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Health Care Affordability Board
 March 25, 2026
 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
4/15/2026	Radu Gabudean	<p>Please keep fighting the hospitals and their lobby, including Stanford Hospital.</p> <p>I am a resident of Santa Clara county, and my family has received care from Stanford Health. We consistently noticed being billed 3x for standard procedures than we paid with other local providers. On the last interaction, we were even up-coded for an emergency room visit. I am happy to provide more details.</p> <p>The most egregious part: Stanford has a huge endowment, it receives a lot of tax benefits, and its students pay exorbitant fees. Yet, they are still fleecing folks that put their health in their hands.</p>
4/16/2026	Jacob Lara	<p>my healthcare premiums went up almost 8000% since 2025. it went from 1.50 premium to 120 premium, PCP copay 15 to 50, specialist 25 to 90, ER 150 to 400, urgent care 50, 45 to 95 for xrays and imagining. How is this affordable? my pay didnt go up 8000%. That premium increase was before i added my wife. now it is all the same costs but 243 a month. we have a gross combined monthly of 3600, and chronic conditions that require on going care. this makes the insurance unaffordable switching to a worse plan with less coverage only decreases the cost by 20 a month on the premium.</p> <p>my healthcare premiums increased 8000% while the cost of copays more than doubled, and in some instances increased nearly 400%. I have to pay for this and deal with being in a ghost network because my time spent on medi-cal resulted in racial discrimination or negligence at each other primary care provider i was assigned to, with my current</p>

Date	Name	Written Comment
		Primary only taking this network. copays 50 for a doctor visit, was 15, was 25 for a specialist now 90, ER was 150 now 400, urgent care was 15 now 50, images were 45 now 95. This is just for myself; the premium doubled when I added my wife.
4/16/2026	Health Access California	See Attachment #1.
4/16/2026	California Hospital Association	See Attachment #2.
4/16/2026	UC Health Systems	See Attachment #3.
4/16/2026	California Association of Health Plans	See Attachment #4.



April 16, 2026

The Honorable Kim Johnson, Chair
Health Care Affordability Board

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Mayra Alvarez
The Children's Partnership

Ramon Castellblanch
California Alliance for Retired Americans

Elizabeth Landsberg, Director
Health Care Access and Information Department

Juliet Choi
Asian and Pacific Islander American
Health Forum

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

Sarah Dar
California Immigrant Policy Center

Lori Easterling
California Teachers Association

2020 W. El Camino, 12th Floor
Sacramento, CA

Jenn Engstrom
California Public Interest Research Group

Stewart Ferry
National Multiple Sclerosis Society

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

Jeff Frietas
California Federation of Teachers

Health Access, the statewide consumer coalition committed to quality, affordable, equitable care for all Californians, offers comments on the following:

Lorena Gonzalez Fletcher
California Labor Federation

Alia Griffing
AFSCME California

Kelly Hardy
Children Now

Linda Nguy
Western Center on Law and Poverty

Maribel Nunez
Inland Empire Partnership

Tia Orr
Service Employees International
Union State Council

Joan Pirkle Smith
Americans for Democratic Action

Juan Rubalcava
Alliance of Californians for Community
Empowerment

Andrea San Miguel
Planned Parenthood Affiliates of California

Kiran Savage-Sangwan
California Pan-Ethnic Health Network

Rhonda Smith
California Black Health Network

Nicole Thibeau, PharmD
Los Angeles LGBT Center

Joseph Tomás Mckellar
PICO California

Sonya Young
California Black Women's Health Project

- Public process and accountability during the stages of enforcement
- Spending target penalties
- The interaction of the growth targets with rate review conducted by the Department of Managed Health Care and the California Department of Insurance
- Recommendations on the annual report due June 2026, based on the baseline report from June 2025
- Consideration of hospital or health systems and enforcement of the targets

Public Transparency and Accountability for Enforcement

Health Access yet again calls on the OHCA staff and Board to consider seriously what will be public and when during the process of enforcement. Health Access has made recommendations multiple times in multiple letters to this Board. Public transparency of enforcement steps should not be an afterthought but built in to enforcement throughout. We stand ready to work with staff and the

Amanda McAllister-Wallner
Executive Director

Organizations listed for
identification purposes

Board on how best to achieve this. But what we are not willing to do is to allow this critical aspect of the enforcement process to be overlooked.

Spending Target Penalties

The law on spending target penalties contains several key provisions:

- First, the law permits penalties commensurate with the amount by which the target is exceeded and allows escalating penalties for continued failure to meet the target. The precise language is:

“Commensurate with the health care entity’s offense or violation, the director may take the following progressive enforcement actions: (4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets¹.”

- This penalty structure helps to address the situation identified at the last Board meeting in which an entity that exceeded the target subsequently benefits from increasing its spending from a higher base.
- It also reflects a deliberate rejection by the Legislature and the Governor of a cap on penalties that would be far less than the damage to consumer affordability. A cap on penalties disproportionately benefits larger entities, precisely those large health plans or health systems able to inflict the greatest costs on consumers.
- Second, the law allows the director to consider the financial resources of a larger system of which the entity is an element as well as affiliates or subsidiaries of the entity when determining penalties.
 - The Board has already heard a number of examples of entities with affiliates or subsidiaries such as a standalone hospital with an associated foundation with substantial reserves or a network of ambulatory care clinics or physician practices.
 - In other instances, a hospital or health plan is part of a larger system of entities with substantial reserves here or nationally. Examples are numerous: the majority of California hospitals are part of hospital systems, many insurers control other entities, such as Optum Medical or pharmacy benefit managers that provide substantial financial capacity.

¹ Health and Safety Code 127502. (a) (4)

- This language was also meant to distinguish the smaller, standalone hospital, physician organization or health plan that lacks other financial resources from the larger systems.
- Third, the law allows the director to consider a variety of factors customary in setting penalties such as the nature, number and gravity of offenses and the market impact of the entity as well as the fiscal condition of the entity, including the system or affiliates and subsidiaries the entity controls².

This Board has set a precedent on the scope and of the data submission penalty which allows for a lower initial penalty, escalating for continued violations. This penalty is based on a different set of provisions in law than the spending target penalties, that is the provisions of the law on entities knowingly or willfully failing to provide information or otherwise comply with OHCA requirements such as filing a performance improvement plan. Because these are two different categories of penalties with different legal requirements and standards, the precedent set by the data submission penalty structure suggests options but options that should be considered in the context of the differing provisions of law on spending target penalties and any differences in the likelihood of compliance.

The law on penalties for exceeding the spending target begins with penalties commensurate to the amount by which the target is exceeded and escalates from there. The Legislature and the Administration considered and rejected other penalty schedules such as those similar to hospital licensure penalties. As we have noted, the director may consider other factors in imposing a penalty. In the case of compliance with the spending targets of 3.5% declining to 3% in 2029, available evidence suggests that a substantial share of entities have exceeded those targets and in some cases that spending growth continues to be in the 8%-10% or even the 10%-12% range³. Such blatant violations of the target deserve harsh action. We might perhaps feel differently if there were evidence of entities moving toward compliance but at the moment, that is lacking.

We again note that the spending target penalties are only one of three categories of penalty provided to the Office to assure compliance with the provisions of the law:

1. Penalties for exceeding the spending growth target

² Health and Safety Code 127502.5 (d) (6).

³ Cite DMHC rate increases for 2025-2026

2. Penalties for willfully or knowingly obstructing the activities of the office, such as failing to provide required information or a performance improvement plan.
3. Penalties on health plan administrative costs and profits if the health plan exceeds the target.

Each of these types of penalties is governed by different provisions of law: hence the scope and range of penalties is likely to be different for each.

Rate Review by DMHC and CDI: Interaction with OHCA Targets

The most frequent question we get about the Office of Health Care Affordability is how will it make my health care costs more reasonable? And the second most frequent question is when? The existing law governing rate review by the Department of Managed Health Care and the California Department of Insurance includes a provision tying rate review by those regulators to the OHCA targets. That law requires health plans and insurers in filing rates for review by these regulators to “demonstrate the impact of any changes in the rate of growth in health care costs resulting from the health care cost targets” and the law also states that:

“In determining whether a rate is unreasonable or not justified, the director shall consider the impact on changes in health care costs as a result of the health care cost targets” set by the Health Care Affordability Board.

In our public testimony to the Departments, including DMHC, CDI and OHCA at the public meeting on March 11, 2026, Health Access asked that DMHC and CDI find rates unjustified unless the plan or insurer complied with state law by demonstrating the impact of the OHCA targets on rates.

In our preliminary review of one subset of small group rate filings since this provision of law took effect, plans have routinely ignored the OHCA targets. Indeed, one plan asserted that it used national medical trend data, failing even to acknowledge that the OHCA targets might affect medical trend for its California book of business. As best we can determine, another plan simply failed to respond to the Department’s query. A third plan said it supports OHCA’s goals but failed to document how the targets affected its rates, instead pointing to factors such as the aging of the population though OHCA’s carrier-specific review of how much aging

changed year over year found a very little impact on THCE, about 0.3%. Based on current law, these filings are unjustified. That is also true of other filings that fail to “demonstrate the impact of” the (OHCA) targets.

Health Access questions whether proposed rates well in excess of the OHCA target are reasonable or not. Rate review is not within the jurisdiction of the Office, but the law recognizes that the rates should be affected by the OHCA targets, along with other statutorily required factors such as financial solvency of the carrier. Most health plans have reserves that are not merely ample but arguably excessive so bringing rates more into alignment with the OHCA target growth will not endanger financial solvency of these plans.

Annual Report: Recommendations

In June 2025, last year, OHCA released its baseline report on “total” health care spending for 2022-23 and other aspects of its work to date. In July 2025, Health Access offered comments on that report: <https://hcai.ca.gov/wp-content/uploads/2025/07/June-2025-Written-Public-Comments-to-Board-1.pdf> Our work benefitted from a review of similar reports released in other states with health care cost target programs.

In anticipation of the annual report to be released in June 2026 on the 2023-24 years, we summarize those earlier comments:

- Administrative costs and profits
 - For commercial coverage, the 2025 report found that despite a significant dollar increase in profits and administrative costs, the percentage of THCE spent on administrative costs and profits was 7.8%, well under the thresholds of 15% or 20% set in state and federal law on the medical loss ratio.
 - In contrast, for Medi-Cal managed care, administrative costs and profits were 15% of THCE, which validated the Governor’s May 2025 May revise proposal to lower administrative costs and profits for Medi-Cal managed care plans.
- Consumer costs:
 - As the report found, consumer costs were climbing much faster than income.

- Health Access recommends additional reporting on consumer costs, including a comparison to incomes at or below median income as well as more detail on cost sharing, such as deductibles, copays, coinsurance and actuarial value as well as worker share of premium.
- Health Access also recommends the following:
 - Progress toward the primary care benchmark should be featured.
 - Equity and quality measures, many of which address preventive care: more description should be included. Preventive care has been prioritized in many pieces of legislation in recent years so featuring this is appropriate.
 - Behavioral health: a discussion of the progress toward developing a benchmark both in terms of the statutory minimum and the broader vision discussed by OHCA.
 - Medi-Cal spending: we look forward to seeing more reporting on Medi-Cal, including not only Medi-Cal managed care but also spending on the remaining but high-cost fee-for-service population.
- Spending compared to the target, recognizing that the initial target year is 2025: where was spending growth in advance of the target being in effect? We look forward to learning this.

Enforcement: Hospital System Improvements

Throughout the work of the Office, hospitals and health systems have explained how they are trying to control costs while improving outcomes and equity by increasing primary care and other care in the community. While under current law, the cost target applies to the licensed hospital facility, as we look ahead to performance improvement plans, Health Access recommends consideration of looking at performance improvement at the system level while maintaining the current legal obligation of the hospital itself to comply with the growth target⁴.

⁴ We provided a longer discussion in our letter dated March 19, 2026. We summarize here.

Conclusion

We look forward to continuing to work with the Board and the staff on these and other issues,

Sincerely,



Beth Capell, Ph.D.
Policy Consultant



Amanda McAllister-Wallner
Executive Director

CC: Members, Health Care Affordability Board
Richard Figueroa, Deputy Cabinet Secretary, Office of the Governor
Christine Aurre, Legislative Affairs, Office of the Governor, Attn.:
Paula Villescaz
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Mike McGuire, President Pro Tempore, California State Senate, Attn.: Marjorie Swartz
Mary Watanabe, Director, Department of Managed Health Care
Michelle Baass, Director, Department of Health Care Service
Assemblymember Mia Bonta, Chair, Assembly Health Committee, Attn.:
Lisa Murawski
Senator Caroline Menjivar, Chair, Senate Health Committee, Attn.:
Teri Boughton
Brendan McCarthy, Deputy Secretary, California Health and Human Services Agency, Attn.: Darci Delgado
Dr. Akilah Weber Pierson, Chair Senate Budget Subcommittee 3 on Health and Human Services, Attn.: Scott Ogus
Dawn Addis, Chair, Assembly Budget Subcommittee 1 on Health, attn.:
Patrick Le
Josephine Figueroa, Deputy Commissioner, California Department of Insurance



April 16, 2026

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

Subject: CHA Comments for the April 2026 OHCA Board Meeting
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

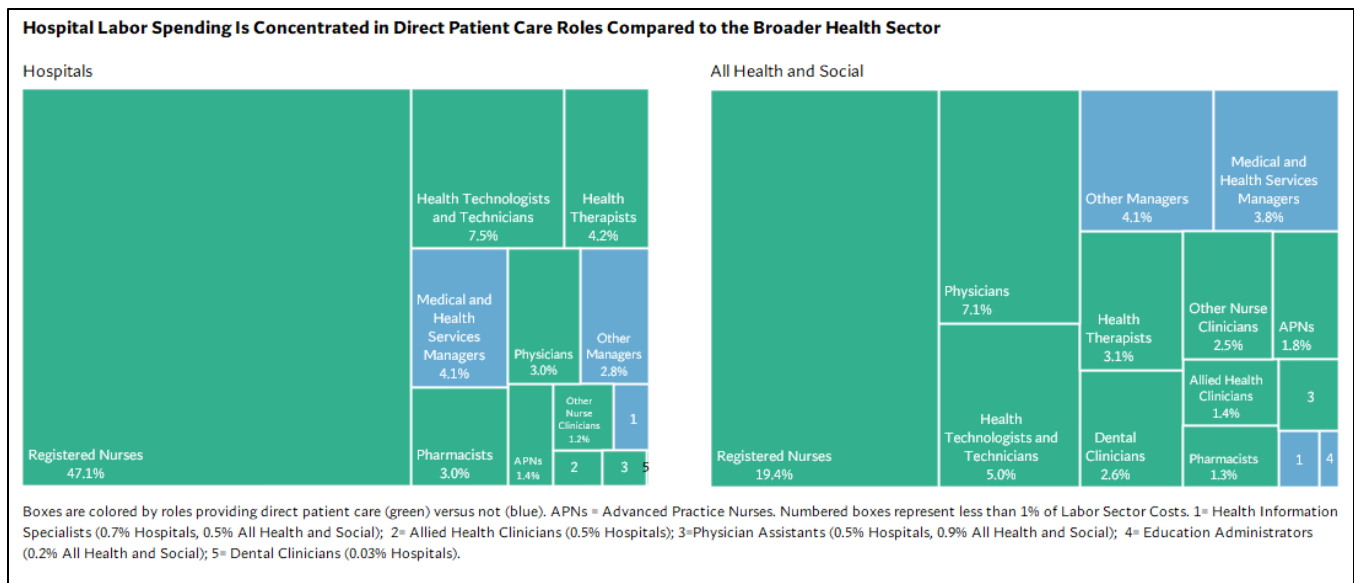
California's hospitals share the Office of Health Care Affordability's (OHCA's) goal to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of nearly 400 hospitals, the California Hospital Association (CHA) appreciates the opportunity to comment ahead of OHCA's April 2026 board meeting.

Labor Costs Are a Key Driver of Hospital and Health Care Spending

Providing lifesaving hospital care, 365 days a year, 24 hours a day, requires a highly skilled and diverse workforce composed of doctors, nurses, and technicians, as well as support and administrative staff. In California hospitals, six staff are needed, on average, to care for each patient who enters their doors. As a result, 56% of hospital spending goes to labor, a far higher share than other sectors of the economy. Hospital labor costs are difficult, if not impossible, to control. In large part, this is due to state laws that mandate minimum staffing **and** compensation levels. Combined with workforce shortages, ever growing care needs as the population ages, and the soaring cost of living, hospitals have no choice but to spend more to attract and retain the highly trained workers on whom care depends.

The Vast Majority of Hospital Payroll Supports Direct Patient Care

The U.S. Bureau of Labor Statistics' (BLS) 2024 Occupational Employment and Wage Statistics data for California show the distribution of hospitals' payroll spending among different classes of health care workers. Nearly half of hospital labor costs (47%) go to nurses, followed far behind by health technologists and technicians, therapists, clinical care supervisors, physicians, and pharmacists. Administrative management workers, including all hospital leadership positions, make up just 2.8% of payroll spending. When combined with clinical managers, supervisory payroll spending accounts for not even 7% of total hospital payroll costs. For health (and social services) spending overall, the picture looks quite different, with nurses and technologists and technicians comprising a much smaller share of spending, and physicians and administrative management workers comprising significantly more spending compared to hospitals.



OHCA Must Protect All Health Care Workers

At the March board meeting, OHCA unveiled a plan to adjust individual health care entities’ spending targets based on growth in their nonsupervisory organized labor costs. Unfortunately, this proposal falls short of the Legislature’s overarching goals and directives, as well as the policy imperative to treat all workers equitably.

OHCA Has a Statutory Duty to Protect Workforce Stability

The Legislature vested OHCA with several responsibilities, including promoting affordability, maintaining access to quality care, and protecting workforce stability. Moreover, the Legislature tasked OHCA with incorporating all these objectives directly into the setting of spending targets. Specifically, in Section 127502(c)(6) of the Health & Safety Code, state law requires that OHCA’s targets “promote the stability of the health care workforce, including the development of the future workforce, such as graduate medical education, training, apprenticeships, and research.” This means that OHCA is under an affirmative obligation to ensure that its targets do not undermine health care workforce stability broadly, not for only a subset of workers. To date, OHCA has made no adjustments that would fulfill this responsibility, nor has it conducted analysis demonstrating that the targets are consistent with this prerogative.

Disappointingly, the March 2026 framework for prospectively adjusting spending targets for health care providers is based only on collectively bargained cost increases. The framework is at odds with OHCA’s broader workforce stability mandate and fails to protect the hundreds of thousands of health care workers who have elected not to be part of a union. This inequitable treatment would result in some getting a free pass from contributing toward the state’s affordability goals, while shifting the burden to workers and their employers not eligible for the organized labor adjustment discussed below. This undoubtedly was not the Legislature’s intent in authorizing OHCA’s work. Rural health care will be especially challenged, given the lower penetration of organized labor in these areas of the state. **A different approach is needed.**

OHCA's Spending Target Adjustment Methodology Must Equitably Protect ALL Workers

Fortunately, state law affords OHCA the flexibility necessary to make various adjustments to the spending targets to ensure fulfillment of its overarching statutory obligations. Most notably, (d)(4) of Section 127502 establishes that the spending target methodology shall review the following factors for adjusting the targets:

- Health care employment cost index
- Labor costs
- Consumer price index for urban wage earners and clerical workers
- Impacts due to known emerging diseases
- Trends in the price of health care technologies
- Provider payer mix
- State or local mandates such as required capital improvement projects
- Relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs

While OHCA is subject to a more specific legal obligation to adjust targets for organized labor cost growth (see Health & Safety Code § 127502(d)(7)), that more targeted clause for a subset of regulated providers does not absolve OHCA of its overarching directive to consider and promote stability for the entirety of the workforce. The above cited provision on factors for future adjustments (paragraph (d)(4)), alongside OHCA's foundational duty to promote workforce stability broadly in establishing and adjusting spending targets, clearly directs OHCA to consider all labor cost growth when reviewing, and ultimately adopting, adjustments to the spending targets. OHCA **must protect all workers** by exercising this authority and prospectively adjusting providers' spending targets for all nonsupervisory labor cost growth. The methodology could be largely similar to, but of course broader than, what OHCA presented for organized labor cost growth at the March board meeting.

Enforcement Discretion Is Another Essential Tool for Protecting All Workers

As a principle, OHCA should promote access to high-quality care and protect the workforce by incorporating all identifiable, predictable, and uncontrollable or desirable drivers of health care spending increases into the spending targets themselves, including through adjustments. Then, as a fallback and secondary means of assurance, OHCA should account for such drivers, as well as others that may not be readily identifiable or predictable in advance, as considerations in the enforcement process. As with spending target adjustments, the office has significant flexibility as to what factors to consider in the enforcement process. However, that flexibility is ultimately subordinate to OHCA's statutory objectives, including the protection of workforce stability. Accordingly, OHCA can and must use its enforcement discretion to protect and promote high-quality jobs for **all** workers, not only the subset that have elected to organize. All labor cost growth, whether or not it is collectively bargained, must be among the enforcement considerations OHCA uses in the enforcement process.

Conclusion

California's hospitals appreciate the opportunity to comment and look forward to continued engagement toward our shared goals of promoting affordability, access, quality, equity, and workforce stability 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



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April 16, 2026

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

Submitted electronically via email to ohca@hcai.ca.gov.

Subject: Adjusting Cost Targets for Non-Supervisory Organized Labor Costs

Dear Secretary Johnson,

On behalf of the University of California (UC) Health, I am writing to provide recommendations to the Office of Health Care Affordability (OHCA) and the Health Care Affordability Board (Board) concerning its development of a process to adjust cost targets for non-supervisory organized labor costs (hereafter simplified as “organized labor costs.”)

UC Health and its six academic health centers and 21 health professional schools are part of California’s public health care system and form the core of the state’s health care safety net. UC Health’s mission is to improve the health and well-being of all people living in California now and in the future by educating and training the inclusive workforce of tomorrow; delivering exceptional and equitable care; and discovering life-changing treatments and cures.

UC’s academic health centers also operate “designated public hospitals” for purposes of the Medi-Cal program and support the state’s investment in innovative Medi-Cal quality, payment, and service delivery reforms by funding the non-federal share that is necessary to match federal financial participation to cover and pay for these programs.

Use Recent Cost Data as the Basis for Initial Spending Target Adjustment

UC Health appreciates OHCA’s attention to the complex and important issue of organized labor costs. We agree with comments shared by representatives from labor at the March 2026 Board meeting that OHCA must get this process right, which will take time and careful attention to technical details, and that OHCA’s cost targets should not be a factor at the bargaining table.

With these shared goals in mind, UC Health suggests the following principles to

guide the process for organized labor cost adjustments:

- Fully account for all organized labor costs.
- Base adjustments on known information rather than subjective judgment.
- Follow a transparent process.
- Limit administrative burden on health care entities.

The key challenge in adjusting for organized labor costs is that the statutory process used to set cost targets does not align with the collective bargaining process. Statute requires the Board to “discuss recommendations at a public meeting for proposed targets on or before March 1 of the year prior to the applicable target year.”¹ Prior to March 1, OHCA must build in time to review adjustment requests and develop its recommendations for the Board. OHCA has initially suggested that health care entities submit documentation about six months prior to the Board discussion. Under this process, health care entities would be required to submit documentation related to their labor cost adjustment more than one year prior to the start of the target year.

We offer an example of a recent bargaining contract to illustrate the challenges this target setting process poses for organized labor cost adjustments. On November 8, 2025, UC and the University Professional and Technical Employees union announced a contractual agreement covering November 2025 through September 2028.² This agreement covers 2025 (partial year), 2026, 2027, and a portion of 2028. Under OHCA’s suggested timeline and process, UC could not have predicted the cost of this contract in fall 2023, when information relevant to the 2025 target year would have been submitted to OHCA had the process been in place at that time. Labor cost adjustments therefore are unknown at the time the Board is considering OHCA’s recommendations. OHCA and the Board should recognize that if entities are expected to project their future organized labor costs for the purposes of spending target adjustment, these projections would be highly subjective and there would be no one “right” initial adjustment that could be made.

To create more predictability in the adjustment process, limit the degree of subjectivity in the process, and avoid disagreement over the “right” adjustment, **we recommend that OHCA consider basing the initial spending target adjustment on recent historical organized labor costs.** In general, it is reasonable to assume that recent growth in organized labor costs will be close to the growth rate for the upcoming target year. Depending on how the organized labor costs of a given entity have changed in recent years, OHCA could consider entities’ recommendations to place more weight on a specific year in order for the adjustment to be closer to the expected actual. Moreover, OHCA could consider allowing entities to request a deviation from their recent cost data if they demonstrate that an already agreed-to contract includes provisions that will result in future costs differing significantly from recent trends. If OHCA were to design the adjustment to capture at least one year of actuals, the process would also increase transparency in how organized labor costs would be considered in the enforcement process because year-to-year growth in organized labor costs would be available in the information reviewed by the Board. Because entities will need to track these costs in the event

¹ Health and Safety Code Sec. 127502(m).

² <https://www.universityofcalifornia.edu/press-room/joint-statement-uc-and-upte-agreement-reached-following-uptes-request-resume-mediation> and <https://ucnet.universityofcalifornia.edu/resources/employment-policies-contracts/bargaining-units/technical/contract/>

they are required to justify their adjustments during the enforcement process, this approach would also limit the administrative burden of the initial adjustment.

OHCA staff have posed the question of whether the Board should adjust for one agreement at a time or the projected total change in all organized labor costs for a given provider. **We recommend that OHCA give entities the choice of whether to submit costs by agreement or for all agreements combined.** Contracts are complex. As discussed later in this letter, they can contain numerous types of salary and wage compensation, different approaches for benefit cost sharing, and various types of ancillary benefits. Different entities may reasonably track these costs in different ways, and providing entities with flexibility would limit the administrative burden of the labor cost adjustments.

Ensure That All Labor Costs Are Accounted for in Adjustments

State statute requires the Board to “adjust cost targets...to account for actual or projected nonsupervisory employee organized labor costs, including increased expenditures related to compensation.”³ The terms “cost” and “compensation” are very broad. The Legislature did not choose to use terms like “salaries” or “wages” to describe these cost target adjustments. Thus, **we recommend that OHCA ensure that labor cost adjustments include all forms of employee compensation.** Also implicit in labor costs is growth in the size of the workforce—OHCA must not design labor cost adjustments to be based on a per-employee measure of compensation. Keeping in mind the principle that OHCA should not be a factor at the bargaining table, an expansive view of labor costs is necessary to avoid potentially disincentivizing certain forms of compensation in collective bargaining. The types of costs that should be accounted for in the adjustment process include, but are not limited to, the following:

- **Salaries and Wages.** Salary and wage compensation is provided in many forms. These include, but are not limited to, across-the-board adjustments, step increases, one-time lump sum payments, and pay differentials.
- **Health Care Benefits.** Labor adjustments must fully cover the employer share of health care benefits provided to employees.
- **Retirement Benefits.** OHCA should be clear that labor costs include employer costs for defined benefit pension plans, retiree health benefits, and defined contribution plans.
- **Other Compensation.** OHCA should be clear that other forms of compensation should also be eligible for adjustment. Examples include paid holidays, paid vacation and sick leave, premium-pay holidays, and family medical leave.
- **Insurance Costs.** OHCA should also be clear that labor-related insurance costs, including workers’ compensation premiums, should be accounted for in the adjustment process.

In addition to the need to take an expansive view of “labor costs,” we want to highlight one final issue that is important for OHCA to acknowledge. The Legislature was clear in statute that cost targets be adjusted for non-supervisory organized labor costs in all years in which a health care entity is subject to the target. OHCA’s initial plan appears to begin this process for the 2028 target year due to constraints around when the Board must act in order to establish the cost target for an upcoming year. OHCA should explain how labor costs for

³ Health and Safety Code 127502(d)(7).

Secretary Johnson

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years prior to 2028 will be accounted for in the enforcement process, in line with the statute and clear legislative intent.

Thank you for the opportunity to provide input as OHCA develops its organized labor cost adjustment process. As this letter illustrates, it is crucial that OHCA take the time to get this process right. Given the complexities of collective bargaining and employee compensation, please do not hesitate to contact UC Health if we can provide useful technical assistance as you develop this process.

Sincerely,



Tam M. Ma
Associate Vice President
Health Policy and Regulatory Affairs

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
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April 16, 2026

Kim Johnson, Chair
Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director
Office of Health Care Affordability
2020 West El Camino Ave.
Sacramento, CA 95833

Sent via email:
ohca@hcai.ca.gov

Re: OHCA Considerations Regarding Financial Reporting, Data Transparency, and Enforcement Frameworks

Dear Chair Johnson, Director Landsberg, Deputy Director Pegany, and OHCA Board Members:

On behalf of the California Association of Health Plans (CAHP), we appreciate the opportunity to engage with OHCA as you continue your important work to improve health care affordability in California. We recognize the complexity of your mission and value the ongoing dialogue between our organizations.

As OHCA’s work increasingly moves from development to implementation, we must ensure the Board and the public are armed with sound analyses that describe the Office’s data sources, methods and limitations, and public health and economic factors that are key to shaping the public’s understanding of OHCA’s policies and maintaining confidence in the validity of its work. Our comments below are intended to support clarity, transparency, and effective execution as the Board considers how data, financial metrics, and enforcement tools are presented and applied to payer data in particular.

Interpretation and Presentation of Plan Financial Data

We share OHCA’s interest in using financial data to inform affordability policy; however, we are very concerned with how plan financial data—particularly information related to administrative costs and profits—is being interpreted and presented in recent Board materials and public discussions. Certain figures have been highlighted without sufficient context or methodological explanation, increasing the risk of misunderstanding and misapplication. In releasing findings, whether in a formal spending report or an interim two-slide analysis, OHCA should ensure that findings are reported with integrity and with sufficient detail on data sources, definitions, methods, rationale, and limitations.

For example, recent Board materials emphasizing a substantial increase in plan “profit” have understandably drawn attention. OHCA Advisory Committee members also raised questions around the profit figure, noting that such an increase is a “major swing” and “almost too much to believe” without further clarification about how this number was calculated. Available information suggests that the reported figure may be influenced by the inclusion of certain categories of dollars that, for actuarial and financial reporting purposes, warrant careful consideration—such as investment income, asset-related transactions, or other items—rather than reflecting a sustained change in underlying plan operating margins.. When viewed in

context (with appropriate exclusions and methodological clarity), profit levels appear far more modest and consistent with historical experience. Absent that context, highly aggregated figures may inadvertently paint a misleading picture of plan financial performance.

More generally, the presentation of administrative cost and profit trends would benefit from greater methodological clarity. As a reminder, Medical Loss Ratio methodologies are established by federal requirements and are designed to evaluate administrative costs and profits as a percentage of premium revenue. When overall health care costs rise and premiums increase accordingly, the dollar value of administrative costs and profits may increase even when the underlying percentage remains stable. OHCA's use of total health care expenditures as the denominator can materially magnify year-over-year percentage changes when compared to measures expressed as a share of premium revenue, which are not just more familiar to policymakers and the public, but are used by regulators in reviewing Medical Loss Ratio filings and by the health plan industry in developing retrospective spending and pricing trends. While both approaches may be analytically valid, absent clear explanation, these methodological differences may obscure the fact that administrative costs and profits are already subject to review by multiple oversight entities as part of existing rate review and negotiation processes. For these reasons, CAHP encourages OHCA to clearly articulate how and why its methodological choices differ from those used by other regulatory bodies, including MLR-based review, and to consider whether greater alignment would improve interpretability for policymakers and the public.

We would also like to point out the specific need to disclose OHCA's methods for calculating administrative costs and profits. The two slides presented do not detail or link to a resources that outlines the step-by-step process and rationale for reaching these findings. The Board, the public, and payers themselves would all greatly benefit from transparency of this kind in any analyses that OHCA performs.

Plans are also concerned that OHCA's current presentations lump together fundamentally different markets and products. As one Advisory Committee member noted during a recent discussion, the aggregation of markets has also led to confusion regarding product categorization, including uncertainty around the inclusion of Covered California products within the broader commercial market. Fully insured and self-insured products also operate under distinct regulatory and financial frameworks, and administrative cost components—such as taxes, assessments, and commissions—vary significantly across market segments. Aggregating these products without explanation may also inadvertently create confusion regarding OHCA's jurisdiction, which is limited to state-regulated health care entities. For example, in the March Board materials, OHCA did not provide further data detail or explanation by lines of business. This type of context is critical to highlight for the public the difference in how certain products are sold and the costs health plans must incur to remain competitive in a given line of business within a market segment. Presenting these figures in the aggregate, without explanation, limits their usefulness for policy deliberation.

CAHP respectfully encourages OHCA to accompany financial metrics with clear narrative explanation, including disclosure of data sources, key assumptions, and known limitations. Providing this context, particularly when presenting information related to profits and administrative costs, would support informed board deliberation, improve public understanding, and strengthen the credibility of OHCA's affordability analyses.

Data Submission Process: Timing, Stability, and Transparency

Over the past several months, CAHP member plans have identified ongoing challenges with OHCA’s health care data submission process. While we recognize the complexity of building a data submission infrastructure and process, plans continue to experience significant operational strain due to the pace, timing, and frequency of changes to submission requirements.

Each year, material updates to file specifications, validation expectations, and data definitions are introduced with relatively short lead times—often during the summer months—while submissions remain due by early September. This compressed timeline limits plans’ ability to make necessary system configuration changes, conduct internal quality assurance, and ensure accurate and complete submissions. These challenges are further compounded when validation expectations, such as cross-file checks, are not communicated clearly or documented in advance, leaving plans uncertain as to how submissions will ultimately be evaluated.

As OHCA continues to refine its data strategy, we respectfully encourage greater stability in requirements year over year, earlier communication of changes, and more transparent documentation of validation standards. These steps would significantly improve data quality while reducing avoidable compliance risk. We thank OHCA staff for acknowledging these challenges in its responses to public comments and look forward to further collaboration in this space.

Data Submission Enforcement and Penalty Framework

Concerns regarding the data submission process are heightened by the proposed enforcement and penalty framework currently under consideration. While CAHP understands the importance of accountability mechanisms, plans are concerned that enforcement is advancing more rapidly than the data submission process itself has matured.

To date, health plans have demonstrated strong compliance with OHCA’s data reporting requirements, even in the absence of financial penalties. Against this backdrop, the proposed escalation of penalties—combined with earlier enforcement timelines—raises questions about proportionality, process fairness, and readiness. Plans remain concerned that penalties could be imposed for issues stemming from evolving guidance, late-breaking clarifications, or requirements that were not fully defined at the time of submission.

We respectfully urge OHCA to prioritize technical assistance and corrective action pathways before imposing significant monetary penalties, particularly where submission challenges are driven by process changes or unclear expectations. Clear definitions of what constitutes a “complete” and “timely” submission, along with sufficient time for remediation, will be critical to ensuring that enforcement supports compliance rather than undermines it.

Spending Target Enforcement and Reasonableness Considerations

CAHP remains concerned about the developing framework for spending target enforcement, particularly following OHCA’s recent decision not to pursue a formal waiver of enforcement process at this time. While we understand OHCA’s interest in streamlining enforcement considerations, the removal of a waiver pathway raises important questions about how mitigating factors will be evaluated and applied in practice.

As currently described, the enforcement framework lacks sufficient transparency regarding how reasonableness factors will be weighed, how the statutory burden of proof will be established, and how OHCA will ensure consistent application across entities with vastly different populations, benefit designs, and cost structures. Many significant drivers of cost growth—such as the introduction of new high-cost therapies, changes in state or federal law, organized labor cost adjustments, or other systemic factors outside an entity’s control—may not be fully or consistently captured under the current approach.

CAHP is also concerned by stakeholder interpretations of the statutory spending target framework suggesting that exceeding a target would require freezing or capping a health plan’s administrative costs or profits at prior-year levels. In our view, such interpretations extend beyond both the text and intent of the statute. Spending targets are designed as growth benchmarks, expressed as percentages, to inform evaluation of cost trends over time—not as mechanisms to impose absolute caps or retroactive constraints on plan operations. Reading the statute otherwise risks transforming the spending target framework into de facto rate setting, which is not within OHCA’s authority.

Equally important, applying backward-looking constraints based on retrospective data (often lagged by multiple years) creates significant practical and policy challenges. Health plans must make prospective decisions based on current mandates, market conditions, and regulatory requirements that evolve well after the data used to evaluate spending targets is finalized. CAHP respectfully urges the Board to ensure that spending target enforcement remains forward-looking, consistent with statutory authority, and grounded in operational reality.

Without clearer standards and upfront guidance, entities may be required to respond within a limited timeframe without meaningful insight into how their information will be assessed or what evidence is necessary to satisfy OHCA’s expectations. We respectfully request greater clarity regarding the enforcement decision-making process, including how reasonableness factors will be applied and how similarly situated entities will be treated equitably.

Technical Assistance, Public Testimony, and Process Clarity

Relatedly, additional clarity is needed regarding the role of technical assistance and public testimony within the enforcement framework. While CAHP appreciates OHCA’s efforts to distinguish technical assistance from performance improvement plans and to comply with statutory requirements for public testimony, stakeholders remain unclear about how these tools will function in practice.

In particular, questions remain regarding the purpose of public testimony, the extent to which confidential information will be protected, and how stakeholder input will be used in enforcement decisions. Clearer definitions and procedural guardrails would help ensure that these mechanisms serve their intended purpose without creating unnecessary risk or uncertainty for participating entities.

Importance of Transparency and Predictability as Programs Mature

Finally, as OHCA’s programs continue to evolve, CAHP emphasizes the importance of transparency, predictability, and shared understanding. Board-level discussions, public commentary, and external analyses—especially those related to insurer financial performance and medical loss ratio concepts—

underscore the need for policy development to be grounded in clear data, accurate context, and operational realities.

CAHP respectfully encourages OHCA to provide greater transparency regarding the data sources, calculations, and assumptions underlying Board materials and public reports. In several instances, stakeholders have sought clarification after information was presented publicly in order to understand how figures were derived, which markets or products were included, or how trends were calculated. Providing this information upfront would reduce confusion, improve consistency, and strengthen confidence in OHCA's analyses.

In particular, clearer explanations of how administrative cost components are defined, how markets and products are aggregated or separated, and how year-over-year changes are measured would materially improve the usefulness of these materials for policy deliberation. Where figures may otherwise be interpreted as reflecting current conditions or ongoing trends, transparent discussion of data limitations, sensitivities, and lags is especially important. As OHCA continues to develop interim reports and Board presentations, pairing quantitative findings with clear narrative explanations—including market context and methodological description—would support informed decision-making and help ensure that data is interpreted as intended.

In this regard, CAHP notes that other states engaged in similar affordability efforts, such as Massachusetts, have paired quantitative analyses with clear narrative explanations describing market conditions, methodology, and known limitations, which has helped ensure complex data are interpreted as intended. As OHCA develops forthcoming interim reports and Board materials, we respectfully encourage the Office to consider a similar approach and, where feasible, provide stakeholders an opportunity to review draft content prior to public release to support clarity, accuracy, and shared understanding.

CAHP remains committed to working collaboratively with OHCA staff to provide technical expertise, operational insight, and educational resources as needed. Continued engagement will be critical to avoiding unintended consequences and ensuring that OHCA's enforcement frameworks are both effective and sustainable.

Cost and Market Impact Reviews

Lastly, we wish to bring to the Board's attention OHCA's waiver of a formal Cost and Market Impact Review (CMIR) for the Palomar Health-University of California Board of Regents transaction that will establish a Joint Powers Authority to oversee the operations of Palomar Health and hold its pharmacy and hospital licenses. As we have previously noted to OHCA staff, this transaction and its potential to impact increases in health care spending raises concerns for payers. OHCA, Palomar Health, and UC have released scant public details on the nature of how this unique Joint Powers Authority will operate and the impact this will have on payer contract negotiations. We would like to reiterate for the Board that we believe OHCA missed a critical opportunity to review a major health system transaction in the state that may very likely increase costs. We are particularly concerned with and curious to understand how the three entities, Palomar Health, UC, and the Joint Powers Authority, intend to collaborate on contract negotiations and share rate information among each other in compliance with antitrust law.

Conclusion

Taken together, these issues highlight the need for a more deliberate and transparent approach as OHCA advances its data submission, analysis, and enforcement initiatives. We respectfully encourage OHCA to provide clear guidance, longer implementation runways, and enforcement mechanisms that align with the complexity of health care data and cost drivers. CAHP and its member plans stand ready to continue partnering with OHCA to refine these processes in a way that supports accountability, equity, and long-term sustainability.

We appreciate OHCA's commitment to stakeholder engagement and respectfully request consideration of these recommendations.

Sincerely,

A handwritten signature in cursive script, appearing to read "Anete Millers".

Anete Millers
Vice President of Legal and Regulatory Affairs
California Association of Health Plans