Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Health Care Affordability Board
October 28, 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
11/13/2025	California Hospital Association	See Attachment #1.
11/14/2025	Health Access California	See Attachment #2.

California Hospital Association

November 13, 2025

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

Subject: **OHCA Must Pursue a Collaborative Approach to Enforcement That Considers Uncontrollable and Desirable Spending Growth**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

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

Further Clarity Is Needed for Enforcement Process

OHCA's legislative mandate not only directed it to improve health care affordability, but to balance affordability with maintaining and improving access, quality, equity, and workforce stability. As OHCA analyzes cost growth, it must consider the impending Medicaid impacts from the One Big Beautiful Bill Act and the potential expiration of the federal enhanced premium tax credits, along with cost increases due to various economic factors and policies (e.g., tariffs, inflation, labor cost pressure). OHCA must provide entities that exceed the target a meaningful opportunity "to respond and provide additional data to explain all or a portion of the entity's cost growth in excess of the applicable target" and avoid further enforcement (see HSC § 127502.5 (b)(2) and (3)). Without such an opportunity, health care entities will have no choice but to slash spending and investment in ways that ultimately impede OHCA's broader goals for the health care system aimed at promoting access, quality, and equity.

The October board meeting featured an extensive discussion of how the enforcement process would be carried out. However, it did not clearly convey how OHCA will ultimately enforce compliance with the spending targets. California's hospitals urge the OHCA board to revisit key parts of these discussions in the coming months and codify, in regulation, detailed rules for each component of the enforcement process.

Decision to Forgo Waiver Process Requires Reconsideration

OHCA staff stated its intent to **not** implement the waiver process established in law, and instead use an alternative process that ostensibly would achieve similar ends. In discussion to date, OHCA touts that this alternative process would allow greater flexibility. This decision raises serious questions — most notably by running counter to the intent and letter of OHCA's authorizing legislation. OHCA states that the alternative process would better allow it to "prioritize" enforcement actions — but what this means, and what factors would inform that prioritization, are unclear. Significantly more information is needed and clear rules for prioritization must be codified in regulation to avoid any appearance of arbitrary decision-making.

Additionally, OHCA states that the waiver process outlined in statute overly restricts the factors that may be considered when determining enforcement actions; its alternative process would purportedly allow broader range of factors to be considered. However, the factors contemplated in the waiver provision of statute are broad — they include factors outside an entity's control, anticipated costs for investments, and extraordinary circumstances. Together, these factors encompass most if not all the "potential enforcement considerations" that OHCA seeks to incorporate through its alternative process. OHCA should clarify which factors it believes could not be considered under the waiver process.

Finally, OHCA should clearly articulate in future board discussions any other flexibilities it is seeking in the enforcement process, beyond the aforementioned. Absent clear and convincing answers to all these questions — most importantly, why it is appropriate for OHCA to forego the waiver process clearly established in law for rendering enforcement decisions — OHCA should reverse its decisions and move forward in development of a reasonable and sound waiver process.

Create a Transparent Waiver or Similar Process Defined in Regulation

OHCA must detail the enforcement process — including a comprehensive list of reasonable factors for exceeding the target —in regulations so entities can understand what actions and circumstances will and won't result in penalization. Moreover, given the dynamic health care and political landscape, OHCA must also include a catch-all provision that offers an opportunity for non-enumerated factors to be considered. Guidance on the kinds of engagement, analysis, and documentation that OHCA may require of or that entities may submit for assessment is also needed to help entities prepare for such a process. Lastly, OHCA must establish an appeal process so entities that disagree with OHCA's determination have the opportunity to provide additional supportive documentation and further explanation.

Rely on Public Data to Streamline Reasonableness Determinations

When making enforcement decisions, OHCA should rely on public data as much as possible. Doing so will reduce the administrative burden on both the office and regulated entities. For factors that affect health care entities, the economy, or public health broadly, OHCA should look to preexisting public datasets that summarize statewide, regional, and industry-wide trends. For example, OHCA should look at public inflation indices to see whether elevated economy-wide cost growth should be considered as a reason many entities are exceeding the target. OHCA should also rely on public data wherever possible to examine individual entities' cost drivers, such as by looking at hospitals' Annual Financial Disclosure

Reports. Proprietary data should be a tool of last resort — and if it is used, OHCA must ensure it is protected.

Technical Assistance Should be Meaningful, Actionable, and Recognized

At the October Board meeting, OHCA staff provided details on what technical assistance would entail for entities that exceed the spending target. Specifically, OHCA defined technical assistance as simply providing a letter to the entity with high-level resources that they could use to come into compliance (e.g., research studies, literature, and cost-reducing strategies); it would not include OHCA directing an entity to implement specific changes to their operations. OHCA staff further indicated that the office would not assess entities' efforts to implement the technical assistance prior to moving to the next steps of the progressive enforcement process.

To ensure this step of the enforcement process is meaningful, OHCA should tailor technical assistance to the class and context of different health care entities. Accordingly, OHCA should provide entities with actionable and realistic steps, as well as time for entities to implement them. Moreover, health care entities' efforts to implement the technical assistance provided by OHCA should be recognized and accounted for in OHCA's determination of whether an entity is subject to stricter enforcement. This measured approach should be considered and adopted so entities have an earlier opportunity to make changes to meet OHCA's spending goals.

Public Testimony Must Enhance Mutual Learning, Not Provide an Opportunity for Political Theater

OHCA staff also provided details about public testimony at the October OHCA Board meeting. In particular, OHCA noted that compulsory public testimony (in-person or written testimony) from entities that exceed the target is an optional step in the progressive enforcement process, at the discretion of OHCA's director. Some board members noted that the public testimony is of interest to consumers, the public, and community members — and presents an opportunity for the public to engage with the entity that exceeded the target.

OHCA should be cautious in implementing this component so that it does not become spectacle, rather than an opportunity for mutual learning between the entity and OHCA board and staff. OHCA should establish parameters specifying when a health care entity would be required to testify and the types of information needed for testimony. Lastly, to truly have a progressive enforcement process, engagement in public testimony should be considered before proceeding to subsequent enforcement steps.

Conclusion

California's 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

November 14, 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: November 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 an alternative proposal on the data submission penalty, comments on technical assistance and public testimony elements of growth target enforcements as well as possible waivers of enforcement. We continue the discussion of rate review as well as waste, administrative overhead and profits of health plans, insurers, hospital systems and large physician organizations, including the impact of the 340B program.

Executive Summary:

- Health Access supports using consumer affordability as the basis for the cost growth targets because:
  - It is consistent with the law
  - 80% of California taxpayers live on less than $175,000 a year
  - Half of all Californians skip or delay care because of costs—and about three out of four low-income Californians go without care because of costs
- Health Access commends the Board, the Department and the Office for early action to meet the statutory deadlines for both the statewide target and the sector target, which served as the basis for the very high-cost hospital targets.

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- Health Access offers a revised proposal on data submission penalties that scales up over three years to an amount commensurate with an estimate of the avoided penalty for exceeding the growth target in year one.
- Health Access comments on the enforcement process for exceeding the growth targets,
    - Technical assistance provides general guidance based on type and perhaps size of entity, not entity-specific consulting services
        - Public testimony is the enforcement step after public notice of an entity exceeding the target and the extent by which it exceeded the target, including written testimony by all entities exceeding the target as well as verbal public testimony by some entities at a Board meeting or other public meeting.
    - Performance improvement plans:
        - Public notice should be provided when an entity is in discussion with the office about a performance improvement plan since not all entities will proceed to that stage.
        - Public notice, including a detailed summary, is required for an entity for which the office has finalized a performance improvement plan.
- Health Access opposes blanket waivers of enforcement in all but rare instances.
    - Even instances such as a major quake like Loma Prieta or Northridge on further examination are more appropriately addressed through enforcement considerations than a blanket waiver.
    - Health Access supports the staff recommendation to defer further discussion of blanket waivers to future consideration.
- Health Access urges caution with respect to "enforcement considerations"
    - Every "enforcement consideration" further worsens consumer affordability.
    - Some alleged cost factors on further scrutiny may be revenue centers, such as hospital-administered drugs subject to the 340B program.
    - Enforcement involves consideration of the financial capacity at the system level, including reserves and investment income. Insurance rate review begins with the question of excessive reserves: so should enforcement across health care entities.

Why Growth Target Matters: Lack of Consumer Affordability Today

Consistent with the enabling statute, the Board based the growth target on a measure of the capacity of consumers to afford care: the trend in median family income over the last twenty years. The Board discussed other possible measures of consumer affordability as well as reviewed information on larger economic trends and demographic factors such as

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aging of the population. The enforcement of the target will be adjusted annually based on changes in the age and sex of the population served.

Health Access supported basing the growth target on consumer affordability. Eight out of ten Californians live on less than $175,000 a year. Even in California, only the top 1% earn more than $1 million a year.

Those making less than 200%FPL (about $32,000 for an individual or $64,000 for a family of four[1]), in the bottom half of the income distribution, are much more likely to skip or delay care because of costs. Literally, three out of four lower income Californians reported skipping or delaying care because of costs and a majority had some medical debt[2].

Income Distribution of Taxpayers in California: ITEP (2026)[3]

Income Group	Income Range From	To	Average Income
Bottom 20%	$0	$31,000	$17,300
Second 20%	$31,000	$59,600	$44,500
Third 20%	$59,600	$106,600	$81,200
Fourth 20%	$106,600	$174,800	$138,900
Next 15%	$174,800	$450,700	$266,600
Next 4%	$450,700	$1,088,900	$659,300
Top 1%	$1,088,900	And Above	$3,496,200
TOTAL			**$154,800**

Health Access also commends the Health Care Affordability Board, HCAI, and the staff for acting in advance of the statutory deadlines for both the statewide target and the sector target that served as the basis for the very high-cost hospital target. It is rare for a state agency not only to meet a deadline but to do it early. OHCA merits commendation for its timely actions.

[1] https://www.coveredca.com/pdfs/FPL-chart.pdf

[2] https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFCAHealthPolicySurvey.pdf. A national study with similar results: https://www.federalreserve.gov/publications/files/2023-report-economic-well-being-us-households-202405.pdf

[3] Analysis of Tax Provisions in the Senate Reconciliation Bill: National and State https://itep.sfo2.digitaloceanspaces.com/Senate-Reconciliation-Bill-Numbers-Revised-7-2.xlsxLevel Estimates – ITEP

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Data Submission Penalty: Health Access Revised Proposal

Health Access offers a revised proposal on data submission penalties based on the Board discussion and further consideration of that penalty at the October 2025 Board meeting. The proposal is revised from our earlier proposal.

Health Access is pleased that 48 of the 50 health plans required to submit data have done so timely and completely and that the other two are on track to do so. We hope that the data submitted meets the reasonableness test when subjected to further scrutiny. Again, as we said in October, past performance is no guarantee of future compliance and while helpful in establishing "knowing" or "willful" failure to comply, is not alone sufficient. Once real money is on the line in terms of growth penalties, behavior may change. The data submission penalty is intended to ward against that.

The board discussion has been clear: data submission is foundational to the entire enterprise and a larger penalty in year one is necessary to ensure that data is reported completely and timely.

$5 is not enough: Penalty based on Benefit to Payer of Avoiding Data Submission

Health Access concurs with most Board members that a larger penalty imposed in December of year one of failure to submit data is important and appropriate.
$5 per member per year is not enough. Doubling it to $10 for year two and then $20 for year three is not enough and not fast enough. Instead, Health Access proposes that the penalty by year three be commensurate with an estimated failure to meet the growth target and that the penalty for year one escalates over time. Why do we propose this?

Factors to Consider: Scale of Multi-State, Multi-Part Entities

The law governing OHCA requires commensurate penalties for failure to meet the growth target. This law is deliberately different than the law governing penalties for health plans, which was largely put in place in 1975 when HMOs were mostly small, local non-profits, not the multi-state, multi-entity behemoths they are today.

The law governing OHCA requires the director when determining penalties to consider the financial capacity of the health care entity as part of a larger system. National revenue is a measure of the financial capacity of a health plan or health care provider. The OHCA statute says that when determining penalties, the director shall consider:

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(B) The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity[4].

The director is required to consider "fiscal condition" as well as the "nature, number and gravity" of offenses and the market impact of the entity. A big entity should face the threat of a big penalty while a smaller entity, or one that is in financial distress and is not part of a larger system, should have size and financial distress taken into consideration.

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

Health Plan Top Five 2022	*California Enrollment: Medicare, Medi-Cal, Commercial, 2022*[5]	*National Revenue: 2024*	October 2025 staff proposal: $5/member/yr Penalty	Estimated Commensurate Penalty If Growth is 4.5% instead of 3.5%[6]
Kaiser Permanente	8.5 million	$115.8 billion[7]	$42.5 *million*	$677 million
Elevance (Anthem)	5.9 million	$175.2 billion[8]	$29.5 *million*	$237 million
Blue Shield	3.2 million	$27.4 billion[9]	$16 *million*	$235 million
Centene HealthNet	2.6 million	$163.1 billion[10]	$13 *million*	$202 million
United	2.0 million	$298.2 billion[11]	$10 *million*	$200 million

Some argue that revenues are not relevant. But the law says they are. It is correct that plans pay out more than 80% of premium revenues in claims. But the point of OHCA is to slow the rate of growth of claims costs as well as administrative overhead and profits. This is confirmed by the provision of the OHCA law that penalizes the administrative overhead and profits of payers (health plans and insurers) that fail to reduce claims costs[12]. Ignoring

[4] Health and Safety Code 127502.5 (d).
[5] Slides 20 and 4: https://www.chcf.org/wp-content/uploads/2024/10/HealthInsurersAlmanac2024.pdf
[6] The estimate of the commensurate penalty was calculated using California revenues as a proxy for THCE and multiplying by 1%.
[7] https://about.kaiserpermanente.org/news/press-release-archive/kaiser-foundation-health-plan-hospitals-risant-health-report-2024-financial-results
[8] https://www.elevancehealth.com/newsroom/elv-quarterly-earnings-q4-2024
[9] https://news.blueshieldca.com/mission-report-2024-financials
[10] https://investors.centene.com/2025-02-04-CENTENE-CORPORATION-REPORTS-2024-RESULTS
[11] https://investors.centene.com/2025-02-04-CENTENE-CORPORATION-REPORTS-2024-RESULTS
[12] Health and Safety Code 127502.5 (f)

the scale of the entities in question is precisely contrary to both the Board discussion and the plain language of the law.

Past Experience by State Agencies Informs Health Access Proposal

Those who drafted the OHCA statute were well aware that California state agencies have had ample experience with large multi-state entities failing to comply with California law or failing to respect the reasons for it. A few examples, among many:

- Cigna routinely charged small businesses rates that the Department of Managed Health Care (DMHC) found unreasonable—until California law changed, and health plans were required to notify their purchasers if a rate was found unreasonable or unjustified. No unreasonable rate has been charged to an individual or small business since[13].
- Several large health plans have been penalized by DMHC over the years for failing to pay for out-of-network emergency care in accordance with California law, which is different than federal law and has been for 30 years.
- As the National Union of Healthcare Workers (NUHW) and others have testified both at the OHCA Board and in a recent legislative oversight hearing, Kaiser has not complied with the provisions of the settlement to improve access to behavioral health to timely and clinically appropriate behavioral health care.
- Trinity health system, a large multi-state hospital system, refused to accept California Attorney General conditions on its takeover of Madera hospital, even though similar conditions have been routinely imposed for over 30 years by California Attorneys General of both parties.

This is a partial list of large health care entities ignoring or failing to respect California law. We propose a substantial initial penalty in order to prevent OHCA data submission from being added to this list.

A Data Submission Penalty Sufficient to Induce Prompt, Complete Reporting

The threat of the penalty should be large enough to cause the entity, in this case the health plan, to prioritize producing the data timely and completely. And it should grow as health care costs grow and not be frozen in ancient history like some relic of an earlier time. As indicated in the table above, the $5 per member penalty amounts to $10-$20 or $30-$40 million depending on the number of enrollees, while a penalty commensurate with exceeding the growth target by only 1% amounts to hundreds of millions of dollars. A penalty of $10 million to $40 million for the big five health plans is puny given the scale of

[13] Unfortunately, large purchasers have had less satisfactory experiences with DMHC rate review.

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health plans that have revenues of $100 *billion* to several hundred *billion* dollars a year. A small per member per year penalty is not sufficient given the scale of the entities involved.

Profits and Administrative Overhead Not Appropriate Basis for Data Penalty

We do not propose penalties based on profits, administrative costs or a combination of them for several reasons:

- First, hospitals and most large physician organizations do not provide complete information to state government so OHCA could not extend data submission penalties based on profits or administrative costs to other health care entities.
- Second, health plans and insurers as well as many hospitals and large physician organizations are usually part of larger entities and both profits (to shareholders) and administrative costs can readily be camouflaged by the larger system or subsidiaries and affiliates. For example, all of the administrative overhead of the Permanente Medical Group or a Risk Bearing Organization (RBO) counts as "medical claims", even if it is used to pay for accounting clerks and other administrative costs.
- Third, the reason the OHCA targets apply to health plans and insurers is to transform the health care system by requiring plans and insurers to negotiate effectively over cost and quality.

How to Estimate the Avoided Commensurate Penalty for Failing to Submit?

Because of the insurer rate review process, DMHC and CDI have information on how much health plans and insurers expected rates and total medical expenditures to escalate, both prospectively and retrospectively. Rates are set prospectively but they are based on a retrospective review of trend. From this information, it may be possible to estimate the avoided commensurate penalty for a plan or insurer that fails to submit data for a year or two. For example, if medical trend for total medical expenditures is 8% while the growth target is 3.5%, then the benefit to the payer of failing to submit timely and complete data is roughly 5.5% of the amount spent on hospitals, professional services, and other benefit categories.

Escalating Penalties: Quarterly? Annually?

Escalating penalties on a monthly or quarterly basis run into the practical reality of how penalties would be enforced first through an Administrative Law Judge (ALJ) at the Office of Administrative Hearings (OAH) and then through a Superior Court if the dispute proceeds to litigation. Other agencies, including DMHC, have found per-day penalties effective in

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enforcing Independent Medical Review (IMR) decisions[14]. Monthly or quarterly escalating penalties are worth considering and could lower the amount of the initial penalty, but that virtue must be balanced against the practical reality of administering such penalties.

Escalating Penalties Based on Estimated Benefit to Payer to Fail to Submit:

Two Options

Health Access offers two options on escalating penalties based on an estimate of the benefit to a payer of failing to report data:

- Option One: the penalty in year one would be imposed in December and amount to 1/3 of the estimated miss on the growth target. For year two, the amount would double to 2/3s (adjusted for any corrections to the estimate). And for year three, it would amount to the entire amount, the "commensurate" amount. If the benefit of the avoided commensurate penalty for the growth target is $200 million, one third would be $67 million in year one, another $67 million in year two for a total of $134 million, and then the full $200 million for year three. This amount is based on a commensurate penalty for exceeding the growth target, the standard provided in the law.
- Option Two: if it is administratively feasible to escalate penalties quarterly, particularly in year one, a second option would be to calculate the amount of benefit and require payment of one third of the 1/3 each quarter in December, March and July, cumulating to 1/3 by July (since the data reporting process begins in August). If the benefit of failing to submit the data amounted to $200 million in avoided penalties for exceeding the growth target, then $66 million would be due December 31, another $22 million on March 30 (adding up to $44 million if not yet paid), and a third $23 million for a total of $67 million by July.
- At some point, presumably amounts of this scale would get the attention of those within a payer organization who can prioritize the resources to break loose the data.

Again, we hope this penalty is never used. To date, it would not have been necessary.

<u>Growth Target Enforcement Process</u>

A. Setting the Target, Determining an Entity Exceeded It.

The Board has already taken the first step in the enforcement of a growth target by establishing a target. The next step is to determine whether an entity has exceeded it. The Board has had some of this discussion by contemplating the impact of age/gender

[14] The per-day penalty is for failure to implement the IMR decision promptly.

adjustments as well as general discussions of possible enforcement considerations. Still to come is a discussion of the organized labor cost adjustment which the law treats differently than other labor costs.

B. Technical Assistance

Health Access concurs with staff that "technical assistance" provided as the first step in the enforcement process is likely to consist of general information. We suggest that it should be tailored to the size and type of entity. Technical assistance to a health plan which faces rate review and the medical loss ratio is likely different than such technical guidance to a large physician organization. Similarly, what is appropriate for a health system like Stanford with hundreds of beds and billions of dollars in liquidity annually will probably be somewhat different than such assistance to a standalone critical access hospital with 25 beds and little cash on hand.

We appreciate the staff's clarity that technical assistance is not intended to provide an entity with a laundry list of specific or required changes. It is not the state's responsibility to provide consulting support tailored to a specific entity. Instead, the state's role should be to encourage the entity to think through from the entity's perspective how it can come into compliance with the growth target and to offer additional insight into any disagreements over data or other elements of the excessive growth in spending. If the Legislature and the Governor had wanted to give OHCA the authority to require specific changes, they could have done so. They did not.

C. Public Testimony as Part of Enforcement

The law on enforcement also includes the potential for the director to request or compel public testimony by an affected entity. This is part of enforcement and as such, is intended to be mildly punitive.

A question for the Board is when does the Board want to hear from an entity that exceeded the target? One Board member pointed out that written testimony is (almost always) appropriate and helpful.

Health Access proposes that in every instance in which, consistent with the law, OHCA "makes public the extent to which the health care entity has exceeded the target"[15], the entity should be required to provide a formal written statement for the public record. The Board and the staff may select entities to provide public testimony at a Board meeting,

[15] Health and Safety Code 127502.5 (c) (1).

including answering questions from Board members, about cost drivers and the entity's progress in addressing them.

Over the months and now years that the Board has met, they have received written comments from numerous entities and their trade associations as well as other stakeholders, with the majority of comments supporting growth targets based on consumer affordability and strong action on very high-cost hospitals. How is the public testimony provision of enforcement different than the public comment now provided to the Board? The Board and director could allow more than two minutes for such testimony. Does the Board wish to do this in every instance? The answer may depend on how many entities exceed the target and how disparate the reasons are.

An unusual or emerging pattern might also bear further public testimony: for example, the work on high-cost hospitals began because the community in Monterey protested high health care costs that were impoverishing working teachers, hotel workers, farm workers, building trades and others in that community. In that instance, the public meeting in Monterey systematically exposed the alleged reasons for the high costs as lacking a basis: people in Monterey are healthier, not sicker; wages for health care workers (aside from administrators) are not higher than in the Bay Area; and quality on standard quality measures was not better. Prices were higher in Monterey because of market power, not quality of care.

Because of the constraints of the open meeting law, public testimony in this setting will be different than that in a legislative hearing, particularly a legislative hearing in which a legislator interrogates the head of a state agency. Instead, the Board members may find their ability to question or engage in back and forth with the entity constrained by law or other process associated with enforcement.

D. Performance Improvement Plans

The third step in progressive enforcement is a "performance improvement plan", which is corporate speak for a "corrective action plan", the terminology used by other state agencies. Whatever the label is, a corrective action plan called a performance improvement plan is still a requirement that the entity that exceeded the target correct what they have done.

The burden will be on the entity to explain how it intends to come into compliance without harming quality, equity, or workforce stability. Because the Office has the authority to accept or reject the plan and the Board will provide input, this is likely to be an interactive

process of developing an acceptable plan to correct the failure to meet the growth target. Only a single entity in another state has yet proceeded to this stage: the back and forth over what constituted an acceptable performance improvement plan took months, if not years, and then additional time to implement and assess.

The law requires that:

> The office shall publicly post the identity of a health care entity implementing a performance improvement plan and, at a minimum, a detailed summary of the entity's compliance with the requirements of the performance improvement plan while the performance improvement plan remains in effect.[16]

Since the identity of the entity that has exceeded the target and the extent to which it has exceeded the target will already be public, there will be questions about which entities have entered into discussions about performance improvement plans. The fact that an entity has moved to the stage of discussing a performance improvement plan should be available to the Board and the public.

E. Waivers of Enforcement

The law includes the possibility of "waiving" enforcement. In the words of the October Board discussion, this is an "on/off" switch in which all enforcement is waived rather than progressing through various enforcement steps.

Health Access supported the inclusion of waivers of enforcement because we recognized that in rare instances, it may be appropriate to waive enforcement, although for a limited period of time. Examples of when it might be appropriate to waive enforcement:

- In March of 2020, facing a once-in-a-century global pandemic with considerable uncertainty about the impacts on the health care system and the need to reconfigure health care spending on the fly, a waiver of enforcement might well have been a reasonable step. A waiver in this situation might have been for a year or two, but not indefinitely.
- When a hospital such as Madera Community re-opens, consideration should be given to a start-up period of several years, just as was done with the distressed hospital fund.

Examples of when a waiver is not appropriate, even in the face of Acts of God:

- *Closing or other failed entity:* A waiver would not be appropriate when a hospital closes, or a health plan fails because enforcement only applies when the target is

[16] Health and Safety Code 127502.5 (c) (2).

exceeded. An entity having zero revenue or rapidly diminishing revenue should obviate enforcement because the entity won't exceed the target.

- *Major quake:* A large earthquake such Loma Prieta in 1989 or Northridge in 1994 is not an appropriate example of the need for a waiver because different health care entities, including hospitals, were affected differently. For example, in the Northridge quake, two hospitals in Santa Monica[17] were severely damaged. One never re-opened (so it would not have exceeded the target). Even today, when more than 95% of California hospital buildings are no longer at risk of collapsing, engineers estimate that one out of four hospital buildings that meet current seismic requirements would not be safe to occupy after a major quake and would need to be promptly evacuated[18]. Similarly in Loma Prieta, some hospitals were "yellow-tagged", that is deemed unsafe to enter and never re-opened. Other hospitals stepped forward to provide needed care. Considering the differential impact of an earthquake is a legitimate enforcement consideration but not an occasion for a blanket waiver of enforcement[19].
- *Fires*: California has had the unfortunate experience of losing a hospital, Paradise, to fire. Other hospitals treated affected patients, though the number and intensity of care varied. Again, this would be an appropriate enforcement consideration for the other affected hospitals, not the occasion for a blanket waiver. The Board should also recall that the target is on a per capita basis so a simple increase in enrollment or discharges should not cause an entity to exceed the target.

Applications for complete waivers of enforcement should be treated with caution by the Board and staff. Health Access appreciates the staff recommendation that further development of the standards for waivers of all enforcement be deferred until a later date when the Board and the Office have more experience. We offered several examples of when a waiver might at first glance appear appropriate but on further consideration, is likely not.

Enforcement Considerations: Costs? Or Revenue Sources? Investment Income?

Health Access urges caution with respect to enforcement considerations that weaken the enforcement of the growth target.

[17] That area in Santa Monica was built on fill and alluvial land so shaking was magnified.
[18] The hospital seismic safety standards for the year 2030 require that hospitals be not just survivable but operational post-quake.
[19] We note that the financially responsible thing to have done was to have spent the years since 1994, planning to meet the standards for the year 2030. If the average consumer can pay off a mortgage in 30 years, so can a hospital.

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First, every enforcement consideration that raises the amount a health care entity receives undermines consumer affordability and moves in the wrong direction. Approving an enforcement consideration translates into the reality that half of all Californians continue to be unable to afford needed care. If the office does not hold the line on cost growth targets under these conditions, we will not achieve the vision that led to the creation of OHCA and finally slow the cost curve of health care spending.

Second, some proposed "enforcement considerations" may actually be *revenue sources* rather than costs to the health care entity. An interesting presentation on the 340B program to the Minnesota Prescription Drug Affordability Board concluded that Minnesota hospitals net $600 million in *revenue* from the 340B program[20]. Scaled to California scale, that would that California hospitals participating in the 340B program net $3.5-$4 billion from the 340B program—and are free to keep that benefit while passing on the underlying drug cost without the 340B discount to commercial payers, and do so after further marking up the cost of the drug beyond the actual cost of administration. The University of California health system as reported to the U.C. Board of Regents that UC hospitals have benefited from the 340B program to the tune of $1.3 billion in revenue.[21] One very high-cost hospital, Doctors Modesto, appears to mark drug costs up by eleven times as high as the cost to the hospital. That is excessive. High-cost drugs and often high-cost patient outliers are often cited as enforcement considerations, but further documentation will be needed to demonstrate that these are costs, not revenue generators for the health care entity proposing that consideration.

Third, some health care entities have substantial reserves that may be used to buffer high-cost outliers as well as to slow the rate of growth of health care spending. Rate review for insurers, whether auto insurance or homeowners or health insurance, always begins with a discussion of whether an insurer is holding (and profiting from) excessive reserves. Not only insurers and health plans, but some hospitals and health systems also have substantial reserves. The Community Hospital of the Monterey Peninsula, a very high-cost hospital, had $1 billion in reserves. Stanford University had $2.2 billion in investment income in 2024[22] while Fitch ratings found that Stanford heath system had $5.9 billion in unrestricted liquidity[23], which would allow it to cushion the rate of increase in its costs to consumers and other purchasers. Other hospitals and health systems such as Sutter also publish financial statements showing substantial investment income. Sutter alone had

[20] mn.gov/commerce-stat/insurance/pdab/06-10-2025/pdab_presentation.pdf
[21] https://regents.universityofcalifornia.edu/regmeet/may25/h2.pdf
[22] https://bondholder-information.stanford.edu/sites/g/files/sbiybj21416/files/media/file/fy24-annual-financial-report_0.pdf, p. 4
[23] https://www.fitchratings.com/research/us-public-finance/stanford-health-care-california-21-05-2024

investment income of over $800 million in 2024[24]. Reserves and investment income can buffer short-term impacts such as transitory inflation and one-time impacts of tariffs.

Unfortunately, because hospitals, health systems and most large physician organizations are not subject to a medical loss ratio or rate review, information on investment income, reserves, and various revenues sources for health providers are not comparable to information readily available for health plans and insurers. A medical loss ratio framework for hospitals, hospital systems and large physician organizations could parallel that for insurers, setting a clear expectation for how much spending should be tied to care delivery versus overhead, marketing and profit. Is financing baseball parks by health plans or hospital systems care delivery or marketing?

Conclusion

Health Access, the statewide health care consumer advocacy coalition, has offered:

- Recognition that basing the statewide target on a measure of consumer affordability is consistent with the law and the work done by the Board and staff.
- Commendation for not just meeting the statutory deadlines for setting a statewide growth target and sector targets but doing so ahead of the deadlines.
- An alternative proposal on the data submission penalty, escalating over three years to the estimated amount of an avoided penalty for exceeding the growth target.
- Comments on elements of growth target enforcements, including technical assistance, public testimony both written and verbal and performance improvement plans intended to correct spending in excess of the target.
- Possible waivers of enforcement supporting no action at this time and providing examples of both possible waivers and situations, such as a major quake, in which a waiver would be inappropriate.
- We continue the discussion of rate review as well as waste, administrative overhead and profits of health plans, insurers, hospital systems and large physician organizations, including the impact of the 340B program.

Thank you for your consideration of these comments,

Sincerely,

Beth Capell, Ph.D.

Amanda McAllister-Wallner

[24] https://vitals.sutterhealth.org/sutter-health-posts-2024-audited-financial-statements/

1127 11th Street | Suite 925 | Sacramento, CA 95814

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

1127 11th Street | Suite 925 | Sacramento, CA 95814