability.

As such, OHCA has considered the following factors as justifiable reasons for exceeding the spending target:

- Acts of God or catastrophic events
- Annual changes in age and sex of the entity's population
- Changes in an entity's patient base/acuity
- Changes in Medicare and Medi-Cal reimbursement
- Costs associated with increased organized labor costs
- Emerging and unforeseen advances in medical technology
- Emerging high-cost/high-value pharmaceuticals
- Investments to improve care and reduce future costs
- Statutory changes impacting health care costs

In anticipation of OHCA and the Board considering these factors, we surveyed our member systems to identify which of these are especially critical for PHS. W**e urge the Board to consider the following significant cost drivers part of the enforcement process**. Please note this is not an exhaustive list, and we look forward to providing additional feedback as these discussions continue.

1. Statutory and regulatory changes impacting health care costs (both Federal and State)
   These include implications from emerging federal legislation (e.g., HR 1) and evolving Medi-Cal regulations, particularly those affecting safety net financing, value-based care requirements, and supplemental payment mechanisms.
2. Costs associated with increased organized labor
   OHCA should clarify that organized labor costs must include benefits and pension costs for public health care system employers. For most PHS, labor constitutes 60 to 75% of their total system costs. OHCA also should consider overall (non-organized) labor cost growth to account for SB 525, the health care worker minimum wage, which will increase labor costs for health care entities.
3. Emerging high-cost/high-value pharmaceuticals
   While our members share OHCA's goal of improving affordability, the spending growth targets do not account for the impact of high-cost, curative therapies, disproportionately affecting pharmacy budgets and placing innovation at risk. OHCA should consider the impact of these therapies in its enforcement of spending growth targets.

We urge OHCA to include these factors in the enforcement regulations as permissible reasons for exceeding the spending target.

We also urge OHCA to acknowledge that improvements in Medi-Cal reimbursement rates are permissible reasons for consideration in the enforcement process. Medi-Cal rates are already extremely low and do not cover the costs of delivering care, as recognized by the DHCS and

state lawmakers in recent years in their efforts to increase rates. That is why it is important that any increases to Medi-Cal base rates or SDP's PHS receive over the next several years should not be subject to the target. Any such increases would provide critical sources of funding to help offset losses stemming from federal and state policy decisions.

As OHCA staff and the board continue discussions over the next year to define the spending target enforcement process, we ask that OHCA account for these reasonable factors that contribute to growth beyond the spending targets by:

- Building in front-end adjustments to the spending targets where allowable that appropriately reflect uncontrollable or mandated growth in costs. These adjustments would be the ideal solution as they would avoid health care entities having to explain after-the-fact why they exceeded the target.
- Providing backend waivers when health care entities exceed the target, if the entity can verify that the spending growth was due to justifiable reasons as specified in the enforcement regulations. These backend waivers should apply when it is difficult to quantify the spending target adjustments up front, or when the entity experiences unpredictable growth.

It is imperative that OHCA include these factors for justifiable growth in the enforcement regulations to make the process as efficient and streamlined as possible.

As our PHS try to navigate these uncharted times with unprecedented cuts to Medi-Cal, we hope OHCA adopts an approach to the spending target enforcement process that ensures health care entities can continue providing affordable, accessible and high-quality care to all Californians.

Thank you for your consideration and partnership to support California's health care safety net.

Sincerely,

Erica B. Murray
President and CEO

cc: Members of the Health Care Affordability Board:
Secretary and Board Chair, Kim Johnson
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Dr. Donald Moulds
Dr. Richard Pan
Elizabeth Landsberg, Director, HCAI
Vishaal Pegany, Deputy Director, OHCA
Darci Delgado, Assistant Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom
Michelle Baass, Director, Department of Health Care Services

August 22, 2025

The Honorable Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

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

Re: August 2025 Board Meeting,

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

Health Access, the statewide consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments to the Health Care Affordability Board and Office of on:

- The impact of H.R. 1 on the uninsured and Medi-Cal as well as employer-sponsored coverage
- Recommendations on enforcement, including transparency and penalties for untimely or inaccurate data submissions and
- Behavioral health benchmark recommendations

H.R. 1 Impacts: Recognizing the Impacts, Minimizing the Damage

H.R. 1 is now law. It is the biggest change in health care since the enactment of the Affordable Care Act. Sadly H.R. 1 moves California and the nation in the opposite direction from universal coverage and affordable care.

Health Access' goal in our work on H.R. 1 whether at OHCA, with Medi-Cal and Covered California, the Legislature or elsewhere is to minimize the damage from it while recognizing the unfolding impacts of the law. Health Access strongly opposes any proposal to "cost-

shift" health care costs to commercial coverage from the cuts to Medi-Cal and possible Medicare reductions in H.R. 1 by undoing or revising the cost growth targets or granting blanket waivers of enforcement of those targets.

Raising health care prices for commercial coverage, and the working families who depend on that coverage as well as the employers who pay for that coverage, would worsen the crisis of the uninsured rather than minimizing the damage from H.R. 1.

"Cost-Shifting" to Commercial Coverage Would Worsen the Crisis of the Uninsured

Proposals to shift health care costs from Medi-Cal cuts and possible Medicare reductions to commercial coverage that covers about half of all California workers are proposals to worsen the crisis of the uninsured inflicted on California by H.R. 1. Whether you use the estimates developed by the Newsom Administration based on other states such as Arkansas and Georgia or national estimates such as those by KFF, H.R. 1 will increase the number of uninsured by millions. OHCA can either minimize the damage by attempting to prevent cost shifting by providers and plans to commercial coverage or make it worse by allowing avoidable cost shifting.

OHCA has heard testimony from Small Business Majority and presentations from Covered California about how many small business employers are already priced out of offering coverage and rely on Covered California and Medi-Cal to provide coverage to both the owners and the workers. Other larger employers attest to the suppression of wages because of the cost of health care benefits. Increasing prices for commercial coverage will drive up premiums and out of pocket costs, such as deductibles, for both employers and working families, forcing more employers and workers to drop coverage because of unaffordability.

Low wage workers, making less than 200% of federal poverty, about $31,000 for an individual, already disproportionately go uninsured or rely on public programs: low wage workers are three or four times as likely to be uninsured, and three times as likely to use Medi-Cal, as higher wage workers[1]. Family share of premium and

[1] Forthcoming analysis of coverage of low-wage workers compared to higher wage workers, UC Berkeley Labor Center. Over 80% of higher wage workers rely on commercial coverage from their own employer or a family member while fewer than half of low wage workers get coverage on the job, either their own or a family member's. Even for someone making $40,000 or $50,000 a year, affording over $10,000 in family share of premium and median deductible may well make coverage unaffordable.

median family deductible was over $10,000 in 2022[2]: driving up these costs even further will only make employer coverage even more unaffordable, especially for lower wage workers. If OHCA allows payers and providers to drive up the cost of commercial coverage even further through cost shifting while the combination of H.R. 1 and the state budget simultaneously closes the door to Medi-Cal and rips away enhanced federal subsidies for Coverage California will only worsen the crisis of the uninsured.

State and federal law requires hospitals to provide only the bare minimum of emergency care to the uninsured, care designed to prevent the uninsured from dying in that emergency room in front of that doctor. We also know from our history as an organization that without those state and federal laws, hospitals often did not provide even that bare minimum of care[3].

California can make things worse or minimize the damage from H.R. 1. Health Access proposes recognizing the damage and doing whatever is within our power to minimize it. Cost shifting to commercial coverage by allowing providers such as hospitals and physicians or health insurers to raise prices for commercial coverage goes in the wrong direction.

Documenting Increased Charity Care and Compliance with Discount Hospital Payments

Health Access recommends that increases in documented charity care, but not bad debt[4] or other uncompensated care, as well as demonstrated compliance with longstanding California law on discounted payments by low and moderate income uninsured and underinsured be considered by OHCA. HCAI has collected data on charity care spending for as long as HCAI and its predecessor, the Office of Statewide Health Planning and Development, have existed. HCAI now enforces state law on hospital discount payments by the uninsured and underinsured.

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[2] https://laborcenter.berkeley.edu/wp-content/uploads/2024/02/Measuring-Consumer-Affordability_revisedFeb82024.pdf

[3] The predecessor coalition to Health Access formed because hospitals, and emergency physicians, were denying the uninsured even the bare minimum of emergency care. In the summer of 1987, activists delivered to the California Legislature a story each day of the uninsured bleeding to death in hospital parking lots, babies dying and other bad things. State law changed to stop that. Out of that fight, Health Access became a formal entity committed to quality, affordable care for all Californians. Coverage means care.

[4] "Bad debt" is debt in which a consumer is pursued through collections. This is not a consumer-friendly practice.

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Health Access recognizes that some hospitals may respond to the increase in the uninsured by providing somewhat more charity care, that is care provided without expectation of payment. Since the ACA, California hospitals have spent about 1% of revenue on charity care[5]. Before the ACA, hospitals spent about 2% of revenue on average on charity care[6]. If a hospital can document that the changes in federal law in H.R. 1 have led to an increase in charity care, that is free care, for the uninsured over what that specific hospital spent on free care prior to H.R. 1, then that may be a legitimate factor for enforcement consideration.

Health Access also recommends that HCAI assure that any hospital asserting an increase in charity care for the uninsured be expected to document compliance with California law on discount care for the uninsured and underinsured both in terms of the hospital's formal policy and its actual practice by providing evidence of posting of notices and the materials and procedures used for screening the uninsured and underinsured. Failure to comply with these state laws intended to ensure that the uninsured and underinsured pay no more than what Medicare or Medi-Cal would have paid for the same care should disqualify a hospital from consideration for any adjustment to the cost growth targets or enforcement consideration. A hospital that does not comply with longstanding state law on how to treat the uninsured and underinsured should not be rewarded by OHCA, another part of HCAI.

The burden should be on the hospital to document additional free care provided to the uninsured as well as compliance with existing state law that dates back to 2006, twenty years ago.

Risk Mix Worse as Coverage Rates Decline

Sources of coverage in California[7]:

- Individual market: 2.3-2.4 million people:
    - Of these 2 million were enrolled in Covered California in 2025
- Small group market: 2.2 million

[5] NASHP data on over 300 of the 440 California hospitals demonstrates that almost all hospitals spend only 1% of revenue on charity care.
[6] LAO analysis, Ballot Measure using 2014 HCAI data: https://lao.ca.gov/ballot/2015/150588.pdf
[7] https://www.chbrp.org/sites/default/files/2024-02/Sources%20of%20Health%20Insurance%20%28projecting%202025%29%20021224.pdf and https://www.chcf.org/wp-content/uploads/2025/02/CAHealthInsurersEnrollmentAlmanac2025QRG.pdf.pdf

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- Large group market: state regulated: 8.2-9.4
- Self-insured lives: 5.9 million
- Medi-Cal: 14-15 million

Eliminating coverage for 4 million Californians, including an estimated 3.4 million Californians on Medi-Cal and 600,000 in Covered California will have profound effects across health care markets, including the small group market which provides coverage to small employers with fewer than 100 employees and dependents.

Health Access recognizes that the possibility of worse risk mix because of an increased number of uninsured may require OHCA to consider the impact on a per capita basis. For now, we recommend that OHCA monitor risk mix in different payer segments, particularly Medi-Cal and the individual insurance market, which Covered California currently dominates.

Health Access recognizes that the risk mix of those Californians who remain covered is likely to be somewhat worse than those who drop coverage because those who are sicker or have worse health status will go through more paperwork or spend more to keep insurance. This will be true whether the barriers are phony paperwork barriers to those who remain enrolled in Medi-Cal, lack of affordability because of the loss of enhanced federal subsidies for Covered California or higher health care costs for commercial coverage. Barriers to coverage worsen risk mix. Worse risk mix increases per capita costs, even as an increased number of uninsured will drop overall health spending. Approaching universal coverage through affordable options had improved risk mix across health care markets in California. Now we go in the opposite direction, because of H.R. 1 and the failure to date to extend enhanced Covered California subsidies.

For Medi-Cal, the loss of coverage due to the imposition of work requirements and twice-yearly eligibility verification is likely to have somewhat mixed impacts that will depend in part on how California implements these provisions. If California maximizes automatic verification of work requirements and ex parte verification of eligibility, it may be possible for some populations, such as those earning more than $580 a month, to have their eligibility verified without burdensome paperwork. This will keep lower risk working populations enrolled in coverage instead of discouraging those who are less frequent users of care from staying

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enrolled. Other populations, such as those unable to work due to severe behavioral health needs, are higher risk: for them, the definition of disability will be key. The net impact on the risk mix for Medi-Cal managed care plans will require careful analysis.

For Covered California, the story is starker and sadder. In 2025, the enhanced federal subsidies resulted in almost two million Californians enrolled in Covered California coverage with most retaining that coverage throughout the entire year. Current estimates are that about 600,000 of these Californians will drop coverage. The loss of affordability due to the loss of the enhanced subsidies across the income spectrum combined with the elimination of all subsidies over 400%FPL will leave a smaller, sicker population enrolled in Covered California, projected by Covered California to almost *double* current premiums. While happily, the state budget provided $190 million for state subsidies, this is not a full substitute for the $2 billion in enhanced federal subsidies provided in 2025. The Covered California Board wisely chose to use state assistance in 2026 to help those at the lowest end of the Covered California affordability range, those below 165% FPL.

The small group market in California was both large and stable prior to the ACA and prior to H.R. 1. Continued cost increases for health insurance coverage, driven by physician services, hospital care, prescription drug prices, and profits and administrative costs across the health care system have driven some small businesses to drop coverage and rely on Covered California and Medi-Cal. H.R. 1, and the failure to extend enhanced ACA subsidies, will make this worse and thus likely worsen risk mix in the small group market as well as encourage various forms of bad behavior by insurers, such as association health plans, intended to separate healthy lives from the broader small group market.

For the large employer insurance market segments, the impact of H.R. 1 is likely to be modest and possibly not measurable. While many workers rely on Medi-Cal or Covered California because their employers do not provide affordable health coverage, whether it is Wal-Mart, McDonalds or Uber, the existing insurance markets for larger employers is less likely to suffer the worsening of risk mix readily anticipated for both Medi-Cal and Covered California unless OHCA allows for cost shifting to commercial coverage.

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Enforcement: Data Submission Penalties

Health Access commends the staff for recognizing that data submission must move ahead promptly and completely and that the data must be as accurate as possible. The entire OHCA effort rests on timely, complete and accurate data. If a health plan or insurer fails to submit data, or fails to submit it timely, completely, or accurately, OHCA will be unable to measure compliance with the cost growth target, the primary care benchmark, behavioral health spending, or other measures.

Health Access recommends:

- Recognition of the standards in the OHCA law that when an entity "willfully" or "knowingly" fails to report or provide required information, it may be subject to administrative penalties.
- Transparency at each step in the process for the entity, the Board and the public.
- A data submission penalty sufficient to deter failure to submit timely, completely or accurately.

High Legal Standards for Failing to Report Timely and Accurately

The legal standards for complete, timely, and accurate data submission are different than the penalties in the law on failure to meet the cost growth targets. The law governing health care entities that fail to report complete and accurate data or fail to provide information required by the office sets high standards for administrative penalties.

For failing to provide required information, the standard in the law is "knowingly", a somewhat lesser standard than "willfully" but still a legal hurdle for the department[8]. For failing to report complete and accurate data, the director must establish that the entity "willfully" did so, a specific and knowable legal standard. The director may also have other powers to issue penalties. We note these standards to remind all of us that the director cannot simply pass out penalties like pizza coupons: any penalty imposed by the Department would risk litigation by the affected entity. Public documentation of the failure of an entity to submit data

[8] https://www.justice.gov/archives/jm/criminal-resource-manual-910-knowingly-and-willfully#:~:text=An%20act%20is%20done%20%22willfully,do%20something%20the%20law%20forbids.

timely or completely will support actions of the Department in enforcing data submission requirements.

Transparency at Each Step

Health Access recommends transparency at each step in the process of data submission to ensure that data is timely, complete, accurate and reasonable[9]:

- If a plan fails to submit data by September 1, the entity should be noticed and the failure should be publicly posted and reported at the next OHCA Board meeting in the staff presentation to the Board.
- Similarly, if staff grant an extension of the reporting deadline, either once or twice, each time that fact and the reason for the extension should be publicly posted and reported for the public record at the next Board meeting.
- At each subsequent step in the data submission penalty process, public posting and reporting to the Board should occur. Each public posting should identify the plan or insurer that failed to report timely and completely.
- Health Access supports compelling public testimony by the plan or insurer at a Board meeting if data submission has not occurred by November 1.
- The Department of Managed Health Care, the Department of Insurance, the Department of Health Care Services and Covered California should be notified of the failure of their license-holder or contracting entity to report timely and completely as provided in the OHCA regulations.
- When information regarding the accuracy of the data is verified, similar reporting should occur to the Board and the public.
- The staff should also develop "reasonableness" tests or metrics for comparable entities so that errors comparable to NorthBay reporting Medicare Advantage revenue as commercial are spotted and can be corrected.

These transparent steps along the way are intended to encourage compliance by data submitters, just as posting the speed limit encourages compliance with that standard. This transparency will also support the actions of the director if she determines that the legal standards for administrative penalties have been met by establishing a clear public record of the failure of the submitter to comply completely and timely. This public transparency will also allow the Legislature and

[9] Medi-Cal refers these data metrics as "CART" for complete, accurate, reasonable and timely. We list them here in the sequence in which they arise.

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other stakeholders to monitor OHCA's progress in collecting data. We note that both CMS and DHCS use a similar approach for Medicaid data to encourage compliance.

Data Submission Penalty Amount

Health Access recommends that the penalty for failure to submit complete and accurate data in a timely manner be substantial and sufficient to deter insurers and health plans from delaying or avoiding submitting the data. As we testified publicly at the last Board meeting, while there are a lot of zeroes on the dollar figures proposed by staff, we are skeptical that the amounts are sufficient to ensure compliance. Here's why:

- Take an insurer with 200,000 covered lives in state-regulated coverage, a smaller insurer in the context of California.
- Multiply 200,000 covered lives by the difference between a cost growth target of 3.5% and a premium increase of 7%, using $7,600 per person per year as the cost of coverage (NHE for private health insurance for 2024[10]).
- The difference is over $53 million.
- Even exceeding the target by hitting 4.5% instead of 3.5% results in a significant difference exceeding $15 million, a far heftier sum than the $110,000 to $2 million proposed.

The numbers are big because the cost of care is too high. Insurer enrollments in California also tend to be larger than 200,000 lives which would make the dollars even larger, both in terms of the incentives to delay or avoid submitting data and the impact on affordability.

Health Access supports escalating penalties for repeated or recurrent failure to comply. Our observation of enforcement efforts by sister departments, whether it is the Department of Managed Health Care or the Department of Public Health's facility licensure, is that some entities are repeat offenders while other entities are routinely compliant.

Penalties should be a last resort, but penalties should also be more than the cost of doing business. The arithmetic of paying even a $2 million penalty to obscure or

[10] https://hcai.ca.gov/wp-content/uploads/2025/07/July-2025-OHCA-Board-Meeting-Presentation.pdf, slide 5

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conceal a $53 million failure to comply with a cost growth target runs counter to the spirit of the OHCA law that provides "commensurate" penalties for the failure to meet the cost growth targets. Saving $50 million, or even $13 million, for failure to meet a target, by delaying data for a year is bound to tempt someone while consumers and other purchasers continue to pay the price of out-of-control health care costs in the commercial market.

Enforcement: Cost Growth Targets

Health Access reiterates our recommendations for enforcement of the cost growth targets.

First, an entity seeking an adjustment for that entity to the target based on the statutory enforcement considerations, should be required to justify and document the dollar impacts on the overall ability of that entity to meet the target, not rely on generalizations or overly broad assertions.

Second, as discussed in prior letters from Health Access, "enforcement considerations" should look to the California law which points to:

- What is within the control of the entity wholly or partly?
- What is the share that consideration contributes to exceeding cost growth target by factoring in other costs?
- Documented impacts on access, quality, equity, or workforce stability

Third, staff inquired "How should OHCA distinguish between controllable overspending and external cost pressures?" Health Access recommends that OHCA consider:

- Documented evidence of the actual costs, whether it is prescription drug costs, spending on labor costs, or any other assertion made by an entity. How much did the drug actually cost after the various rebates and discounts? How much was spent on various labor categories such as nursing or radiology and how much did they change?
- Second, entities should be asked to develop a comparison to other similarly situated entities. For example, the Monterey hospitals were not more expensive than other Bay Area hospitals. Wages were not higher (except for

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administrators), the risk was not worse, and the payer mix was not more reliant on public programs.
- Third, if an entity asserts that changes in state or federal law, are there independent cost impact analyses, such as CHBRP, to confirm the costs?
- Fourth, an entity says it invested in primary or preventive care for the entity subject to the targets, can it document the investments[11]? And is the affected entity subject to the cost target or is it another element of a health system?

In the future, Health Access will offer additional comments on how OHCA might address increased investment in primary or preventive care by other elements of a hospital system which are not the licensed hospital facility or the large physician organization.

Fourth, the law envisions public transparency at numerous steps along the path of enforcement of the cost growth target:

- OHCA shall "make public extent to which the entity exceeded the target" as well as the identity of the entity[12].
- If OHCA imposes a performance improvement plan, OHCA shall make public identity of entity subject to the plan plus a detailed summary of the entity's compliance with the plan[13]. In addition, the law requires OHCA to provide the plan to the relevant regulator to assure that oversight for the responsibilities of that regulator may occur, whether it is DMHC or CDI assuring financial solvency or CDPH assuring compliance with provisions of state law such as nurse staffing ratios.

Health Access also recommends other steps to provide transparency along the way, including:

- Public notice of which entities are receiving technical assistance
- Public notice of which entities may progress to a performance improvement plan.

These public steps would build public accountability going forward and would be helpful to HCAI in building a case that an entity has knowingly withheld or delayed submission of data or information.

[11] We note that this would be easier to do at a system level than an individual facility. this is why Health Access sponsored AB 1415 to include health systems as well as individual hospitals or large physician organizations. We will work with other entities to attempt to achieve this goal within existing law.
[12] Health and Safety Code 127502.5 (c) (1)
[13] Health and Safety Code 127502.5 (c) (2)

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OHCA staff should routinely report on each of these steps to the Board and post and toll each of these steps on its website. Such public transparency will assist if there is ever a question from policymakers or others about the enforcement steps underway.

Next, the law on penalties is also clear:

- The director may assess penalties "initially commensurate with failure to meet cost target"[14]
- Penalties escalating up from commensurate penalties may be assessed for repeated failure to meet the target[15]
- Mitigating factors for the penalties as provided in the statute include[16]:
    - Federal match or nonfederal share of match for Medi-Cal
    - Nature, number and gravity of offenses
    - Fiscal condition of the entity
    - Market impact of entity

Finally, the law provides for a waiver of enforcement. Health Access recommends that a complete waiver of enforcement be reserved for rare, extraordinary circumstances such as the actual or imminent financial collapse of a hospital, physician organization or health plan. The measures of financial distress developed by HCAI for hospitals have parallels with DMHC for health plans and risk bearing organizations (RBOs) as well as the Department of Insurance for insurers. The requirements for progressive enforcement combined with enforcement considerations and the mitigating factors for administrative penalties should suffice in most instances. Only in very rare and limited cases should a waiver of enforcement be granted.

Behavioral Health

Health Access will submit formal comments on the proposed behavioral health methodology. We regret that the law requires measuring the fraction of "total" health care expenditures spent on behavioral health because "total" health care expenditures, that which is spent by health plans on covered benefits is a measure that is particularly inapt for behavioral health. Far too much of behavioral health spending is out-of-pocket spending by middle class consumers on out-of-network

[14] Health and Safety 127502.5 (a) (4) and (d) (1)
[15] Health and Safety 127502.5 (d) (5)
[16] Health and Safety 127502.5 (d) (3), (4) and (6)

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care because of the lack of timely access to appropriate behavioral health care as well as the various funding streams for Medi-Cal and other public funding of behavioral health. The proposed methodology may accurately capture behavioral health spending as a subset of "total" health care expenditures, but "THCE" misses a very large share of spending on behavioral health such as out-of-pocket, out-of-plan spend as well as important programs like Drug Medi-Cal and county behavioral health. This is despite the best efforts of this Governor and this Legislature to improve access to appropriate behavioral health care.

We support the proposed focus on "upstream" behavioral health care, just as we supported increases in primary care. The literature is clear on both: both approaches improve outcomes while reducing overall health care costs (and human misery). Neither primary care nor "upstream" behavioral health alone is sufficient on a system basis but greater emphasis on both can achieve the California triple aim of lower costs, improved outcomes and greater equity.

Health Access appreciates consideration of these comments by both the Health Care Affordability Board and OHCA staff.

Sincerely,

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