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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Wednesday, June 25, 2026
10:00 am

Members Attending: Secretary Kim Johnson, Dr. Sandra Hernández, Richard Kronick, Ian Lewis, Don Moulds

Members Absent: Dr. Richard Pan

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; Megan Brubaker, Engagement, Governance, and Policy Group Manager, HCAI; Andrew Feher, Research and Analysis Group Manager, HCAI; CJ Howard, Assistant Deputy Director, HCAI; Heather Hoganson, Assistant Chief Counsel, HCAI

Meeting Materials: https://hcai.ca.gov/public-meetings/june-health-care-affordability-board-meeting-4/

Agenda Item #1: Welcome, Call to Order, and Roll Call
Secretary Kim Johnson, Chair

Chair Johnson opened the June meeting of the California Health Care Affordability Board. Roll call was taken, and a quorum was established.

Agenda Item #2: Executive Updates
Elizabeth Landsberg, Director, HCAI
Vishaal Pegany, Deputy Director, HCAI

Director Landsberg provided an overview of the meeting agenda.

Director Landsberg then provided Executive Updates, including the following:

- HCAI's five-year Behavioral Health Services Act (BHSA) Workforce Education and Training Plan was approved last week. The plan identifies critical behavioral health workforce needs within California's county behavioral health system and provides a strategic framework for allocating BHSA funds.
- Mathematica's report on California's $4.7 billion Youth Mental Health Initiative, which includes research on HCAI's Certified Wellness Coach program. The report shows the program has improved student well-being, strengthened school

capacity, and built a more representative behavioral health workforce. The report is available on the California Health and Human Services Agency website.
- In collaboration with OHCA, the Health Care Payments Data (HPD) Program released two data briefs.
    1. GLP-1 Prescriptions for Weight Loss Over Time, 2018 to 2023
    2. Insulin and Metformin Geographic Access and Mail Order Use
- An announcement that requests for applications for the California Rural Health Transformation Program will be issued next week along with a grant guide, frequently asked questions, and information about an upcoming webinar.
- An announcement that the Office of Statewide Health Planning and Development is tracking the 5.6 magnitude earthquake that occurred in Willits this morning. Early reports from Adventist Health at Ukiah and Adventist Health Howard Memorial indicate that there is no physical damage but there is a power and natural gas outage, so facilities are operating on generators. HCAI's facilities team contacted all facilities in the area to obtain updated information.

Deputy Director Pegany provided Executive Updates, including the following:
- An overview of the May 2026 Health Affairs article "Private Equity Acquisitions In Primary Care: Changes In Utilization, Spending, And Workforce."
- An overview of the May 2026 JAMA article "Primary Care as a Public Utility: The Case for a Common Fund."
- An overview of the June 2026 Health Affairs article "States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?"
- An overview of key findings from the HCAI data brief regarding GLP-1 Prescriptions Regarding for Weight Loss Over Time, 2018 to 2023.
- An announcement that OHCA released proposed regulations for public comment governing requests for spending target adjustments based on non-supervisory organized labor costs. Regulations will be submitted for approval later in 2026. If approved, OHCA will begin accepting adjustments to the 2028 spending target in October.

Discussion and comments from the Board included:
- A member asked if the JAMA article regarding the common fund for primary care included regulatory requirements or waivers that would be necessary to implement such a fund.
    - The Office explained that the article did not include that information.
- A member expressed appreciation for the mention of Dr. Grumbach's work regarding ways to create unified financing for primary care.
- A member commented, with regard to the Health Affairs cost target article, that Rhode Island had come in well below the cost target with its approach to regulating prices.

Public comment was held on agenda item 2. Four members of the public provided comments.

Agenda Item #4: Action Item (out of order)
Vote to Appoint Advisory Committee Members
Megan Brubaker, Engagement, Governance, and Policy Group Manager, HCAI

Megan Brubaker presented the proposed slate for the Health Care Affordability Advisory Committee. Advisory subcommittee members Lewis and Hernandez provided additional context for their recommendations.

Discussion and comments from the Board included:

- A member asked whether the subcommittee recommended that current Advisory Committee members in purchaser positions remain in those roles until new purchasers are appointed, after which the current members could move to other roles.
  - A subcommittee member replied affirmatively.
  - The Office added that the next Advisory Committee meeting is July 7, 2026. Failing to approve the slate would leave the committee without purchaser representation at that meeting.
- A member asked if the nominated physician works with patients or is in an administrative position.
  - A subcommittee member replied that this physician works in both areas.

Chair Johnson introduced the action item to approve the proposed slate of Advisory Committee members. Board member Kronick proposed a motion to approve. Board member Lewis seconded the motion.

Public comment was held on agenda item 4. Three members of the public provided comments.

Voting members who were present voted on agenda item 4. There were four ayes, and one member was absent. The motion passed.

Agenda Item #3: Action Consent Item
Vote to Approve May 27, 2026 Meeting Minutes
Vishaal Pegany, Deputy Director, HCAI

Deputy Director Pegany introduced the action item to approve the May 2026 meeting minutes. Board member Hernández proposed a motion to approve. Board member Lewis seconded the motion.

There were no comments or discussion from the Board.

Public comment was held on agenda item 3. No members of the public provided comments.

Voting members who were present voted on agenda item 3. There were four ayes, and one member was absent. The motion passed.

Agenda Item #5: Informational Items
a) 2023-2024 Commercial and Medicare Advantage Spending Overview
Andrew Feher, Research and Analysis Group Manager

Andrew Feher provided an overview of the commercial and Medicare Advantage spending trend data from 2023 and 2024.

Discussion and comments from the Board included:

- A member asked, regarding slide 38, if the Office has access to actuarial value data that shows what the insurer paid as well as the member's liability.
  - The Office replied that the submitters provide member responsibility data by product type.
  - The member suggested using this data to determine actuarial value estimates and to include it in this type of presentation.
  - The Office expressed appreciation for the suggestion.
- A member asked, specific to slide 40, how data from Kaiser medical groups and Kaiser Foundation Health Plan is categorized, given Kaiser's role as both an insurer and a hospital system.
  - The Office explained that the attributed medical file is stratified by Kaiser's two physician organizations and then aggregated to the Kaiser health plan level. Additionally, hospital spending data for Kaiser hospitals are excluded from current hospital reporting because of regulatory exclusions for data submitted to HCAI.
  - The member followed up by confirming that Kaiser Permanente are separate entities but that the Kaiser Foundation Health Plan that is reported is just the insurance function.
  - The Office replied that it is Kaiser's fully insured delivery system spending reported to OHCA for either their commercial or Medicare Advantage market.
- A member asked if this data includes estimates of Kaiser's hospital spending.
  - The Office replied that it does not report payer by service category breakouts but to the extent a health plan pays via claims, service category level changes can be examined at the payer level.
- A member emphasized that for other health plans, many administrative costs are coded as medical expenses and passed down to hospitals.
- A member stated that the data validates the fallacy that large groups have meaningful bargaining power to lower health plan costs.
- A member commented that the quality of the data presented is reassuring in that the information being provided by insurers seems to be high fidelity. The member also recommended that actuarial value be added to the Health Maintenance Organization/ Preferred Provider Organization slide; suggested including external benchmarks to show the completeness of the data; added that it would be useful to compare Medicare Advantage payments to traditional Medicare payments; and suggested specific to slide 33, that the Office add a comment explaining the origin of the non-medical expense by market data related to Medicare Advantage, noting that the indicated percentage appeared unusually low.

- The Office replied that it is considering relying on California Department of Managed Health Care filings to calculate Medicare Advantage non-medical expenses rather than continuing to combine data from different sources. Additionally, the Office noted that it had included footnotes in a couple of slides to indicate that a share of data related to self-insured lives in the commercial market is missing and may account for some of the incompleteness of the data regarding physician organizations. Lastly, the Office expressed appreciation for the assistance provided by the physician organizations to verify enrollment counts and provide additional insights on OHCA's data collection.

Public comment was held on agenda item 5a. Six members of the public provided comments.

b) Examining Utilization in California's Commercial and Medicare Advantage Markets, 2022-2024
Andrew Feher, Research and Analysis Group Manager

Andrew Feher provided an overview of the examination of utilization in California's commercial and Medicare Advantage markets from 2022 to 2024.

Discussion and comments from the Board included:
- A member requested more information regarding the high increase in higher cost members shown on slide 62.
  - The Office replied that not all information included in the issue brief was included in the presentation. The issue brief includes a section that reports high-cost members by chronic condition. There is a correlation between the number of chronic conditions a member has and their representation as a high-cost member.
- A member asked if the high-cost treatments could be noted in a future report, at a minimum noting whether it is pharmaceutical or other, to help determine the drivers of spending. The member was unclear why total medical expenditures are increasing and suggested a better understanding of utilization, such as data related to emergency department visits, number of hospitalizations, number of days in the hospital, and high-cost imaging procedures, to help determine price vs. utilization.
- A member commented that the most important element of health care affordability is the amount of money that a plan receives from the federal government for Medicare. Plans that utilize generic and lower-cost brand name drugs receive higher reimbursements which translates into lower costs for CalPERS members.
  - The Office asked if the member was stating that plans who offer generic and biosimilar substitutions are more affordable.
  - The member replied affirmatively and added that the federal government provides higher reimbursements/incentives to plans that are more efficient in managing the benefit. This makes the most difference for CalPERS in terms of affordability.
- A member emphasized the importance of being able to discern the causes of reduced utilization to determine whether reduced utilization produces more effective

care management and better health outcomes (i.e., good) or if the reduced utilization results in reduced access to care (i.e., bad) and how utilization correlates to out-of-pocket costs. This is important as it relates to evaluating entities meeting the target and performance improvement plans.

Public comment was held on agenda item 5b. Six members of the public provided comments.

c) Spending Target Enforcement – Continued Spending Target Penalty Discussion
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI

Deputy Director Pegany provided an overview of the spending target penalty justification factors, the spending target enforcement penalty setting process, and the spending target penalty range. Assistant Deputy Director Howard provided an overview of procedural penalties scope and range.

Discussion and comments from the Board included:

- A member asked how the non-federal share relates to other agencies and their role in the process.
  - The Office explained that the statute requires consideration of penalty reductions or adjustments for hospitals that provide non-federal share. OHCA could ask the hospital for their non-federal share data and validate it with the Department of Health Care Services.
- A member asked why a 125% penalty was selected as the amount sufficient to deter noncompliance.
  - The Office responded that a 100% penalty is substantial and sends a strong signal to encourage compliance, while the recommended 125% maximum satisfies the statutory requirement for escalating penalties. The Office noted that the percentage could be revisited if it does not achieve the desired level of compliance.
- A member expressed concern that establishing an arbitrary penalty cap could limit OHCA's ability to impose penalties sufficient enough to discourage entities from treating them as a cost of doing business.
  - The Office replied that it is not assuming any type of behavior from entities and that allowing for escalating penalties is clear in statute. The Office has proposed a penalty percentage for the Board's consideration prior to voting on the range and scope of penalties.
- A member asked whether establishing a percentage cap is required or whether greater flexibility without a cap would allow for more adaptability.
  - The Office explained that the statute references a range of penalties, which implies the inclusion of a maximum percentage.
- A member asked whether the Board is required to establish a minimum penalty.
  - The Office replied that the proposed penalty is "up to" 125% but the Office will need to assess the entity's circumstances, such as its fiscal condition, that may

not warrant a 100% penalty, allowing the Office the ability to reduce the penalty below that amount.

- A member asked whether the Board could forgo establishing a minimum penalty even though the statute requires a maximum.
  - The Office clarified that if no minimum is established, the effective minimum penalty would be zero.
- A member expressed support for the 125% maximum penalty as an appropriate starting point unless performance improvement plans (PIPs) do not return entities to what the original baseline trend should have been.
- A member suggested that the Board specify a penalty range of 0% up to 125% to allow for flexibility.
- A member requested clarification regarding the statement that spending target penalties may be issued depending on an entity's compliance with the enforcement process.
  - The Office explained that this provision is intended to prevent an entity from avoiding spending target penalties by choosing not to submit a PIP.
- A member asked whether the Board could proceed with spending target enforcement if an entity failed to submit a PIP while simultaneously accruing $10,000-per-day fines.
  - The Office indicated that it would research the issue further and provide a response at a later date.
- A member asked whether a procedural penalty would be assessed if an entity failed to implement a specific component of a PIP.
  - The Office explained that each situation would require a fact-specific analysis to determine whether the entity was intentionally disregarding the PIP or whether implementation timelines needed adjustment for a milestone. The Office also emphasized the importance of approving effective PIPs, noting that the progressive enforcement approach is designed to help entities meet their spending target. Enforcement penalties would only apply if entities fail to comply with the PIP.
- A member suggested that the Board maintain flexibility when evaluating PIPs by providing recommendations for components that are not working rather than focusing primarily on penalties.
- A member asked whether penalties would be assessed for failing to implement an agreed-upon plan versus implementing a plan that ultimately does not achieve the desired outcome.
  - The Office explained that penalties would apply when an entity fails to make a good-faith effort to carry out the agreed-upon actions in the PIP and noted that penalty decisions are made at the Director's discretion.
- A member noted that both the $10,000-per-day fine and the $500,000 fine include a non-cooperation component.
- A member expressed concern that an entity could view the $500,000 penalty for knowingly falsifying information as a cost of doing business and that the specified amount could limit an administrative law judge's ability to impose a higher penalty.

- A member suggested clarifying that an entity would not be penalized for modifying previously approved PIP actions when changes are necessary during implementation.
    - The Office replied that entities are required to submit periodic progress reports and meet regularly with the Office, allowing modifications to the PIP when appropriate.
- A member asked whether anything in the proposed fee structure would preclude other state entities from intervening under their own jurisdiction if an entity falsifies information.
    - The Office confirmed that nothing in the fee structure would preclude other state agencies from taking action for an entity falsifying information.

Public comment was held on agenda item 5c. Thirty members of the public provided comments.

d) Cost and Market Impact Review Regulations – Comments on Regulatory Text
Heather Hoganson, Assistant Chief Counsel, HCAI

Assistant Chief Counsel Hoganson provided a summary of public comments received on the draft Cost and Market Review regulations.

Discussion and comments from the Board included:
- A member asked about the next steps in the regulatory process.
    - The Office explained that public comments will be incorporated into the regulatory package before submitting to the Office of Administrative Law (OAL) through the emergency rulemaking process. Following a five-day public comment period, the OAL will review all comments received. OHCA will then either respond to the comments or determine that the finding of emergency addresses the comment, in which case no additional public comment period would be required by OAL.
- A member asked whether this would be the final time the Board would review this information in its current format.
    - The Office replied affirmatively.
- A member commented that Real Estate Investment Trusts (REITs) often directly control budgets, hold budget veto authority, and have the power to hire executives and employees of the REIT operating manager. The member expressed concern that this information may not be explicitly stated in the leaseback agreement and may affect REITs in the health care industry.

Agenda Item #6: General Public Comment

Public comment was held on agenda items 5d and 6. Eight members of the public provided comments.

Agenda Item #7: Adjournment

Chair Johnson adjourned the meeting.