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

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HEALTH CARE AFFORDABILITY BOARD

MEETING MINUTES
Tuesday, October 28, 2025
10:00 am

Members Attending: Dr. Sandra Hernandez, Ian Lewis, Elizabeth Mitchell, Dr. Richard Pan, Richard Kronick, Don Moulds, Secretary Kim Johnson*

Members Absent: none

Presenters: Elizabeth Landsberg, Director, HCAI; Vishaal Pegany, Deputy Director, HCAI; CJ Howard, Assistant Deputy Director, HCAI

Meeting Materials: https://hcai.ca.gov/public-meetings/october-health-care-affordability-board-meeting-3/

*Attended virtually

Agenda Item # 1: Welcome and Call to Order
Elizabeth Landsberg, Director, HCAI

Director Landsberg provided an overview of the meeting agenda, noting that the topic of data submission enforcement, including feedback from the Heath Care Affordability Advisory Committee, will be taken out of order prior to a potential vote to approve the data submission enforcement penalty scope and range. If the Board decided not vote today, the item will be placed on the November agenda.

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

Director Landsberg provided Executive Updates, including the following:
- Acknowledgment of Indigenous People's Day along with HCAI's Land Acknowledgement Statement developed by HCAI's Racial Equality Team.
- Acknowledgment of the California Hospital Association's suit filed against HCAI, the Office of Health Care Affordability, and the Health Care Affordability Board in San Francisco Superior Court on October 15, 2025.

- HCAI's CalRx biosimilar insulin initiative in which California became the first state to offer its own low-cost insulin beginning January 1, 2026, and recognition of Senator Pan's leadership in starting the CalRx program.
- Review of health care affordability legislation that Governor Newsom signed into law:
  - Assembly Bill 1415, which expands material change notice of transaction filing requirements and provides OHCA new data collection authority.
  - Senate Bill 660, which officially moves the data exchange to HCAI, adds new participation requirements, revises the stakeholder governance process, and requires a legislative report.
  - Assembly Bill 1312, which requires presumptive eligibility approach to hospital discount policies and charity care.
  - Senate Bill 40 and Senate Bill 41, which are related to prescription drug affordability.
  - Assembly Bill 144, a budget trailer bill passed in August, which establishes the Abortion Action Fund to support abortion access and services in response to Medicaid funding limitations imposed by HR1.
- Attendance at the medical debt summit in Los Angeles where she discussed HCAI's efforts to improve health care affordability. Los Angeles has identified medical debt as a public health problem and has created a coalition to address this public health crisis.
- Update on the California Rural Health Transformation Program application which HCAI will submit next week. It will focus on a transformative care model, additional investment in technology and tools, and the need to develop a locally rooted workforce for rural communities.

Deputy Director Pegany provided Executive Updates, including the following:
- Aliza Arjoyan has resigned from the Health Care Affordability Advisory Committee in her role as a representative for Payers. The Advisory Committee submission of interest process will open soon. The Board will be asked to establish a subcommittee to review submissions and make a recommendation to fill the vacancy at the November Board meeting. The next Advisory Committee meeting is in January 2026.
- Highlights from three recently published articles:
  - An article published by the California Healthcare Foundation titled "The 25% Problem: Why Health Care is So Expensive (And What We Can Do About It)."
  - An article published in Health Affairs Forefront titled, "How Insurers that Own Providers Can Game the Medical Loss Ratio Rules."
  - An article published in Health Affairs Forefront titled, "How States Are Using Hospital Price Caps to Save Money."
- Update on OHCA's 2025 Data Collection process, including that 48 of the 50 submitters had submitted all files and past validations as of that morning and that the remaining two submitters were expected to submit files by the following morning.
- A reminder about slide formatting.

Discussion and comments from the Board included:

- A member expressed appreciation for HCAI's work and the Newsom administration's implementation of CalRx. The member noted that capping co-pays does not bring down the cost of pharmaceuticals, it only distributes the cost by raising health care premiums for all. The member cited a USC study that linked increased insulin costs to pharmaceutical benefit managers (PBMs) and emphasized the importance of transparency regarding pharmaceutical pricing. The member mentioned that the Trump administration is planning to preempt any state's efforts to remove medical debt from peoples' credit reports.
    - The Office replied that the federal regulatory change regarding the reporting of medical debt on credit reports will have to be evaluated since California passed legislation that medical debt cannot be reported to credit agencies. In terms of Medicaid and other cuts in HR1, a series of webinars sponsored by California Health and Human Services Agency (CalHHS) are available on the CalHHS website and HCAI's website discussing Medicaid cuts and new work requirements. The Office also stated that the Newsom administration has filed a lawsuit against the Trump administration for its planned discontinuation of SNAP benefits beginning on November 1, 2025.
- A member asked if there were any contingencies within HR 1 or Centers for Medicare and Medicaid Services (CMS) regulations that would compromise equitable care, specifically sexuality or gender-based care, in the rural health funds.
    - The Office replied that there are some requirements regarding following executive orders that need to be reviewed more closely. It is California's position that we are not discriminating against, or granting preferential treatment, on the basis of sex, race, or ethnicity.
- Regarding the Rural Health Transformation fund, a member offered to share evidence from the California Quality Collaborative about effective practices regarding transformation and technical assistance. The member asked how health systems and hospitals have responded to the offer of technical assistance.
    - The Office replied that the entities have been receptive and collaborative in terms of ideas. The Office will begin with an assessment of each component to clearly ascertain the needs of the rural clinics and hospitals to create a structure that is most helpful to them. The Office accepted the member's offer of information.
- A member offered to share the Pacific Business Group on Health's pricing analysis using newly available price transparency data with claims, quality, and safety for both Northern and Southern California. The member also commented that when there is downward pressure on state employee plans, costs are shifted to private employers and suggested having a multi-purchaser strategy to consider price caps to avoid cost shifting.
    - The Office replied that hospital price caps tend to focus on state regulated plans. There are some proposals that focus on capping the amount that hospitals can charge rather than negotiated payments between self-insured employers and hospitals, which is the domain of the federal government.
- A member stated that the framework of the California Health Care Foundation report is very helpful. The member speculated that both the scale and distribution of money that is not going to fund care differs greatly by market segment, with the commercial

segment likely being sensitive to cost-sharing. The member suggested that keeping this framework up-to-date and focusing on its differences, especially as related to the commercial markets, could be built into OHCA's annual reporting.

- A member commented on the administrative waste mentioned in the California Health Care Foundation report and noted that allowing primary care doctors to spend 50% of their time with patients would almost double the primary care workforce without training any new primary care physicians. The member referenced the article on medical loss ratios and advocated looking at the cost being shifted to providers that is not value-added in terms of care, as well as time spent on overhead.
- A member stated that, regarding the research articles, a lot of the administrative complexity mentioned is borne by consumers and that there is an urgency to the work that is being done on the data exchange that could alleviate this complexity for consumers.
- A member added that many physicians and their staff are spending time assisting patients with administrative issues rather than providing them with health care.

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

Agenda Item# 3: Action Consent Item
Vishaal Pegany, Deputy Director, HCAI
a) Vote to Approve the August 25, 2025, Meeting Minutes

Deputy Director Pegany introduced the action item to approve the August meeting minutes. Ian Lewis proposed a motion to approve. Dr. Richard Pan seconded the motion.

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

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

Agenda Item #5b: Spending Target Enforcement – Waiver of Enforcement, Technical Assistance, and Public Testimony (out of order)
Vishaal Pegany, Deputy Director, HCAI

Deputy Director Pegany provided an overview of spending target enforcement, specifically focusing on assessing performance, technical assistance, and public testimony. He asked the Board for input on how OHCA is defining technical assistance or how it fits into the enforcement process, as well as the circumstances under which the Board would want to hear from health care entities regarding the reasons why they exceeded the target. Deputy Director Pegany also presented the timeline for future enforcement discussions and OHCA's determination to not implement a waiver of enforcement.

Discussion and comments from the Board included:

- A member asked what the consequences would be for an entity that did not choose to follow the technical assistance it had been offered.
  - The Office explained that it would not wait for the entity to implement technical assistance to proceed with additional steps in enforcement.
- A member asked if the Office is identifying organizations that provide technical assistance that are independent from HCAI.
  - The Office replied that it would not provide a list of, for example, consulting services. It could, for example, provide information such as highlighting effective advanced primary care practice models and include citations to those models so that the entities can conduct their own follow-up. The Office also notes that the term technical assistance as used in statute is high-level and broad and that OHCA does not have statutory authority to enforce whether an entity implemented the suggested steps. Conversely, a Performance Improvement Plan (PIP) is a particular set of strategies for a specific entity. If an entity does not comply with a PIP, penalties could be imposed.
- A member clarified that regardless of whether technical assistance is taken up, if OHCA thinks a PIP is in order, the PIP would be specific to the institution.
  - The Office affirmed this understanding.
- A member commented their understanding is that it is not right to say “technical assistance is taken up” since it is a general set of resources.
  - The Office replied that there is no reporting requirement regarding technical assistance so it would not know the entity’s actions. The member then asked if this information has been shared with the Advisory Committee. The Office replied that it had an introductory discussion with the Advisory Committee and that it intended to present this content to them at the January 2026 meeting.
- A member asked for clarification about the enforcement process flow and whether the Office will provide a tailored response to an entity who has exceeded the cost target, as well as monitoring implementation.
  - The Office explained that the Performance Improvement Plans (PIPs) have a specified timeframe of up to three years that could be extended. The Office would be monitoring a PIP for specific milestones that are quantifiable and measurable.
- A member asked about the relationship between the suggestions in the technical assistance and those in the Performance Improvement Plan.
  - The Office replied that there could be some overlap between the two but clarified that technical assistance is general guidance, while the PIPs are specific to each organization. The PIP will involve dialogue with the health care entity to assess areas of excess spending and discuss potential strategies.
- A member asked if the cost reducing strategies included in the Performance Improvement Plans would be coming from the health care entity.
  - The Office replied that the health care entity would propose specific strategies, and the Office would review to see how they stack up against the guardrails for access, quality, equity, and workforce stability. The Office would have a dialogue with the health care entity before the PIP would be approved.

- A member asked if the technical assistance provided by the Office to particular entities would be in the public domain.
  - The Office explained that the statute has specific requirements on confidentiality laid out in three sections. Some information related to methods of improving performance may be confidential and would not be allowed to be entered into the public domain.
- A member asked if technical assistance that is broadly available would have any restrictions by the statute.
  - The Office replied that anything that is already in the public domain or any strategies and experiences that have been discussed before, are in the public domain.
- A member asked for clarification about the degree to which technical assistance would be specific to the entity.
  - The Office explained that HCAI would try to identify the most applicable technical assistance items that would work for that entity and offer those to the entity.
- A member asked for clarification about how an entity would integrate technical assistance into its Performance Improvement Plan.
  - The Office replied that, at the highest level in terms of meeting the spending target, the entity could either implement changes in price or utilization. The technical assistance letter would broadly speak to these two levers while the PIP could also ask for specific proposals on how the entity will change prices or utilization. The Office also responded that the PIP comes from the entity as it is their corrective action plan on how they will come into compliance. Some of the strategies listed in technical assistance that apply or are useful to the entity could be incorporated into their PIP, as the PIP is the Office's way of monitoring what they will do to come into compliance.
- A member asked if there was anything that the Office could do to enable the implementation of technical assistance to assist entities in reducing costs.
  - The Office replied that in terms of strategies to slow down spending, it already has the Alternative Payment Model (APM) workstream, as well as the Primary Care workstream. The technical assistance letter would be broad but would not include the full universe of strategies.
- A member asked how public testimony ties into other types of enforcement, such as waivers or PIPs.
  - The Office explained that in terms of progressive enforcement, there is technical assistance, public testimony, and performance improvement plans. Depending on the situation, the entity could be brought in at the discretion of the director and testify publicly, or it could submit a written testimony, with the possibility of ending the process without moving forward to a PIP. Each step of the progressive enforcement process is not always required.
- A member asked for clarification about how public testimony would inform subsequent actions or decisions in relation to enforcement action or waivers.
  - The Office replied that waivers are an optional step that would precede public testimony. Public testimony would not be part of the waiver process if the Office were to implement the waivers.

- A member asked for clarification about how public testimony fits into the universe of enforcement mechanisms as well as how public testimony would be scheduled by the Board.
    - The Office replied that it is soliciting the Board's input on this matter because public testimony is an optional step that could be in written or oral form. There is a logistical issue with hearing from an unknown number of entities that may exceed the spending target.
- A member stated a desire to read responses from all entities that exceed the spending target, in response to OHCA's question about circumstances under which the Board would want to hear from entities that exceed the target. The member would occasionally like to hear public testimony from entities that merit further discussion, recognizing potential time constraints.
- A member stated that they would like to see written testimony from all the entities but given time constraints, at least from those entities that staff may find are difficult to work with. Another reason for public testimony would be to inform the Board about those entities that exhibit uniquely important lessons either by market, by provider type, or by other categories; the member found value in past presentations from health care entities. In addition to an entity's public testimony, it would also be an opportunity for members of the public to comment on the way in which OHCA's engagement does or does not impact the affordability of health care in their communities, informing the Board where to focus its efforts moving forward.
- A member asked for clarification about the circumstances in which an entity would refuse to appear for public testimony, and if the Board would be informed of this refusal should this occur.
    - The Office replied that the enforcement steps are progressive. The first step is technical assistance. The director could require or compel an entity to appear for public testimony as the second step. Failing to comply with the statutory standard of knowingly or willingly refusing to appear for public testimony would result in administrative penalties due to non-compliance.
- A member stated that compelling an entity to appear before the Board to explain why it missed the spending targets seems unhelpfully punitive and that imposing penalties onto entities that choose not to appear seems to serve no function.
    - The Office explained that an entity that fails to meet the spending target is given 45 days to respond. The response could explain why they missed the spending targets, or it could make a case for a waiver described in the statute. The response or part of the response from the entity could be confidential and by law would not be put in the public domain. Public testimony is a discretionary item that the director can decide. The purpose of this discussion is to decide how the process would look.
- A member stated that public testimony seems like an extra step without a purpose, particularly if the entity is not disagreeing with the judgement. If the goal is to force the conversation into the public, that has different implications.
    - The Office replied that another option is written testimony. The Office asked if the member is saying that there may not be real value in public testimony and whether it feels punitive.

    - The member clarified that the opportunity to testify has value, but that compelling testimony is problematic.
    - The Office replied that the authority to compel is written into the statute.
- A member stated that there may be community members who would like to hear and respond to what the entity has to say. There is value in compelling an entity to testify publicly and if the entity chooses not to appear, it is reasonable to have a legal remedy to satisfy the community's desire for answers.
- A member suggested that the hearing should be held even if an entity refuses to appear to allow opportunity for public comment. The decision about whether to compel public testimony could be made at that time.
    - The Office replied that the administrative penalty is discretionary.
- A member stated that there seems to be a consensus about the value of providing an opportunity for written testimony under some circumstances and that there is value in holding public comment under other circumstances. However, penalties for noncompliance of public testimony are not as important as moving forward in the enforcement process and towards performance improvement plans.
- A member asked if a public hearing is held, would people be allowed to ask questions about confidential information submitted to OHCA by an entity that is confidential under statute, or would that information have to remain confidential under the terms of the statute.
    - The Office replied that the OHCA statute has strict confidentiality provisions that apply to OHCA staff and the Board, so they should not ask questions at a public hearing about confidential information. Additionally, OHCA does not envision members of the public asking questions during public testimony.
- A member asked if any responses submitted by an entity as written testimony or public testimony would be posted publicly.
    - The Office replied responses would be publicly posted.
- A member asked if waivers could potentially be created for extraordinary circumstances, such as earthquakes, as a way to efficiently deal with many of the affected entities at once.
    - The Office replied that under enforcement considerations, it can be considered under extraordinary circumstances and eliminate the need for the entities to undergo additional steps in the progressive enforcement process. Under a waiver process, each entity must apply for a waiver for approval from the Office.
- A member asked if a future waiver of enforcement would eliminate duplicate circumstances that are incorporated into procedure as part of the enforcement process and if the entity would be waived completely.
    - The Office replied that, depending on what is learned from experience, it may potentially have a basis for having a waiver program. The waiver program would not waive the entity's performance against the cost target, but it would waive the entity from any further enforcement action. There would not be a partial waiver, essentially the waiver would act as a single on/off switch during the enforcement process. Over the years, the recognition of a pattern or more experience in developing criteria that justify a waiver will allow the Office to set out requirements for a waiver.

- A member envisioned a scenario where an entity missed the target and filed a waiver saying they increased primary care reimbursement rates by 20% to explain why. The member asked how verifiable evidence would be obtained and whether the waiver application would be more seriously considered if the entity had proof for their claim.
    - The Office explained that we have primary care investments as an enforcement consideration, and it is also mentioned in the waiver provision. Regardless of the vehicle in which the factor is mentioned, OHCA would require documentation and is having active conversations about how to verify increased primary care spending at the practice level.
- A member suggested that if the Office were to do waivers, this step should be moved between steps 4 and 5 in the enforcement process rather than between steps 3 and 4 as an entity could provide new data to show that it had met the target but that it had given bad data the first time, before there is consideration for a waiver.
    - The Office explained that this is due to the phrasing of the statute that outlines what happens during the 45-day submission period – the entity submits the data and information, including information supporting a waiver. The decision on approval of the waiver could occur between steps 4 and 5 because the Office would still be reviewing the application.
- A member asked about the differences between the waiver process and the process of assessing performance in terms of imposing next steps.
    - The Office replied that there are similarities except that the enforcement considerations cover a broader list of factors, whereas the waivers have a more limited set of criteria that do overlap with enforcement considerations. Waivers would still require a review and assessment of performance, but a waiver would be granted on the basis of reasonable factors, anticipated costs, and extraordinary circumstances.
- A member asked if the Office envisions making an enforcement determination for every entity that exceeds its cost target.
    - The Office confirmed that following the notice letter, each entity who exceeds the spending target will undergo a review of the enforcement considerations. It is still being decided how the office will use the enforcement considerations to prioritize which entities proceed to the next step.
- A member stated that the Office already has statutory authority to compel testimony and a waiver process and asked if a separate, more specific authorization is needed.
    - The Office replied that public testimony is separate from waivers, but that is on a parallel track.
- A member suggested that given statutory authority no action on this item is needed at this time.
- A member stated that barring some extraordinary circumstance that affects multiple entities, it would be better to ascertain information from implementation of the enforcement process rather than by utilizing the waiver process.

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

(Secretary Johnson joined the meeting at this point. A vote was held to approve her virtual attendance per requirements in California Government Code Section 11123.2.)

Agenda Item #5a Data Submission Enforcement, Continued, Including Advisory Committee Feedback (out of order)
Vishaal Pegany, Deputy Director, HCAI
CJ Howard, Assistant Deputy Director, HCAI

Assistant Deputy Director Howard provided an overview of the data submission penalty and penalty amounts.

Discussion and comments from the Board included:

- A member commented that the penalty for plans that do not comply with the legislation has to be sizeable enough to deter them from non-compliance.
- A member asked for clarification about the fines for dealing with entities that do not submit required data on time and if that data would still be collected at some point.
    - The Office replied that it would pursue other actions to acquire the data that was not submitted by the December 1st deadline, and the per member penalty would be assessed. A complete and accurate data submission covers a two-year period.
- A member asked what would happen if an entity did not submit data for three years.
    - The Office replied that other legal remedies would be sought for each year on non-submission in addition to assessing penalties.
- A member asked how long it takes for a decision to be rendered on an administrative action.
    - The Office explained that there is no average time, but it is unlikely to take years.
- A member suggested that the $5 per member penalty is too low to be an effective deterrent given how small a percentage of the plan's revenue would be affected. The steeper the penalties are the less likely that compliance will be an issue.
    - The Office replied that to reframe the denominator, the numbers were presented as a percentage of revenue, but to keep in mind revenue does not mean all the dollars a health plan retains. Much of that revenue is paid out in claims. It is more appropriate to look at the additional metrics provided that consider profits and tangible net equity rather than the percentage of net revenue.
- A member asked why additional fines would only be imposed one year after the December 1st deadline and not earlier than that, in February or March, for example.
    - The Office replied that the penalties would be imposed right after the December 1st deadline and further legal remedies would be pursued if there is continued non-compliance.
- A member suggested that imposing increased penalties as incentives for being three or four months late in submitting the data rather than waiting for the full year for the increase would make sense if the data would still be usable.
    - The Office replied that timely data would be included in the report, provided that the compressed timeframe allows for engagement with the submitter to validate the accuracy of the data.

- A member suggested that the penalty be large enough to become problematic enough for the C-suite to notice it to be more effective for timely submissions.
- A member stated that entities should be knowledgeable of the timeline to submit and working towards timely submission. Methods that would accelerate the submission of data would be meaningful for receiving the data in a timely way.
- A member suggested that doubling the $5 per member penalty every three months would increase the penalty to $20 per member in a year, which is a more significant percentage of profit.
- A member stated that entities that do not submit data hamper the Office's ability to complete its comprehensive reporting, and that the penalty structure of fines should reflect the negative impact that non-submission has on the Board and the Agency.
    - The Office replied that the data is important because it will be also used to measure physician organizations. There is a concern about doubling the penalties every three months because at some point increased penalties need to stop and OHCA needs to pursue legal remedies.
- A member suggested having a larger monetary penalty up front to encourage the timely submission of data.
    - The Office explained that a penalty would be imposed on the entity if it misses the due date, an administrative law judge would say that the fine must be paid, and the data must be submitted within a certain time frame. Non-compliance could result in a referral to its licensing entity, which could affect its license status. It could also result in an action to enforce a penalty in the Superior Court and an order to pay interest.
- A member stated that having a larger penalty up front and then having enforcement by an administrative law judge would be more aligned with the goal of disincentivizing untimely submission of data.

Secretary Johnson suggested tabling agenda item 4 and revisiting it at the November 2025 meeting for further discussion. She asked if Deputy Director Pegany had questions or points of clarity needed from the board to develop another recommendation. Deputy Director Pegany asked for clarity regarding the $5 per member penalty.

- A member stated that the consensus seems to be that a larger initial penalty makes more sense if the data is no longer useful after three months or six months.
- A member asked for a review for accuracy of the statistics regarding what percentage of a plan's profits the $5 penalty equals.
- A member asked if the Office had the ability to review proportionate penalties on a national revenue basis. The member also requested more clarity about how the administrative law judge would handle penalties for late submissions of data and asked about the California Department of Managed Health Care's (DMHC's) experience with administrative actions.
- A member stated that the maximum penalty may be too low to ensure compliance from all entities.
- A member stated that CalPERS' experience with the administrative law judge has been in relation to independent grievance procedure, and that the penalties for non-compliance would be enforced through the terms outlined in a contract.

Secretary Johnson stated that the information gathered in this meeting would be utilized to craft a new motion for consideration in November.

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

Agenda Item #6: General Public Comment
Public comment was held on agenda item 6. One member of the public provided comments.

Agenda Item #7: Adjournment

Chair Johnson adjourned the meeting.