HCAi Department of Health Care Access and Information
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Sacramento, CA 95833
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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
6/07/2025	Diane Dooley	I am a pediatrician working with the American Academy of Pediatrics on behavioral health access and quality for children and youth in California. We appreciate the work that you are doing to increase behavioral health services in California. Pediatricians regularly identify behavioral health disorders in their practices, but referrals to care have a very low success rate because of the ongoing barriers to access for behavioral health services. I am very concerned that the Milbank Memorial Fund method of capturing behavioral health spending will not accurately identify expenditures for the pediatric population. The Milbank method of capturing behavioral health spending assumes that the primary diagnosis will be a behavioral health disorder, however primary care providers routinely perform behavioral health screening during a well child exam in early childhood or adolescence, consistent with the American Academy of Pediatrics Bright Futures guidelines. A diagnosis consistent with behavioral health or substance use disorders may be made during this visit, however it will usually not be the primary diagnosis because the provider is using a template for a well child visit which labels the visit as primarily a preventive care visit. This inaccurate method of identifying behavioral health concerns may explain why only 2% of behavioral health expenditures were noted to be in primary care settings. I would suggest using the behavioral health diagnosis as an indicator of primary care expenditure whenever it is present, not just when it is a primary diagnosis. I would also suggest separating out these expenditures by

Date	Name	Written Comment
		age. The rates of developmental and behavioral disorders varies by age in pediatrics and a measurement of expenditures by age is necessary to determine the appropriate medical support for these conditions. Thank you for the work that you're doing on this very important topic.
7/02/2025	Local Health Plans of California	See Attachment #1.
7/17/2025	California Hospital Association	See Attachment #2.
7/17/2025	Health Access of California	See Attachment #3.

July 2, 2025

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

Re: LHPC June 9, 2025, Health Care Affordability Board Meeting Comments

Dear Director Landsberg,

On behalf of the 17 local health plans that collectively serve over 70% of Medi-Cal managed care enrollees across the state, the Local Health Plans of California (LHPC) is taking this opportunity to provide comments in follow-up to the Office of Health Care Affordability (OHCA) June 2025 Board meeting. LHPC and local plans appreciate the significant effort that OHCA has dedicated to the recently released Baseline Report on Health Care Spending and Growth Trends in California for 2022 and 2023. We recognize the inclusion of high-level commentary on the variations in Medi-Cal expenditures due to policy shifts and benefit changes. **However, LHPC and local plans respectfully request that future iterations of this report provide more detailed context regarding these Medi-Cal variations**. Specifically, greater clarity on the nature and impact of administrative or programmatic changes would enhance public understanding and support more informed policy discussions. Without this additional detail, readers, both policymakers and the public, lack the necessary context to fully interpret the drivers behind the spending data. Additionally, our letter addresses our recommendation that OHCA continue to leverage available data through existing reports Medi-Cal managed care plans provide to the Department of Health Care Services (DHCS) to the greatest extent possible. This will avoid costly, administratively burdensome, and potentially duplicative reporting requirements.

It is important to recognize that the Medi-Cal program is distinct from Medicare, Commercial, and other markets. Medi-Cal spending is governed by state, legislative, and contractual requirements that set it apart from other coverage types. Unlike Commercial or Medicare plans, Medi-Cal managed care plans are required to accept rates developed and set by the state, rather than establishing their own.

In addition, the underlying populations and covered services within the Medi-Cal program differ substantially from those in Commercial or other market categories, making direct comparisons inherently problematic. Medi-Cal serves a disproportionately high-need population, including individuals with disabilities, seniors requiring long-term care, and those with complex behavioral health conditions. As a result, Medi-Cal spending includes a higher share of costly services such as inpatient care, long-term services and supports (LTSS), and other wraparound benefits not typically covered in Commercial plans. These high-cost services significantly inflate the total spending denominator, which in turn deflates the relative percentage attributed to primary care, even when primary care access and delivery may be robust. LHPC would appreciate further insight into how

OHCA plans to use the results of this data submission and account for or normalize these fundamental differences in population needs and benefit design when making cross-market comparisons.

Below, we provide additional information and context related to OHCA's Baseline Report, specific to Medi-Cal plans. We believe this context is essential for the public to better understand the unique factors driving expenditure changes within the Medi-Cal program.

Recent Medi-Cal Program Changes

To better understand the Medi-Cal specific expenditures of the baseline report and Medi-Cal specific policy changes that drive spending more broadly, it is important to understand there have been significant program changes that occurred to the Medi-Cal program recently. Some of those changes include, but are not limited to:

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multi-year initiative that began in CY 2022 and is intended to improve quality of life and health outcomes for the Medi-Cal population. It is important to note some newly carved-in services, such as major organ transplants and long-term care, contributed to the significant variations in cost increases to specific plans as those services were new in some counties but not for others. Local plans generally serve a defined and limited-service area, whereas commercial plans tend to have larger footprints and may have already covered these services in certain counties.

In addition, the implementation of new programs and benefits under CalAIM required significant administrative investments from health plans to ensure their successful rollout within the Medi-Cal program. These necessary investments contributed to increased administrative costs.

Included in these initiatives were:

- The carve-in of long-term care (LTC) services for partial-dual and full-dual Medi-Cal members. This included Skilled Nursing Facilities (SNFs), Intermediate-Care-Facility-for-Developmentally-Disabled (ICF-DD), and Subacute facilities. Previously, these services were only covered by County Organized Health Systems (COHS) plans and, for SNF services, plans participating in the Coordinated Care Initiative (CCI);
- The carve-in of major organ transplants for all non-County Organized Health System (COHS) health plans;
- Implementation of Enhanced Care Management (ECM) services; and
- Enabling plans the ability to offer select community support services

Targeted Rate Increase

Effective January 1, 2024, Medi-Cal implemented a significant programmatic change known as the Targeted Rate Increase (TRI) pursuant to the Budget Act of 2023 and Assembly Bill (AB) 118 (Chapter 42, Statutes of 2023). This legislative mandate resulted in substantial increases to provider reimbursement rates, particularly for primary care providers, without any underlying change in service utilization or care delivery patterns. As a result, the percentage of spending attributable to

primary care may appear to shift dramatically, but this is purely a function of policy-driven reimbursement adjustments rather than any meaningful change in how care is being delivered. This underscores the need for caution when comparing Medi-Cal spending patterns across years or against other markets where such targeted funding mechanisms are not present.

Medi-Cal Eligibility Redeterminations

Another important consideration is the impact of the COVID-19 public health emergency unwinding of administrative flexibilities, specifically, eligibility redeterminations for the Medi-Cal population. As the state resumed post-pandemic redeterminations, many lower-acuity individuals were disenrolled from the program. This has shifted the overall risk profile of the Medi-Cal population, leaving a higher concentration of individuals with more complex health needs. As a result, per-member spending may appear to increase, not because of changes in utilization patterns or program performance, but simply due to the higher acuity of the remaining population. This dynamic makes it challenging to derive meaningful insights from year-over-year trends within Medi-Cal, and even more so when comparing Medi-Cal to other market categories that have not experienced similar enrollment shifts.

Eligibility Expansion of Individuals without Satisfactory Immigration Status

Over the last several years, California also continued its Medi-Cal eligibility expansions to provide access to full-scope Medi-Cal for all income eligible individuals, regardless of immigration status. As part of this transition, undocumented individuals aged 50 and older became eligible for Medi-Cal managed care beginning in May 2022.

However, the majority of this population did not fully transition into managed care until 2023, which contributed to the cost differences observed between 2022 and 2023. Additionally, this newly enrolled group often had higher health needs and limited prior access to comprehensive care, factors that made their care more complex and costly. Subsequent to the expansion of eligibility for older adults, individuals ages 26 to 49 became eligible for full-scope Medi-Cal and transitioned into managed care on January 1, 2024.

State Directed Payment Programs

Adding to recent Medi-Cal cost growth are increasing levels of state directed payments. Not only are there newly implemented state directed payment programs (i.e. district and municipal hospital directed payment), but also significant payment increases to existing programs. These programs are critical to support sustainable funding for Medi-Cal providers but do add substantially to overall costs. Also note that state directed payments are a unique payment methodology in Medi-Cal, and the payment process and timing is different from typical plan payments to providers. This will need to be accounted for in future reporting. There were also increased administrative costs that came with implementing new state directed payments and many of the programs require Medi-Cal plans to reconcile data with providers to ensure proper encounter data is submitted to the state.

OHCA Reporting Requirements for Medi-Cal Managed Care Plans

LHPC and local plans appreciate OHCA's thoughtful approach to the Total Health Care Expenditures (THCE) reporting for Medi-Cal plans, particularly the collaboration with DHCS to obtain managed

care plan data that has already been submitted. This coordination helps reduce duplicative reporting and administrative burden, and we encourage continued efforts to align reporting requirements wherever possible. While we understand the intent behind OHCA's request to capture primary care spending, meeting the data requirements as proposed in OHCA's THCE data submission guide introduces substantial administrative challenges for health plans. If these requirements are expanded, these challenges would only increase and would impose significant administrative concerns. **We are committed to working collaboratively with OHCA and DHCS to ensure that, to the greatest extent possible, reporting requirements are aligned, not duplicative, and that existing reports are leveraged to minimize administrative burden**.

LHPC and local plans thank OHCA and the Board for consideration of our feedback. We look forward to continued conversations and collaboration with the Department.

Sincerely,

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

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

Members of the Health Care Affordability Board:

Dr. Sandra Hernández

Dr. Richard Kronick

Ian Lewis

Elizabeth Mitchell

Donald B. Moulds, Ph.D.

Dr. Richard Pan

Vishaal Pegany, Deputy Director, Office of Health Care Affordability

July 17, 2025

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

Subject: OHCA Must Shift Approach to Account for Catastrophic Federal Cuts and Exorbitant Growth in Health Insurer Profits
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

California's hospitals share the goals of the Office of Health Care Affordability (OHCA) 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 comment.

Federal Policy Changes Will Decimate California's Health Care Delivery System

On July 4, President Trump signed the "One Big Beautiful Bill Act" (OBBBA) into law, ushering in the largest health care cuts in the country's history. The cuts will reduce access and coverage for economically disadvantaged children and families on Medicaid, the growing senior population on Medicare, and families with coverage through the Affordable Care Act (ACA). The largest cuts are to the Medicaid program (Medi-Cal in California), resulting in nearly $1 trillion in cuts nationally over the next decade — and $66 billion or more in cuts to California hospitals alone. Before OBBBA was passed, 50% of California's hospitals were operating in the red. That number will undoubtedly rise as more hospitals face even greater financial distress. The immediate, devastating, and long-lasting effects will not only be borne by health care providers and their patients; when layered with the reduction to the Supplemental Nutrition Assistance Program, or CalFresh in California, the Commonwealth Fund estimates severe economic losses to states, including 1.22 million jobs lost nationwide by 2029. What's more, these only reflect the estimated impacts from OBBBA. Additional cuts are already being considered by federal policymakers that would further devastate California's health care delivery system.

More Than 1.8 Million Californians Will Lose Coverage. Nearly 15 million Californians (more than a third of the state's population) are covered by Medi-Cal. Many of the OBBBA cuts to Medi-Cal will make

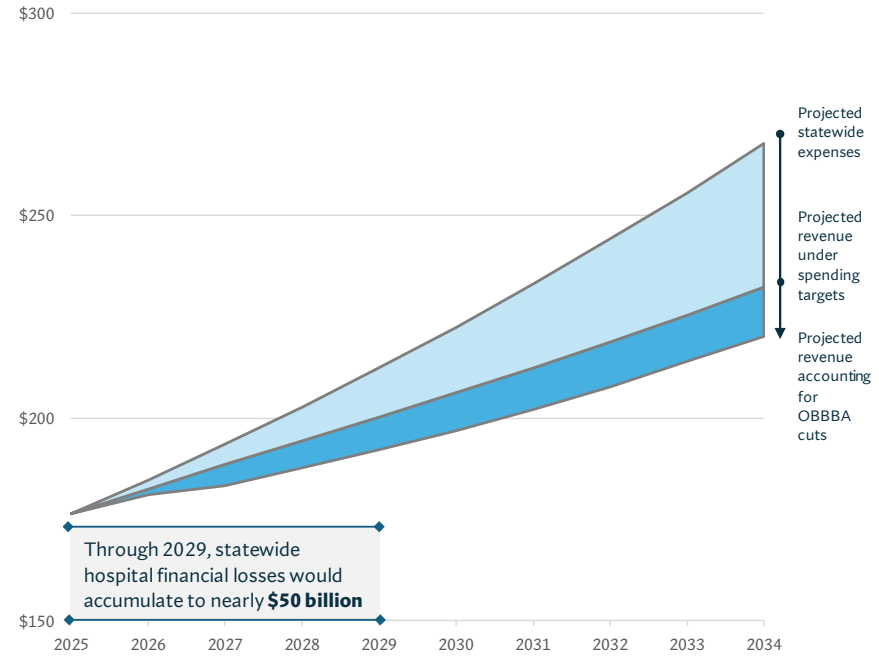
it harder for individuals to maintain their health care coverage by requiring them to jump through burdensome procedural requirements like work and community engagement activities, putting them through more frequent eligibility redeterminations, and subjecting them to broader eligibility verifications. For the Medi-Cal expansion population with income greater than 100% of the Federal Poverty Level, states must impose copayments of up to $35 for certain services. OBBBA provisions, combined with allowing the enhanced premium tax credits to expire, also will reduce the ability of low and middle-income individuals and families to purchase affordable health care coverage through Covered California. For example, OBBBA shortens the open enrollment period and restricts coverage for Deferred Action for Childhood Arrivals recipients.

In California alone, the Medi-Cal and Covered California cuts will result in lost coverage for an estimated 1.8 million Californians over a 10-year period, a 75% increase from the estimated 2.4 million uninsured as of 2023. Taken together, the changes in OBBBA will reverse many of the health coverage gains made since the ACA was passed. Californians will face higher health care costs and reduced access to coverage, with many becoming sicker and delaying care until their conditions worsen to the point that they must resort to seeking emergency stabilization at the hospital.

Federal Policy Changes Will Reduce Payments for California's Hospitals by 14% or More. Not only does OBBBA affect health care coverage and uncompensated care, it cuts Medicaid payments for hospitals directly by restricting both the funding sources (health care-related taxes) and mechanisms (payments structured by the state and directed through managed care plans) that California hospitals rely on to narrow, but not eliminate, the gap between what Medi-Cal pays and what it costs to care for Medi-Cal patients. These federal changes put California's Prop 35 managed care organization tax entirely at risk and will require significant changes and reductions to the Hospital Quality Assurance Fee Program.

Spending Targets, Combined With Federal Cuts, Will Generate Enormous Financial Losses for Hospitals That Will Have to Be Addressed Through Job Reductions, Service Line Cuts, and Full Closures

Dollars in Billions



Hospital expenses are grown at the recent historical average of 4.75%, revenues are grown at the statewide spending target through 2029, and the One Big Beautiful Bill Act (OBBBA) cuts include the bill's mandated reductions in hospital payments, the elimination of funding from the managed care organization tax, Medicare sequestration cuts, and rule changes that will reduce coverage and increase uncompensated care at hospitals.

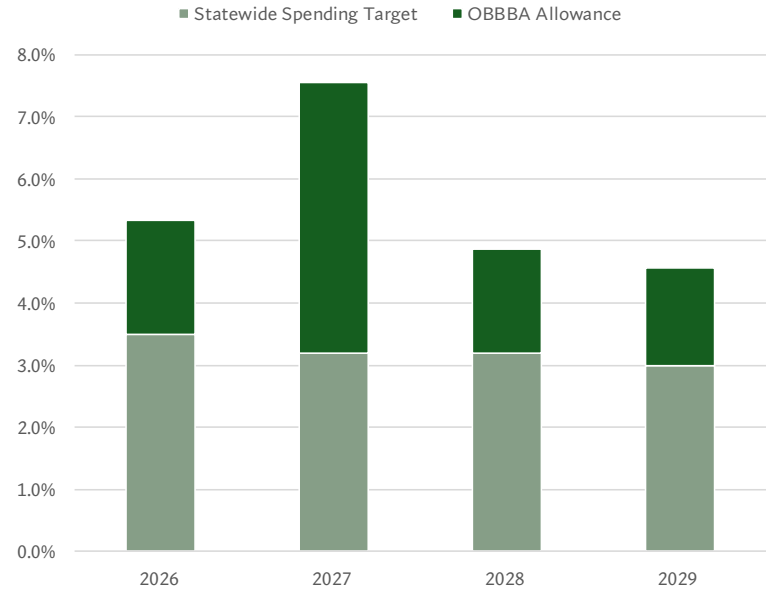
Automatic Medicare Cuts Are Looming. OBBBA is projected to increase the deficit by $3.4 trillion over 10 years. Under the federal Statutory Pay-As-You-Go Act of 2010 (S-PAYGO), if a bill is enacted that increases the deficit, the federal government is required

to enact across-the-board cuts to certain programs, also known as sequestration. Unlike Social Security and programs for low-income individuals, Medicare is not exempt from these cuts. Unless Congress intervenes, sequestration will trigger an expected 4% reduction to most Medicare spending effective October 1, 2026, resulting in Medicare cuts in the hundreds of billions of dollars over the 2026-2034 period (the Congressional Budget Office previously estimated these cuts to be $500 billion from the prior deficit estimate of $2.3 trillion). These cuts will affect payments to hospitals, physicians and health care providers, Medicare Advantage plans, and prescription drug plans. Today, Medicare already reimburses hospitals 75 cents for every dollar hospitals spend on care. These Medicare cuts will exacerbate the inadequacy of Medicare reimbursement to hospitals.

To Protect Access to Care, OHCA Must Provide Blanket Waivers Against Enforcement for Providers Whose Funding Is Cut. These federal cuts will come on top of those already mandated by OHCA's 3.5% spending cap for hospitals (ramping down to 3% by 2029), and an even lower cap for a select few. The combination of federal and OHCA cuts will threaten the stability of California's entire health care delivery system. As the figure on the previous page shows, through 2029, these federal and state actions will cause hospitals to suffer nearly $50 billion in financial losses unless drastic steps are taken to slash costs. If the statewide spending target were maintained, these losses would only further compound.

OHCA must ensure that its actions do not exacerbate the devastating impacts of the federal cuts. To do so, OHCA must act now by declaring that spending growth offsetting losses from the federal cuts is a justifiable reason for exceeding the spending target. Absent this action and other concessions, hospitals will be forced to take drastic actions that run counter to OHCA's mission of promoting access to high-quality and equitable care and maintaining a stable health care workforce. The figure on the right translates the federal cuts into spending-target terms, showing that additional allowances of 2% to 4% on hospitals' commercial spending targets would be necessary, on a statewide basis, to offset the devastating cuts coming from Congress.

Allowance Needed for the Commercial Line of Hospitals' Spending Targets to Offset the Largest Health Care Cuts in History

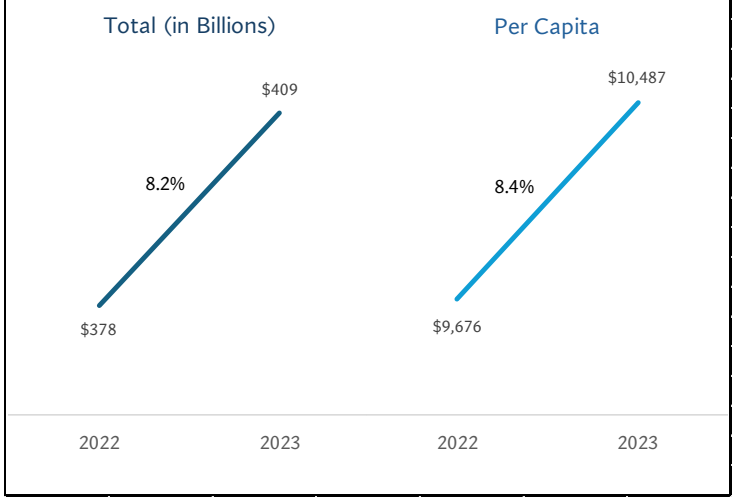


Over just the next 4 years, the One Big Beautiful Bill Act (OBBBA) will reduce hospital funding by over $20 billion, necessitating an allowance for growth above the spending target within hospitals' commercial line of business.

OHCA Baseline Report Revealed That Health Insurer Profits and Drug Cost Growth Drove Spending Growth in 2023

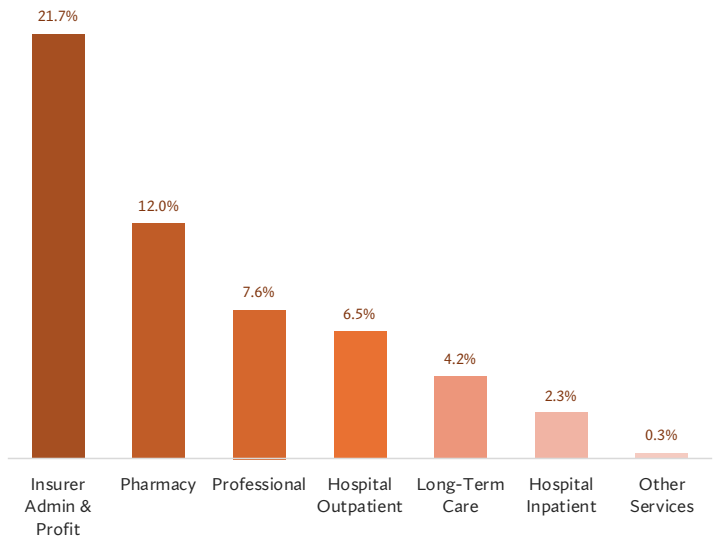
At the June board meeting, OHCA presented findings from its first report on the annual growth of health care spending in California. The report's release represents a major implementation milestone and is the culmination of significant work on the part of the office and its implementation partners. Importantly, it revealed several striking trends that should inform OHCA's work going forward. It also left key questions unanswered.

Total and Per Capita Health Care Spending Grew by Over 8% in 2023



Spending Growth Far Exceeded OHCA's Prospective Spending Targets. California's first statewide spending target was implemented in 2025, starting at 3.5% and ramping down to 3% by 2029. By contrast, the baseline report tracks the growth of health care spending between 2022 and 2023. This earlier period marked the state's unofficial emergence from the COVID-19 pandemic, which fundamentally altered health care utilization and spending patterns and threatened the financial stability of hospitals and other providers across the state. Undoubtedly, this influenced the resulting growth patterns. Nevertheless, the 8.4% growth in per capita spending — a rate that is nearly 2.5 times higher the 2025 spending target — shows that a reevaluation of the spending target is needed sooner than later. The above figure displays the statewide spending growth figures.

Insurer Profits and Pharmacy Costs Drove Health Care Spending Growth in 2023



Note: Insurer Admin & Profit figure is a combined estimate for commercial, Medi-Cal, and Medicare payers, while, due to reporting limitations, the other figures reflect claims payment growth for commercial and Medicare payers only. Pharmacy spending does not factor in rebates.

Health Insurer Profits Are Growing at Stunning Rates. As the figure on the left shows, health insurer profits grew exorbitantly between 2022 and 2023. In fact, statewide health insurer profits grew at more than 4 times the rate of their spending on actual medical care (which saw 5% growth). This meant that 21 cents of every dollar increase in health care spending in 2023 supported higher health insurance company profits, not improvements in medical care.

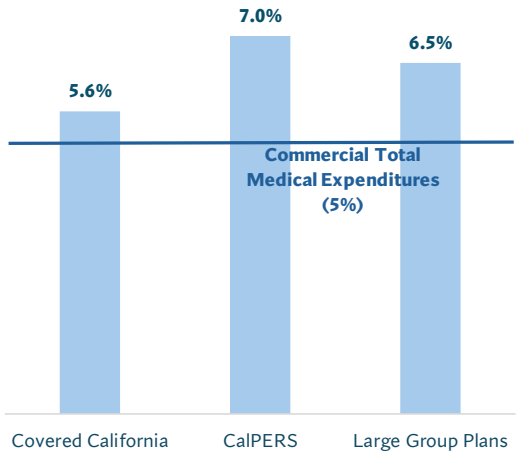
Spending on Hospital Care Grew Far Slower Than Spending Overall. While total per capita health care spending grew by 8.4% in 2023, hospital spending for inpatient and outpatient services grew more modestly — by 2.3% and 6.4%, respectively. These divergent trends mirror utilization patterns. According to hospital financial reports, the number of statewide inpatient discharges grew by 2.6% between 2022 and 2023, while outpatient visits grew by 4.9%. This relatively higher growth in outpatient care is partly attributable to hospitals' work to, when clinically appropriate, shift care from the inpatient to outpatient setting. In addition to being less costly, outpatient care can be more patient-centered, allowing patients to return to their homes and communities of support more quickly. Less encouragingly, however, the trend also likely stems from increased reliance on emergency room care, including for conditions that could have been treated in primary care settings. As evidence, emergency room visits grew by 4% between 2022 and 2023.

Thorough Analysis of the Drivers of Health Care Spending Growth Remains Outstanding. OHCA's baseline report accurately identifies the variable spending trends for different categories of services. However, it does not reveal the drivers behind these variable trends or for rising health care spending overall. Below are several areas that are ripe for further exploration:

- **Health Insurer Profitability.** The baseline report showed that health insurers' profits and administrative costs are together growing at exorbitant rates. This could be because insurers are hiring more care managers, as envisioned under CalAIM, or updating their systems to streamline utilization management and provider payments. Alternatively, it could simply be a surge in profits paid out to investors and additional contributions to their already enormous reserves. Furthermore, it is unclear whether a few large insurers disproportionately enjoyed higher profits, or if this is an industry-wide trend. Follow-up analysis is needed to answer these important questions.
- **Drug Cost Growth.** Even after accounting for rebates, total retail drug spending grew by 10% between 2022 and 2023. However, even this high number understates the full impact of rising drug prices on overall health care spending growth. This is because a significant portion of drug costs are covered under medical, rather than pharmacy, claims and are therefore rolled into OHCA's hospital and professional services categories. Identifying the true influence of rising drug costs on health care spending growth is essential.
- **Coverage and Demographic Changes.** Sizable shifts in coverage occurred between 2022 and 2023, with Medicare rolls increasing by nearly 0.9%, Medi-Cal rolls increasing by 3.5%, and commercial coverage going down by 0.6%. These diverging trends likely significantly influenced health care spending growth that year, given both the higher health care needs Medicare enrollees and the lower reimbursement for health care paid by the two government payers, Medi-Cal and Medicare, that saw inflows in covered lives. OHCA should evaluate the impacts of these coverage and demographic changes on health care spending.

Elevated Scrutiny of Health Insurance Companies Is Needed Now

Commercial Premiums Grew Far Faster Than Health Plan Spending on Medical Care in 2023



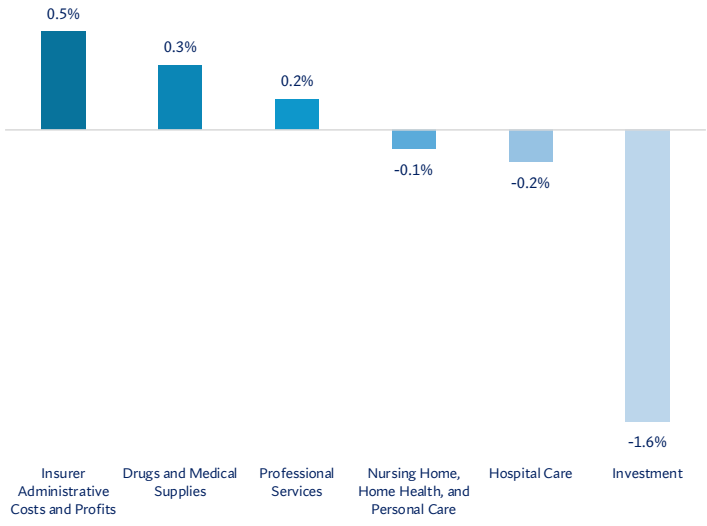
Data from the Health Plan Aggregate Premium Rate Report, Measurement Year 2024, and the OHCA Baseline Report

Commercial Health Insurer Premiums Grew Far Faster Than Medical Spending in 2023. As the figure on the left shows, premiums for the most common types of commercial health insurance plans went up by between 5.6% and 7% in 2023. At the same time, per capita total medical expenditures in the commercial market went up by just 5%, according to OHCA's baseline report. This alarming gap between what insurers earned in premium revenue and what they paid for medical care translates to billions of dollars simply supporting higher health insurer profits, not the treatment of life-threatening diseases or investments to improve access to high-quality care. It is unclear how much of this excess premium growth was refunded to premium payers under medical loss ratio requirements. Going forward, OHCA must analyze the difference between premium growth and reported medical expenditures to understand whether the state's spending targets are actually achieving their aim of promoting greater affordability for Californians.

Excessive Growth in Insurance Company Profits Is an Enduring Trend. The high growth of health insurer profits could be ignored if it were a one-time phenomenon in 2023. However, as the figure below shows, inflated growth in insurer administrative costs and profits has persisted for more than a decade. Annually between 2013 and 2023, this component of national health expenditures grew one-half percentage point faster than the overall spending growth. Ultimately, it shows that dollars are increasingly being diverted away from patient care.

Health Insurer Administrative Costs and Profits Grew Significantly Faster Than Total National Health Expenditures Between 2013 and 2023

Percent Difference in Compound Annual Growth Between Major Categories of Health Expenditures and National Health Expenditures



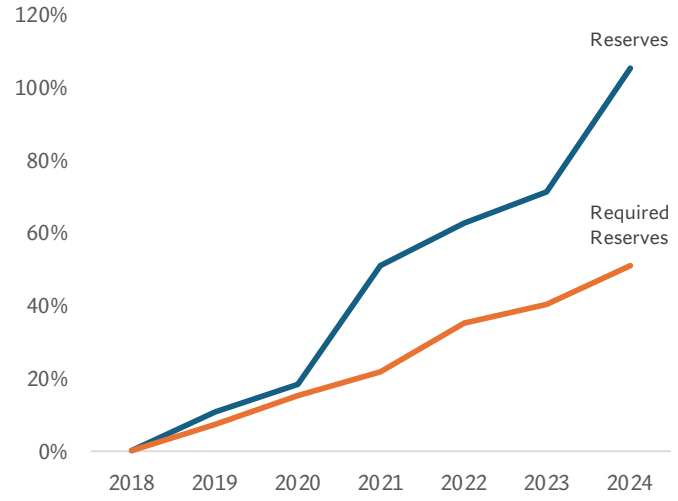
Note: All data are based on the latest nationwide National Health Expenditure release. Insurer administrative costs and profits reflects the net cost of insurance category. The nursing home, home health, and personal care category is an aggregate of the following categories: nursing care facilities and continuing care retirement communities; home health care; and other health; residential, and personal care.

Insurers Have Amassed Enormous Excess Reserves. The longstanding trend of excessive profits by health insurance companies, nationally, is corroborated by high statewide growth in health plan reserves. As the figure on the next page shows, health plan reserves have grown by over 100% in just the last six years, twice the rate of growth of their regulatorily required reserves. This raises serious questions about why Californians are

charged so much in premiums and requires investigation by OHCA.

Insurers Should No Longer Receive a Free Pass from Scrutiny. Data from OHCA on recent health care spending growth, the Centers for Medicare & Medicaid Services on long-term spending trends, and the Department of Managed Health Care on health plan premium and reserve growth all point in the same direction: skyrocketing health insurance prices are a main driver of the state's affordability challenges. Nevertheless, health insurance companies have received scant scrutiny from OHCA. OHCA must conduct an in-depth evaluation of health insurance premium and reserve increases to see whether these have increased spending and investment in high-quality health care, or been syphoned off as profits and retained earnings. OHCA should propose options, and the board should adopt, stricter spending targets for health insurance companies that are high cost, as shown by these and other measures. OHCA should also develop recommendations for the legislative and regulatory changes that ensure that the dollars Californians spend on premiums support the health care they need.

Health Plan Reserves Have Risen to Record Levels, Far in Excess of Regulatory Requirements



Reserves reflect tangible net equity, as measured by the Department of Managed Health Care.

Conclusion

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

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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

HEALTH ACCESS CALIFORNIA

July 17, 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: July 22, 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 on the baseline report and recommendations for future reports as well as enforcement process for both failure to submit accurate and complete data timely and the Cost Growth Target with a particular focus on Board action on scope and range of penalties as well as a discussion of what factors are partly or wholly within the control of an entity that fails to meet the cost target.

Baseline Report

Health Access appreciates the work of the Office of Health Care Affordability to develop and publish the baseline report. We offer comments about future annual reports, with the goal of strengthening future public reporting by the Office, particularly the impacts on health care costs for consumers and other purchasers as well as primary care, behavioral health, and equity and quality measures. Future reports would benefit from a more detailed analysis of the underlying causes of changes to health care spending or cost trends.

Administrative Costs and Profits: Big Jump

The report shows a 25%-26% increase in profits and administrative costs of health plans and insurers under commercial coverage and Medi-Cal managed care from 2022 to 2023. This is a remarkably large increase that is reported with little explanation for commercial coverage and none for Medi-Cal managed care. Is the large increase anticipatory spending in advance of the OHCA cost targets? Does it result from

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spending anomalies during the COVID years? Or some other explanation? Are the increases in administrative costs and profits for Medi-Cal managed care plans a function of new administrative responsibilities or the rearrangement of Medi-Cal managed care contracting such as separately contracting with Kaiser for Medi-Cal managed care?

We also note that based on this data, commercial coverage shows about 7.8% is spent on profits and administrative costs while for Medi-Cal managed care, the percentage spent on profits and administrative costs is almost twice as high, 15.5%. This raises questions about the administrative efficiency of the Medi-Cal managed care plans, many of which are local health plans as well as some for-profit plans such as Centene/HealthNet. It validates the May Revise proposal of the Administration to reduce administrative costs and profits of Medi-Cal managed care plans from over 15% to 10% to more closely align with commercial coverage.

The discussion of profits and administrative costs by line of business would be further strengthened if it were separated into Kaiser and not-Kaiser.[1] This is because Kaiser, which is 40% of both commercial coverage and Medicare Advantage markets in California, has a medical loss ratio of 95%.[2] For the non-Kaiser coverage in the commercial and Medicare Advantage lines of business, it would be useful to see the share spent on profits and administrative costs. Based on other reports, medical loss ratios for non-Kaiser plans in both the commercial and Medicare Advantage markets are 80% or 85%. Bundling together Kaiser and non-Kaiser coverage masks this. We note that many reports published by DMHC separate out Kaiser and non-Kaiser plans.

Consumer Costs: Continuing to Climb Faster than Family Income

Health Access appreciates the inclusion of the analysis of consumer costs for both share of premium and out of pocket costs such as deductibles with the impact on consumer affordability. We commend the Office for including this in the first baseline report and look forward to further analysis and development of this reporting in future years. From Day One of the Health Care Affordability Board and the work of the staff, consumer affordability has been the central focus here in California. To quote:

> Taken together, the widening gap between incomes and the cost of health care places an increasing burden on Californians. While wages have increased over time, escalating premiums and deductibles have disproportionately outpaced household incomes. This growing disparity places a greater financial strain on

[1] Kaiser will become a more important player in Medi-Cal managed care in years to come as a result of changes in Medi-Cal managed care contracting.

[2] The administrative costs of the Permanente Medical Groups and the hospitals are counted as claims cost

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workers, making health coverage increasing unaffordable for many California households[3].

Health Access appreciates the data and analysis on consumer affordability. Other states in their initial reports failed to focus on consumer affordability and only considered these impacts in later years.

In future years, we look forward to the inclusion of data and analysis of consumer affordability based on both total health care expenditure (THCE) data and data from the HPD. Future reports would also be strengthened by including data from the DMHC and CDI reporting on consumer out of pocket costs by market segment, including individual, small group and large group in their annual rate review reporting[4]. Aligning reporting by OHCA on cost targets with DMHC and CDI rate review process reporting will help to facilitate consumers and other purchasers reaping the benefits of OHCA's cost growth targets.

Health Access recommends that in future reports, staff expand the discussion of consumer affordability to include

- Comparison of consumer share of cost to income distribution
    - For example, another state compares consumer costs to the wages for a Licensed Vocational Nurse.
    - Comparison of consumer costs for share of premiums as cost sharing such as deductibles and copays to the income distribution by quartiles would also be illuminating because those at or below the median income face the greatest affordability challenges but even those in third highest quartile find some health care costs, such as the maximum out of pocket, unaffordable.
- Consumer costs in terms of share of premium and out of pocket costs such as deductibles, coinsurance, copayments, and the limit on maximum out of pocket costs.

Recent analysis finds that half of California taxpayers live on less than $81,000 a year[5]. In that context, the damage from ever-escalating health care costs inflicted on most California families is even starker.

Primary Care, Behavioral Health, Equity and Quality Measures: Future Reporting

- Primary Care Benchmark Progress toward Compliance?

[3] https://hcai.ca.gov/wp-content/uploads/2025/06/Baseline-Report-Health-Care-Spending-Growth-Trends-in-California-3.pdf
[4] DMHC Aggregate Premium Rate Report: https://www.dmhc.ca.gov/Portals/0/Docs/DO/HealthPlanAggregatePremiumRateReport2024.pdf
[5] https://itep.org/analysis-of-tax-provisions-in-senate-reconciliation-bill/

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The Board set an ambitious goal of plan spending of 15% of THCE for primary care. Health Access looks forward to future reporting on annual progress toward this goal. That reporting should separate out PPOs from HMOs and Kaiser from not-Kaiser. In addition, in the future, it would also be helpful to report separately on Medi-Cal managed care. We anticipate that some plans and market segments will be more likely to meet the 15% benchmark than others. Understanding where primary care spending lags will be helpful to making future progress. The Board set this ambitious overall goal because emphasizing primary care has been demonstrated to improve outcomes while reducing costs.

- Behavioral Health Spending

Measuring so-called "total" health care expenditures by health plans on behavioral health is a particularly inapt way to measure behavioral health. A substantial share of spending on behavioral health is not in-network spending[6] by health plans, insurers and self-insured plans (and the concomitant consumer cost sharing for such in-network care). Health Access seeks reporting on county behavioral health, drug Medi-Cal, out of pocket spending by consumers on out-of-network behavioral health care, and other behavioral health spending that is not a covered benefit counted as THCE because of the failures of the existing system of coverage and care delivery.

- Equity and Quality Measures

The Board and the Office have already adopted recognized equity and quality measures and has a statutory obligation to update those annually. Going forward, reporting on performance on these measures should be aggregated in the annual reports. The reason the law includes reporting on equity and quality measures is to ensure that slowing the rate of growth of health care costs does not come at the expense of equity or quality.

Medi-Cal Spending

Reporting on Medi-Cal spending has been delayed. Health Access looks forward to the Office reporting on Medi-Cal spending, including Medi-Cal managed care and the small remaining (but high-need) Medi-Cal fee-for-service population as well as the many supplemental payment streams such as GME, DSH, IGT/CPE, PPS, QAF, MCO, Prop. 56 and more. Medi-Cal today covers a third of Californians. Reporting compliance with the cost growth target for Medi-Cal both on a total and a per capita basis reflects a program that today covers one third of all Californians and that even after the pending federal cuts is still estimated to cover about 12 million Californians, greater than the population of almost every other state.

[6] We include spending under SB 855 as in-network spending because it is paid by health plans and insurers in lieu of providing timely access to necessary care by in-network behavioral health providers.

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Hospitals and Large Physician Organizations

The baseline report is limited to health plans, insurers and self-insured plans. Health Access looks forward to future reporting on hospitals and large physician organizations as well as efforts to track cost growth at the health system level, similar to what some other states do. The absence of such reporting in the baseline report is understandable. But in the future, annual reports should be expected to include reporting at the level of hospitals, large physician organizations and health systems.

Performance Against the Cost Growth Targets, Both Statewide and Sector

The statewide cost growth target of 3.5% is in effect for 2025, although it is a non-enforcement year. Health Access looks forward to future annual reports that will determine progress both overall and by specific health care entities toward compliance with this target. If an entity exceeds the cost growth target, the law requires the office to "make public the extent to which the health care entity exceeded the target".[7]

Health Access looks forward to future annual reports that will determine progress both statewide and by specific health care entities toward compliance with the target.

Again, we commend the staff on the initial report and offer these comments to strengthen future annual reports. We anticipate that these reports will be referenced and used by policymakers and others in numerous settings so comprehensive and accurate reports will be helpful in that.

Enforcement

Board Responsibility: Scope and Range of Penalties, within the Framework of the Law

The responsibilities of the Health Care Affordability Board include approving "the scope and range of administrative penalties, and the penalty justification factors for assessing penalties".[8] Under the OHCA law, administrative penalties include both penalties for failure to submit data required under the law and penalties for exceeding the cost growth targets.[9]

A. Penalties for Failure to File Timely, Complete and Accurate Data

Data is the foundation of OHCA's work to control costs while improving outcomes and equity. Timely submission of accurate data has already proven important in the discussions around very high-cost hospitals. While the office has had general

[7] Health and Safety Code 127502.5 (c) (1)
[8] Health and Safety Code 127502 (b) (2).
[9] Health and Safety Code 127502.5 (h) for failure to submit data and Health and Safety Code 127502.5 (a) (4) and (d) for exceeding cost growth targets.

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compliance from health plans in submitting "total" health care expenditure data, the law provides for administrative penalties for "failing to submit complete and accurate data", "failing to provide information required by the office," or "falsifying information required by this section".[10] Assuring that the data that is the basis of OHCA's work is complete, accurate and timely is foundational.

Whether it is meeting the cost targets, greater reliance on primary care or assuring workforce stability, data needs to be received on an annual cycle to allow monitoring of progress toward OHCA's goals. Timeliness of data is important. We support the Board and staff moving to adopt penalties for failure to submit complete, accurate data in a timely manner to support the annual review of progress toward goals. We look forward to further discussion about the specifics of such penalties.

B. Penalties for Exceeding the Cost Growth Target

Health Access strongly supports the existing law which provides financial penalties commensurate in amount with the failure to meet the cost growth target.[11] As the OHCA law was being developed, across the country in Massachusetts, Massachusetts General Brigham repeatedly failed to meet their state's cost growth target, exceeding it by $293 million but the only penalty available to the Massachusetts cost growth program was a $500,000 penalty for failure to submit the performance improvement plan. While Massachusetts was successful in negotiating cost growth mitigation to move the entity toward meeting the cost target, other entities might have chosen to pay the modest penalty as the cost of doing business without changing behavior.

Learning from experience in Massachusetts and other states, the California law provides not only commensurate penalties but also escalating penalties in a case of continued noncompliance. The point of these penalties is to encourage compliance with cost growth targets without the necessity of levying penalties through a deterrence effect. We look forward to the board discussion on the scope and range of penalties, within the constraints of the California statute. This is a discussion that we hope will happen over the next year.

Factors Partly or Wholly Within the Control of the Entity: California Law Emphasis

California law emphasizes consideration of whether a factor is within the control of an entity or is outside the control of that entity with respect to whether an entity may be held in violation of the cost growth target. The section on enforcement begins by pointing to:

[10] Health and Safety Code 127502.5 (h) (1).
[11] Health and Safety Code 12502.5 (a) (4) and (d).

> "factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target[12]."

Other states, by law or practice, have looked at "reasonable factors". When looking the list of factors used in other states, a factor may appear to be reasonable but may, in practice, be partly or wholly within the control of the entity. In last month's letter to this Board, Health Access began to outline some of these factors that in our view are in whole or in part within the control of the entity, such as compliance with longstanding state mandates and prescription drug costs. Here we provide an overview of factors that may appear reasonable but that entities can, and should, exercise at least some control over and which should not be excuses for not meeting the target.

A. Changes in federal law regarding Medi-Cal and Covered California:

Health Access opposed, and opposes, the cuts made in H.R. 1, the recent federal law to Medicaid and Covered California. As Governor Newsom and DHCS Director Michelle Baass said on June 27, 2025, these cuts will result in 3.4 million Californians who rely on Medi-Cal or hundreds of thousands who are covered by Covered California losing health coverage and in too many cases being unable to obtain it in the future.[13]

Health Access points out that OHCA's enforcement is focused on entities that exceed the cost growth target and is measured separately for the three market segments of Medicare, Medi-Cal and commercial markets. Cuts to Medi-Cal revenue for hospitals should not cause hospitals to exceed the cost growth targets for the Medi-Cal segment. Cuts to Medi-Cal hospital revenue should not justify cost shifting to commercial coverage and is not a reason to void enforcement of cost targets for commercial and Medicare market segments.

The uninsured are not counted toward the cost growth target. The health care cost growth target is defined as:

> "Health care cost target" means the target percentage for the maximum annual per capita total health care expenditures.[14]

And "total health care expenditures" is limited to health care spending by health plans, insurers and public programs for covered benefits.[15] By definition, the uninsured are

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[12] Health and Safety Code 127502.5 (a) states: "The director shall consider each entity's contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target."

[13] https://www.gov.ca.gov/2025/06/27/governor-newsom-slams-trump-over-bill-that-would-cut-millions-in-health-coverage-food-assistance-for-california/ and https://govca.app.box.com/s/ea4g7lvekzv4agf18hgl5f2ztuelg0zb

[14] Health and Safety Code 127500.2 (j).

[15] Health and Safety Code 127500.2 (s).

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excluded from the cost growth target measurement unless entities engage in unjustified cost shifting.

When the ACA passed, California had more uninsured than Massachusetts had people. Literally, the population of uninsured in California in 2010 exceeded the entire population of Massachusetts. Those uninsured Californians lived sicker, died younger and were one emergency away from bankruptcy because of the lack of access to comprehensive health care, including primary and preventive care as well as specialty care and non-emergency hospital care.

What little care the uninsured do receive is often limited to the hospital emergency room and usually does not include even non-emergency hospital care, once the clinical emergency has been stabilized. Pre-ACA, most hospitals routinely denied care to the uninsured except for emergency care to stabilize an emergent condition. For example, for those with diabetes, this limited care meant care for diabetic comas and debates about whether to cover amputations should be limited to gangrenous limbs, not managing a major life-long condition to prevent complications.

All of us are still sifting through the debris left behind by the major changes in federal Medicaid and ACA coverage and timing of those changes. A number of changes taking effect over the next few years, will impact whether low-income Californians receive care at all, who pays for care for low-income Californians who do have coverage, and the rates paid to providers for services under Medi-Cal.

- Lawful immigrants: October 2026: the changes in federal law will exclude many lawful immigrants, particularly those lawful permanent residents here less than five years (the five-year bar) as well as most refugees and asylees from coverage under Medicaid and Covered California. For those under the five-year bar in the Medi-Cal income range, California has provided state-funded Medi-Cal coverage[16] but the recent budget trailer bill subjects coverage for adults ages 19 and older to an enrollment freeze and premiums.

- Medicaid work requirements: December 2026: ex parte verification of income could be accomplished for about half the affected Medi-Cal recipients if the Medi-Cal program worked with EDD Tax Branch, which is responsible for personal income tax withholding from employers. Some exemptions from the work requirements can be determined using information within DHCS' databases.

- Changes to provider taxes, including both the Managed Care Organization tax (MCO) and the hospital Quality Assurance Fee (QAF) may not fully take effect until 2028. State-directed payments that have elevated Medi-Cal hospital managed care rates above 100% of Medicare will be reduced to 100% of

[16] In most states, these individuals are covered in the exchanges as provided under the ACA. California continued state-only coverage.

Medicare. In future years, the Board may wish to consider these impacts in determining adjustments to the cost growth targets for the Medi-Cal market segment. Cost growth targets for commercial insurance and Medicare should not be affected by Medicaid provider taxes.

Cost shifting from Medi-Cal revenue losses for hospitals to commercial coverage could only be justified if hospitals could demonstrate that they were providing comprehensive care to the uninsured as part of commercial coverage. The onus should be on hospitals to demonstrate that reduced revenues are not commensurate with reductions in the number of people served or cuts to the services provided. If reductions to revenue result in cuts to care, then how can hospitals demonstrate the need for cost shifting?

Pre-ACA, spending on charity care amounted to no more than 2% of revenue for almost all hospitals while post-ACA charity care has fallen to 1% of a greater revenue base. Until 2006, hospitals charged the uninsured sticker price, not a discounted rate, and collected a higher proportion of charges from the uninsured than from the commercial insurers and some California hospitals still do.[17] The uninsured go without care, live sicker, die younger and live one emergency room visit away from medical bankruptcy.

B. State mandates: hospitals, insurers:

- Hospital seismic is a longstanding state mandate that dates to 1994:

HCAI reported last year that 80% of hospital buildings were compliant with structural requirements for the year 2030. Most buildings are not yet fully compliant with nonstructural requirements to remain operational post-quake (such as having water, elevators, electricity and sewer).[18]

Failure to comply in a timely manner with hospital seismic requirements is not a reasonable factor that is outside the control of the hospital in most instances. Hospitals have had thirty years to plan for compliance: many have.

Hospitals have routinely misestimated the cost of compliance with seismic requirements or attributed to that cost other updating, such as marble-clad lobbies, koi ponds, and other improved amenities not required under state law. Any estimates of the cost of compliance should be independently verified through the HCAI seismic branch process.

- Mandated covered benefits: insurers/health plans:

[17] California law now limits payments by the uninsured to a “discount” rate of the greater of 100% of Medicare or Medi-Cal, even though many hospitals appear to fail to comply even today.
[18] Senate Health analysis of SB 1432 (Caballero), April 24, 2024, www.leginfo.legislature.ca.gov

The California Health Benefits Review Program (CHBRP) performs an independent analysis of the cost of each benefit mandate bill as introduced. The Legislature should request an updated analysis of the final form of each bill.

In most instances, the cost impact of benefit mandates on premiums is very small, far less the increases in costs from hospitals, prescription drugs, and large physician organizations. California law has long required coverage of medically necessary care, including comprehensive prescription drug benefits. Rarely will the cost of a new benefit mandate be sufficient alone to cause a health plan or insurer to miss its target.

C. Pharmaceutical: hospitals, large physician organizations, insurers

- Prescription drugs administered in a hospital or large physician organization:

Medicare pays the actual price paid by a hospital or physician organization plus a small administration fee. Costs above that amount are within the control of the entity. Some hospitals, according NASHP, charge as much as 11 times the cost of the drug (Doctor's Modesto). The 340B program, which includes roughly half the hospitals in California, and which impacts the costs paid by commercial payers, are costs within the control of the entity: if the entity pays the 340B price, then that price should be the one paid by the commercial payer and when it's not, the facility should be held accountable for that price and its growth.

- Outpatient prescription drugs are partly within the control of an insurer or health plan,

The ability of a plan or insurer to control the costs of outpatient prescription drugs is allegedly greater if that insurer or health plan is merged with a pharmacy benefit manager. Again, the attributed cost should be based on the actual price paid, net of rebates and discounts. Plans and insurers should be expected to negotiate aggressively to reduce prescription drug costs. Best practices to reduce prescription drug spending also include not permitting prescribers to receive payments or other gifts from pharmaceutical manufacturers.

D. Labor costs:

California law recognizes that for the many entities with collective bargaining agreements, the costs associated with collective bargaining agreements are legally binding and can be documented. California law does not require an adjustment for labor costs that are not collective bargained. If OHCA wishes to consider labor costs for non-collectively bargained entities or labor force elements not subject to collective bargaining, OHCA should put the burden on an entity without collective bargaining

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agreements to produce requirements similar to entities with collective bargaining agreements. In our experience, many employers without collective bargaining agreements lack salary schedules and detailed budgets documenting labor costs. Assertions regarding labor costs should be based on documented costs, not broad generalities regarding the health care workforce. Trust but verify.

SB 525 of 2023, the health care worker minimum wage, will increase labor costs, in part, for some health care entities but again should be subject to documentation requirements in which entities have the burden of proof in demonstrating the cost impacts.

Summary of Recommendations

Health Access recommends that:

- Future annual reports include
    - Additional analysis of consumer costs as well as topics such as equity/quality measures and primary care, behavioral health.
    - Further analysis and explanation on not only health plans but also hospitals, large physician organizations, and health systems.
- Enforcement:
    - For data submitters, apply to timely, accurate and complete data submission because data is foundational to OHCA's timely work. The OHCA Board and staff should develop processes
    - For entities exceeding the cost target, administrative penalties are commensurate with the amount of the violation and escalate from there for repeated failures.
- The changes in federal law will result in millions of Californians becoming uninsured and not receiving the care they need, including primary and preventive care, prescription drugs, and comprehensive hospital care.
    - Cuts in federal revenue to providers do not justify cost shifting to commercial payers when the uninsured receive the bare minimum of emergency room care provided by most hospitals to the uninsured.
    - Cost shifting to commercial coverage because of Medicaid revenue cuts to providers is not a sufficient substitute for coverage.
- Factors asserted by entities to explain exceeding the target:
    - State law focuses on whether a factor was within the control of the entity.
    - Consider whether the factor used to justify exceeding the target is wholly or partly within the control of the entity, whether it is prescription drugs or excessive ER use.
    - For mandates, OHCA should look to analyses of cost impacts independent of the entity subject to the target, rather than relying on the entities

Thank you for your consideration,

Sincerely,

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