HCAi Department of Health Care Access and Information
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Health Care Affordability Board
November 19, 2025
Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox.

Date	Name	Written Comment
11/20/2025	Robert F. Kennedy Farmworkers Medical Plan	On behalf of the Robert F. Kennedy Farmworkers Medical Plan I wanted to express my appreciation to the entire staff and the partners who performed a very thorough analysis of the hospitals in Monterey County and the reasons the prices charged in that region are so high relative to most other parts of California and the nation. I have previously testified to the Board on this subject. The analysis confirmed what we have seen and experienced for many years in that region. We still hear the same arguments from hospital representatives in that region and the report rebuts virtually all of them. I will add one often overlooked issue when analyzing prices relative to what Medicare pays for the same services at the same facility. Medicare pays based on the prevailing price for services in various regions to reflect that there is a difference in the overall costs in different regions. Monterey County and nearby counties are considered to be relatively high cost and Medicare places the region at 1.2 times the base Medicare level - essentially paying for the same services there at a higher level than a lower cost region. So when a Monterey County hospital charges five times Medicare it will yield a significantly higher amount than what a hospital in a lower cost region would be paid so that hospital billing at five times Medicare will have a lower price than a Monterey County hospital even though both use the same multiplier. The reason I raise this issue is to rebut the argument we hear from Monterey County hospital representatives that they are in a high cost area. If we pay them using a multiplier of Medicare - say

Date	Name	Written Comment
		250% of Medicare - the price at that level implicitly accounts for the fact that Monterey County is in a higher cost region. We appreciate the production of this report and hope that the issue I note here is included in any discussion about using Medicare as a baseline for assessing relative pricing. Patrick Pine
11/25/2025	Bleeding Disorders Council of California/ California Rare Disease Access Coalition	See Attachment #1
12/10/2025	California Hospital Association	See Attachment #2
12/11/2025	Health Access California	See Attachment #3

Attachment #1

November 25, 2025

Director Elizabeth Landsberg
Department of Healthcare Access and Innovation
Office of Health Care Affordability

Submitted electronically

Re: Health Equity Considerations- High-Cost Drugs, Treatments, and Services for High-Cost Patient Populations

Dear Director,

On behalf of the Bleeding Disorders Council of California (BDCC) and the California Rare Disease Access Coalition (RDAC), I write to urge the Office of Health Care Affordability (OHCA) to consider health equity factors when assessing hospital cost targets. The BDCC's mission is to promote access to care and advance the quality of life for people living with bleeding disorders through advocacy, education, and outreach. The RDAC is a coalition of rare disease stakeholders, led by patients and focused on ensuring access to diagnosis and care for the rare disease population in California. Both BDCC and CRDAC advocate to ensure people living with rare diseases can access genetic and other testing, medical treatments, drug therapies, medical devices, and supportive services to help people with rare diseases live healthier lives.

As you are aware, the Health Care Affordability Board has set a statewide target and a lower target for hospitals identified as having disproportionately high prices, which requires hospitals to manage growth in prices or volume or both. In addition, the Board is currently considering setting annual revenue targets per hospital. This approach is similar to spending targets but done in a prospective manner as opposed to a retroactive manner.[1] In addition, the Board is also considering limiting commercial reimbursement to a set percentage of Medicare rates (e.g., 250%).[2]

We are deeply concerned that a focus on "disproportionately high prices" and hospital spending targets, or revenue caps, could be damaging to health equity for rare disease patients. Rare disease patients often require health care services that are complex and multidisciplinary and rely on treatments, therapies, and devices that are more expensive than the general population. Thus, statewide spending targets and revenue caps, such

[1] See November 19th Health Care Affordability Board Meeting presentation
[2] Id.

as Medicare rate caps, could impact access to care for rare disease populations. Medicare, for example, is not always representative of costs to provide care to the rare disease population. Likewise, we are concerned that hospital spending targets could result in hospitals refusing to treat rare disease patients, who are more expensive to treat than the general population.

As a result, we urge the OHCA to consider certain equitable factors when assessing spending targets and revenue caps for hospitals. Specifically, we urge OHCA to:

Exempt high cost or new pharmaceuticals, and new uses of existing pharmaceuticals, or new medical treatments entering the market, including new medical procedures and devices.

We are concerned that hospital spending and revenue caps could create a barrier to equitable access for marginalized patient populations by creating disincentives for hospitals to administer new, costly treatments in the inpatient setting. For example, new gene therapies to treat sickle cell disease that are administered in the inpatient setting have given hope to patients who suffer from the debilitating disease, which overwhelmingly affects Black people and people of color. Many who suffer from the disease require multiple hospitalizations and blood transfusions, which can leave them unable to work. An analysis by the University of Washington found that even at a price of $2 million or less, the one-time gene therapy treatments would provide an acceptable value, offsetting the lifetime medical and quality-of-life costs for acute sickle cell patients.[3] We, therefore, urge OHCA to exempt high cost pharmaceuticals, new uses of existing pharmaceuticals, or new medical treatments entering the market, including new medical procedures and devices, from its calculations when determining whether a hospital has exceeded a spending or revenue cap.

Exempt high-cost patient populations, especially services for those populations connected to a center of excellence.

Rare diseases are significantly more expensive to treat than common diseases per person per year. One study found that the overall economic burden of rare disease is approximately 10 times the cost associated with mass market diseases. [4] For example, hemophilia is a rare, inherited, chronic genetic disease that require lifelong treatment, resulting in high financial costs for individuals, their families, as well as health care systems. One study found that the total annual health care costs per hemophilia patient

[3] Gene therapy for sickle cell disease could substantially increase life expectancy, but its cost-effectiveness compared to conventional treatment will depend on price - School of Pharmacy
[4] Report: Economic Burden of Rare Diseases Is 10 Times Higher Than Mass Market Diseases | AJMC

ranged from $213,874 to $869,940.[5] Optimal care of patients with hemophilia requires a comprehensive approach that is coordinated by a multidisciplinary team of specialists and is provided at a dedicated hemophilia treatment center (HTC.). A 2000 study showed that those who used an HTC were 40% less likely to die of a hemophilia-related complication compared with those who did not receive care at an HTC.[6] Similarly, a separate study by CDC researchers revealed that people who used an HTC were 40% less likely to be hospitalized for bleeding complications.[7] Centers of excellence like HTCs can lower overall health care costs for rare disease patient populations by providing comprehensive care. We, therefore, urge OHCA to exempt high-cost populations, like hemophilia, and centers of excellence, like HTCs, from its calculations of whether a hospital has exceeded a spending or revenue cap.

While we applaud OHCA for focusing on making health care more affordable, we are concerned that cost and revenue caps on hospitals could impact equitable access to care for people living with rare, complex, and costly diseases. As a result, we urge OHCA to exempt high-cost drugs and treatments, and high-cost patients and their services from its calculations. By doing so, OHCA can ensure that California's healthcare system remains accessible, high-quality, and equitable for all Californians.

Sincerely,

Lynne Kinst
Executive Director
Bleeding Disorders Council of California

CC: Vishaal Pegany, Deputy Director

[5] Health care costs and resource use of managing hemophilia A: A targeted literature review - PMC
[6] Mortality among males with hemophilia: relations with source of medical care. The Hemophilia Surveillance System Project Investigators - PubMed
[7] Home-based factor infusion therapy and hospitalization for bleeding complications among males with haemophilia - PubMed

California Hospital Association

December 10, 2025

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

Subject: **Comments for the December 2025 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

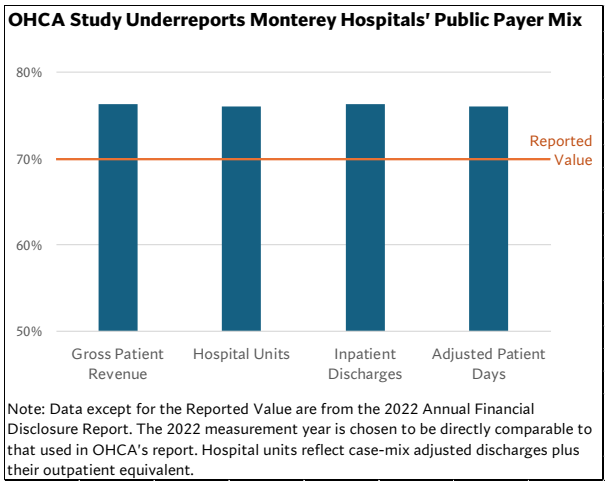
California's hospitals share the Office of Health Care Affordability's (OHCA's) goal to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of nearly 400 hospital members, the California Hospital Association (CHA) appreciates the opportunity to provide feedback on the most recent board meeting, which raised significant concerns with both the enforcement process and the data OHCA are relying on to support and inform affordability discussions.

Deeply Flawed Study on the Monterey Region Misses the Mark on Hospital Competition and Finance

OHCA was created to be a forum for focused, data-driven, and honest conversations about why health care is unaffordable for too many Californians, as well as collaboration on scalable solutions. OHCA has not fulfilled this promise. Too often, the office has reflexively emphasized a single factor (high prices), ostensibly brought about by a single cause (lack of competition), and blamed a single set of providers (hospitals). OHCA's recent report, *An Investigative Study of Hospital Market Competition in Monterey County*, is the latest example of this slanted approach. The study presents a carefully curated set of analyses that paint Monterey's hospitals as charging high commercial prices simply because they can, dismissing underlying factors driving these hospitals' prices higher than elsewhere in the state, including the Bay Area. As this analysis makes clear, Monterey County's hospital landscape is unique. This uniqueness, however, is not due to a lack of competition — in fact, the county is home to robust competition, especially given its size. Rather, Monterey's high commercial prices are explained by three factors: reimbursement shortfalls, payer mix, and the area's high cost of doing business.

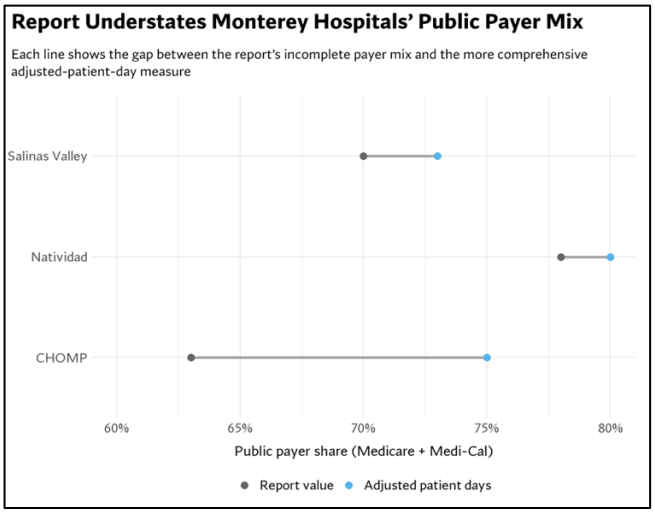
The Cost Shift Largely Explains High Commercial Hospital Prices in Monterey

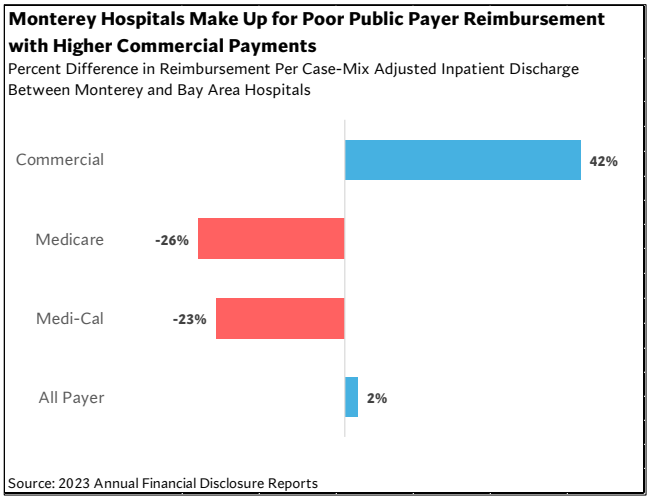
Payer mix and shortfalls in reimbursement from public payers are fundamental drivers of hospitals' financial performance. And yet, OHCA's study dismisses these issues on merely theoretical grounds and by analyzing a narrow slice of non-representative data. First, the study states that economists do not believe cost shifting exists because hospitals, in theory, are already always getting the best rates possible. In reality, hospital rate negotiations are contingent on various factors — including payments from other payers. OHCA board member Elizabeth Mitchell understands this all too well, having recently shared the following concerns with *Politico* while discussing looming federal health care cuts: "We all use the same delivery system, and if a hospital loses Medicaid coverage or other public coverage, they always seek to recoup those costs by passing them on to private coverage." Ultimately, this quote underscores hospitals' basic dilemma: make up for public payment shortfalls with higher commercial payments, or cut back on the services they provide. Monterey's hospitals are no exception.



In evaluating whether payer mix (a concept closely related to the cost shift) explains high Monterey prices, it appears the study's authors used hospital inpatient and emergency department utilization data from OHCA's parent department to show that the Monterey hospitals do not have an unfavorable payer mix. Missing from these data, however, were all non-emergency room outpatient utilization data — an omission that skews the data and renders the conclusion unreliable. The data in the study peg Monterey hospitals' average public payer mix (i.e., Medi-Cal and Medicare) at 70%. However, as the figure on the left shows, four standard measures of payer mix (all of which include all outpatient services) converge on a different, significantly higher number. The figure below shows OHCA's data was especially skewed for the Community Hospital of the Monterey Peninsula (CHOMP).

However, payer mix, as judged by patient volumes, tells only a small part of the story. The need for higher commercial payments to offset losses from public payers is not driven solely by which patients come through a hospital's doors, but also by the level of reimbursement the hospital receives from those public payers. Here, Monterey hospitals stand in stark contrast to their Bay Area peers. The figure on the next page reveals that Medi-Cal and Medicare inpatient payments for Monterey hospitals are 23% and 26% lower, respectively, than for Bay Area hospitals. On net, including commercial payments, Monterey hospitals receive all-payer inpatient payments that are just 2%





higher than Bay Area hospitals. If these hospitals instead charged Bay Area *commercial* prices, their all payer-reimbursement would be 12% lower than Bay Area hospitals'. The result: the Monterey hospitals would face hundreds of millions of dollars in losses that would force tough decisions about what services they can provide.

Clearly, cost shifting — or "cross subsidization," depending on the preferred nomenclature — is a major part of this story. The failure to place Monterey hospitals' higher commercial payments within the context of these enormous public payer shortfalls — or to ask straightforward questions as to why reimbursement is so low — calls into question the depth and balance of OHCA's analysis.

OHCA's report, and the board discussion that followed in November, did acknowledge an additional form of cross-subsidization present in Monterey County — that the hospitals' operating surpluses support local physician and outpatient practices that cannot survive independently. OHCA's report, which contains data showing that professional (e.g., physician) reimbursement is around 20% to 40% lower in Monterey compared to the Bay Area, corroborates the need for this subsidization. Without hospitals' support, attracting physicians and other health professionals to Monterey would be impossible. Ultimately, while the hospitals on their own look profitable, the health systems they sit within earn only the small margins necessary to remain financially sound and able to provide future care for the community.

Monterey Hospitals' Cost of Doing Business Is High

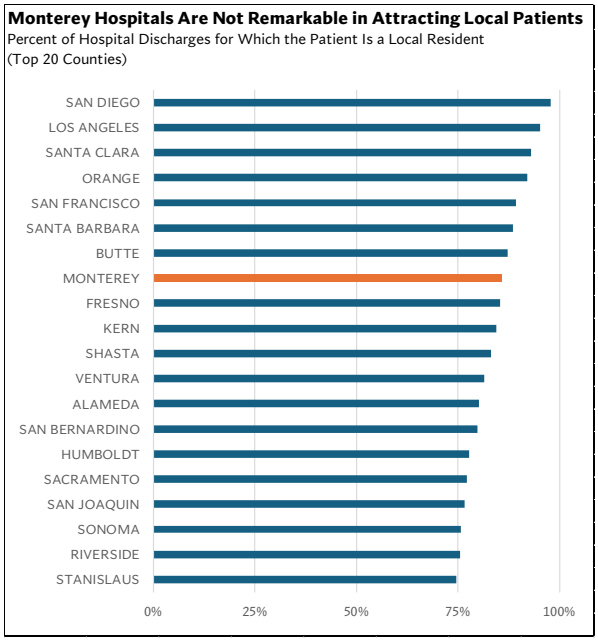
Monterey County is an expensive place to live, work, and operate a business. Coastal Monterey has some of the most expensive real estate in the entire country. Attracting workers means paying living wages — wages that are among the highest in the state. Moreover, Monterey hospitals compete with their neighbors to the north to recruit and retain physicians, nurses, and other essential staff, subjecting them to the economic forces present in **the** most expensive region in all of California (the greater Bay Area).

OHCA's study obscured these facts by selectively reporting different views of hospitals' labor costs. For example, OHCA ignored the standard assessment (hospitals' total salary and benefits costs per full-time-equivalent worker), which would have shown that the three Monterey hospitals have 5% higher per-worker costs than the study's Bay Area comparison group. The OHCA report only included salaries, not benefits, in its assessment of labor costs, and used hospital utilization to control for hospitals' varying sizes, instead of using cost per worker. Compared to all other hospitals in the state, Monterey hospitals pay a 47% premium on salaries and benefits per worker, far higher than the 13% higher all-payer reimbursement they receive.

The Monterey Hospital Market Is Highly Competitive for a County of Its Size

OHCA's study squarely blames high commercial hospital prices in Monterey on hospital market power and insurance companies' imperative to have hospitals in their network. The analysis supporting these claims is woefully insufficient — and data left out of the report paint a very different picture.

The report finds evidence of market power because Monterey residents visit Monterey hospitals in high proportions. That local residents prefer their local hospitals is an entirely unsurprising aspect of the hospital market, or any market where a service is provided in person. Moreover, the report did not even attempt to compare whether Monterey residents disproportionately tend to visit their county's hospitals, compared to residents in other areas of the state. The figure below shows Monterey is hardly unique in terms of the proportion of patient discharges attributed to county residents — and other counties are significantly higher.



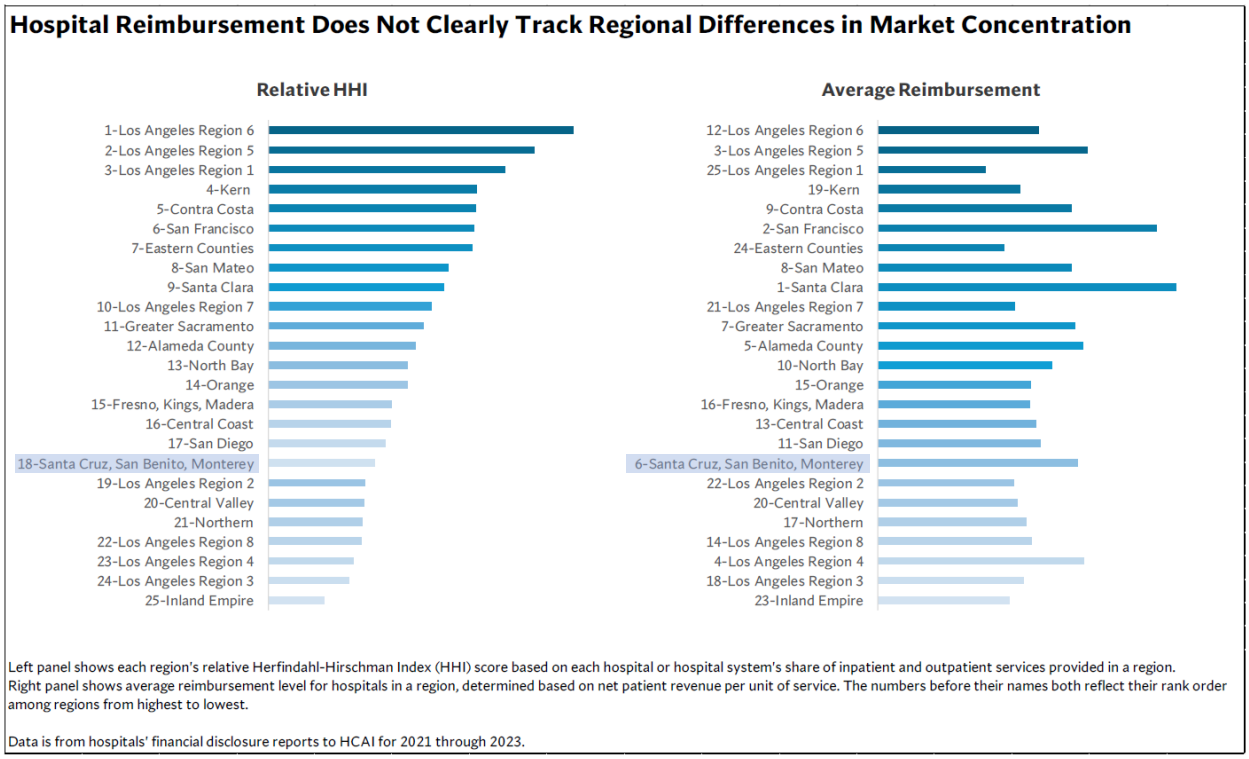
The study's second key piece of evidence is a simulated model showing that local residents have varying, and in some cases high, willingness to pay for access to the local hospitals. Simulations of human behavior must pass an extraordinarily high bar to count as evidence. Even if the model's outputs were reasonable, this constitutes zero evidence that the hospitals are in fact **exercising** their favorable market position. Ultimately, this analysis shows that local residents have reason to prefer their local hospitals, which is hardly a condition that public policy should strive to upend.

Contrary to the unsatisfying analytics used by OHCA, multiple data points show that hospital competition is relatively strong in Monterey, especially considering its size. Most simply, the county has four unaffiliated hospitals. Only two of the state's 42 counties with fewer than 500,000 residents have more than four unaffiliated hospitals. Moreover, and counter to claims by an OHCA board member at the November meeting, there is no shared hospital ownership between Montage Health and Salinas Valley Health.

Another common measure of market concentration, known as the Herfindahl-Hirschman Index (HHI), tells the same story. The graphic on the next page sorts each OHCA region (as they were originally formulated[1]) by their HHI score. Monterey, combined into a single region with Santa Cruz and San Benito, comes in just 18th among the 25 regions. As the graphic further illustrates, HHI scores for each region are not a strong predictor of average reimbursement. Even if there were a stronger connection, such a low HHI score compared to other

[1] The original OHCA geographic regions were based on Covered California regions, plus additional subdivisions for Los Angeles given its enormous size. These Los Angeles subdivisions were later removed due to administrative complexity, but their relevance to the geography of different health care markets in California remains.

regions is a clear indication that a lack of market competition is not driving higher hospital prices in the Monterey region compared to other areas of the state.



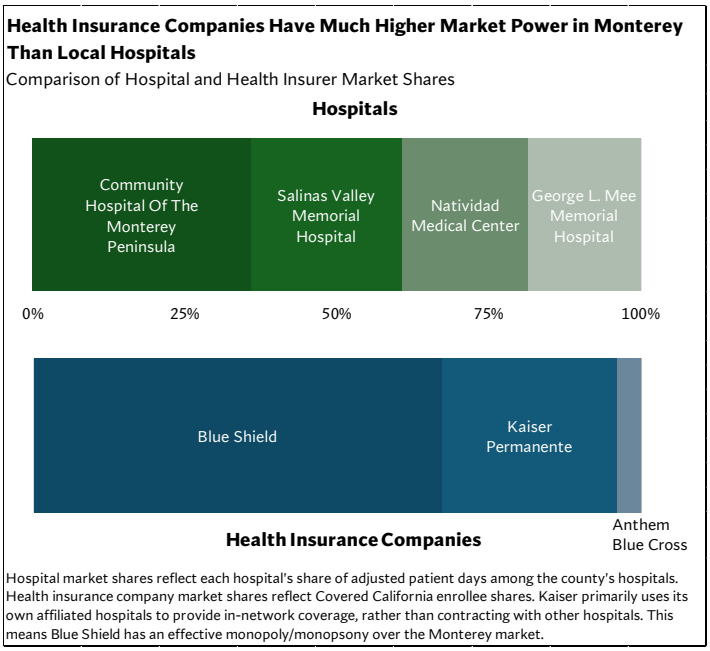
The report also echoes — without assessment or critique, which would have been appropriate —health insurance industry executives' claims that Monterey hospitals are "must haves" in their networks due to the state's network adequacy laws. OHCA provides no data to substantiate this claim, nor does it ask why the state's hospital network adequacy rules — which do not vary by county — are particularly problematic in a county with four unaffiliated and independent hospitals but not in the 33 other counties that are home to fewer hospitals.

The state's network adequacy standards are far from etched in stone, and therefore not the problem that insurance leaders allege. The state's 30-minute or 15-mile hospital travel-time standard is regularly waived for insurers that claim they cannot meet it. While data from the main regulator of commercial coverage in California, the Department of Managed Health Care, are less readily available, the state's Medi-Cal regulator publishes data on every zip code where it has waived its equivalent standard.[2] In 2024, the Medi-Cal regulator approved 647 waivers of the state's time or distance standard, meaning residents in 25% of all California zip codes have to travel farther than what is deemed safe and appropriate for in-network hospital care. In 40 zip codes, residents have to travel 75 miles or more. In one, they have to travel more than 300 miles. These data call into serious question insurance company executives' claims, but OHCA's report simply states them as fact rather than undertaking proper due diligence to confirm or debunk these claims.

[2] See the 2024 ANC Alternative Access Standards Requests report here: https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx

Ignoring Health Insurance Companies' Role in Affordability Challenges Reflects a Major Oversight

The study of competition among Monterey's hospitals and the subsequent review of the report at the November board meeting provided yet another example of how OHCA has myopically focused on one segment of the health care field and ignored other actors and drivers. At the meeting, advocates rightfully raised issue with high patient shares of cost for emergency room visits — but there was no acknowledgment that health insurance companies establish patient cost-sharing requirements, not hospitals. And while the report singles out hospital concentration as a driver of high costs — and takes the statements of other industry officials at face value — it summarily ignores and dismisses other market dynamics and the perspectives of hospital leaders themselves.



For example, while hospital market power is alleged to be the driver of high premiums in Monterey, the report does not even ask whether market power on the part of the insurance companies that set premiums is part of this problem. While comprehensive data are not readily available, those that are show that one insurer, Blue Shield, controls 67% of the Covered California market in Monterey. The next biggest insurer doesn't generally contract with unaffiliated hospitals, including those located in Monterey, meaning Blue Shield effectively has a monopoly (and monopsony) in the county. Such enormous market power on the part of a single insurer undoubtedly gives it substantial leverage in negotiations with hospitals and other providers, as well as with employers when premiums are being set. This question went unevaluated in OHCA's analysis of the Monterey market's high premiums.

Study Suffers from a Lack of Methodological Transparency and Reliability

The analysis above highlights a number of critical deficiencies, often related to what analyses were included, or excluded, from the report. In addition, in various areas, the report lacks sufficient methodological detail to allow the public to evaluate its claims. Below are several key examples:

- *Defining the Bay Area Comparison Set* – The report shows various comparisons between the Monterey hospitals and a sample of Bay Area hospitals to argue that there is no reason Monterey hospitals should be as costly as they are. However, the report provides next to no information on the inclusion or exclusion criteria that defined the Bay Area comparison set, which includes 46 out of a possible 64 general acute care hospitals. This methodological information is essential for determining whether the 46-hospital sample constitutes a reasonable comparison group.

- *Misuse of NASHP Hospital Operating Costs* – The report uses the National Academy for State Health Policy's (NASHP's) to compare cost structures between Monterey and Bay Area hospitals. However, this tool inappropriately excludes major categories of legitimate hospital expenses and therefore is unreliable.

- *Exclusion of One of Monterey's Four Hospitals from the Analysis* – The report excludes Mee Memorial Hospital from its analysis without sufficient empirical analysis to support its claim that Mee Memorial is not an integral part of the county's hospital care landscape.

- *No Modeling Details Provided for CalPERS and Covered California Analyses* – The report summarizes regression analyses performed on CalPERS and Covered California spending, but does not disclose full model specifications, analytical code, or summary statistics, making it impossible to judge the strength of the models or replicate the analysis.

- *Partial Portrayal of the Relationship between Hospital Quality and Price* – The report states "The research literature indicates little to no correlation between hospital price and quality." However, the report references a study that actually finds a significant relationship between higher prices and lower mortality under common market conditions. Other research also finds that being appropriately resourced positively affects a hospital's ability to deliver consistently high quality.[3,4]

Hospitals Urge OHCA to Acknowledge Deficient Approach and Course Correct in Future Work

OHCA's investigation of Monterey's hospital market underscored a continued lack of balance in its work, a tendency to dismiss the perspectives of entire segments of the health care field, and discomfort with acknowledging the complexity behind California's very real affordability challenges. Hospitals urge OHCA to take all necessary steps to restore faith that it is creating a fair process, with open and data-driven dialogue where all parties' voices are heard.

More Work Needed to Develop a Sound Outpatient Spending Measurement Methodology

Over the past several months, OHCA has convened a workgroup of experts to develop a methodology for measuring hospital outpatient spending. The proposed outpatient approach is conceptually similar to OHCA's planned inpatient spending approach: evaluate (outpatient) net patient revenue on a volume and resource-intensity-adjusted basis. Conceptually, the approach holds significant promise as it aims to control for growth and fluctuations in hospital service volumes, patient acuity, and service intensity. Without these controls,

[3] Beauvais, B., Richter, J. P., & Kim, F. S. (2019). Doing well by doing good: Evaluating the influence of patient safety performance on hospital financial outcomes. Health care management review, 44(1), 2–9. https://doi.org/10.1097/HMR.0000000000000163

[4] Beauvais, B., Richter, J. P., Kim, F. S., Sickels, G., Hook, T., Kiley, S., & Horal, T. (2019). Does Patient Safety Pay? Evaluating the Association Between Surgical Care Improvement Project Performance and Hospital Profitability. Journal of healthcare management / American College of Healthcare Executives, 64(3), 142–154. https://doi.org/10.1097/JHM-D-17-00208

hospitals would be at risk of being penalized for factors beyond their control, for offering costly but clinically effective services, for successfully attracting more patients, and for serving patients with higher needs.

However, major data limitations and OHCA's untested approach for intensity adjustment raise serious questions about whether the proposed outpatient model is adequate to the critical task of determining hospitals' compliance against the spending target and, ultimately, identifying which hospitals should be subject to penalties. There are two fundamental issues. First, hospitals do not report outpatient utilization data in sufficient detail to allow for the intensity of a given visit to be estimated. That's why OHCA turned to an emerging dataset, the Healthcare Payments Database (HPD), to measure hospitals' average outpatient intensity scores. The HPD, however, unlike hospitals' financial reports, is not comprehensive. Disappointingly, the HPD only included 19% of all hospital outpatient visits for commercially insured patients in 2022, and only 11% of these visits can be used to create a hospital's average outpatient intensity score. That such a limited dataset could ultimately prove representative of hospitals' outpatient experience is highly suspect, and as of today, is entirely unfounded. For this reason, OHCA's workgroup members broadly declared their discomfort with moving forward with OHCA's approach.

Second, OHCA proposes to calculate hospitals' intensity scores using weights provided by Medicare's ambulatory payment classification (APC) system. This approach has merit, particularly for common services. However, the approach breaks down for certain extremely high-cost outpatient services, such as high-cost drugs for which there is no APC weight. To prevent hospitals from being penalized for offering innovative and often curative pharmaceutical treatments and other services, OHCA must develop ancillary methodologies to exclude or otherwise control for these high-cost treatments.

Oregon's Higher Cost Growth Target Highlights Need for Review of California Spending Target

Oregon operates a spending target program, on which OHCA is closely modeled. In late 2025, Oregon's implementing agency, the Oregon Health Authority (OHA), convened a specialized workgroup composed of representatives of labor, payers and providers, academics, and consumer advocates to reassess its statewide health care spending growth target for the 2026-2030 period. The workgroup met five times and reviewed updated data on economic and health care spending trends, including per-capita health care expenditure growth and Oregon median wage growth. At the conclusion of these focused discussions, the workgroup voted 20-4 to recommend increasing Oregon's growth target from a planned value of 3% to a static 5.5% for 2026-2030. The recommended target is based on a 50/50 blend of two components 1) a five-year lookback (2020-2024) of National Health Care Expenditures per capita growth and 2) the same five-year lookback of Oregon median wage growth, grounding the target in both the reality of growth in health care costs and the aspiration to reduce health care spending growth to what people are experiencing in terms of their paychecks.

OHCA should seriously consider a similar, focused process for evaluating California's spending targets. Adopting the same recommended approach as Oregon's workgroup would result in a California statewide cost growth of 5.52%, substantially higher than currently value starting at 3.5% set by OHCA for 2026.

Following Oregon's Recommended Approach for Updating Its Spending Target Would Make OHCA's Target More Reasonable and Attainable

	U.S. NHCE	California Median Wages	Target
5-Year Average Annual Growth	5.80%	5.24%	5.52%

NHCE: National Health Care Expenditures as measured by the Centers for Medicare and Medicaid Services
California median wages are from the U.S. Bureau of Labor Statistics

Given the alignment between recent wage growth and broader health care cost pressures, Oregon's process offers a data-driven model for recalibrating spending growth targets to make them achievable and reflective of current economic forces. Hospitals urge OHCA to undertake a similar review grounded in updated wage growth, inflation, and national health care expenditure trends and update the state's targets accordingly in 2027.

Conclusion

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

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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

HEALTH ACCESS CALIFORNIA

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California Black Women's Health Project

Amanda McAllister-Wallner
Interim Executive Director

Organizations listed for identification purposes

December 11, 2025

The Honorable Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability
Health Care Access and Information Department

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

Re: December 2025 Health Care Affordability Board Meeting

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

Health Access, the statewide health care consumer advocacy coalition committed to quality, affordable care for all Californians, offers comments on the basis for the growth targets, very high-cost hospitals, the impact of H.R. 1 on consumers, hospital spending measurement and enforcement considerations.

Health Access commends the OHCA Board and staff for taking early action to set both the statewide growth targets for health plans, insurers, hospitals, and large physician organizations as well as growth targets for very high-cost hospitals, hospitals that cost twice as much as other California hospitals. Early action is to be commended, not condemned. Health Access also commends the OHCA Board and staff for basing the growth targets on consumer affordability, consistent with its statutory authority, and not the cost of care, contrary to the statute.

Executive Summary

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- Health Access commends the Board and staff for adopting statewide growth targets for health plans and insurers as well as hospitals and large physician organizations and targets for the very high-cost hospitals that are based on consumer affordability, consistent with the enabling law.
- On very high-cost hospitals, Health Access notes that not only the Monterey hospitals but other very high-cost hospitals fall in the "must-have" category, allowing them to use their market power to obtain high prices.
- Health Access recommends consideration of whether an entity is a "have" or "have-not" entity by looking at measures of financial capacity such as reserves, investments and cash on hand as well as bond ratings and system capacity. This will allow the Board and staff to distinguish entities that are financially distressed from those that have ample resources.
- On the impact of H.R.1, because the uninsured live sicker, die younger and are one emergency away from bankruptcy because they receive the bare minimum of emergency care, Health Access recommends an adjustment for charity care only if spending on charity care increases and if that charity care is not paid for by the patient or other funding sources with the cost of that care based on what Medicare or Medi-Cal pay for the same care. This is consistent with California's hospital fair billing law.
- On enforcement process, Health Access recommends transparency and public accountability throughout the process, from the initial identification of an entity that has exceeded the target through each of the enforcement steps, including "enforcement considerations" that may excuse an entity from compliance.
- Health Access begins a discussion of the "scope and range" of penalties, including offering estimates of the penalty for exceeding the target for the five largest health plans.

Growth Targets Consistent with Statutory Authority, Not Contrary to It

Health Access commends the OHCA Board and staff for setting the statewide growth target based on a measure of consumer affordability, relying on median household income over the last twenty years, and adjusting targets for population measures of aging and gender, and not the cost of care. Basing growth targets on the cost of care as defined by a health care entity subject to the target lacks statutory authority under the enabling statute.

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Basing the growth target on consumer affordability is essential given the data presented at the November 2025 Board meeting that premiums nationally are five times as high today as they were in 1999. California housing prices, which no one considers affordable, are roughly three times as high today as in 1999. Research on health insurance indicates the lack of affordability of health insurance is even worse in California:

- Deductibles are prevalent: In 2003, only three in ten California workers with job-based coverage had a deductible: in 2023, it was eight in ten.
- In 2003, most deductibles in California were $0 (zero). Deductibles for family coverage grew to $3,659 in 2022.[1]
- Premiums for family coverage in California in 2025 now average $28,395, more than $1,000 *higher* than the national average[2]. Overall, one in ten California workers have family deductibles over $7,000 while another six in ten had deductibles of $2,000-$3,000[3].
- As a recent headline says: "Americans are buckling under medical bills. It could get worse."[4]

And we are not getting more for our money: outcomes are not better, equity is not improved, half or more of Californians lack access to care today because of costs. A recent national poll found similar results to what California polling has found: about one quarter of those polled skipped doctor visits and one quarter did not fill prescriptions because of costs—and nearly half of all adults find it difficult to afford health care[5].

Where is the money going? Not to improve outcomes and equity. The current routine public reporting on hospitals, health systems, and large physician organizations does not permit the same level of scrutiny in terms of reserves, investments, or rates paid as the routine public reporting on health plans and insurers. We know, quarterly, how much health plans have in terms of reserves, measured as tangible net equity, but what reserves are the high-cost hospitals holding? How much investment income does each of them have?

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[1] https://laborcenter.berkeley.edu/wp-content/uploads/2024/02/Measuring-Consumer-Affordability_revisedFeb82024.pdf
[2] https://www.chcf.org/wp-content/uploads/2025/11/CaliforniaHealthBenefitSurvey2025.pdf
[3] https://www.chcf.org/wp-content/uploads/2025/11/CaliforniaHealthBenefitSurvey2025.pdf
[4] Americans are buckling under medical bills. It could get worse. - POLITICO
[5] New poll paints a grim picture of a nation under financial strain - POLITICO

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Bending the growth curve will take time but the work that OHCA is doing to move toward a slower rate of growth is essential. The larger mission of OHCA is transformational, moving the health system toward prevention and primacy care, with improved access to behavioral health and slower cost growth.

Very High-Cost Hospitals: Monterey Report and "Must-Have" Hospitals

Health Access appreciates the Monterey market impact analysis presented at the November 2025 Board meeting and the Board discussion of that analysis. We appreciate the effort to analyze the prices of those hospitals in several different ways, each of which reached the same conclusion as earlier work: these are among the most expensive hospitals not just in California but in the entire United States. The higher costs for these hospitals are not justified by higher quality, higher labor costs (except for administrators), higher operating costs, or higher physician compensation.

Why are costs higher at these Monterey hospitals? California's consumer protection requiring health plans to have a hospital within 15 miles or 30 minutes has the effect of making these "must-have" hospitals. Health Access looked at the other very high-cost hospitals and found that most of these are similarly situated in terms of the time/distance network adequacy standard. How do we address these natural monopolies? The answer is not to weaken important consumer protections that provide timely care but rather to use the tools OHCA provides to set lower cost growth targets for these very high-cost hospitals.

Very High-Cost Hospitals: Where the Money Is? Haves and Have-Nots

At the November 2025 Board meeting presentation on the Monterey market study, Board Member Sandra Hernandez asked an important question about the Monterey hospitals: if the money is not being spent on operating costs or labor costs or quality, where is the money going?

Health Access believes analysis of hospital costs would be strengthened by looking at whether these hospitals are "haves" or "have-nots". The consultant provided a partial answer verbally: the three Monterey hospitals have 400 to 500 days of cash

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on hand in contrast to the average hospital which operates with 200 days of cash on hand and in very sharp contrast to those financially distressed hospitals that received state loans in a prior year, most of which had less than 14 days cash on hand, literally not enough to make payroll. Having 400 to 500 days of cash on hand means each of these hospitals could operate for 12 to 18 months with literally no revenue coming in. Few financial managers or chief financial officers (CFOs) would recommend having this much cash on hand unless there were also substantial investments and other reserves.

Health Access recommends that OHCA staff incorporate standard financial measures into its analysis of specific entities and that the staff and Board use their existing statutory authority to look at any larger system of which the entity is a part. An interesting analysis of hospital financial capacity looks at "haves" and "have-nots" by recommending looking at bond ratings, statements of financial position, reserves and investments, as well as days of cash on hand and other standard financial measures[6]. HCAI and CHFFA looked at similar measures for the distressed hospital loan program[7].

This analysis would complement OHCA's work on very high-cost hospitals to date and add nuance to discussions of enforcement, including enforcement considerations and other next steps. Given what is available in the public record, our expectation is that the seven very high-cost hospitals will fall at the higher end of the "have/have-not" continuum with ample reserves, days of cash on hand, and other measures of financial strength either at the hospital level or the system level.

H.R. 1 and the Impact on Consumers

The Newsom Administration has estimated that as many as four million Californians may lose their health insurance when H.R. 1 is fully implemented. Other Californians are losing coverage as a result of actions taken in the 2025-26 state budget, most particularly low-income immigrant adults, both lawful and undocumented.

An increase in the uninsured does not justify a cost shift by hospitals or other providers to commercial payers. The uninsured get little or no care from hospitals

[6] https://www.milbank.org/wp-content/uploads/2025/09/Haves_HaveNots_report_final.pdf
[7] https://hcai.ca.gov/wp-content/uploads/2023/05/DHLP-Powerpoint-Draft-Evaluation-Methodology-Webinar.pdf

beyond the bare minimum of emergency care needed to stabilize an emergency condition. Hospitals often overcharge the uninsured in violation of longstanding California law, worsening the medical debt crisis. Many uninsured patients try to pay what they owe for care. Multiple government funding streams provide funding to hospitals to care for the uninsured.

Before the ACA, even the best funded county hospital systems did not provide comprehensive benefits to the uninsured. Those hospitals with emergency rooms provided the minimum care necessary to stabilize an emergency patient but not the comprehensive care a consumer needs.

Those who are uninsured live sicker, die younger and are one emergency away from medical bankruptcy because they do not have access to medically necessary care in a timely manner. What does the bare minimum of emergency care look like?

- A kid with an asthma attack gets a breathing treatment but not the $8 albuterol rescue inhaler, much less the doctor visit and maintenance drugs to prevent future attacks.
- Someone with cancer goes unscreened, undiagnosed and untreated.
- A person with heart disease may never know it until they can't breathe—and they get minimal emergency care, not annual or quarterly doctor visits, lab tests and medications to manage their condition, much less state-of-the-art surgery.
- A person with diabetes will be treated when they fall into a coma, but no insulin, no other drugs, no doctor visits or lab tests, no screenings to prevent blindness or amputations.

The uninsured live sicker and die younger as a result.

Hospitals pursue the uninsured into medical debt and collections, often ignoring the requirements of California law and overcharging the uninsured for full billed charges, the sticker price, when Medicare or Medi-Cal would pay far less. This remains true in spite of California law against price gouging the poor that dates back to 2006 with multiple subsequent laws to protect consumers against usurious medical debt.

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Hospitals and physician organizations get paid to take care of patients. An increase in the uninsured does not justify cost shifting and would only justify an adjustment to the target for a hospital to the extent that the hospital provides charity care, that is, free care provided without expectation of payment and that the hospital lacks other funding sources to cover the cost of care for the uninsured. Before the ACA was enacted in 2010, hospitals spent about 2% of revenue on charity care. Since the ACA was fully implemented in 2014, California hospitals spend about 1% of revenue on charity care. Many spend far less than that and few spend much more.

Many hospitals benefit from an alphabet soup of public funding sources intended to provide some payment for caring for the uninsured. Counties put up the non-federal share of match for county hospitals: counties vary in their capacity and willingness to fund such care. Federal programs provide a range of funding, from Disproportionate Share Hospital payments in both Medicare and Medi-Cal for care for the uninsured to the 340B drug program to various Medicaid waivers and more. Hospitals vary considerably in which programs they benefit from and the extent of that benefit.

Health Access recognizes that some hospitals may provide emergency care to the uninsured for free, care for which the particular hospital is not compensated by either the patient or another funding stream. If the hospital can document that

a) the care was provided without expectation of payment,
b) no payment was made by the uninsured person, and
c) no other funding source exists,
d) then the cost of care for the uninsured at the Medicare or Medi-Cal payment level, consistent with California law on hospital fair pricing, may result in an amount by which the target should be adjusted.

If the care is paid for by either the uninsured person or another funding source, then a target adjustment is not appropriate.

Formula for charity care “enforcement consideration”:

1) Confirm care is provided without expectation of payment.
2) Subtract any payment made by the uninsured person to the hospital.
3) Subtract other funding sources intended to assist hospitals in caring for the uninsured (DSH, 340B, county, waiver dollars, more).

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4) Confirm hospital complies with Hospital Fair Pricing Act and does not accept payment in excess of the greater of the Medicare or Medi-Cal payment for the same care.
5) Value charity care at the greater of the Medicare or Medi-Cal payment for the same care, not the so-called "cost to charges" ratio.
6) Documentation to be provided by the hospital (or other entity if any) and verified for compliance with these requirements by HCAI.

If the uninsured person paid for the care, it's not charity. If the hospital gets other funding to cover care for the uninsured, it's not a cost to the hospital (and it's not charity). If the hospital sought payment from the uninsured patient greater than what Medicare or Medi-Cal would pay, it violates California law (and it's not charitable to send poor people to collections). Value charity care at what Medicare or Medi-Cal would pay, not a ratio based on theoretical billed charges or fictional costs of care.

Health Access is heartbroken that H.R.1 will deprive millions of Californians of comprehensive health benefits and that the state budget also deprived Californians of needed care. But that loss of coverage does not justify cost shifting to individuals and other purchasers who buy commercial coverage—except to the modest extent a hospital provides charity care in a manner consistent with existing state law.

Enforcement Considerations: Transparency, Accountability, Measurable Impacts

The law requires public reporting of performance on cost targets[8], including the impact on consumer affordability as well as the unadjusted and risk-adjusted performance. Notably this performance is also to be reported on both an aggregate and per capita basis for the entire state, regions, and by insurance market (Medicare, Medi-Cal and commercial). This will allow OHCA, policymakers, and consumers and other purchasers to track whether health care entities are cost shifting to commercial coverage, even if they are providing minimal or no care to the uninsured[9].

[8] Health and Safety Code 127502 (j)
[9] Insurers pay for care for the insured, not the uninsured.

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The law requires that prior to any enforcement action, the Office shall notify the entity that it has exceeded the target, give it at least 45 days to provide additional information, and

> "If the office determines that additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate[10]."

The law also requires the Office to make public the extent to which the health care entity exceeded the target[11].

Health Access strongly recommends that the Office do the following:

- Report to the Board, and the public, the types or categories of enforcement considerations that explain all or part of the entity's excess spending,
- Allow for public comment prior to modifying its findings to gather a variety of perspectives and not just the views of the affected entity. A few examples:
    - With respect to prescription drug costs in the hospital inpatient and outpatient settings, Health Access has tried to examine the degree to which these costs are within the control of the hospital or health system: excessive markup of drug prices as well reliance on the 340B program and extending it to commercial customers and perhaps other variables mean that high drug costs, overall drug spend, and even high-cost outlier conditions may not be beyond the control of the entity.
    - Scale matters: while one or two high-cost outlier patients may be a problem for a small hospital, an insurer with several million lives should be able to spread risk over a larger population.
- Avoid prematurely codifying such types or categories of enforcement considerations into regulations because that would limit flexibility for both the Office and the entity subject to the target but instead provide public guidance through its regular public meetings.
- Move toward standardizing the information to be submitted while recognizing that scale matters and the type of entity (insurer, hospital, large physician organization) will likely affect which enforcement considerations matter.

[10] Health and Safety Code 127502.5 (b) (1)-(3).
[11] Health and Safety Code 127502.5 (c) (1).

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Health Access has reviewed and provided earlier comment on the list of potential "enforcement considerations" that might impact performance on the growth target in several prior letters within the last few months.

Enforcement Process: Determining Entities the Exceed the Target, Technical Assistance, Performance Improvement Plans, and Public Testimony: Further Comments, Transparency

Health Access provided comments in our prior letter in November 2025 on technical assistance, performance improvement plans, and public testimony. We offer further comments on determination of which entities exceed the target and performance improvement plans as well as the need for transparency in monitoring each of the steps in the enforcement process. Health Access recommends that enforcement process from the initial identification of an entity through each step of the enforcement that provides transparency, public accountability, and the opportunity for public comment. California's health care system has been allowed to grow without any public scrutiny, beyond the year after year hikes in premiums now made public because of the Affordable Care Act[12].

The first step in the enforcement process was to set the growth target. The second step is to determine whether an entity exceeded it. Health Access looks forward to the staff presentation and Board determination of whether entities have exceeded the target. Health Access notes that other states with growth targets have determined that an entity needs to have exceeded a target by a statistically significant amount to be considered in violation of the target. The staff has already determined that risk adjustment will use differences in age and gender for the entity from the prior year. The California law also requires "organized labor cost adjustment" if there is a collective bargaining agreement that affects the measurement period.

Every "enforcement consideration" weakens compliance with the growth target. Enforcement considerations should be permitted only for decisions outside the control of the entity and should be based on concrete documentation by the entity seeking an enforcement consideration, not vague generalizations such as citing

[12] We note that prior to the ACA, rate hikes were confidential communications to purchasers with no public oversight. It was only the requirements of the ACA that led to rate review for health plans and insurers. OHCA can provide similar public accountability for hospitals, large physician organizations and other elements of the health care system.

newspaper articles. The applicability of broad economic indicators such as tariffs or economy-wide inflation to the performance of specific health care entities is open to question. Entities pointing to such broad economic indicators should be prepared to verify the impact on their costs. For example, a tariff hike on coffee or bananas is not likely to have a significant impact on hospital operating costs.

Further comments on Performance Improvement Plans

The Massachusetts growth target program waited almost ten years before imposing its first performance improvement plan. By then, voluntary compliance with the growth targets had been weakened and some observers suggest structural weakening of the impact of the targets. Health Access recommends that OHCA move more quickly to impose enforcement, including so-called performance improvement plans to correct failures to comply with the growth target. High profile enforcement efforts should have a sentinel effect, encouraging compliance among those who doubted the seriousness of this effort.

Health Access recommends that OHCA staff develop, and review with the Board and public, template or templates for corrective action plans for use in the initial year of such plans. Among the elements that may be considered for such plans are:

- Causes of excessive cost growth (e.g. lack of market competition)
- Quantifiable savings goals
- Measures for tracking progress.
- Timeline appropriate to needed corrections.

Health Access recognizes that different types of entities may require somewhat different templates: a large national insurer will face different challenges than a small, stand-alone hospital or a physician organization with 30-50 doctors that has a dominant market position in a market segment, defined either geographically or in terms of clinical specialty.

The law says performance improvement plans may be in place for “up to three years”. “Up to” means the length of time can vary with the type of entity, its scale, and the estimated difficulty of correcting the problems. Some things, such as pricing within the control of an entity as documented for the Monterey hospitals, can be corrected more promptly than shifting care from one setting to another or increasing the proportion of primary care.

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Transparency in Enforcement

Health Access supports an appropriate level of transparency in enforcement. Specifically, we support transparency as follows:

- The law requires public notice if an entity exceeds target and specifies that the "office shall make public the extent to which the health care entity exceeded the target[13]".
    - Health Access recommends that this public information be posted publicly at the time the entity is notified that it has exceeded the target, during the 45-day period in which the entity has the opportunity to provide more information.
    - If an entity provides information that clarifies that it has not exceeded the target, then that should be made public as well. One instance of this already occurred: Northbay Medical Center had misclassified Medicare Advantage spending as commercial spending on HCAI hospital financials and corrected that error during the five-year period under scrutiny.
    - Verbal statements by staff during an OHCA Board meeting are not sufficient: in future years, everyone, including staff and board members as well as stakeholders and policymakers, will be grateful for a written record.
- If "enforcement considerations" apply, the office should make public what these were and the magnitude of the impact on compliance with the target.
    - For example, an organized labor cost adjustment involving a small collective bargaining unit may have a small effect or even no effect on target compliance.
    - Even the cost of a new, very expensive drug may have modest impact overall, depending on the scale of the entity and whether there are offsetting cost reductions from biosimilars or loss of patent protection for other drugs.
- If a performance improvement or corrective action plan is negotiated between the entity and the office, the law requires the office to publicly post the identity of the entity and "at a minimum, a detailed summary of the entity's compliance with" the plan[14].

[13] Health and Safety Code 127502.5 (c) (1).
[14] Health and Safety Code 127502.5 (c) (2).

- Health Access recommends that the office reports at each board meeting any approved performance improvement or corrective action plan as well as a summary of its elements.
- Health Access also recommends performance improvement plan progress reports at regular intervals, with the interval depending on the length of the plan. If a plan's duration is one to three years, updates should be quarterly. If a plan's duration is less than a year, more frequent updates may be appropriate.

Setting the target was the beginning of bending the cost curve. Enforcing the target effectively, and publicly, is equally important in transforming the health system.

Enforcement Considerations Specific to Health Plans and Insurers

Health plans and insurers are expected to bargain with providers, including hospitals, health systems, physician organizations, and other health care entities as well as for prescription drugs in a manner that reduces cost while improving quality and equity and preserving adequate access.

The OHCA statute is premised on the idea that health plans, insurers, and other payers can and should negotiate on the basis of the triple aim of lower costs, improved quality, and greater equity. Excusing state-regulated health plans and insurers from the growing cost of medical claims for hospitals, physician organizations, and outpatient prescription drugs is directly contrary to the letter and intent of the law. The target applies all of the costs subject to the medical loss ratio, including the claims costs as well as to administrative overhead and profits.

If health plans and insurers are unable or unwilling to bargain with providers, what's the point of a health system that relies on insurers? Why not move to a system like traditional Medicare fee-for-service or a Canadian style single payer system or the British National Health Services and simply dispense with health plans and insurers? Part of the point of the design of OHCA is to demonstrate that the current health system can deliver universal coverage while controlling costs, improving quality and equity and maintaining access. Over the four decades of our existence, Health Access has supported a variety of health reforms, including single payer and the Affordable Care Act, always with the goal of achieving these ends.

The enabling statute for the Office provides that if a health plan fails to control underlying claims costs in line with the growth targets, then the share of the premium dollar taken by the health plan for administrative costs and profits shall be reduced:

> (1) Targets set for payers shall also include targets on administrative costs and profits to deter growth in administrative costs and profits.
> (2) The targets established for a payer's administrative costs and profits under this subdivision may be subject to annual adjustment, but *shall not increase to the extent the costs for the medical care portion of the medical loss ratio exceed a target.* (emphasis added)
> (3) The office shall consult with the Department of Managed Health Care, the State Department of Health Care Services, and the Department of Insurance to ensure any targets for payers established by the office consider actuarial soundness and rate review requirements imposed by or upon those departments.[15]

The premise of this provision is that insurers and health plans, referred to in the law as "payers", will negotiate over the "medical care portion" of the medical loss ratio so that it grows in line with the growth target and if the "medical care portion" grows faster than growth target then the target for the payer's administrative costs and profits, the top part of the medical loss ratio, shall not increase. Any proposal that is premised on the theory that plans and insurers cannot control medical claims costs is directly contrary to the letter and intent of the law. Again, the target applies to all of the costs subject to the medical loss ratio, including both claims' costs as well as the administrative overhead and profits of the health plan or insurer.

Scope and Range of Administrative Penalties for Exceeding the Growth Target: Statutory Authority, Types and Varying Scale of Entities

Health Access looks forward to the discussion of the scope and range of administrative penalties for exceeding the growth target. The law states:

> (a)(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 targets.

[15] Health and Safety Code 127502 (h)

> (d) (1) If the director determines that a health care entity is not compliant with an approved performance improvement plan and does not meet the cost target, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target.
>
> (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).[16]

These provisions of law grew out of frustration with the inadequacy of penalties administered by other agencies within the California Health and Human Services Agency, including the California Department of Public Health which licenses hospitals and nursing homes and the Department of Managed Health Care which is intended to regulate health plans but imposes penalties insufficient to change behavior. It was also a learning from the inadequacies of the Massachusetts cost growth program, which after a decade imposed a performance improvement plan on Mass General Brigham for exceeding the target by almost $300 million but the Massachusetts state law only permitted a penalty of $500,000, a ludicrously small amount given the scale of the hospital system exceeding the target.

"Commensurate" means equal to.

"Escalating" means bigger than a penalty equal to the amount of the miss.

For Mass General Brigham, this would have meant a penalty of $293 million and growing from there if the hospital system continued to fail to meet the target.

A scope and range for the penalty for exceeding the growth target that is less than commensurate (and escalating from there) is contrary to the letter and the spirit of the specific California law. Lesser penalties may be appropriate in some circumstances, and the law directs the director to consider other factors such as the nature and gravity of the offense and the market impact of the entity.

[16] Health and Safety Code 127502.5 (a) and (d).

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The law also directs the director to consider the financial capacity not only of the entity subject to the target but of the larger system of which it is a part, if any, and any affiliates or subsidiaries of the entity itself. For example, in looking at Optum California, a medical group with more than 17,000 doctors in Southern California[17], the director should look at United Health, a national insurer and the parent company, not only in California but nationally as well as Optum Rx, another related entity. A rural hospital may be owned or controlled by a large hospital system with money in reserves and ample cash on hand. Conversely a small, stand-alone entity may have little in reserves or cash on hand, and bond ratings that reflect the lack of financial capacity.

Physician organizations will need to be treated distinctly: some have affiliations with larger health systems, others have a tradition of not holding reserves beyond a dollar net positive, even though the organization is lucrative for the participating physicians. Entities will claim poverty even if there is lots of money elsewhere in the system of which they are an element.

Scope and Range of Administrative Penalties for Exceeding the Growth Target: Illustration Using Top Five Health Plans

With respect to the scope and range of penalties, Health Access offers the following on national revenues of the five largest California health plans as well as the scale of missing the target by 1% (that is, coming in at 4.5% instead of 3.5%) or 7% (coming in at 10.5% instead of 3.5%)[18].

[17] https://www.optum.com/en/care/locations/optum-california.html
[18] The Covered California rates increased by about 10% on average: we use that as a proxy for overall increases in California revenues because the 2026 rates are already public.

Top Five Health Plans: Enrollment, National Revenue, and Proposed Penalties

Health Plan Top Five 2022	*California Enrollment: Medicare, Medi-Cal, Commercial, 2022*[19]	*National Revenue: 2024*	Estimated Commensurate Penalty If Growth is 4.5%[20] Target=3.5%	Estimated Commensurate Penalty If Growth is 10.5%[21] Target=3.5%
Kaiser Permanente	8.5 million	$115.8 billion[22]	$677 million	$4.74 billion
Elevance (Anthem)	5.9 million	$175.2 billion[23]	$237 million	$1.66 billion
Blue Shield	3.2 million	$27.4 billion[24]	$235 million	$1.65 billion
Centene HealthNet	2.6 million	$163.1 billion[25]	$202 million	$1.41 billion
United	2.0 million	$298.2 billion[26]	$200 million	$1.40 billion

Health Access strongly supported the inclusion of "commensurate" penalties for the growth targets, penalties equal to the spending growth in excess of the target. Equally, it is our hope that the threat of such substantial penalties would lessen the need to use them.

Conclusion

Thank you for your consideration of these comments on behalf of California consumers who pay too much for health care, and too many of whom cannot get the care they need because they cannot afford that care.

[19] Slides 20 and 4: https://www.chcf.org/wp-content/uploads/2024/10/HealthInsurersAlmanac2024.pdf
[20] The estimate of the commensurate penalty was calculated using California revenues as a proxy for THCE and multiplying by 1%.
[21] The estimate of the commensurate penalty was calculated using California revenues as a proxy for THCE and multiplying by 1%.
[22] https://about.kaiserpermanente.org/news/press-release-archive/kaiser-foundation-health-plan-hospitals-risant-health-report-2024-financial-results
[23] https://www.elevancehealth.com/newsroom/elv-quarterly-earnings-q4-2024
[24] https://news.blueshieldca.com/mission-report-2024-financials
[25] https://investors.centene.com/2025-02-04-CENTENE-CORPORATION-REPORTS-2024-RESULTS
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Sincerely,

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