August 20, 2025

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

Subject: **Comments on the July 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.

Enforcement Process Must Be Fair and Considered to Avoid Unintended Consequences

Hospitals Are Deeply Concerned by Board Discussion of Enforcement Process

At the July OHCA board meeting, OHCA staff began focused discussion of the spending target enforcement process, noting that these discussions will continue into the next year and culminate in the promulgation of related regulations. While the discussion was intended to be preliminary, several board members made many troubling remarks about what they would consider reasonable factors for exceeding the spending cap — essentially, there are none. For example:

- Following the largest health care cuts in the nation's history, passed under the One Big Beautiful Bill Act, hospitals will have no choice but to increase payments from other sources to sustain access to care or be forced to curtail services — but this was disregarded as a compelling reason.
- Cost pressures from new blockbuster drugs like Ozempic and Wegovy — drugs with life-changing impacts and for which patients are clamoring — were not deemed appropriate reasons for exceeding the spending cap.
- One board member stated that only "acts of God" should be justifiable, but even that was curtailed by other board members' opinions that such exceptions should be very narrow to avoid a "slippery slope."

This early reluctance to consider valid reasons a hospital may exceed the spending growth cap — reasons that are often driven by pharmaceutical companies, patient needs, or other forces outside of hospitals' control — is troubling, particularly given that programs in other states **did** account for these realities. Without a means to compensate for these pressures through a waiver process, hospitals would be forced to take drastic actions to curtail costs that run counter to OHCA's legislatively-mandated mission of promoting access to high quality and equitable care — for example, by limiting access to costly services or drugs. As OHCA continues its work to define the enforcement process, the discussion and resulting rules must carefully balance the office's imperative to improve affordability **without sacrificing** health care access and quality.

OHCA Must Account for Health Care Spending Growth that Supports Patient Care

In its pursuit of improving health care affordability, OHCA is also required to maintain and improve quality, equity, access, workforce stability, and the value of health care service delivery. Consequently, as OHCA assesses entities' compliance with the spending target, OHCA must appropriately account for factors that reasonably explain why entities' health care spending has increased — especially increased spending that is in service of improving Californians' health. Hospitals and health systems that invest in and expand services, technology, and programs that provide equitable, high-value, and high-quality care in their communities should not be penalized for increased spending. Reasonable factors outside of an entity's control should also be considered, such as statutory and regulatory changes affecting health care costs and macroeconomic trends, like rising inflation. Without a prudent approach that accounts for these important investments and uncontrollable influences, hospitals would be forced to make changes that will negatively impact patients' access to care and affect their ability to sustainably operate in their communities.

State Law Mandates Implementation of a Meaningful Waiver Process

OHCA staff's presentation at the July board meeting left an impression that the establishment of a meaningful enforcement waiver process is optional. However, this interpretation runs counter to both the letter and spirit of state law. Per statute, prior to any enforcement action, OHCA is **required** to give an entity that exceeds the target a reasonable opportunity "to respond and provide additional data, including information in support of a waiver" and to determine whether that submission "meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target…" (HSC § 127502.5 (b)(2) and (3)). State law only provides discretion in this context for establishing the procedural requirements for filing such waiver requests and the evidentiary burden to be met in considering those reasonable factors outside of an entity's control, such as changes in state or federal law, investments to improve care and reduce future costs, and acts of God or catastrophic events (HSC § 127502.5(i)). So, while OHCA has discretion to promulgate regulations governing the filing of such requests and technical specifications for how those requests will be evaluated, establishing the waiver process itself and providing regulated entities a meaningful opportunity to justify reasons for exceeding a spending target is legally required. The Legislature's reasoning behind this is clear and similar to other states' approach: That there are indeed instances when entities have a reasonable cause for exceeding the target, and therefore should be waived from the enforcement process upon a sufficient showing by the subject entity. OHCA and its board must follow the Legislature's clear direction and the example of other states.

OHCA Must Revisit the Spending Cap and Implement a Reasonable Waiver Process

Under the spending target framework, OHCA has two mechanisms by which it can account for justifiable spending growth:

- **Up-front Quantitative Adjustments to the Spending Target** – OHCA could determine factors that drive health care spending and directly incorporate them when setting spending targets, so that the targets reflect appropriate or unavoidable cost growth within the health care delivery system. For example, the statewide spending target is based on average median household income growth between 2003-2022, a measure that is — at best — only tangentially related to the growth of health care spending. Economy-wide inflation, by contrast, more accurately captures trends in health care spending because it reflects broader economic conditions. When setting the initial spending growth targets, OHCA could have incorporated relevant inflationary data into the spending target to ensure health care entities' ability to sustain levels of access to care to meet their communities' needs.
- **Back-end Waivers of Enforcement** – Alternatively, OHCA may choose to provide waivers after the fact, to account for reasonable factors that caused a health care entity to exceed the spending target. OHCA would obtain from the entities additional information that could help explain the drivers behind their spending and, with this information, determine whether spending growth in excess of the target was worthy of a waiver that would forestall enforcement. This mechanism, however, makes it challenging for hospitals to plan for the future as they will lack clarity on how they will be judged against the targets until after an enforcement period has ended.

OHCA Risks Failing to Account for Any Reasonable Growth Factors

In setting both the statewide spending target and the hospital sector spending target, OHCA did not make up-front adjustments to account for key drivers of health care spending that were needed to balance access, quality, equity, and workforce stability with affordability. These drivers include, but are not limited to, federal and state policy changes and mandates, inflation, coverage and demographic changes, high drug costs, increasing supply and labor costs, payer mix, and cost of living variation. **OHCA must revisit the spending targets for future years to ensure they account for key drivers. Otherwise, the spending target will force health care entities to cut back on the care and services they provide or face penalties for delivering the care their patients need.**

It Is Too Late to Revisit Spending Targets for 2026 — A Reasonable Waiver Process is Necessary

While hospitals encourage OHCA to revisit future targets, the deadline for changing the 2026 spending target has passed and cannot be adjusted. Therefore, incorporating enforcement waivers based on reasonable factors is the only mechanism left for OHCA to account for either uncontrollable or desirable growth above the target. Moreover, not all factors for reasonable but excessive growth can be predicted in advance. For example, changes in payer mix or an increased number of patients with costly medical needs could cause a provider's spending to jump significantly from year to year; these could only be addressed through a meaningful waiver process.

Yet, at the July 2025 OHCA board meeting, OHCA signaled its intent to backtrack on prior commitments to "contextualize" higher spending growth even if it was for reasons articulated in statute or those previously acknowledged publicly — such as when Director Elizabeth Landsberg testified (during the May 1, 2025, Senate

Budget Subcommittee #3 on Health and Human Services) that "there will be an ability to adjust the targets for reasonable considerations." This means that investments to improve access to preventive care or revenue increases to keep pace with the health care worker minimum wage would result in penalties from OHCA.

Given that OHCA failed to account for key drivers of health care spending in the established 2026 statewide and hospital sector spending caps, and that some justifiable factors cannot be anticipated, it is imperative that OHCA establish a meaningful waiver process.

Hospitals Are Committed to Helping Establish a Reasonable Enforcement Process

As OHCA develops and defines each component of the enforcement process, it must do so with transparency, adopt an approach that appropriately assesses compliance, reflect the challenges and constraints that health care entities face, and allow for input and engagement from all stakeholders so that the path toward affordable health care is achieved fairly and collaboratively. In carrying out progressive enforcement actions, OHCA must give entities the opportunity to provide information, allow for the conditions or factors that give reasonable cause for entities' exceeding the target, incorporate a waiver process, and give entities flexibility in carrying out its critical functions — particularly if they are required to implement a performance improvement plan. These guiding principles should be paramount as OHCA develops the enforcement process.

OHCA's Reliance on Selected Reports and Tools Undermines the Affordability Narrative

Hospital Cost Tool Manipulates Data to Reach Misleading Conclusions

At the July OHCA board meeting, OHCA provided an overview of its engagement with stakeholders on high-cost drugs in relation to the spending target. One suggestion to OHCA from these discussions was to use the NASHP Hospital Cost Tool to examine hospital cost-to-charge ratios and drug pricing, with a potential goal of identifying variation across hospitals and understanding whether drug prices might justify a hospital exceeding its spending growth target.

While the tool attempts to make complex Medicare data from the Healthcare Cost Report Information System more accessible, the methodology contains structural biases that make it inappropriate for evaluating hospital pricing or supporting decisions around hospital expenses. A key example: The tool calculates operating margin based on operating costs using only Medicare-allowable expenses, excluding numerous legitimate and unavoidable expenses such as physician recruitment, research, innovation and technology upgrades, intern and resident physician training programs, and portions of many community benefit programs. These costs are essential to delivering care in hospitals, promoting innovation and quality, and training future generations of providers, but because they are not "Medicare-allowable," they are removed from the cost calculation. Problematically, the tool does not make a corresponding adjustment to hospital revenue to exclude associated revenues from the aforementioned costs, meaning the margin calculation compares full revenue against a partial, artificially reduced cost base. Ultimately, this methodology systematically inflates operating margins and gives the appearance that hospitals retain more from patient care than they actually do.

CHA's analysis of the NASHP tool and other data sets for California hospitals illustrates the magnitude of this distortion. When comparing the NASHP tool's 2023 hospital-level net patient revenue and hospital operating costs data to the HCAI Annual Financial Disclosure Report Selected Pivot file for 2023, focusing on the net patient revenue and total operating expense columns, CHA found that hospital revenues in NASHP's dataset matched HCAI's to within 1% on average — but **reported expenses were, on average, 15% lower in the NASHP tool.** This is clear evidence that NASHP is not adjusting revenue appropriately when excluding costs and points to a methodology that is unsound and misleading.

This flawed approach to calculating operating margins raises serious questions about the validity of the tool's other reported measures, including drug costs and cost-to-charge ratio; CHA has similarly found those metrics to be inflated by understated costs. This lack of transparency and systematic exclusion of legitimate expenses produces a one-sided narrative that misleads more than it illuminates. It is especially problematic when the tool is used for purposes it was never designed for — such as informing spending growth targets or determining allowable exceptions for entities exceeding the target.

Conversation on Market Concentration Skips Major Features of the Health Care Market

At the July OHCA Board meeting, OHCA staff presented a 2024 JAMA Health Forum analysis that reported higher insurer concentration is associated with lower commercial-to-Medicare hospital price ratios. Unfortunately, this finding offers an incomplete view of "affordability" and risks misrepresenting the broader patient impact.

Peer-reviewed literature shows that dominant insurers' ability to negotiate lower reimbursement rates from providers can reduce provider prices in markets with high insurer concentration. **However, those lower prices do not translate into lower premiums for consumers.** For example, Trish & Herring (2015)[1] analyzed national employer-sponsored insurance markets and found that higher insurer concentration was indeed associated with **lower hospital payment rates** — but it was also correlated with **higher premiums for patients**. This reflects the exercise of monopoly power on the consumer side: big insurers increase premiums and bank the revenue rather than passing on savings to consumers.

In further evidence of this relationship, Dafny and colleagues (2012[2], 2015[3]), analyzing real-world changes from major insurer mergers and insurers exiting certain markets, found that increased insurer concentration led to significant premium growth — 5% to 7% higher than without the increase in insurer concentration. In their California-specific analysis, Scheffler and colleagues (2018)[4] found that higher insurer concentration was

[1] Trish, E. E., & Herring, B. J. (2015). How do health insurer market concentration and bargaining power with hospitals affect health insurance premiums?. Journal of health economics, 42, 104–114. https://doi.org/10.1016/j.jhealeco.2015.03.009
[2] Dafny, L., Duggan, M., & Ramanarayanan, S. (2012). Paying a premium on your premium? Consolidation in the U.S. health insurance industry. American Economic Review, 102(2), 1161–1185. https://doi.org/10.1257/aer.102.2.1161
[3] Dafny, L., Gruber, J., & Ody, C. (2015). More insurers lower premiums: Evidence from initial pricing in the health insurance marketplaces. American Journal of Health Economics, 1(1), 53–81. https://doi.org/10.1162/AJHE_a_00003
[4] Scheffler, R. M., Arnold, D., & Whaley, C. M. (2018). Consolidation trends in California's health care system: Impacts on ACA premiums and outpatient visit prices. Health Affairs, 37(9), 1409–1416. https://doi.org/10.1377/hlthaff.2018.0472

linked to higher premiums; a 10% increase in insurer concentration was associated with a 2% increase in premiums for patients.

By focusing solely on commercial-to-Medicare hospital price ratios, the *JAMA Health Forum* analysis presented to the board stops at what insurers pay hospitals and does not follow through to what patients ultimately pay. Lower hospital price ratios in concentrated insurance markets do not guarantee improved affordability for patients. In making decisions that will impact the lives and health care of millions of Californians, OHCA must rely on a full affordability analysis that includes the end prices patients pay, not just the prices insurers negotiate. Without this, OHCA risks creating policies that reduce provider revenue while leaving patients facing higher, not lower, health care costs. It is unfortunate that OHCA has chosen to present only one side of this story. Greater balance is needed if the office is to truly achieve its mission of promoting affordability for California residents.

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,

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