OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

June 24, 2026

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Welcome, Call to Order, and Roll Call

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Agenda

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

Item #2 **Executive Updates**
Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

Item #3 **Action Consent Item**
Vote to Approve May 27, 2026 Meeting Minutes
Vishaal Pegany

Item #4 **Action Item**
Vote to Approve Advisory Committee Members
Megan Brubaker, Engagement, Governance, and Policy Group Manager

Item #5 **Informational Items**

a) 2023-2024 Commercial and Medicare Advantage Spending Overview
Andrew Feher, Research and Analysis Group Manager

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

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

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

Item #6 **General Public Comment**

Item #7 **Adjournment**

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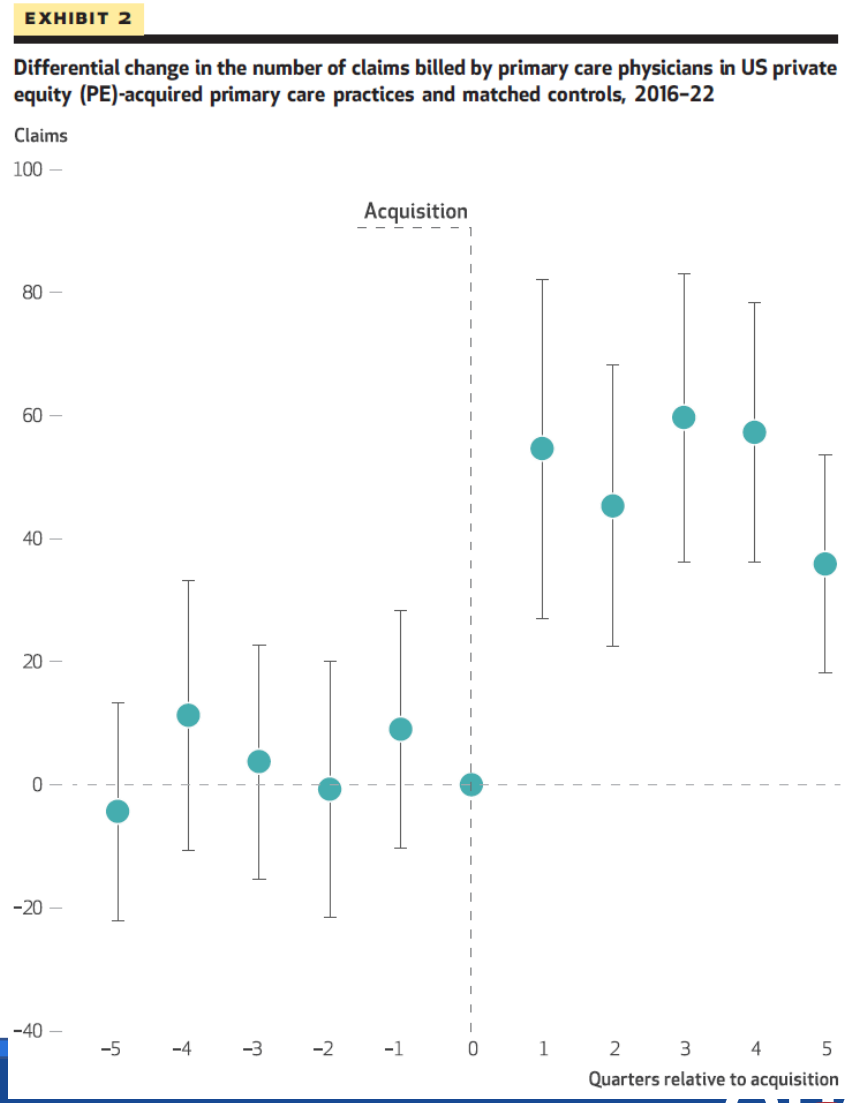
Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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Private Equity Acquisitions in Primary Care: Changes in Utilization, Spending, and Workforce

- An article published in Health Affairs assessed the effects of private equity (PE) acquisitions of primary care practices on primary care physician practice patterns and patient care in the traditional Medicare market from 2016 to 2022.
- After PE acquisition, compared to matched controls:
  - Claims billed increased by 50.6 claims per physician (30.5%)* and Medicare initial annual wellness visits increased by 21.0%*
  - Patients seen per physician increased by eight patients (11.1%)*
  - Medicare spending per physician increased by $846 (14.9%)*
  - Patients received more laboratory tests (11.1%)* and preventive/screening services (11.3%)*
  - Visits per patient decreased by 1.3%*
  - There were no significant changes to Medicare spending per patient on services billed by primary care physicians.



**Results were statistically significant*

Singh Y, Dixit MN, Trivedi AN, Whaley CM (June 2026). Private Equity Acquisitions In Primary Care: Changes In Utilization, Spending, And Workforce. *Health Affairs* 45, No. 6 (2026):629-636. https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.01703

Private Equity Acquisitions in Primary Care: Changes in Utilization, Spending, and Workforce

- Additional workforce analysis found that PE acquisitions increased the total number of primary care physicians (16.9%)* and advanced practice providers (i.e., physician assistants and nurse practitioners) (40.1%)*.
- Limitations of this study include:
  - Incomplete inclusion of all PE acquisitions;
  - Restriction of study to traditional Medicare claims, reducing generalizability;
  - Unobserved differences between PE practices and controls;
  - Spending measures only captured services billed by primary care physicians, potentially underestimating impacts on total Medicare spending;
  - Workforce analysis limited to acquisitions before 2020 due to data availability; and
  - Short follow-up time (five quarters of follow-up).
- The authors concluded that PE investments have the potential to increase the use of primary care services, including preventive services and laboratory tests, and the number of patients seen by primary care providers, in part through greater reliance on advanced practice providers.

**Results were statistically significant.*

Singh Y, Dixit MN, Trivedi AN, Whaley CM (June 2026). Private Equity Acquisitions In Primary Care: Changes In Utilization, Spending, And Workforce. *Health Affairs* 45, No. 6 (2026):629-636. https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.01703

Primary Care as a Public Utility: The Case for a Common Fund

- A recent JAMA article outlines a proposal for **state-administered common fund** that consolidates existing primary care spending by public and private payers and pays primary care practices directly.
  - The fund would function as a multipayer-financed, state-administered, primary care resource pool.
- Sources of funding would include contributions from commercial and self-funded health plans (a percentage of premiums) and transfers from Medicaid.
- Initial contributions from public and private sources would match current primary care spending, with funding rising over time to meet state investment goals.
  - Health plan contributions to the fund would align with state primary care spending targets.
- States would determine primary care payment structure (FFS vs PMPM, level of cost sharing).
- Traditional insurance would remain unchanged for all non-primary care services.
- **Limitations** of this financing approach include vulnerability to state budget pressures, lack of impact on non-primary care sectors, and absence of a direct mechanism to strengthen the primary care workforce.

Song Z, Altman W, Crichlow R, Grumbach K. Primary Care as a Public Utility: The Case for a Common Fund. JAMA. Published online May 20, 2026. doi:10.1001/jama.2026.7194 Primary Care as a Public Utility: The Case for a Common Fund | Health Care Economics, Insurance, Payment | JAMA | JAMA Network

Primary Care as a Public Utility: The Case for a Common Fund

Policy Implementation

- **Compatibility with existing payment systems**: Common fund could operate alongside insurance and ACOs, minimizing system disruption while supporting primary care in line with state goals.
- **Transparency and accountability:** Designated funding and standardized reporting would help ensure that primary care investments flow directly to frontline primary care practices.
- **Precedent for funding mechanism:** Current state and federal assessments already fund Medicaid and the Patient-Centered Outcomes Research Trust Fund; similar pooled-fund mechanisms could support the common fund.
- **Alignment with current trends:** The Direct Primary Care (DPC) model, in which individuals or employers pay primary care practices directly outside of insurance, is growing nationally. A primary care common fund would be akin to a more universal DPC program.
- **State-level readiness:** Implementation of a public utility approach for primary care may be facilitated by existing state initiatives and stakeholder support.

Song Z, Altman W, Crichlow R, Grumbach K. Primary Care as a Public Utility: The Case for a Common Fund. JAMA. Published online May 20, 2026. doi:10.1001/jama.2026.7194 Primary Care as a Public Utility: The Case for a Common Fund | Health Care Economics, Insurance, Payment | JAMA | JAMA Network

States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?

- A recent Health Affairs Forefront article emphasizes that while cost growth targets and transparency can reveal the sources of spending growth for the eight states with targets, complementary polices are necessary to meaningfully bend the cost curve.
- Analysis of commercial claims in hospital services and retail prescription drugs together account for the majority of per person commercial spending and have seen the greatest increases in growth, making them the logical focal point for cost containment policy.
- Spending trends in these areas reflect the significant pricing power and limited regulatory constraints that hospitals and pharmaceutical manufacturers have, which transparency can elucidate but alone cannot address.
  - For hospitals, studies point to provider market consolidation and resulting weak insurer bargaining leverage as a primary contributor to price growth, alongside the strategic use of claim coding to maximize provider revenue.
  - For pharmaceutical manufacturers, pricing power is reinforced by structural factors, including government-granted patent exclusivity, which creates time-limited monopolies, and by the relative absence of any regulatory ceiling on launch prices.

Bailit, M., Angeles, A., Block, R. (2026, June 16). *States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?* Health Affairs Forefront. DOI: 10.1377/forefront.20260610.549590. https://www.healthaffairs.org/content/forefront/states-exceeding-their-health-care-cost-growth-targets-does-mean

States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?

- To constrain spending growth, a number of states (with and without targets) are using their cost data to move toward hospital- and pharmacy-focused approaches, especially in the commercial market.
- State hospital approaches to constrain spending growth include:
  - **Indiana**: Requires its five largest nonprofit hospital systems to reduce aggregate average inpatient and outpatient prices to below the statewide average by June 2029 or forfeit their tax-exempt status until compliance. Also requires these systems to offer direct-to-employer contracting with price caps at or below 260 percent of Medicare prices.
  - **New Mexico, Oregon, Washington**: Authorized hospital price caps in public employee health plans.
  - **Washington**: Established a maximum statewide aggregate reimbursement ceiling of 160 percent of Medicare for provider and facility services for its public option plan, Cascade Select.
  - **Vermont**: Enacted 2025 legislation to apply provider rate-setting authority to establish price caps for hospital services at a percentage of Medicare across the fully and self-insured commercial markets.
  - **Rhode Island, Delaware**: Generally limits average inpatient and outpatient average annual price increases within each insurer-provider contract to the Consumer Price Index plus one percent.
  - **California**: Established a hospital sector spending target equal to its statewide target, with an adjusted lower target for seven hospitals identified as high cost.
  - **Indiana, Maine**: Enacted facility fee bans.
  - **New York and others**: Considering site-neutral payment policies.

Bailit, M., Angeles, A., Block, R. (2026, June 16). *States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?* Health Affairs Forefront. DOI: 10.1377/forefront.20260610.549590. https://www.healthaffairs.org/content/forefront/states-exceeding-their-health-care-cost-growth-targets-does-mean

States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?

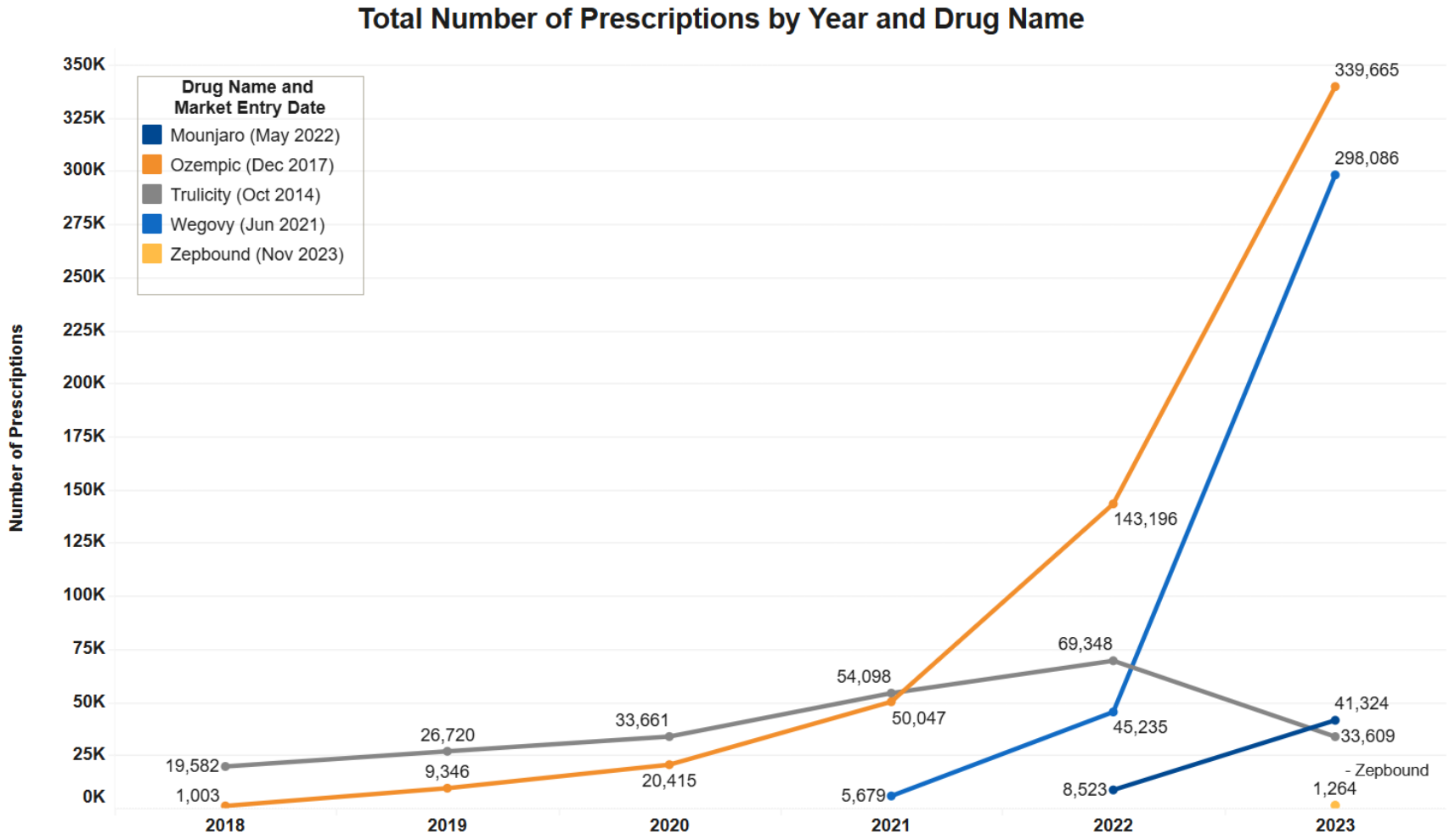
- State pharmaceutical approaches to constrain spending growth include:
  - **Colorado**: Conducts affordability reviews to determine if drugs are unaffordable for Colorado consumers and eligible for the application of upper payment limits.
  - **Maryland**: Authorized to set upper payment limits for all purchaser and payer reimbursements of prescription drugs (excluding Medicare Part C and Part D plans, 340B purchases, and federal purchases that the state is preempted from regulating by federal law). **Minnesota, Oregon, and Washington** have similar authority.
  - **Connecticut**: Caps price increases for off-patent and generic / biosimilar drugs at the rate of inflation.

- Among the authors' conclusions are that these state initiatives represent a fundamental shift in how states exercise authority over health care markets and that states with cost growth targets should treat the failure to meet targets as a mandate for stronger intervention.

Bailit, M., Angeles, A., Block, R. (2026, June 16). *States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?* Health Affairs Forefront. DOI: 10.1377/forefront.20260610.549590. https://www.healthaffairs.org/content/forefront/states-exceeding-their-health-care-cost-growth-targets-does-mean

New HCAI Data Brief: GLP-1 Use and Costs for Weight Loss

- An analysis of Healthcare Payments Data found:
  - GLP-1 utilization for weight loss has increased exponentially from 2018 to 2023
  - In 2023, the total overall cost for GLP-1s for Medi-Cal and Commercial plans was approximately $822 million
  - The total member cost per year varied by county, ranging from $3,051 in Lassen to $5,096 in Mendocino
- Data source: HPD pharmaceutical data from 2018-2023 for Medi-Cal and Commercial payers.
- Note: Patients diagnosed with diabetes were excluded from the analysis to focus on weight loss utilization.



HCAI. (2026, April). *Data Brief: GLP-1 Prescriptions for Weight Loss over Time, 2018-2023*. HCAI Website. https://hcai.ca.gov/visualizations/data-brief-glp-1-prescriptions-for-weight-loss-over-time-2018-2023/

Nonsupervisory Organized Labor Adjustment Request Regulations

- OHCA will release a draft of proposed regulations governing requests for spending target adjustments based on nonsupervisory organized labor costs for public comment.
- OHCA plans to submit the regulations for approval later in 2026.
- If approved, OHCA will begin accepting requests for adjustment to the 2028 spending target from regulated entities this October.

Slide Formatting



Indicates informational items for the Board and decision items for OHCA



Indicates current or future action items for the Board

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Action Consent Item: Vote to Approve May 27, 2026 Meeting Minutes

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Action Item: Vote to Appoint Advisory Committee Members

Megan Brubaker, Engagement, Governance, and Policy Group Manager

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Current Advisory Committee Members

Payers

Kassie Maroney - *Senior Vice* ★
President, Underwriting and Analytics, Chief Actuary, Blue Shield of California

Manan Shah
VP & General Manager, Commercial Business, Elevance Health / Anthem Blue Cross of California

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle ★
Executive Chairman of Health Systems, MemorialCare Health System

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Travis Lakey
Chief Financial Officer, Mayers Memorial Hospital District

Medical Groups

Hector Flores ★
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas ★
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty ★
Emergency Physician, Vituity

Michael Weiss
Vice President, Population Health, Children's Hospital of Orange County

Sumana Reddy
President, Acacia Family Medical Group

Purchasers

Ken Stuart ★
Chairman, California Health Care Coalition

Suzanne Usaj ★
Senior Principal, Health and Benefits
Mercer

Iftikhar Hussain
CFO, Salinas Valley Health
San Francisco Health Service System (Previous Position)

Health Care Workers

Stephanie Cline ★
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez ★
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn Nava ★
Senior Systems Change, Disability Action Center

Mike Odeh ★
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Amanda McAllister-Wallner
Executive Director, Health Access

Marielle A. Reataza ★
Executive Director, National Asian Pacific American Families Against Substance Abuse (NAPAFASA)

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti ★
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

Janice O'Malley ★
Legislative Advocate, American Federation of State, County and Municipal Employees

Kati Bassler ★
President, California Federation of Teachers, Salinas Valley

Academics/ Researchers

Stephen Shortell ★
Professor, UC Berkeley School of Public Health

★ Term ends on June 30, 2026

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Applicant Pool

OHCA received a total of 50 submissions to fill 16 vacancies

- 13 out of 16 incumbents applied for reappointment
  - The 3 incumbents that did not reapply were: Stacey Hrountas, Carmen Comsti, and Marielle Reataza
- 7 submissions were carried forward from OHCA's special payer recruitment
- 30 new submissions

Subcommittee Recommendations

1. Reappoint 10 of the 13 incumbents who reapplied for a term of 2 years.
    - Do not reappoint Adam Dougherty and appoint Katina Murray to the Physician category.
    - Hold all purchaser slots temporarily open while the extended purchaser recruitment is underway.
    - Temporarily appoint Suzanne Usaj and Ken Stuart to serve at the July Advisory Committee meeting. Consider them for 2-year reappointment at the August Board meeting once the purchaser recruitment closes.
2. Appoint 5 new members.
    - Adds 1 net new position to incorporate a pharmaceutical perspective, increasing the size of the AC to 29.
3. Reflect Iftikhar Hussein in the Hospital category based on his change in representation in recent AC discussions. This temporarily increases the number of hospital representatives to 4 and the size of the AC to 30. Through attrition, next year, reduce the number of hospital representatives back to 3.

Recommended Slate

Payers

Kassie Maroney - Senior Vice President, Underwriting and Analytics, Chief Actuary, Blue Shield of California

Manan Shah
Vice President & General Manager, Commercial Business, Elevance Health/Anthem Blue Cross of California

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle
Executive Chairman of Health Systems, MemorialCare Health System

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Travis Lakey
Chief Financial Officer, Mayers Memorial Hospital District

Iftikhar Hussain (formerly purchaser)
Chief Financial Officer, Salinas Valley Health

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

Magdalena Pruitt*
Chief Medical Officer, Senior Vice President, AltaMed Health Services (Previously Stacey Hrountas)

David Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Katina Murray*
Associate CMO, USC Care; Vice Chair Clinical Affairs, Dept Family Medicine, Keck Medicine of USC (Previously Adam Dougherty)

Michael Weiss
Vice President, Population Health, Children's Hospital of Orange County

Sumana Reddy
President, Acacia Family Medical Group

Purchasers

(Temporarily held by Ken Stuart) - Open for special recruitment

Vacant- Open for special recruitment

(Temporarily held by Suzanne Usaj) - Open for special recruitment

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Amanda McAllister-Wallner
Executive Director, Health Access

Nancy Netherland*
Senior Specialist, Family Voices of America (previously Marielle Reataza)

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Mike Rabourn*
Assistant Director of Research, California Nurses Association/National Nurses United (previously Carmen Comsti)

Janice O'Malley
Legislative Advocate, American Federation of State, County and Municipal Employees

Kati Bassler
President, California Federation of Teachers, Salinas Valley

Others

Stephen Shortell
Professor, UC Berkeley School of Public Health

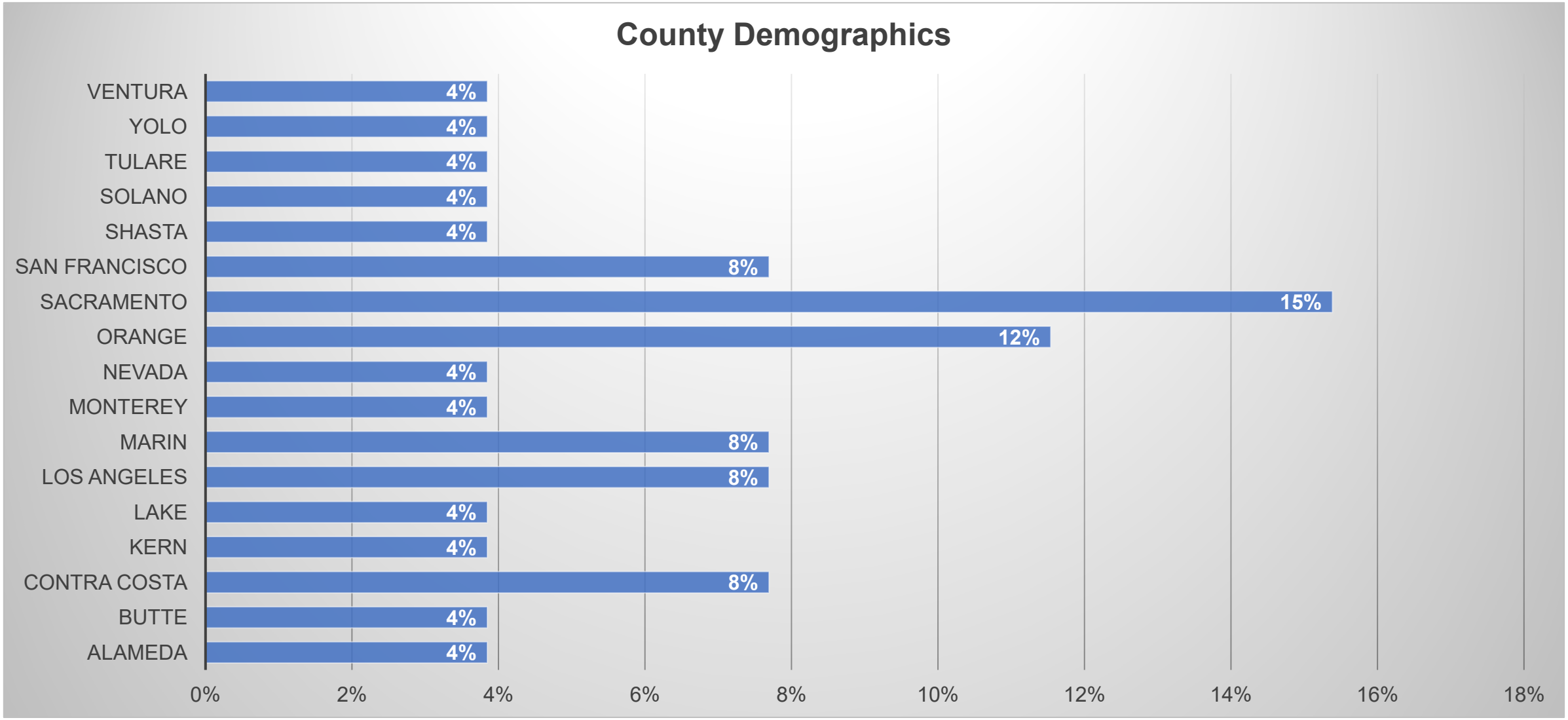
Sean Kim*
Vice President Practice & Professional Development, California Pharmacist Association

= Reappointed Incumbents

= New Appointments

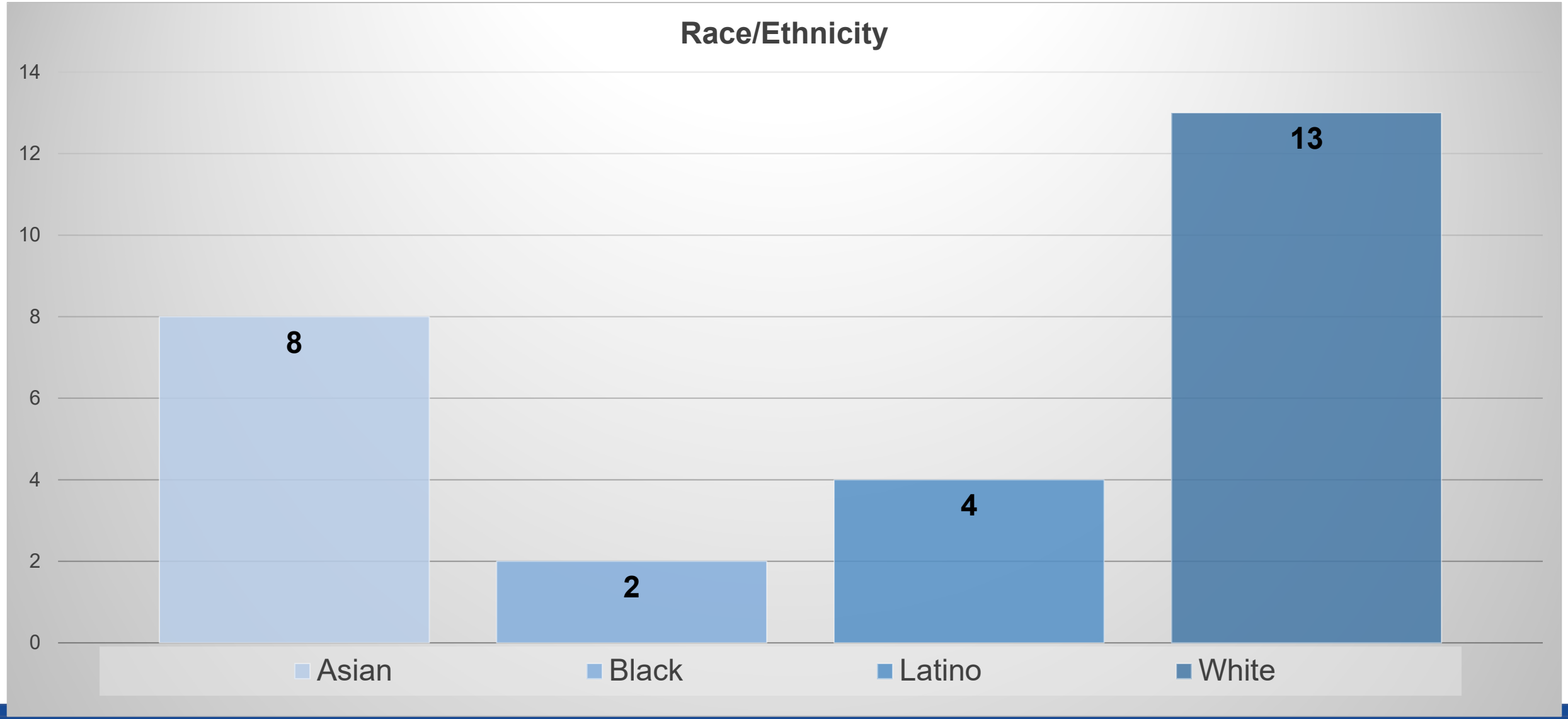
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Demographics of Recommended Slate



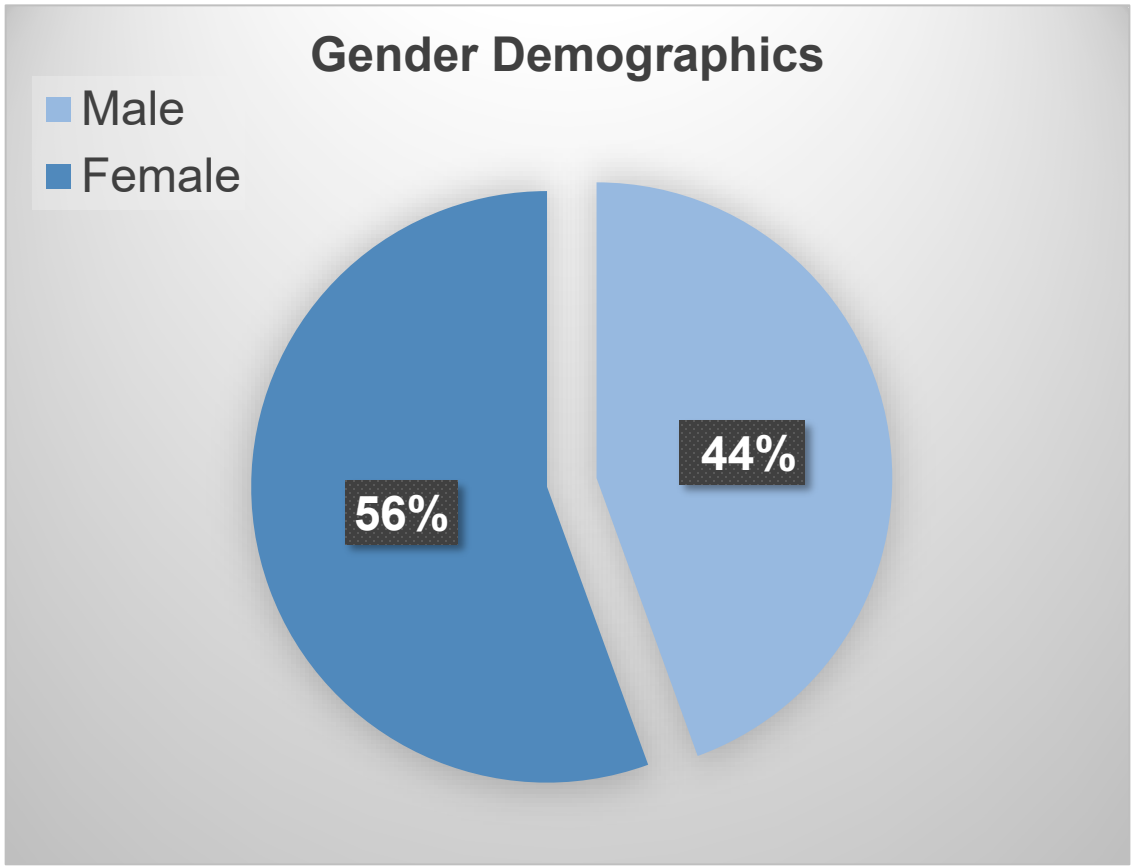
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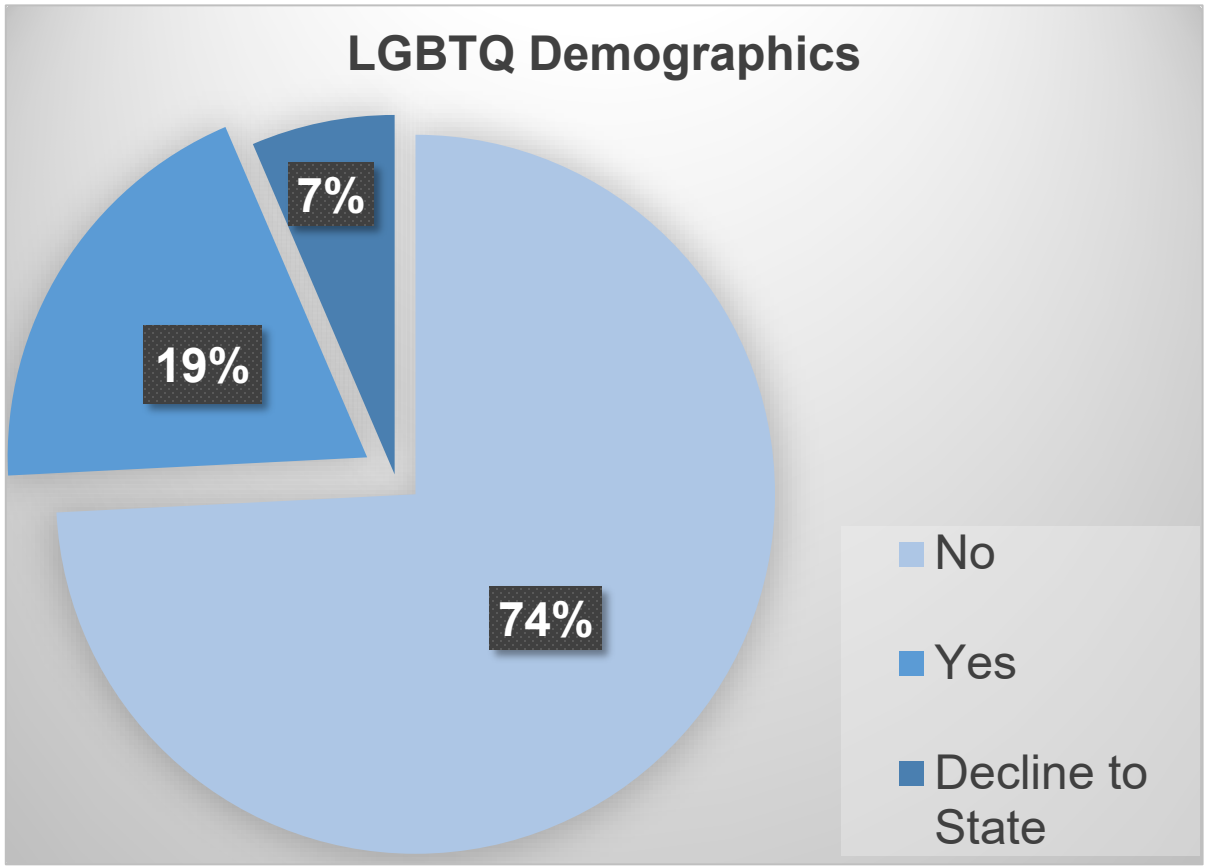
Demographics of Recommended Slate



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Demographics of Recommended Slate





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Next Steps

- OHCA will reach out to the approved Advisory Committee members and inform them of their appointment. The new members will attend their first Advisory Committee meeting on July 8, 2026.
- OHCA is currently holding a special recruitment period to fill the three vacant purchaser perspectives. The submission period will end on June 30, 2026.
- The subcommittee will meet in July to evaluate any new submissions received.
- The subcommittee will present a recommendation to the Board at the August meeting to address the 3 purchaser vacancies.

Draft Motion from the Subcommittee

- Reappoint 10 incumbents for two-year terms: Kassie Maroney (Payers*);* Barry Arbuckle (Hospitals); Hector Flores (Medical Groups); Stephanie Cline and Cristina Rodriguez (Health Care Workers); Carolyn Nava and Mike Odeh (Consumer Representatives); Janice O'Malley and Kati Bassler (Organized Labor); Stephen Shortell (Other/Researcher).
- Appoint 5 new members to two-year terms: Magdelena Pruitt (Medical Groups); Katina Murray (Physician); Nancy Netherland (Consumer Advocate); Mike Rabourn (Organized Labor); and Sean Kim (Other/Pharmacist).
- Reflect Iftikhar Hussain under the hospitals category until his term ends in 2027.
- Hold purchaser slots open until the purchaser recruitment closes and the Board can consider appointments at the August Board meeting.
- Appoint, through August 2026, Suzanne Usaj and Ken Stuart as *Purchasers* and consider for reappointment at the August Board meeting after the special purchaser recruitment closes.

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Informational Items

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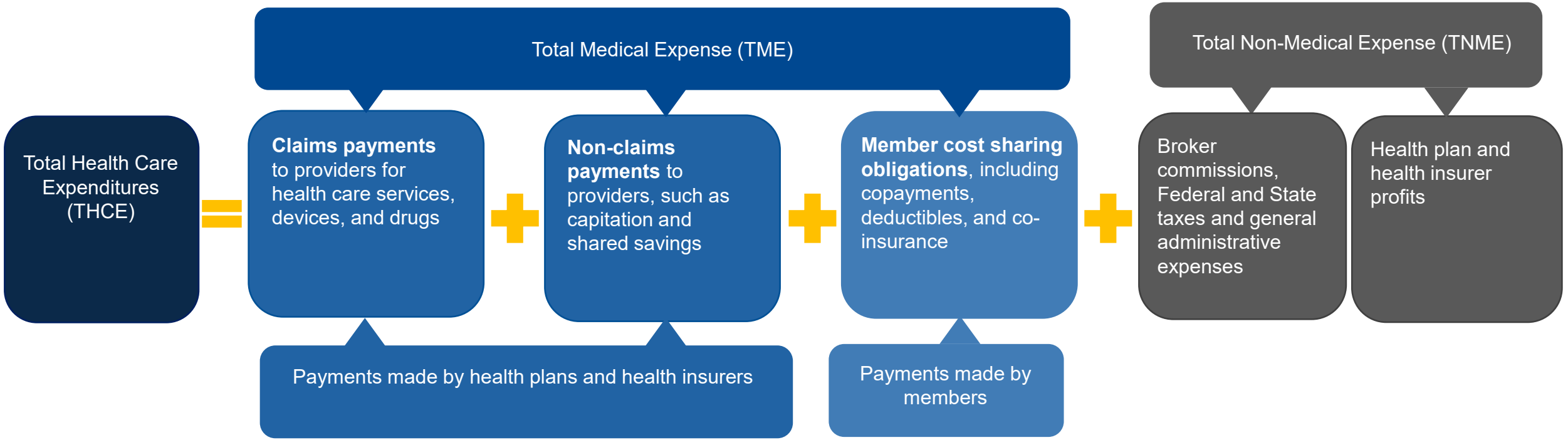
2023-2024 Commercial and Medicare Advantage Spending Overview

Andrew Feher, Research and Analysis Group Manager

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Components of THCE

This graphic describes how OHCA defines Total Health Care Expenditures (THCE) as composed of Total Medical Expense (TME)—which includes claims payments, non-claims payments and member cost sharing—plus total non-medical expense (TNME), which includes health insurer profits as well as broker commissions, federal and state taxes and fees, and general administrative expenses.



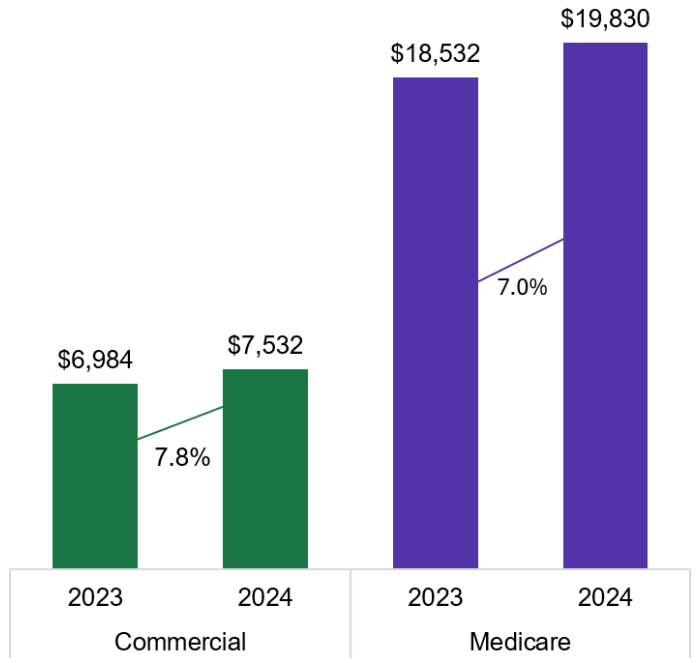
Commercial and Medicare TME

- Commercial Total Medical Expense (TME) was $114.2 billion in 2023 and $122.4 billion in 2024, an increase of $8.1 billion or 7.1%. TME per member per year was $6,984 in 2023 and $7,532 in 2024, an increase of $548 or 7.8%.
- Medicare TME (Medicare Advantage + Fee for Service) was $122.7 billion in 2023 and $134.2 billion in 2024, an increase of $11.5 billion or 9.4%. TME per member per year was $18,532 in 2023 and $19,830 in 2024, an increase of $1,298 or 7.0%

TME by Market
(in billions):



TME PMPY by Market

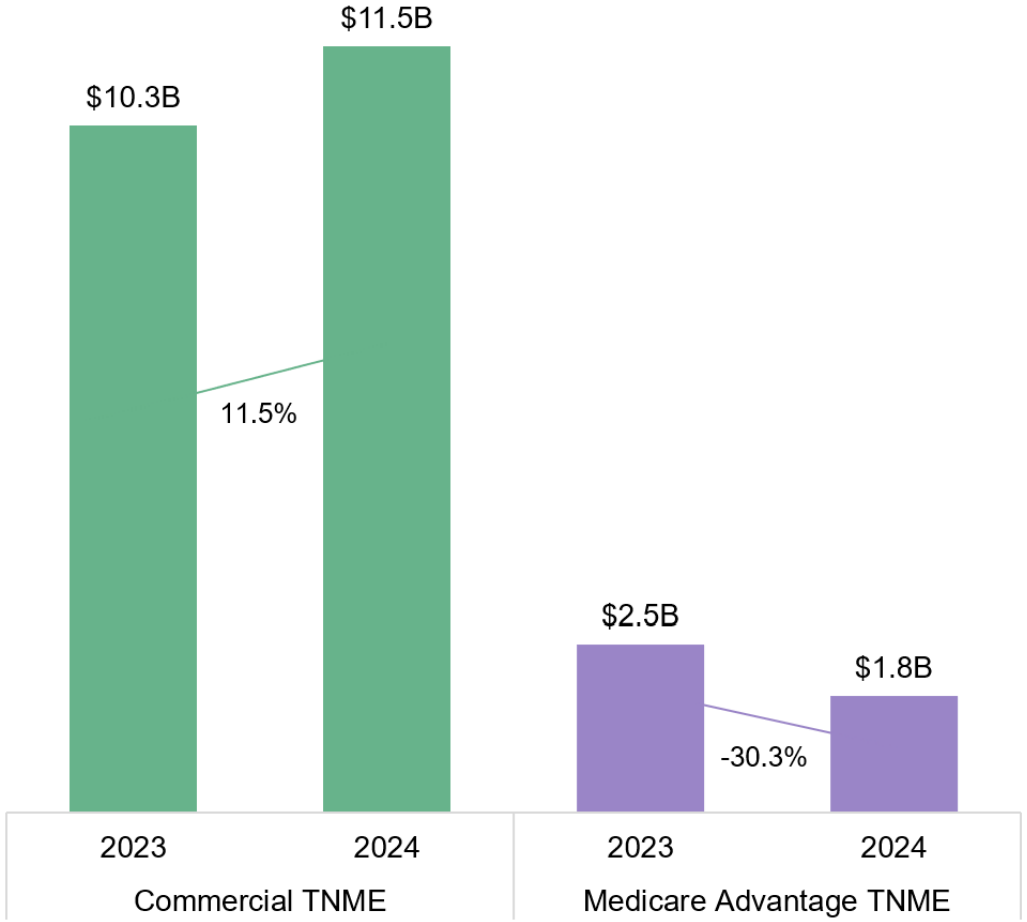


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Commercial and Medicare Advantage Non-Medical Expense

- Commercial Total Non-Medical Expense (TNME) was $10.3 billion in 2023 and $11.5 billion in 2024, an increase of $1.2 billion or 11.5%.
- Medicare Advantage TNME was $2.5 billion in 2023 and $1.8 billion in 2024, a decrease of $0.8 billion or 30.3%.

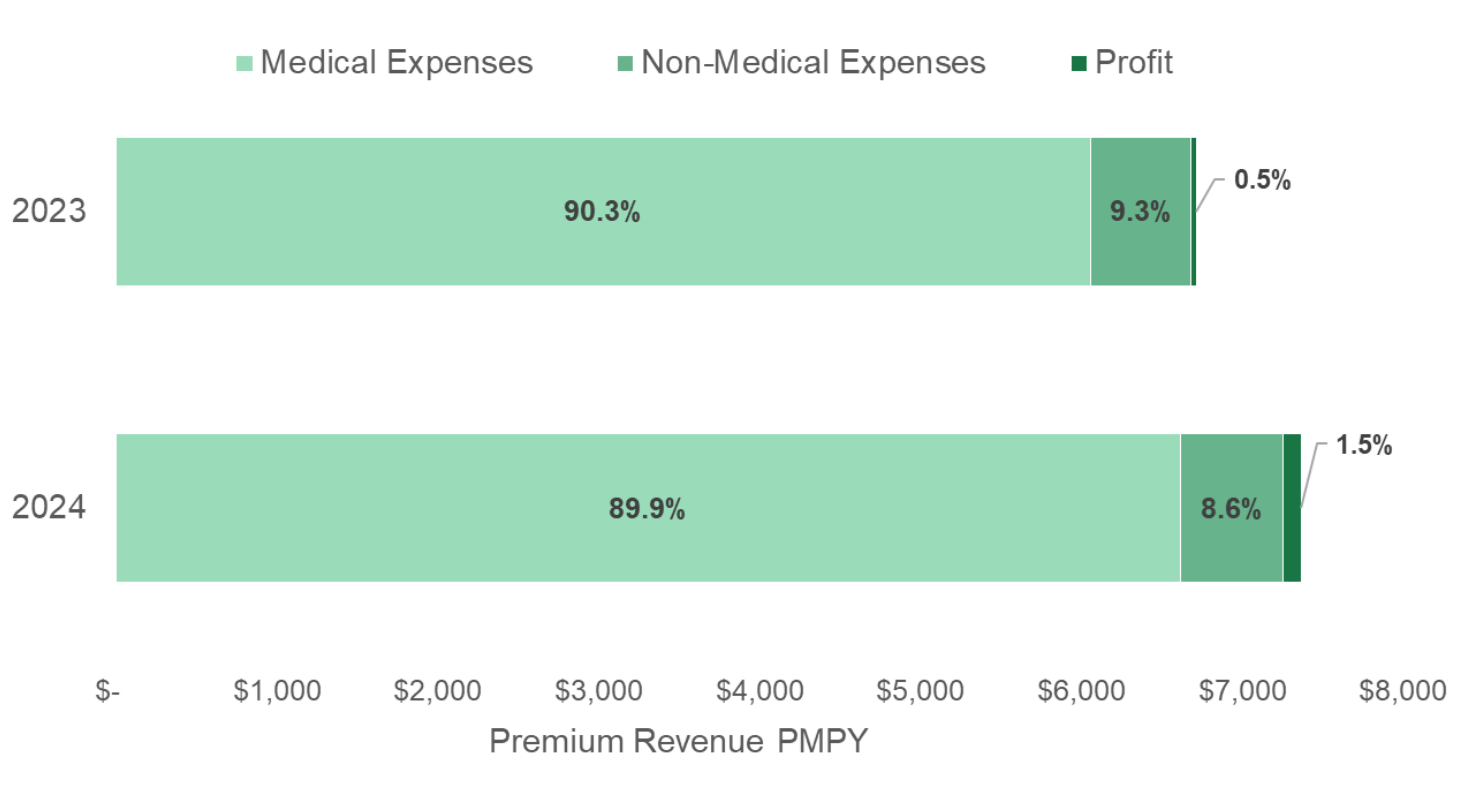
Total Non-Medical Expense by Market
(in billions):



Note: The Commercial summary statistics include fully insured data reported through CCIIO MLRS and self-insured data submitted to OHCA

Use of Premium Revenue in California's Fully Insured Commercial Market

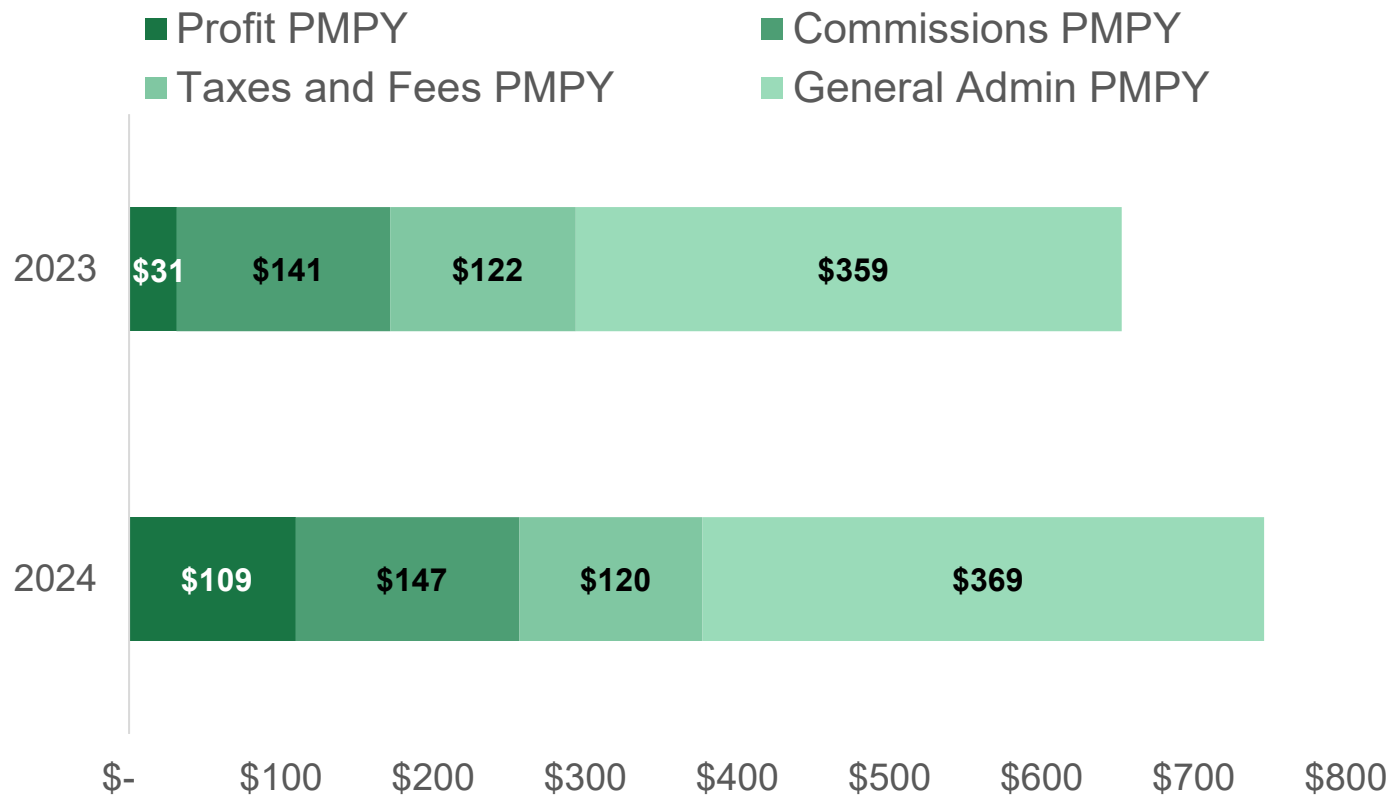
- Using CCIIO medical loss ratio filings for the fully insured commercial market in California, average premium revenue reached $7,366 per member per year in 2024, up from $6,715 dollars in 2023, reflecting an increase of $652 or 9.7%
- The share of premium revenue allocated to medical expenses declined to 89.9%, a decrease of 0.4 percentage points from 90.3% in 2023.
- The portion of premium revenue used for non-medical expenses excluding profit also declined from 9.3% to 8.6%, a reduction of 0.6 percentage points.
- Profit increased from 0.5% to 1.5% of premium, a 1 percentage point increase.



CCIIO MLR Filings 2023 and 2024 among OHCA health plan submitters. Note: Consistent with OHCA statutory definitions used for MLR reporting, quality improvement expenses are excluded.

Non-Medical Spending in California's Fully Insured Commercial Market

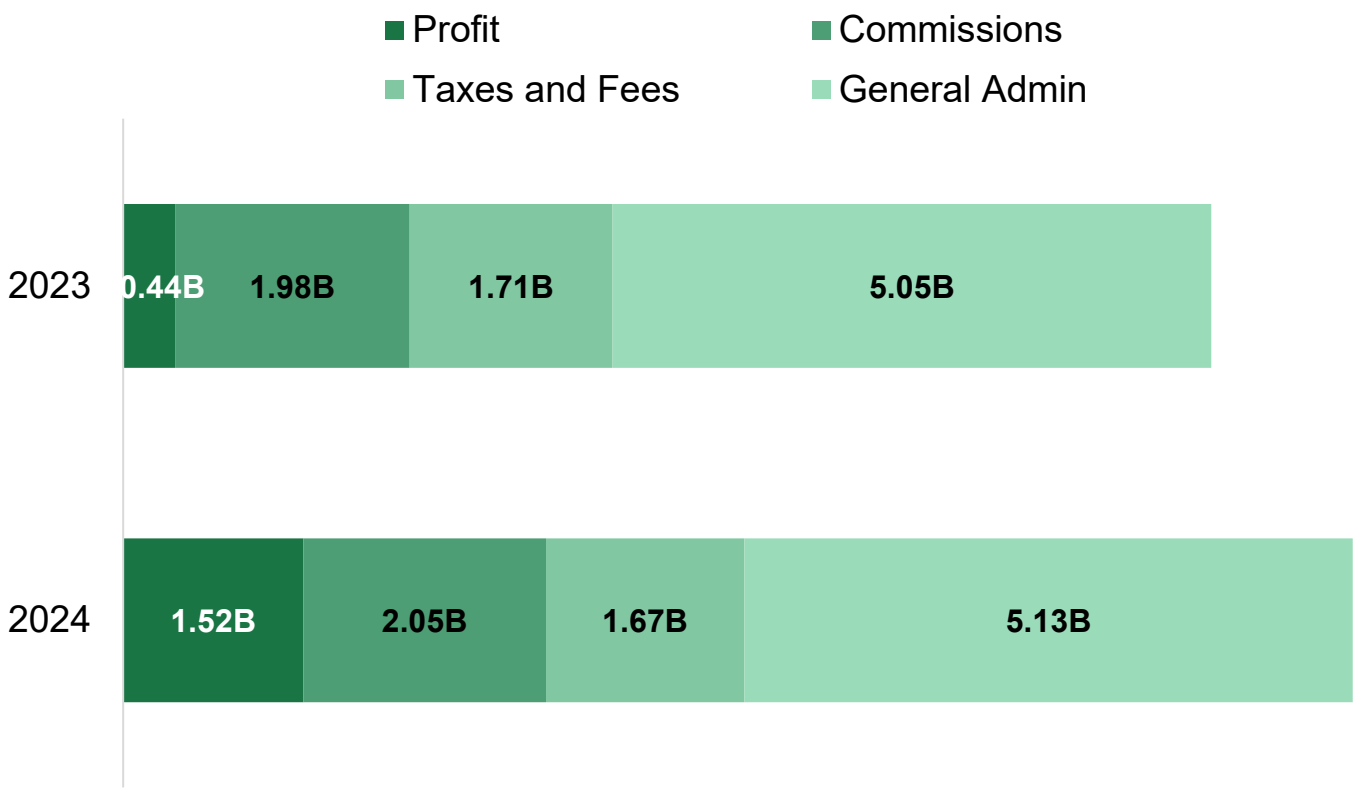
- On a PMPY basis, total non-medical expenses increased by $94 PMPY or 14.3%, rising from $653 in 2023 to $746 in 2024.
- General administrative costs remained the largest category and grew by $10 PMPY or 2.8%.
- Commissions were the second largest category and increased by $7 PMPY or 4.7%.
- Taxes and fees followed, decreasing a little more than $1 PMPY or 1.2%.
- Profits represented the smallest share but saw the largest relative increase, rising by $78 PMPY or 251.6%



CCIIO MLR Filings 2023 and 2024 among OHCA health plan submitters. Note: Consistent with OHCA statutory definitions used for MLR reporting, quality improvement expenses are excluded.

Non-Medical Spending in California's Commercial Market

- When translated into aggregate dollars across the fully insured commercial market, administrative spending components grew 1.3% from $8.74 to $8.85 billion, while profit grew 247.5% from $0.44 to $1.52 billion.



CCIIO MLR Filings 2023 and 2024 among OHCA health plan submitters.
Note: Consistent with OHCA statutory definitions used for MLR reporting, quality improvement expenses are excluded.

Non-Medical Spending in California's Fully Insured Commercial Market by Line of Business

- The aggregate results reflect enrollment segments varying sizes
- Large group represented the largest share at 68% of the fully insured market, followed by individual at 16% and small group at 15%
- Premium revenue allocation differed by segment: medical expense shares ranged from 87.9 to 91.4%, while non-medical shares saw more variation, ranging from 7.2% to 13.4%
- Profit increased across all three lines of business, but only large group showed positive profit; individual and small group losses narrowed but remained negative.

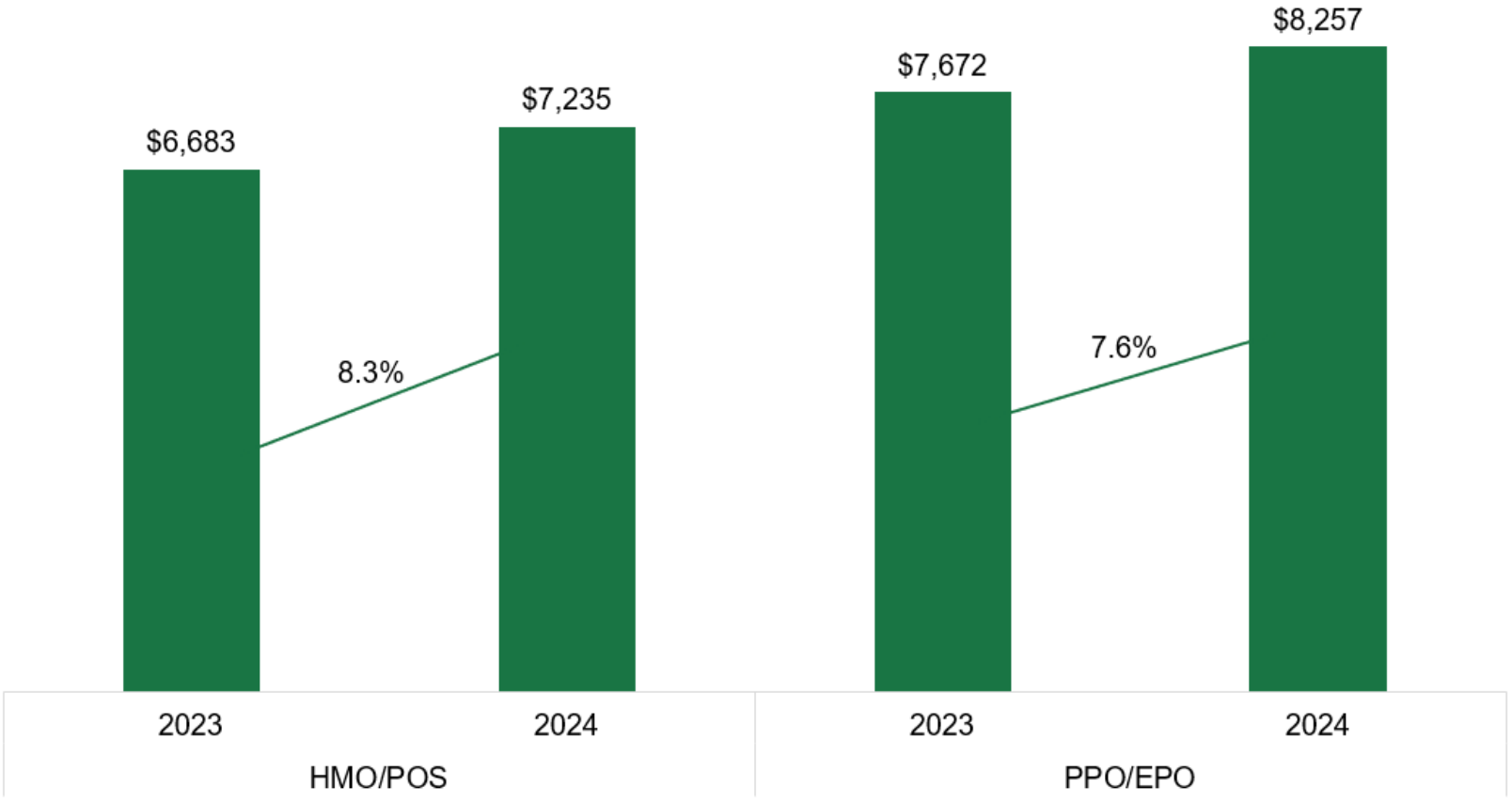
Commercial Market Use of Premiums by Line of Business, 2023-2024

Market	Medical Expenses		Non Medical Expenses		Profit	
	2024 PMPY	% of Premium	2024 PMPY	% of Premium	2024 PMPY	% of Premium
Large Group	$6,513 (+ 10.4%)	89.9% (- 0.2 pp)	$524 (+ 2.0%)	7.2% (- 0.6 pp)	$204 (+ 59.0%)	2.8% (+ 0.9 pp)
Individual	$7,104 (+ 4.8%)	91.4% (- 1.9 pp)	$764 (+ 3.4%)	9.8% (- 0.3 pp)	-$96 (+ 61.6%)	-1.2% (+ 2.2 pp)
Small Group	$6,589 (+ 8.3%)	87.9% (+ 0.3 pp)	$1,003 (+ 1.9%)	13.4% (- 0.8% pp)	-$95 (+ 22.8%)	-1.3% (+ 0.5 pp)

CCIIO MLR Filings 2023 and 2024 among OHCA health plan submitters. Note: Consistent with OHCA statutory definitions used for MLR reporting, quality improvement expenses are excluded.
PMPY changes from 2023 are shown in percentage terms in parenthesis, while changes in each component's share of premium are expressed in percentage points (pp).

Commercial TME by Plan Type

- TME PMPY for HMO/POS plans was $6,683 in 2023 and $7,235 in 2024, an increase of $552 or 8.3%.
- TME PMPY for PPO/EPO plans was $7,672 in 2023 and $8,257 in 2024, an increase of $585 or 7.6%



Payers by Market

Of the 24 payers that submitted data to OHCA in 2025, 17 offered Commercial plans and 19 offered Medicare Advantage plans.

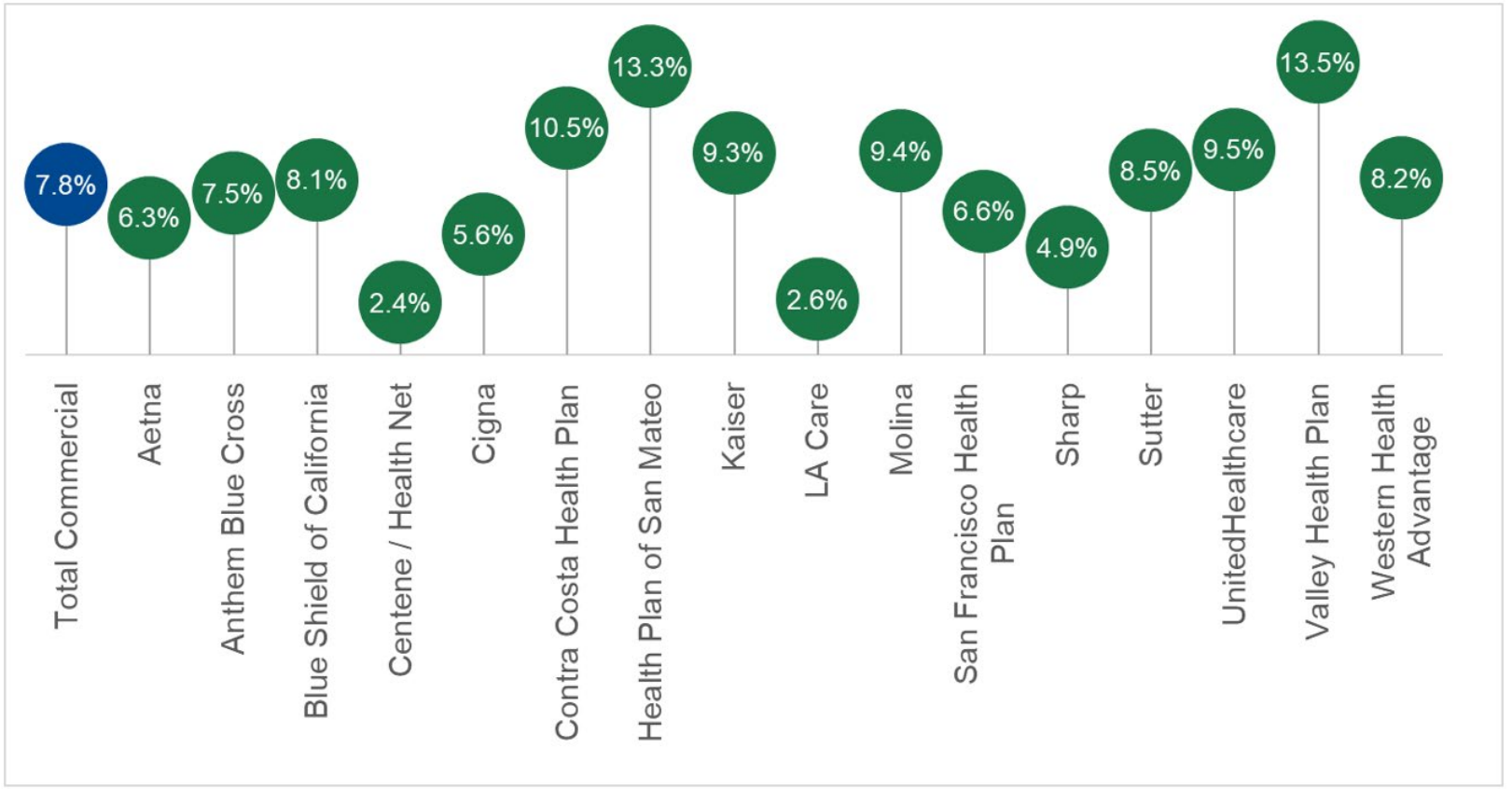
Payer	Commercial	Medicare Advantage
Aetna	✓	✓
Alignment		✓
Anthem Blue Cross / Elevance Health (Anthem Blue Cross)	✓	✓
Blue Shield of California	✓	✓
Bright Health (Universal Care)		✓
CalOptima		✓
Centene / Health Net	✓	✓
Central Health Plan of California		✓
Cigna Healthcare (Cigna)	✓	
Community Health Group		✓
Contra Costa Health Plan	✓	
Health Plan of San Mateo	✓	✓
Inland Empire Health Plan	✓	✓
Kaiser Foundation Health Plans (Kaiser)	✓	✓
Local Initiative Health Authority for Los Angeles County (LA Care)	✓	✓
Molina Healthcare of California (Molina)	✓	✓
San Francisco Health Plan	✓	
Santa Clara Family Health Plan		✓
SCAN Health Plan (SCAN)		✓
Sharp Health Plan (Sharp)	✓	✓
Sutter Health Plan dba Sutter Health Plus (Sutter)	✓	
UnitedHealthcare	✓	✓
Valley Health Plan	✓	
Western Health Advantage	✓	✓
Total payers	**17**	**19**

Commercial Market Enrollment and Spending Growth

Market Share by Enrollment:

Commercial Payers	2024 Market Share
Kaiser	42.8%
Anthem Blue Cross	15.0%
Blue Shield of CA	11.1%
UnitedHealthcare	8.6%
Aetna	7.9%
Cigna	6.9%
Centene / Health Net	3.1%
LA Care	1.43%
Sharp	0.8%
Western Health Advantage	0.7%
Sutter	0.7%
Molina	0.3%
Valley Health Plan	0.3%
Inland Empire Health Plan	0.1%
San Francisco Health Plan	< 0.1%
Contra Costa Health Plan	< 0.1%
Health Plan of San Mateo	< 0.1%
Total Members	**16,246,642**

TME PMPY growth:



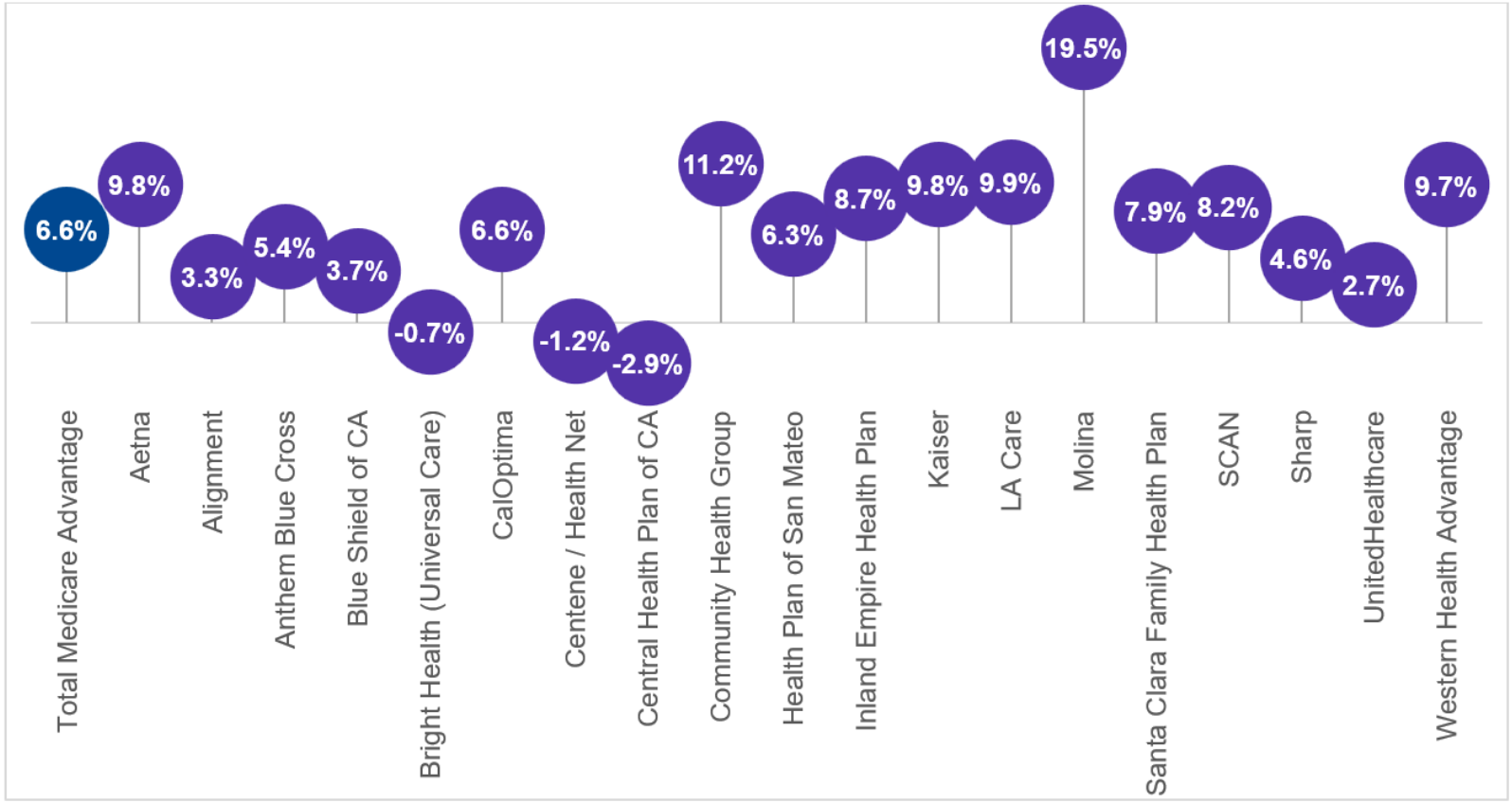
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Medicare Advantage Enrollment and Spending Growth

Market Share by Enrollment:

Medicare Advantage Payers	2024 Market Share
Kaiser	42.1%
UnitedHealthcare	16.4%
Anthem Blue Cross	8.7%
SCAN	8.2%
Blue Shield of California	5.0%
Alignment	4.7%
Centene / Health Net	4.4%
Aetna	3.6%
Bright Health (Universal Care)	1.7%
Central Health Plan of CA	1.2%
Inland Empire Health Plan	1.1%
LA Care	0.6%
Molina	0.5%
CalOptima	0.5%
Sharp	0.4%
Santa Clara Family Health Plan	0.3%
Health Plan of San Mateo	0.3%
Community Health Group	0.2%
Western Health Advantage	0.1%
Total Members	**3,350,003**

TME PMPY growth:



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Physician Organization Attributed Medical Expense

- Of the 144 physician organizations included in OHCA's Attribution Addendum, we report on 27 physician organizations.
- These physician organizations were selected based on either:
  - Having confirmed tax identification numbers (TINs) published in the Attribution Addendum or
  - Having more than 1 million attributed member months across the Commercial and Medicare Advantage markets (approximately 83,000 attributed members) in either 2023 or 2024.
- In addition, several smaller organizations with well-defined attributed populations were included.
- For the organizations with available contacts, we shared physician organization previews – similar to what OHCA shares with payers – and also met with any that requested a meeting.

Member Attribution Steps

- Each year, OHCA collects two years of total medical expense data from payers. This past fall, for example, OHCA collected calendar year 2023 and 2024 data.
- Payers attribute members to POs according to OHCA's attribution methodology:
  1. Capitated, delegated arrangements
  2. Accountable Care Organization (ACO) arrangements
  3. Payer-developed, rules-based approach
  4. Not Attributed
- Attributed TME includes all spending for the member regardless of rendering provider.
- OHCA aggregates attributed spending from all payers to report on PO performance.

OHCA's attribution methodology is described in Section 4.5 of the THCE Data Submission Guide available at: https://hcai.ca.gov/document/thce-data-submission-guide-version-2-0/

Example of Attributed Medical Expense

Member's Payments	Amount
Sierra Medical Group primary care capitation	$1,200
Tango Behavioral Health specialty care	$600
Uniform PBM pharmacy claims	$400
Victor Hospital ER claim	$150
Member's Total Medical Expense	**$2,350**

In this example, the plan has paid four organizations on behalf of the member during the reporting year.

Attributed Phys Org	Member Months	Total Medical Expense
Sierra Medical Group	12	$2,350

In the Attributed TME File, all of the member's expense are attributed to the medical group where the plan has delegated the member's care.

Physician Organization Reporting Example

Attributed TME data payers submit to OHCA

Payer Data Submissions				
Submitter	2023		2024	
	Members	TME	Members	TME
Payer A	10	$1,000	11	$1,100
Payer B	10	$750	9	$750
Payer C	10	$1,000	10	$1,050
Totals	**30**	**$2,750**	**30**	**$2,900**

PO PMPY growth reported by OHCA

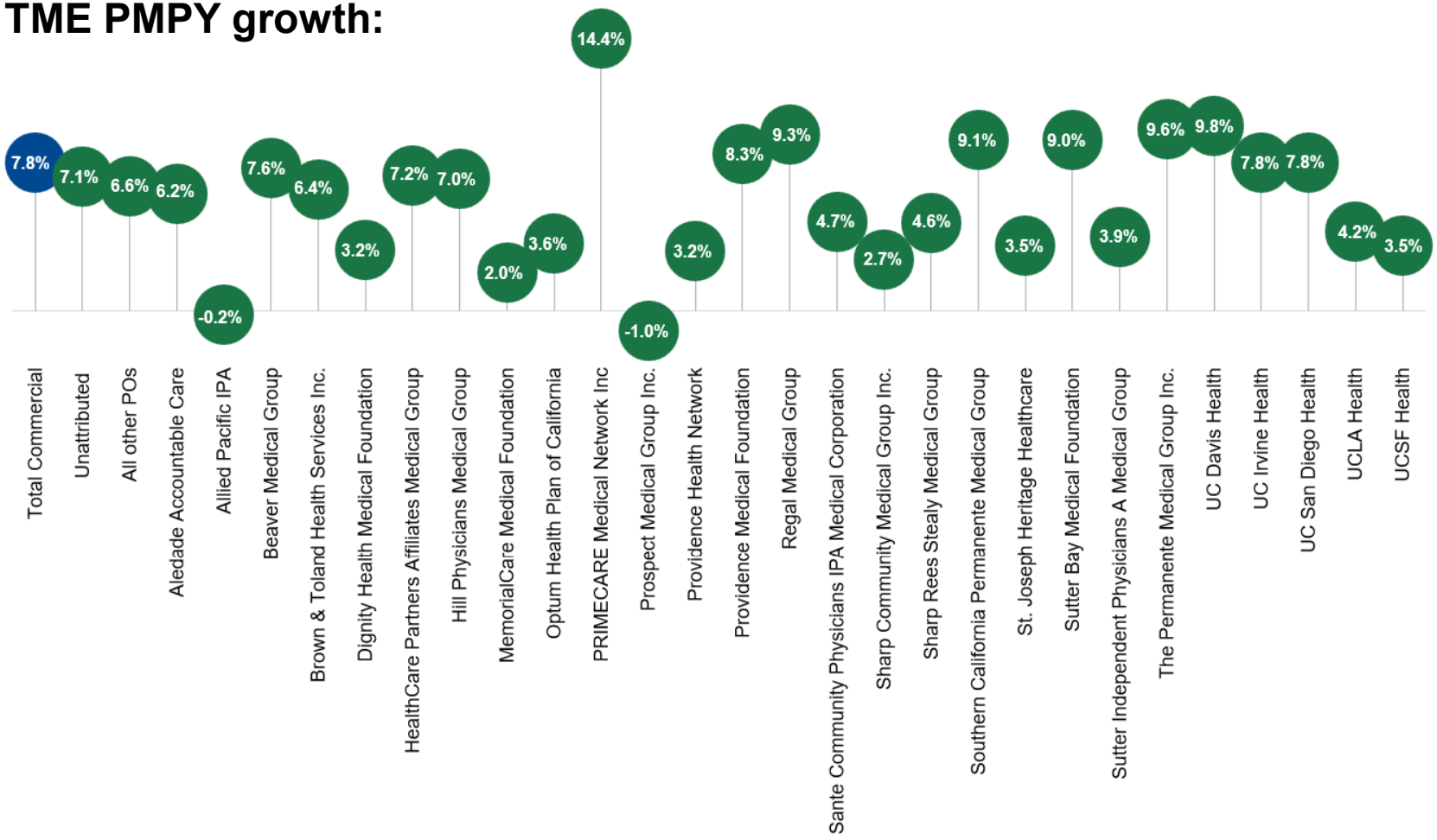
PO Reporting	
2023	2024
$92 PMPY	$97 PMPY
TME Growth	**5.4%**

Commercial Market: Physician Organization Enrollment and Attributed Medical Expense

Commercial Share of Attributed Members:

Commercial Physician Organizations	2024 Market share
Southern California Permanente Medical Group	21.7%
The Permanente Medical Group Inc.	21.1%
Hill Physicians Medical Group	1.4%
Sutter Bay Medical Foundation	1.0%
Sharp Rees Stealy Medical Group	0.9%
UCLA Health	0.9%
HealthCare Partners Affiliates Medical Group	0.8%
Allied Pacific IPA	0.7%
Optum Health Plan of California	0.7%
Dignity Health Medical Foundation	0.7%
Providence Medical Foundation	0.6%
Prospect Medical Group Inc.	0.6%
Aledade Accountable Care	0.5%
Providence Health Network	0.4%
Sharp Community Medical Group Inc.	0.4%
MemorialCare Medical Foundation	0.4%
Sante Community Physicians IPA Medical Corporation	0.4%
UC Davis Health	0.3%
Regal Medical Group	0.3%
UCSF Health	0.3%
PRIMECARE Medical Network Inc	0.3%
St. Joseph Heritage Healthcare	0.3%
UC San Diego Health	0.2%
Brown & Toland Health Services Inc.	0.2%
Sutter Independent Physicians A Medical Group	0.2%
Beaver Medical Group	0.2%
UC Irvine Health	0.1%
All Other Providers	14.2%
Unattributed	30.1%
Total members	**16,246,642**

Commercial TME PMPY growth:



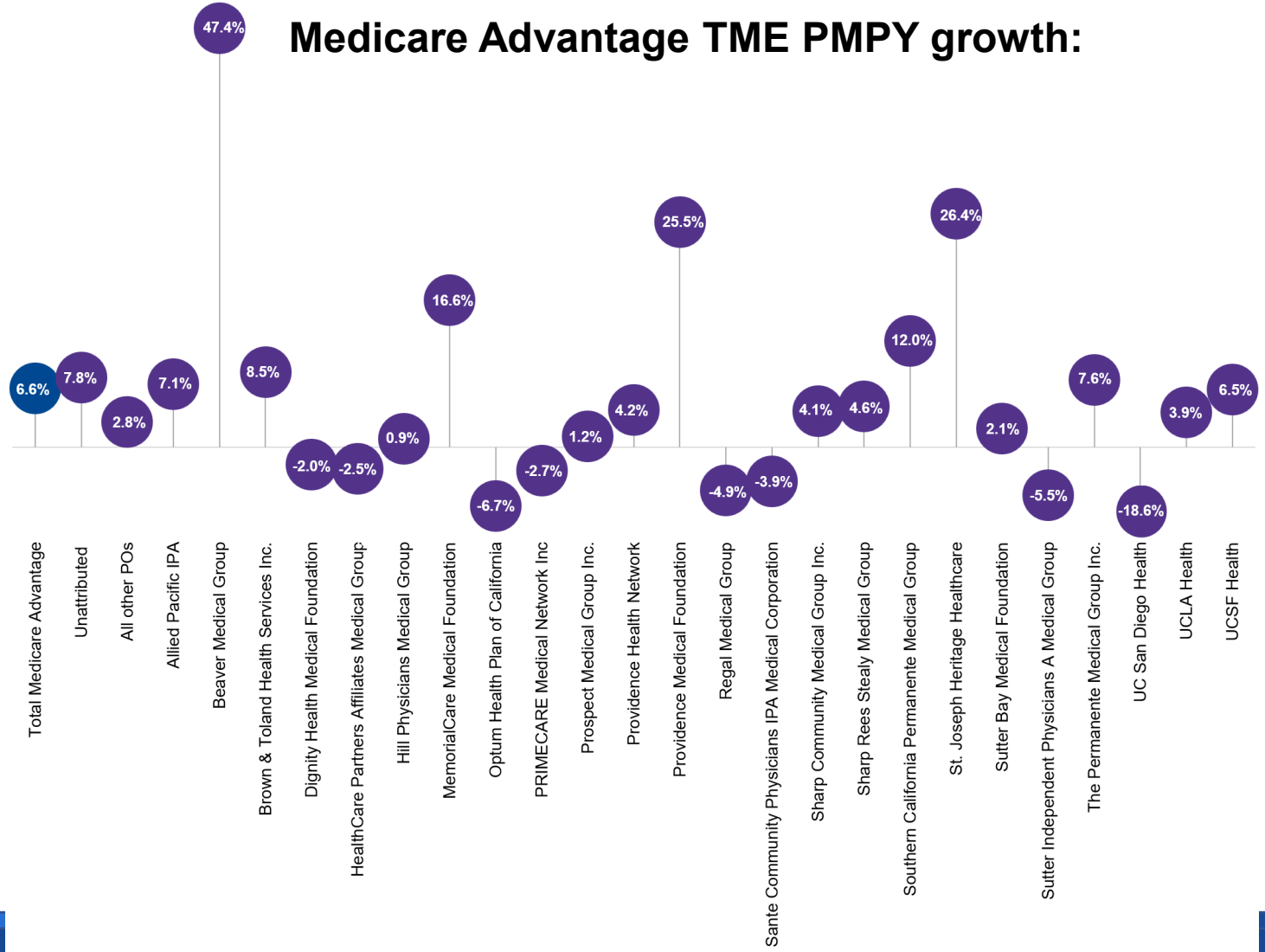
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Medicare Advantage: Physician Organization Enrollment and Attributed Medical Expense

Medicare Advantage Share of Attributed Members:

Medicare Advantage Physician Organizations	2024 Market share
Southern California Permanente Medical Group	21.1%
The Permanente Medical Group Inc.	21.0%
HealthCare Partners Affiliates Medical Group	2.2%
Optum Health Plan of California	2.0%
St. Joseph Heritage Healthcare	1.2%
Sharp Community Medical Group Inc.	1.1%
Regal Medical Group	1.0%
Sharp Rees Stealy Medical Group	1.0%
Sutter Bay Medical Foundation	0.9%
Hill Physicians Medical Group	0.8%
MemorialCare Medical Foundation	0.7%
Brown & Toland Health Services Inc.	0.7%
Sante Community Physicians IPA Medical Corporation	0.7%
Providence Health Network	0.6%
Beaver Medical Group	0.6%
PRIMECARE Medical Network Inc	0.6%
UCLA Health	0.6%
UCSF Health	0.5%
Sutter Independent Physicians A Medical Group	0.5%
Dignity Health Medical Foundation	0.5%
Providence Medical Foundation	0.4%
Allied Pacific IPA	0.3%
Prospect Medical Group Inc.	0.3%
UC San Diego Health	0.3%
All Other Providers	26.8%
Unattributed	13.7%
Total members	**3,350,003**

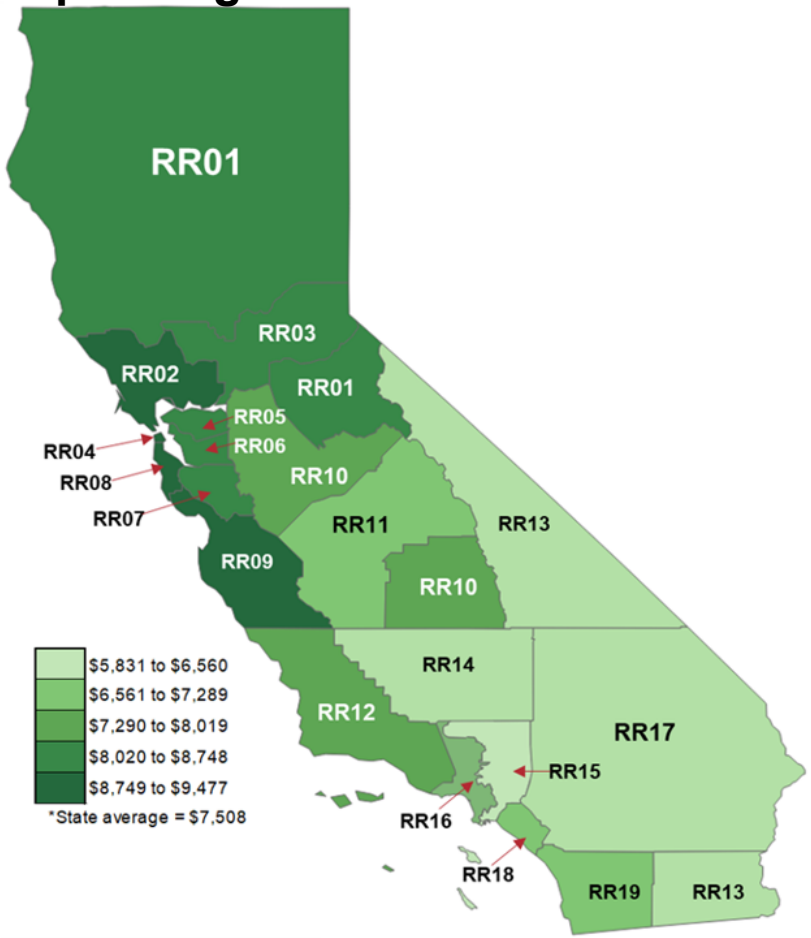
Medicare Advantage TME PMPY growth:



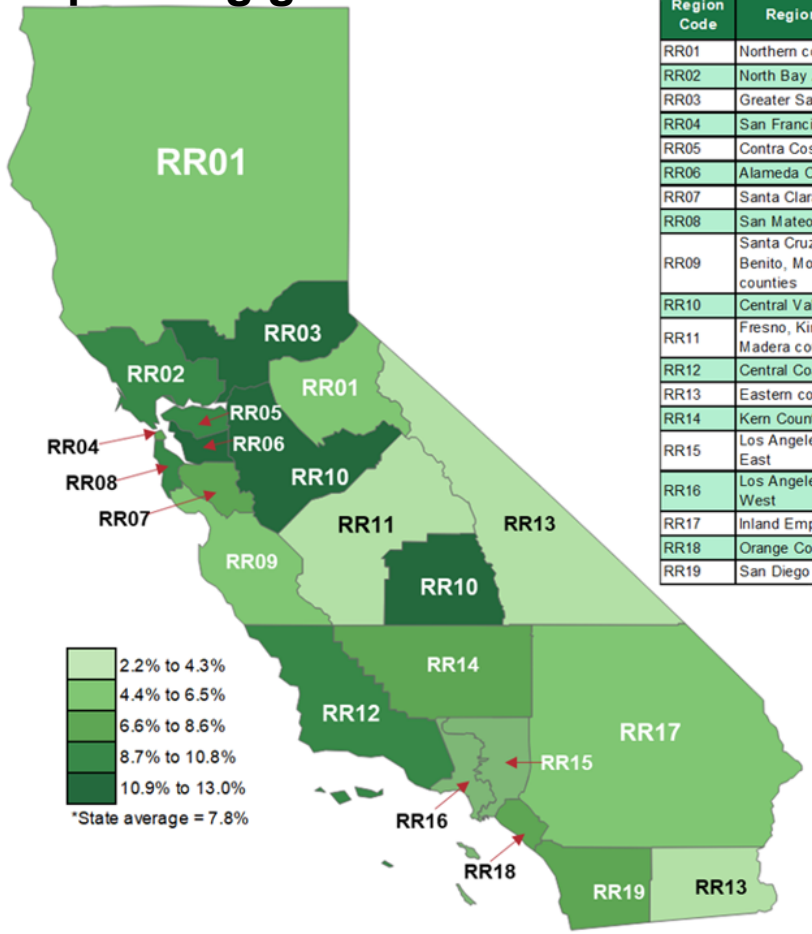
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Commercial Spending by Rating Region

Commercial Spending PMPY:



Commercial Spending growth:



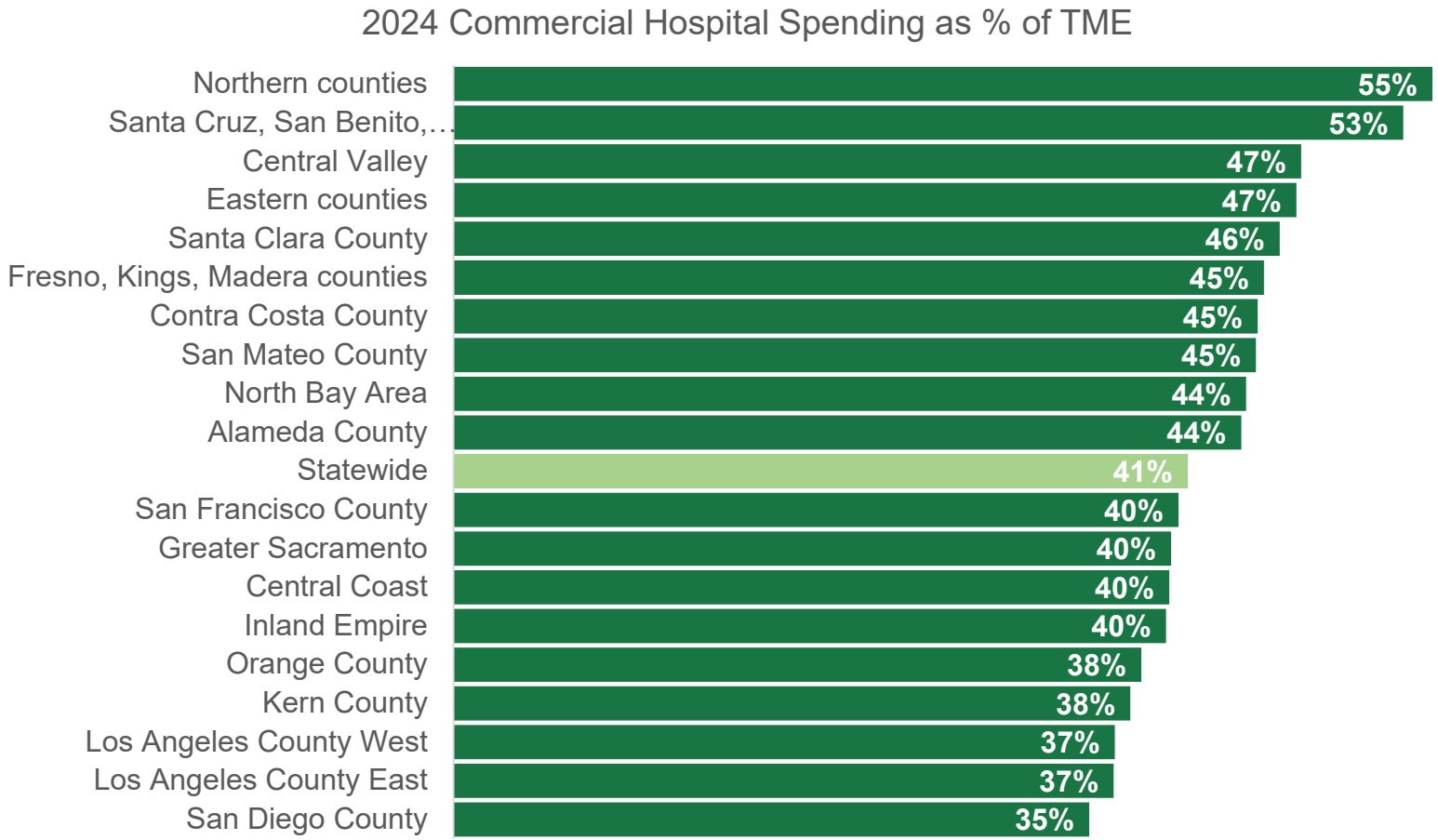
Region Code	Region Name
RR01	Northern counties
RR02	North Bay Area
RR03	Greater Sacramento
RR04	San Francisco County
RR05	Contra Costa County
RR06	Alameda County
RR07	Santa Clara County
RR08	San Mateo County
RR09	Santa Cruz, San Benito, Monterey counties
RR10	Central Valley
RR11	Fresno, Kings, Madera counties
RR12	Central Coast
RR13	Eastern counties
RR14	Kern County
RR15	Los Angeles County East
RR16	Los Angeles County West
RR17	Inland Empire
RR18	Orange County
RR19	San Diego County

Notes: Spending from those living in unknown or unspecified regions are included in the calculation of the state average.

Regional TME includes claims and capitation payments only; other non-claims payments are not included.

2024 Regional Variation in Commercial Hospital Spending as a Share of TME

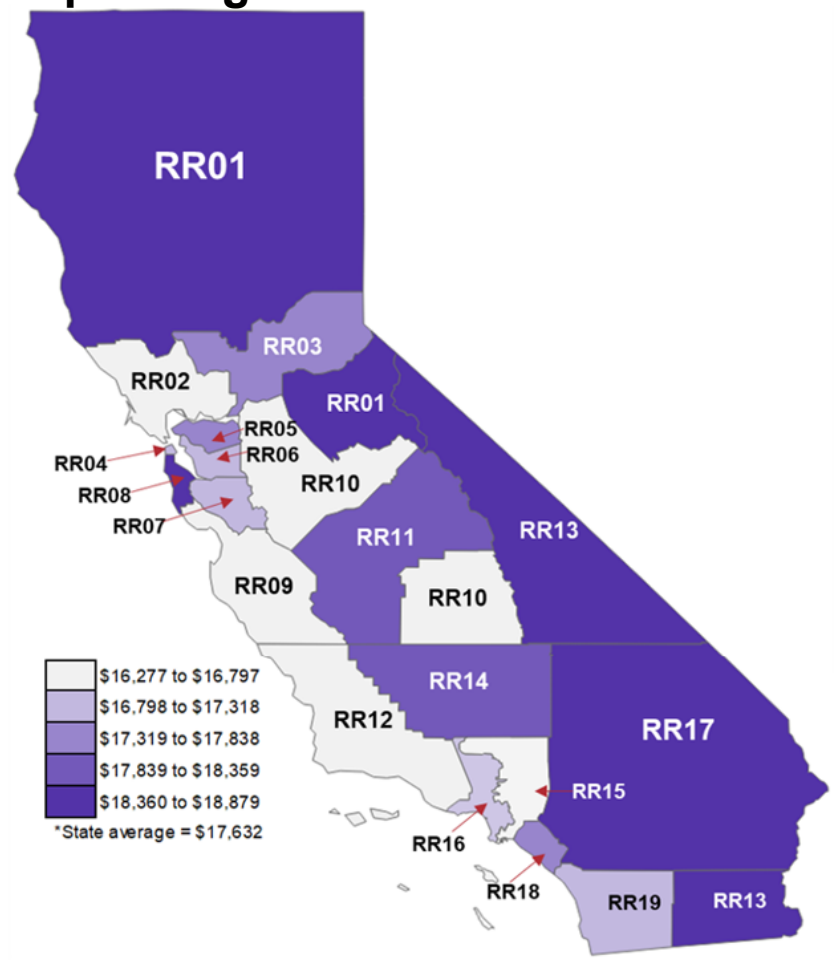
- Hospital spending (outpatient + inpatient) accounted for 41% of commercial TME, though there's wide variation across the state.
- In 2024, hospital spending's share of commercial TME ranged from 35% to 55% across regions.
- Northern and central regions tended to have the highest shares, while regions in the south were below the statewide average.
- OHCA's regional TME data highlights the uneven burden hospital spending has across California, reinforcing the importance of continuing to monitor its trend.



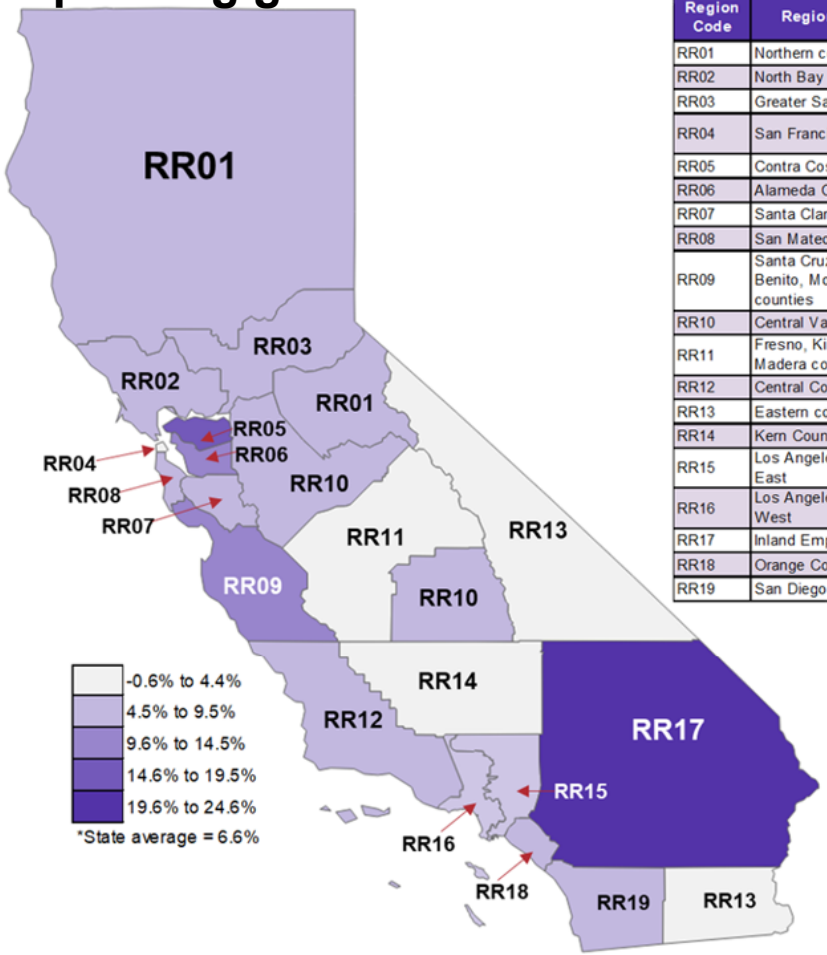
Note for some regions hospital spending may be understated due to capitation payments which do not show which services are driving spending growth. Capitation reflects how care is paid for rather than which services are used, and capitated payments may cover a wide range of care, including hospital, professional, and pharmacy services that appear separately under claims-based spending.

Medicare Advantage Spending by Region

MA Spending PMPY:



MA Spending growth:



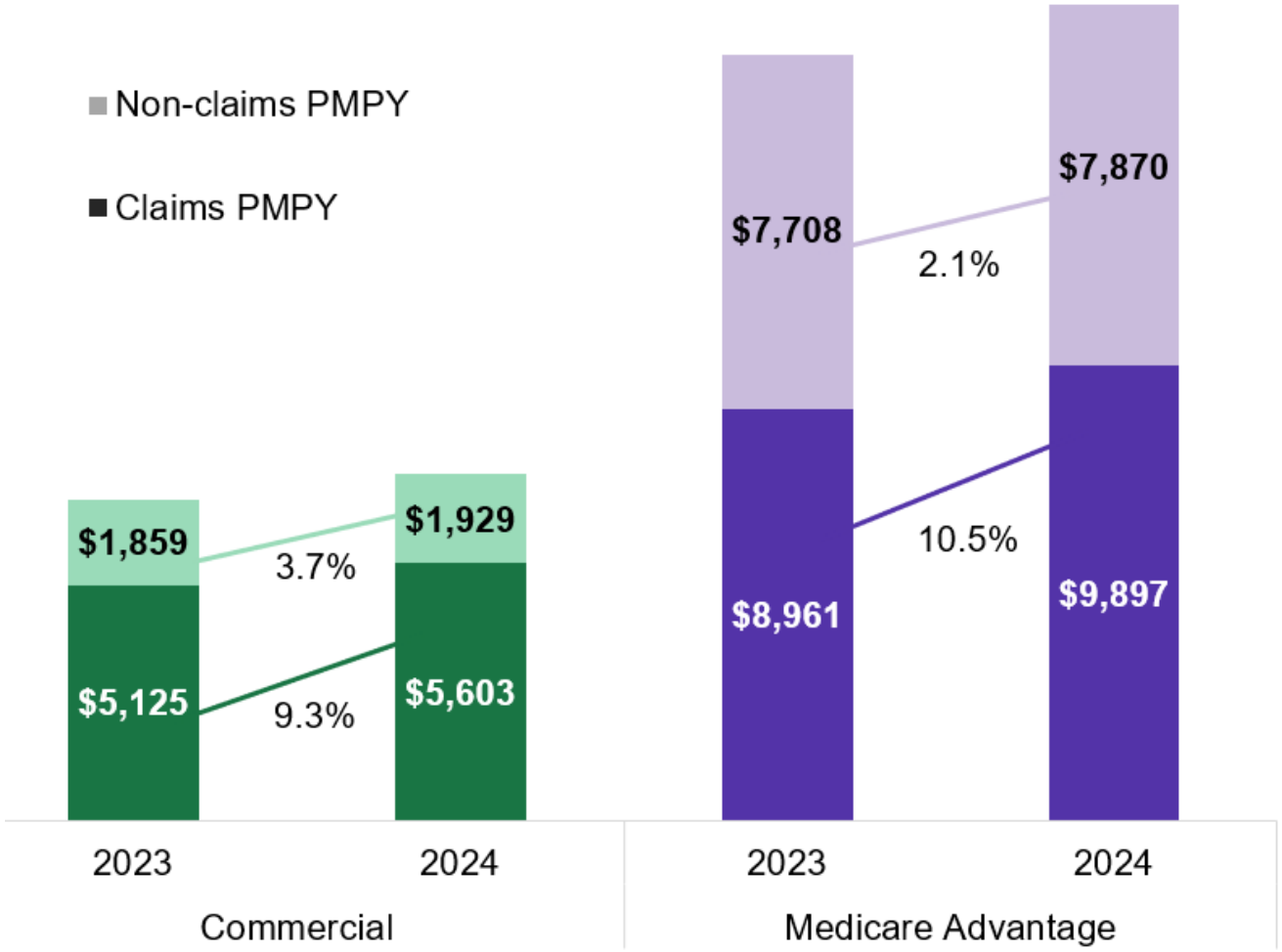
Region Code	Region Name
RR01	Northern counties
RR02	North Bay Area
RR03	Greater Sacramento
RR04	San Francisco County
RR05	Contra Costa County
RR06	Alameda County
RR07	Santa Clara County
RR08	San Mateo County
RR09	Santa Cruz, San Benito, Monterey counties
RR10	Central Valley
RR11	Fresno, Kings, Madera counties
RR12	Central Coast
RR13	Eastern counties
RR14	Kern County
RR15	Los Angeles County East
RR16	Los Angeles County West
RR17	Inland Empire
RR18	Orange County
RR19	San Diego County

Notes: Spending from those living in unknown or unspecified regions are included in the calculation of the state average.

Regional TME includes claims and capitation payments only; other non-claims payments are not included.

2023-2024: Claims vs Non-claims by Market

- Commercial claims spending PMPY in 2023 was $5,125 and $5,603 in 2024, an increase of $478 or 9.3%. Commercial non-claims spending PMPY in 2023 was $1,859 and $1,929 in 2024, an increase of $70 or 3.7%.
- Medicare Advantage claims spending grew from $8,961 PMPY in 2023 to $9,897, an increase of $936 or 10.5%. Medicare Advantage non claims spending PMPY in 2023 was $7,708 and $7,870 in 2024, an increase of $162 or 2.1%



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2023-2024: Service Category by Market

Commercial: Hospital inpatient and outpatient services represented the largest shares of TME PMPY in 2024, with spending of $1,506 and $1,564 respectively – each accounting for approximately 20% of total PMPY spending. Inpatient spending grew 5.0%, while outpatient spending increased 12.4%.

Medicare Advantage: Pharmacy spending (gross of rebates) was the largest claims category in 2024 at $3,309 PMPY (~19% of total spending and grew by 5.9%), followed by hospital inpatient spending at $2,737 (~15% of total spending and grew by 9.7%) and hospital outpatient spending at $1,527 (~9% of total spending and grew by 16.9%).

Category	Commercial TME PMPY			Medicare Advantage TME PMPY		
	2023	2024	Share of Total (2024)	2023	2024	Share of Total (2024)
Claims						
Hospital inpatient	$1,435	$1,506	20.0%	$2,495	$2,737	15.4%
Hospital outpatient	$1,392	$1,564	20.8%	$1,306	$1,527	8.6%
Professional	$769	$835	11.1%	$815	$938	5.3%
Long-term care	$66	$71	0.9%	$578	$656	3.7%
Pharmacy (gross of rebates)	$1,138	$1,273	16.9%	$3,125	$3,309	18.6%
Other	$325	$353	4.7%	$641	$730	4.1%
Non-claims						
Capitation	$1,843	$1,905	25.3%	$7,580	$7,729	43.5%
Non-claims, non-capitation	$17	$23	0.3%	$129	$141	0.8%
Total (gross of rebates)	**$6,984**	**$7,532**	**100.0%**	**$16,669**	**$17,767**	**100.0%**

Category	Commercial Growth	Medicare Advantage Growth
Hospital inpatient	5.0%	9.7%
Hospital outpatient	12.4%	16.9%
Professional	8.6%	15.0%
Long-term care	8.1%	13.6%
Pharmacy (gross of rebates)	11.9%	5.9%
Other	8.6%	13.9%
Capitation	3.4%	2.0%
Non claims, non capitation	38.7%	9.3%
Total (gross of rebates)	7.8%	6.6%

Note for Medicare Advantage hospital spending is likely understated due to capitation payments which do not show which services are driving spending growth. Capitation reflects how care is paid for rather than which services are used, and capitated payments may cover a wide range of care, including hospital, professional, and pharmacy services that appear separately under claims-based spending.

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Examining Utilization in California's Commercial and Medicare Advantage Markets, 2022-2024

Andrew Feher, Research and Analysis Group Manager

HCAI
Department of Health Care Access and Information

Executive Summary

Background: From 2022 to 2024, OHCA's total medical expense data show double-digit spending growth in the commercial (15.8%) and Medicare Advantage (13.3%) markets

Objective: Use 2022-2024 HPD data to examine the extent to which changes in enrollee demographics and utilization frequency may contribute to these trends in accelerated spending growth

Findings:

- The average age of commercial and Medicare Advantage enrollees increased 0.6% and 0.4%, respectively.
- In the commercial market, the utilization rate decreased by 4.2%, while remaining flat in Medicare Advantage.
- The average number of encounters per member decreased 3.0% in the commercial market and increased 3.5% in the Medicare Advantage market.
- The share of enrollees diagnosed with a chronic condition increased 9.6% in the commercial market and 4.1% in the Medicare Advantage market.
- While the share of high-cost members – those with $1 million or more in annual spending – represented around 0.01% of the total enrolled population, their proportion increased 25.4% in the commercial market and 15.9% in the Medicare Advantage market.

Key Metrics of Interest

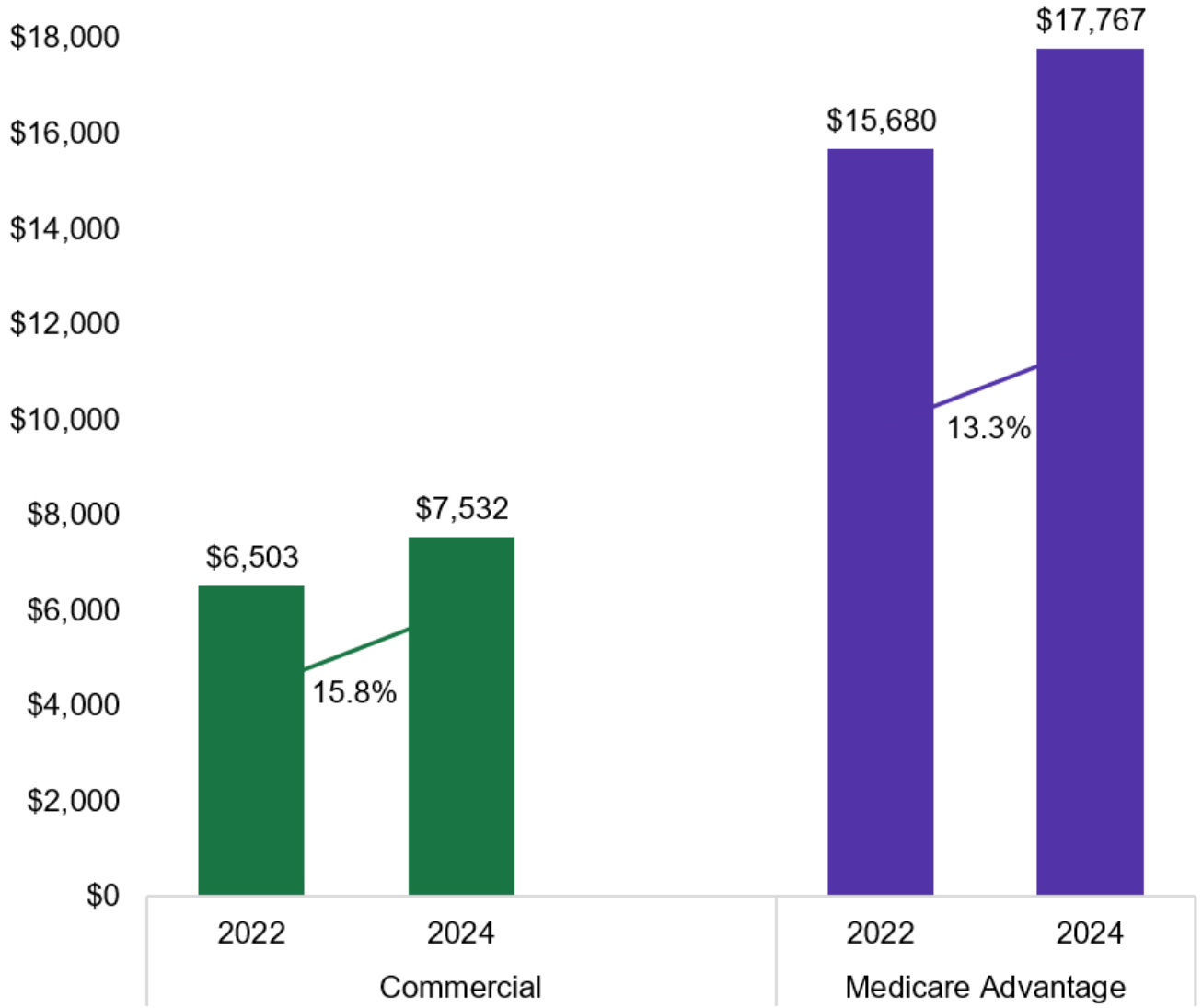
- **Member age:** the eligibility table reports an individual's age on a member-month basis. For this analysis, age was converted to one value per member per year
- **Utilization rate**: the proportion of members who have any service claims in a calendar year
- **Utilization frequency**: the number of encounters per member per year
- **Share of high-cost members**: those with annual spending of $1 million or more
- **Chronic condition prevalence**: the number of distinct conditions that a member was diagnosed with within the year.

Limitations

- The analysis describes market-level patterns over time, but it does not quantify the contribution of each factor to spending growth.
- We only examine the commercial and Medicare Advantage markets; in future analyses, we intend to incorporate the Medi-Cal managed care market segment.
- Our analysis excludes several health plans that submit to OHCA due to either not having data available for the full three-year period or due to data quality.
- We measure chronic conditions based on claims, which depend on observed diagnoses and coding practices. Thus, observed prevalence can increase even without changes to the underlying health status.
- We use encounter counts as a measure of utilization frequency but do not capture the underlying intensity.
- We use a fixed threshold to define high-cost patients. While the share of patients above the threshold shows the cost burden, changes in shares do not explain why spending increased.

TME Per Member Per Year and Growth Rate

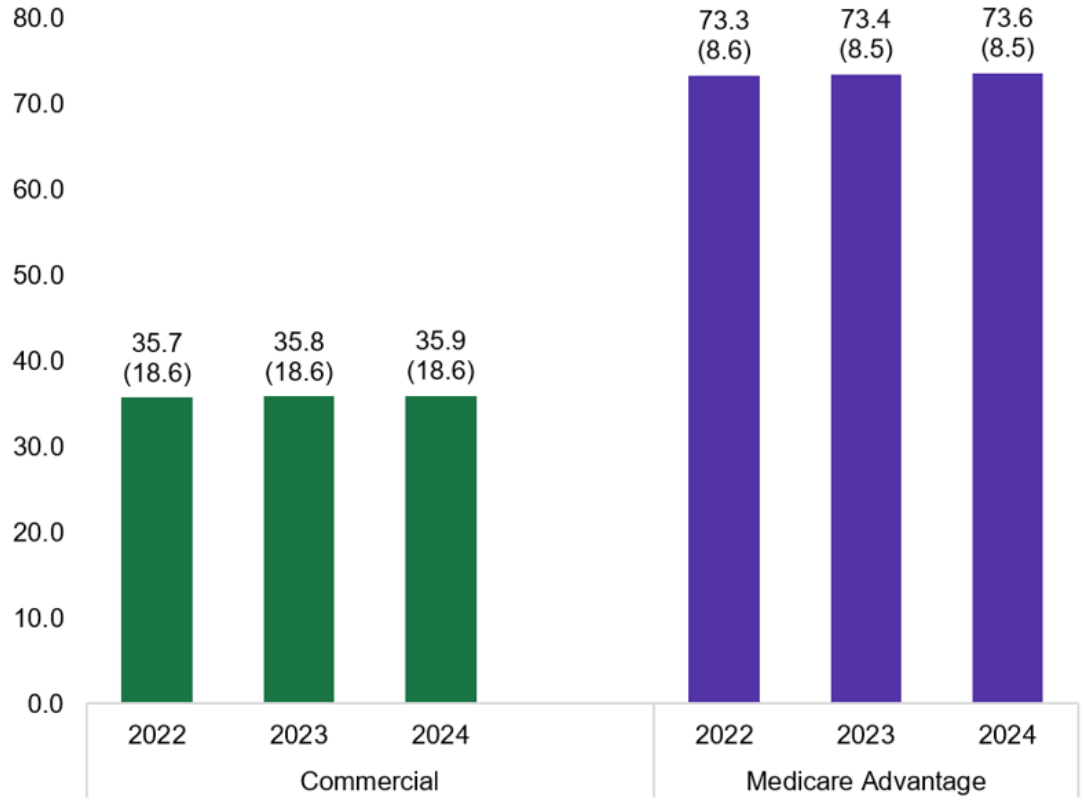
From 2022 to 2024, TME PMPY increased 15.8% in the commercial market and 13.3% in the Medicare Advantage market.



Average Age of Enrollees

From 2022 to 2024, the average age in the commercial market increased 0.6% and 0.4% in the Medicare Advantage market.

Figure 1. Average age of members, by market and year, 2022-2024

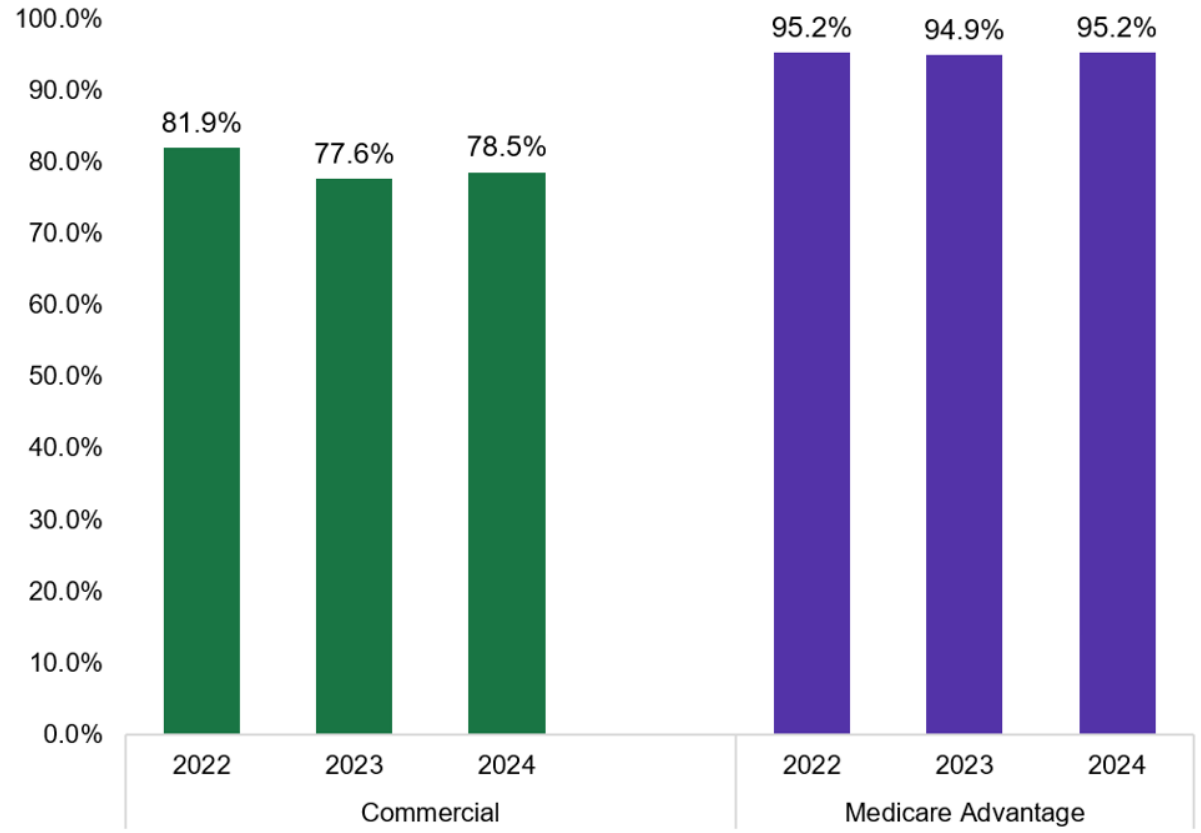


Notes: Bar labels show average age of members for year and a market with standard deviation in parentheses. Payers included for each market are listed in Table A1.

Utilization Rate

From 2022 to 2024, the utilization rate decreased 4.2% in the commercial market while remaining flat in the Medicare Advantage market.

Figure 2. Utilization Rate, by market and year, 2022-2024

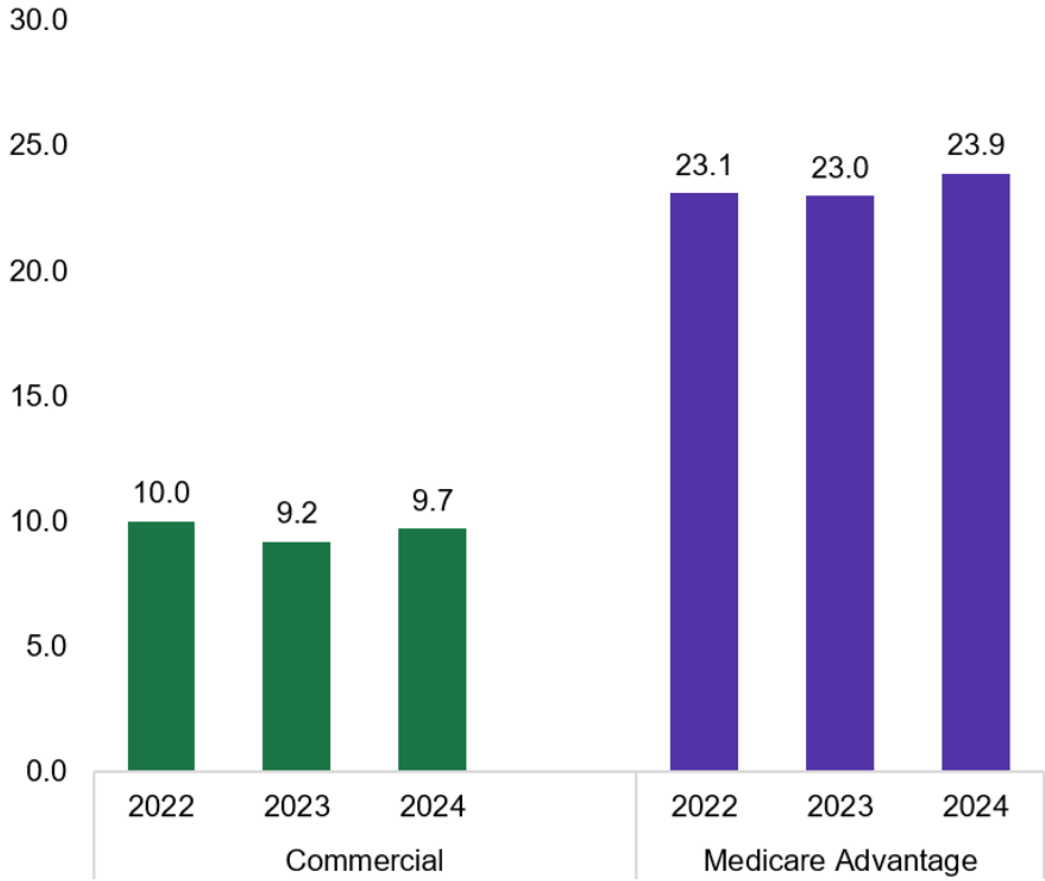


Notes: Figure shows the share of members with at least one encounter, by year and market. Utilization rate includes medical services and pharmacy use. Payers in each market included are listed in Table A1.

Utilization Frequency

From 2022 to 2024, utilization frequency decreased 3.0% in the commercial market, while increasing 3.5% in the Medicare Advantage market

Figure 3. Average annual encounters per member, by market and year, 2022-2024



Note: Average number of encounters is calculated for all members, including members without any claims or encounters. Encounters include both medical services and prescriptions fills.

High-Cost Members

- From 2022 to 2024, the share of high-cost members represented around 0.01% of the total enrolled population but increased 25.4% in the commercial market and 15.9% in the Medicare Advantage market.
- Their share of spending increased 3.2% in the commercial market, while decreasing 1.4% in the Medicare Advantage market.

Table 3. Share of high-cost members and their share of total spending, by market and year, 2022-2024

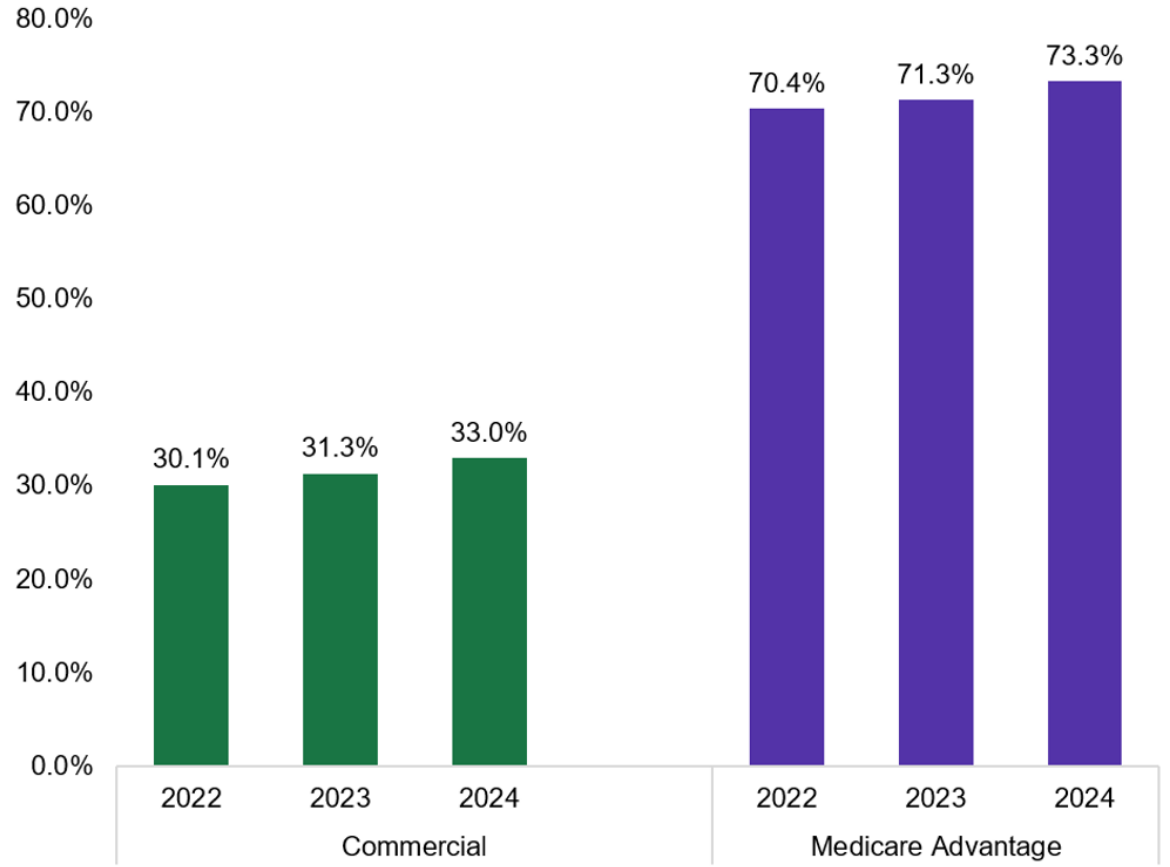
	Commercial			Medicare Advantage		
	2022	**2023**	**2024**	**2022**	**2023**	**2024**
Number of High-Cost Members	1,584	1,633	1,947	422	491	520
Share of High-Cost Members	0.0114%	0.0118%	0.0143%	0.0145%	0.0161%	0.0168%
Share of Total Spending by High-Cost Members	3.78%	3.80%	3.90%	2.17%	2.36%	2.14%

Notes: "Spending" includes both medical and pharmacy spending. Medical spending includes medical services allowed amounts for fee-for-service arrangements and estimated fee-for-service equivalents for capitated payment arrangements. Pharmacy spending is calculated as a sum of fee-for-service allowed amounts.

Chronic Conditions

From 2022 to 2024, the share of members diagnosed with at least one chronic condition increased 9.6% in the commercial market and 4.1% in the Medicare Advantage market.

Figure 4. Share of members with at least one chronic condition, by market and year, 2022-2024

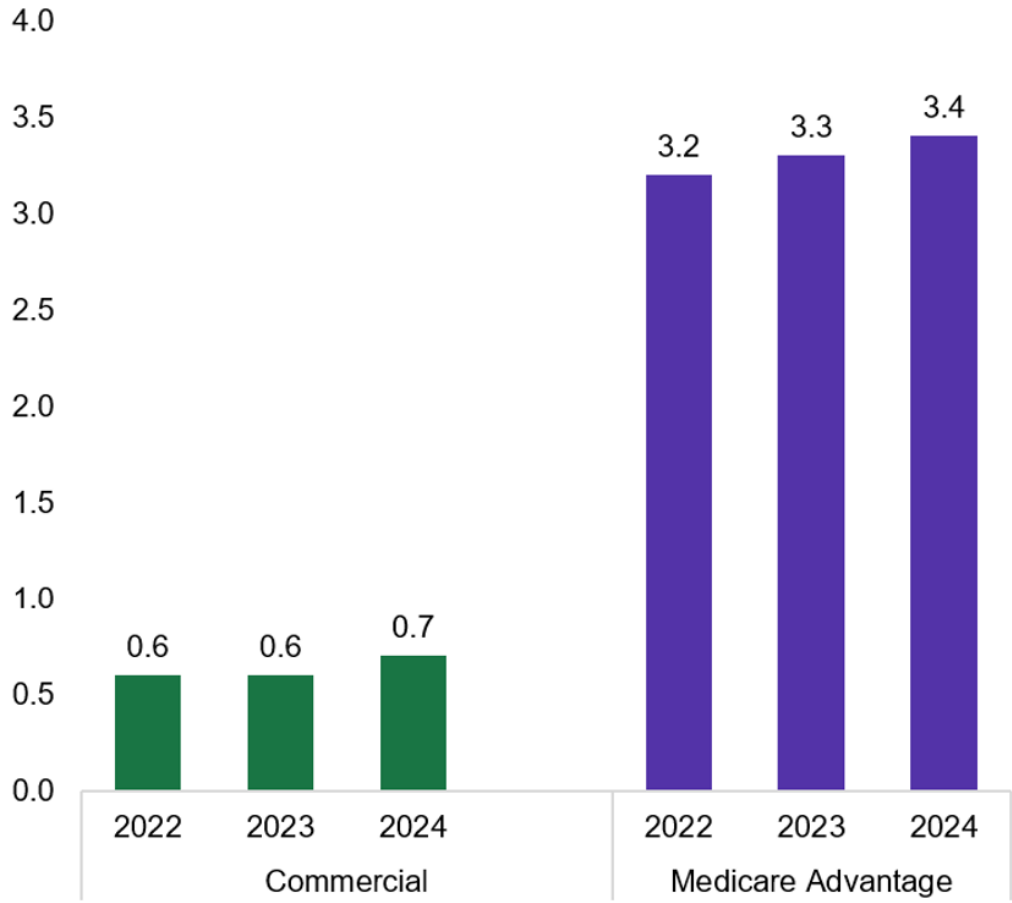


Notes: Member with a chronic condition defined based on the presence of diagnostic codes listed with Chronic Condition Warehouse on claims and encounters.[8]

Multiple Chronic Conditions

From 2022 to 2024, the average number of diagnosed chronic conditions per member increased a 16.7% in the commercial market and 6.2% in the Medicare Advantage market.

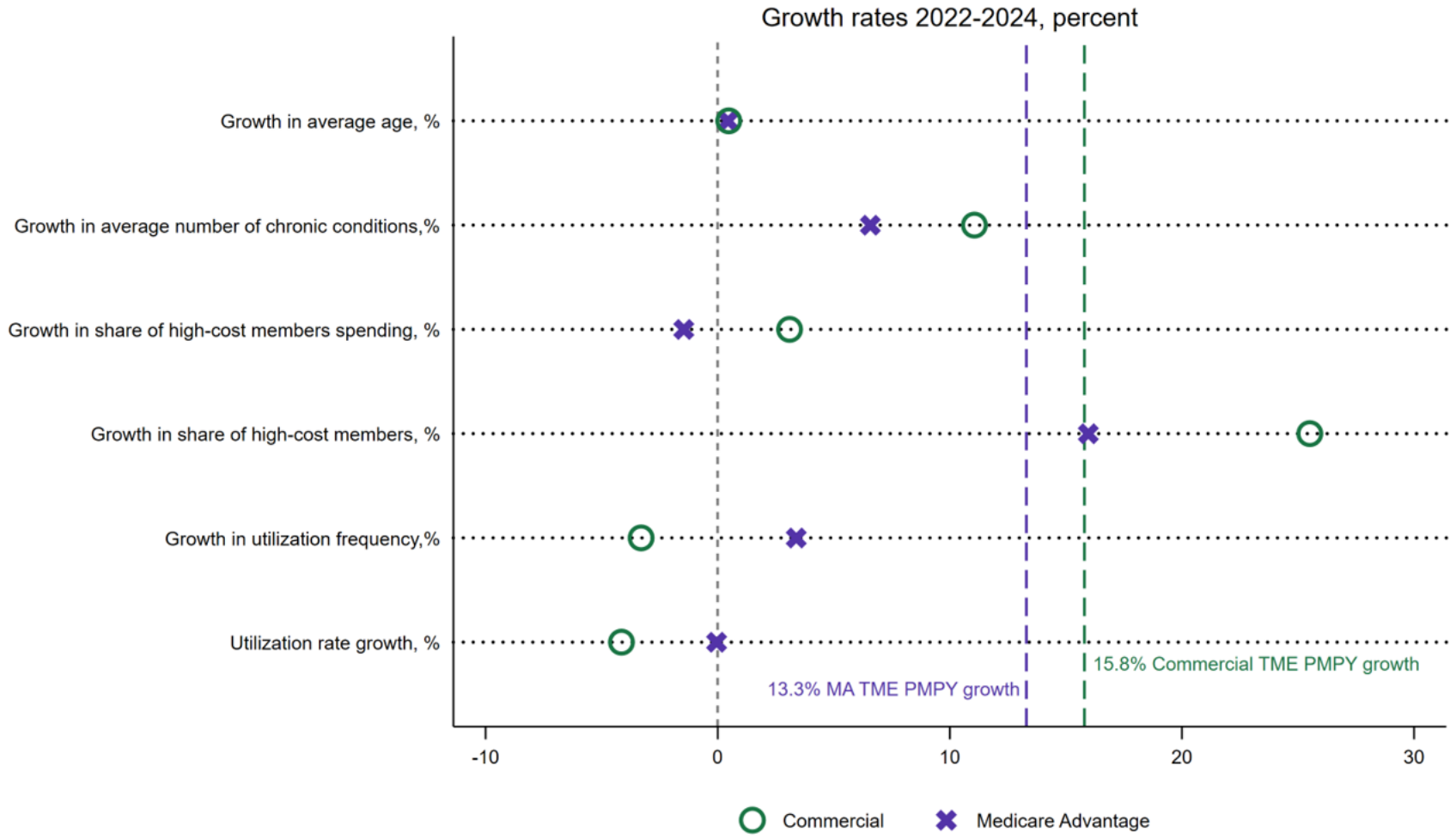
Figure 5. Average number of chronic conditions, by market and year, 2022-2024



Notes: Averages are calculated with all members, including those without any chronic conditions.

Growth Rates of Different Factors Compared to Growth of TME PMPY Between 2022-2024

Figure 6. Summary of growth rates in TME PMPY and factors examined



Notes: Green circles represent growth rate of each measure between 2022 and 2024 in commercial market. Purple cross represents growth rate of each measure between 2022 and 2024 for Medicare Advantage market. Dashed vertical lines represent growth in TME PMPY between 2022 and 2024 in commercial (green) and Medicare advantage market (purple). Dashed gray line represent 0% growth. TME PMPY in Medicare Advantage includes dual eligible and D-SNP members. Utilization frequency growth is calculated as a change in average number of encounters by market.

Takeaways and Next Steps

- Using the HPD, we examined the extent to which changes in enrollee demographics and utilization patterns could explain accelerated spending growth in the commercial and Medicare Advantage markets.
- We found an increase in the share of high-cost members, though it remained a small proportion of the total enrolled population, as well as an uptick in the share of members with chronic condition diagnoses.
- Other metrics we examined showed stable or small relative increases between 2022 and 2024, and thus, are unlikely to be significant drivers of spending growth in this period.
- These findings can inform policymakers seeking to understand the role of enrollee characteristics and patterns of utilization amid rising health care costs in California.

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Spending Target Enforcement: Continued Spending Target Penalty Discussion

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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Items for Today's Discussion

1. Board follow-up question: Can OHCA assess penalties if an entity does not meet their Performance Improvement Plan (PIP) milestones?
2. Clarification on spending target penalty justification factor: nonfederal share for Medi-Cal Reimbursement.
3. Review and discuss spending target enforcement penalty setting process.
4. What should be the range of spending target penalties?
5. What should be the procedural penalties for violations described under Health and Safety Code section 127502.5 (h)(1)?

Items for Future Discussion

- Board vote for spending target penalty scope, range, and justification factors for Health and Safety Code section 127502.5(a) and (d)
- Board vote for procedural penalties scope, range, and justification factors for Health and Safety Code section 127502.5 (h)(1)
- Draft regulations for spending target enforcement

Enforcement of PIP Milestones

Can OHCA assess penalties against an entity for missing performance improvement plan (PIP) milestones prior to the end of the PIP's implementation period?

Yes. OHCA could assess penalties against an entity for missing performance improvement plan milestones.

Penalty Justification Factor - Nonfederal Share

When determining administrative penalty amounts, OHCA would, in accordance with statute consider provision of nonfederal share.

Statute
Health and Safety Code Section 127502.5 (d) (3) Prior to assessing an administrative penalty against a health care entity, the director may consider related provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement. (4) To the extent that an administrative penalty is related to a Medi-Cal expenditure, including federal financial participation, the office shall coordinate with the State Department of Health Care Services to ensure appropriate treatment and return of any federal funds pursuant to Subpart F commencing with Section 433.300 of Part 433 of Title 42 of the Code of Federal Regulations.

Review: Spending Target Penalties

OHCA recommended the following approach to calculating spending target penalties.

Step 1: Initially Commensurate

- Calculate penalties that are initially commensurate with the degree to which the entity exceeded the spending target.
- "Initially Commensurate" is the difference between an entity's actual spending growth and what the growth would have been had the entity met the target.
- If 2023 were an enforceable year, "initially commensurate" penalties would have ranged from $4M - $350M.

Step 2: Penalty Justification Factors

- Consider a variety of penalty justification factors that could result in an increased or decreased final penalty amount.
- Penalty justification factors listed in statute include nature, number, and gravity of offenses, the fiscal condition and market impact of the entity, and consideration of provision of nonfederal share.
- Other potential adjustment factors include input from other state agencies, other factors approved by the Board, and escalating amounts for repeated failure to meet targets.

Review: Penalty Justification Factors

Penalty Justification Factor	Non-exhaustive potential examples of what each factor could include on a case-by-case basis
The nature, number, and gravity of the offenses.	• Excess growth beyond the state average or that was an extreme outlier • Conduct that resulted in harm to public, patients, access to care, affordability, market competition, etc. • A history of exceeding the target • Excess growth due to investments in primary care
The fiscal condition of the health care entity…	• Bankruptcies or other legal proceedings • Whether the proposed penalty negatively impacts the entity's financial standing with other state and federal regulators • If the entity's revenue, profit, assets, etc. significantly increased, especially in comparison with other years, while exceeding the target
The market impact of the entity.	• If the entity's share of total covered lives statewide is significant or greater than the average • The entity's impact on spending in its county or Covered California region • If the entity plays a unique or essential role in providing care to underserved populations

Discussion: Options for Penalty Structure

Does the Board have any initial feedback on the penalty structure? Specifically:

A penalty structure that calculates penalties that are initially commensurate and then makes adjustments based on a variety of factors.

Penalty justification factors would be those listed in HSC section 127502.5.(d) as listed below:

- The nature, number, and gravity of the offenses.
- The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.
- The market impact of the entity.
- Consideration of provision of nonfederal share.

Spending Target Penalty Range

Statute
Health and Safety Code section 127501.11 (b) “The board shall approve all of the following: … (2) The scope and range of administrative penalties and the penalty justification factors for assessing penalties.” Health and Safety Code section 127502.5 (d)(5) “If, after the implementation of one or more performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan, the director may assess escalating administrative penalties that exceed the penalties imposed under paragraphs (1) and (2) of this subdivision and paragraph (4) of subdivision (a).”

Spending Target Penalty Range Considerations

Considerations

- The range should give OHCA the flexibility to lower or increase the penalty during step 2 of the proposed spending target penalty calculation from the initially commensurate penalty.
- Escalating penalties must be large enough to deter future noncompliance.

Recommendation

OHCA recommends a percentage-based range of up to 125% of the initially commensurate excess growth.

- A percentage instead of a fixed dollar limit offers a range of penalty amounts depending on the level of excess spending over the target.
- A percentage above 100% allows for escalating penalties as required in statute.
- A limit of 125% will create a penalty large enough to deter future noncompliance.
- The range allows the office to adjust the penalty below 100% of the initially commensurate amount based on penalty adjustment factors.

Spending Target Penalty Range Maximum Example

Example Commensurate Penalties	Non-Exhaustive Examples of Penalty Range		
100%	115%	125%	150%
$4M	$4.6M	$5M	$6M
$100M	$115M	$125M	$150M
$350M	$402.5M	$437.5M	$525M

Example penalty amounts based on commercial market excess growth over 3.5% from 2022 to 2023, at the aggregate parent company level for health plans.

Discussion: Spending Target Penalty Range

Does the Board have any initial feedback on the recommendation of a spending target penalty range of up to 125% of the initially commensurate excess spending growth?

Procedural Penalties

Statute

Health and Safety Code section 127502.5 (h)(1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following:

(A) Willfully failing to report complete and accurate data.
(B) Repeatedly neglecting to file a performance improvement plan with the office.
(C) Repeatedly failing to file an acceptable performance improvement plan with the office.
(D) Repeatedly failing to implement the performance improvement plan.
(E) Knowingly failing to provide information required by this section to the office.
(F) Knowingly falsifying information required by this section.

Procedural Penalties – Pursuant to HSC 127502.5 (h)(1)

Considerations

- Procedural penalties need to allow OHCA to respond to non-compliance with enforcement actions, including public testimony and performance improvement plans (PIP).
- Procedural penalties should encourage entities to participate in the enforcement process.
- Procedural penalties can be issued in addition to spending target penalties depending on the entity's compliance with the enforcement process.

Procedural Penalties – Pursuant to HSC section 127502.5(h)(1)

Administrative Penalty	Recommendation	
	Per Day Penalty	Flat Penalty
(A) Willfully failing to report complete and accurate data.	For annual THCE data submission, the Board voted on combination of per day and flat penalties.	
(B) Repeatedly neglecting to file a performance improvement plan with the office.	X	
(C) Repeatedly failing to file an acceptable performance improvement plan with the office	X	
(D) Repeatedly failing to implement the performance improvement plan.		X
(E) Knowingly failing to provide information required by this section to the office.	X	
(F) Knowingly falsifying information required by this section.		X

Health and Safety Code section 127502.5

Procedural Penalties – Pursuant to HSC section 127502.5 (h)(1)(B), (C), and (E)

Recommendation

A penalty of up to $10,000 per day for:

- (h)(1)(B) Repeatedly neglecting to file a performance improvement plan with the office.
- (h)(1)(C) Repeatedly failing to file an acceptable performance improvement plan with the office.
- (h)(1)(E) Knowingly failing to provide information required by this section to the office.
- “Repeatedly” means not filing a PIP or failing to file an acceptable PIP more than once.

- Depending on the entity’s compliance with the enforcement process, spending target penalties may still be issued in addition to procedural penalties identified above.
- A per day penalty prompts entities to take action to prevent penalties from continuously accruing.
- $10,000 per day aligns with other programs:
  - The California Public Utilities Commission’s $5,000-$20,000 per day financial penalty for failure to submit supply and pricing information.
  - The California Department of Health Care Services has an up to $25,000 per day financial penalty for Medi-Cal Managed Care Plans that fail to implement corrective action plans. These penalties increase to $50,000 per day for second offenses and $100,000 per day for subsequent offenses.

Discussion: Procedural Penalties

Does the Board have any initial feedback on a penalty of up to $10,000 per day for violations under 127502.5 (h)(1)(B), (C), and (E)?

- (h)(1)(B) Repeatedly neglecting to file a performance improvement plan with the office.
- (h)(1)(C) Repeatedly failing to file an acceptable performance improvement plan with the office.
- (h)(1)(E) Knowingly failing to provide information required by this section to the office.

Procedural Penalties – Per HSC section 127502.5 (h)(1)(D) and (F)

Recommendation

A one-time flat penalty of up to $500,000 for:

- HSC section 127502.5 (h)(1)(D) Repeatedly failing to implement the performance improvement plan.
  - "Repeatedly" means failing to implement a PIP more than once, which could mean failing to implement more than one component of a single PIP or failing to implement multiple PIPs over an extended period.
- (h)(1)(F) Knowingly falsifying information required by this section.

- Depending on the entity's compliance with the enforcement process, spending target penalties may still be issued in addition to procedural penalties identified above.
- A flat penalty is appropriate for these violations because OHCA is no longer compelling an action – the entity has already failed to implement the PIP or has already falsified information.
- A flat penalty of up to $500,000 aligns with Massachusetts' approach for entities that do not implement their PIP.

Discussion: Procedural Penalties

Does the Board have any initial feedback on a one-time flat penalty of up to $500,000 for violations under HSC section 127502.5 (h)(1)(D) and (F)?

- (h)(1)(D) Repeatedly failing to implement the performance improvement plan.
- (h)(1)(F) Knowingly falsifying information required by this section.

Next Steps

- Board vote for spending target penalty scope, range, and justification factors for Health and Safety Code sections 127502.5(a) and (d).
- Board vote for procedural penalties scope, range, and justification factors for Health and Safety Code section 127502.5 (h)(1).
- Draft regulations for spending target enforcement.

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Cost and Market Impact Review: Comments on Regulatory Text

Heather Hoganson, Assistant Chief Counsel

HCAI
Department of Health Care Access and Information

Public Comment Summary

- Proposed regulations were discussed at the Health Care Affordability Board meeting in May 2026.
- OHCA published draft Cost and Market Impact Review regulations on May 22, 2026.
- Public comments were accepted from May 22 to June 11, 2026.
- OHCA received 11 comment letters.

Public Comment Themes

Topic	Comments
Filing	Prevent duplicative reporting Allow all submitters to file jointly Allow for incorporating by reference information previously reported to other regulators
Definition of Health Care Entity	Do not include owner
Definition of Transaction	Expand / Narrow
Real Estate Investment Trusts	Delete / Expand Offer an exemption or expedited review Require actual agreements to be submitted
Serial Transactions	Shorten length of lookback (3 years) / Aggregate more robustly (include sub-25 physician practices)

Public Comment Themes

Topic	Comments
Management Service Organizations (MSO)	Draft regulation is too narrow / too broad Expand who should file (no thresholds) / narrow who should file (exclude clinically integrated network, medical foundation; add revenue threshold) Do not narrow definition in statute Include “normal course of business” exclusion for filing

Public Comment Themes

Topic	Comments
Private Equity	Expand who should file (no threshold) / narrow who should file (25% or 40% interests) Consider divestitures, exit transactions
PE Portfolio Disclosure	Narrow to California health care operations / capture relevant health care and MSO footprint of participating asset managers and funds to see if part of broader acquisition strategy or consolidation pattern

Public Comment Themes

Topic	Comments
Confidentiality	Do not require submission of anything confidential or public or submitted to another agency Allow more redacted information to be submitted Deem more automatically confidential / Do not presume confidentiality Require Attorney General to keep any referred matters confidential
Org Charts	Increase reporting threshold to owners possessing governance rights / Decrease reporting threshold to partners of general fund Delete subsidiary organizations

Board Input

Does the Board have any input on the draft text or comments received?

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General Public Comment

Written public comment can be emailed to: ohca@hcai.ca.gov
To ensure that written public comment is included in the posted board materials, e-mail your comments at least 4 business days prior to the meeting.

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Next Board Meeting:
August 26, 2026
10am

Location:
2020 West El Camino Ave, Conference Room 900, Sacramento, CA 95833

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Adjournment

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