

Office of Health Care Affordability (OHCA): Progress, Challenges, & What's Ahead

October 20, 2026

01 **OHCA Background**

02 **Hospital Spending Measurement**

03 **Progressive Enforcement Process**

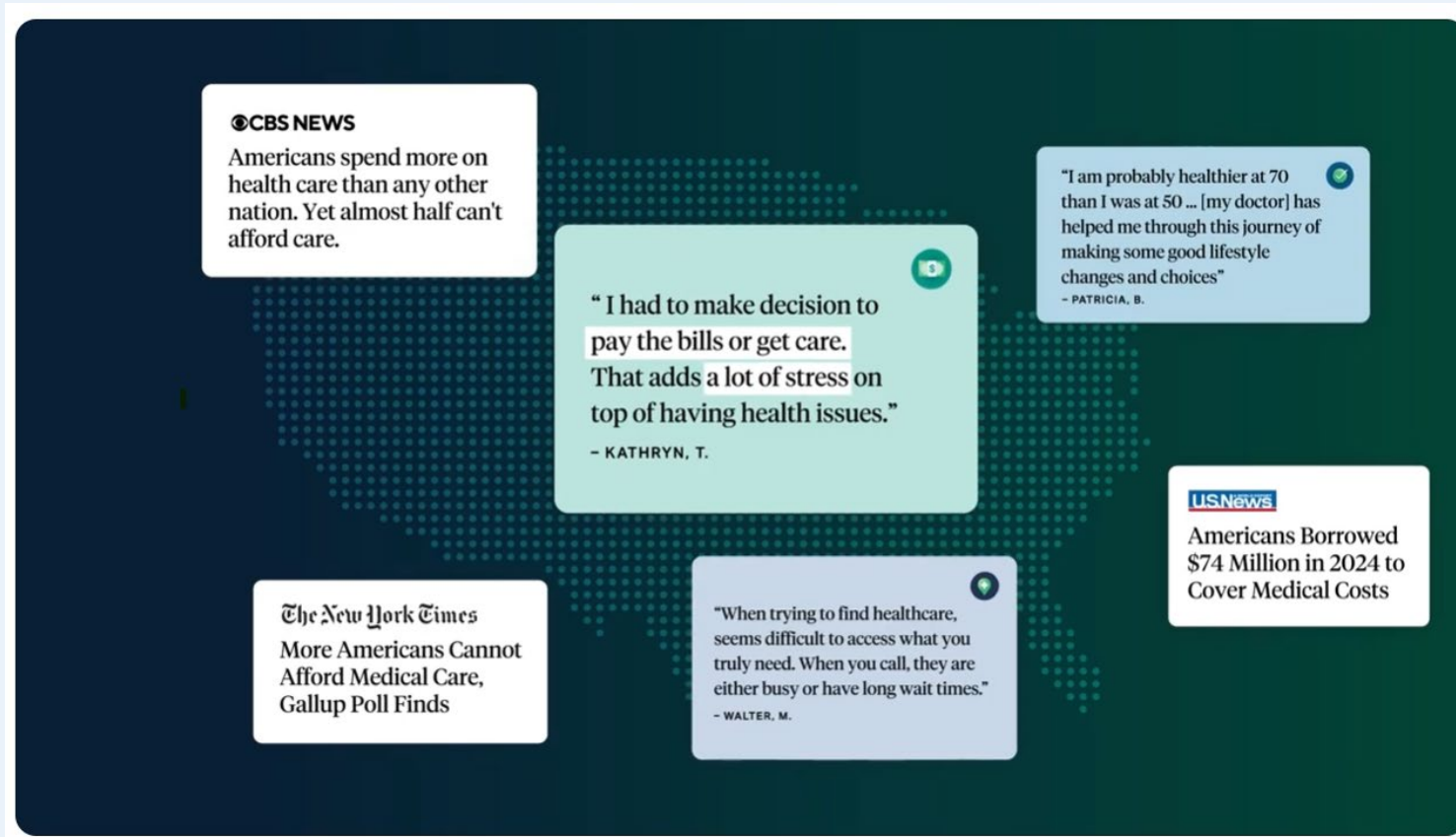
04 **Penalty Structure**

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OHCA Background

Affordability Concerns Are Here to Stay



Californians worried about...

64%

unexpected medical bills

Compared to...

48%

paying their rent or mortgage

2025 California Health Care Foundation
Survey

OHCA's three charges

01

**Reduce the growth
of health care
spending**

02

**Promote quality,
value, and
workforce stability**

03

**Monitor and review
market transactions**

GOVERNING BOARD

Health Care Affordability Board

Decision-making body within OHCA · 8 members · appointed members serve 4-year terms

Composition

- 4 Governor (Senate-confirmed)**
Chase, Hernández, Kronick, Owen
- 1 Senate Rules Committee**
Pan
- 1 Assembly Speaker**
Lewis
- 1 CalHHS Secretary — Chair**
Johnson
- 1 CalPERS Chief Health Director**
Moulds (nonvoting)

Responsibilities

- Sets the statewide spending target and sector-specific targets
- Approves benchmarks for primary care and behavioral health spending and APM adoption
- Approves sector definitions, target methodology, and exemption standards
- Weighs in on enforcement, including penalty ranges
- Appoints the Advisory Committee

Board sets and provides input on policy · Office implements and enforces

advises

LEADERSHIP · WITHIN HCAI

Office of Health Care Affordability

Collects data, runs analyses, drafts regulations, enforces targets



Elizabeth Landsberg
Director



Vishaal Pegany
Deputy Director

ADVISORY

Advisory Committee

Stakeholder members appointed by the Board — providers, payers, purchasers, labor, consumer advocates. Gives input on targets, benchmarks, and quality and equity metrics.

Staff and resources

118

authorized positions

25

attorneys

\$32 million

annual budget

Consulting resources

Bailit Health

RAND

Arnold Analytics

Statewide Spending Target

Established in 2024

DEFINITION: Limit on the annual growth of per capita health care expenditures

- 1 Based on average annual median household income growth from 2003-2022
- 2 Does not account for drivers like policy mandates or inflation
- 3 Includes a glide path that ramps the target down over time

Performance Year	Per Capita Spending Growth Target
2025	3.5%
2026	3.5%
2027	3.2%
2028	3.2%
2029	3.0%

Notes

- 2025 target was non-enforceable

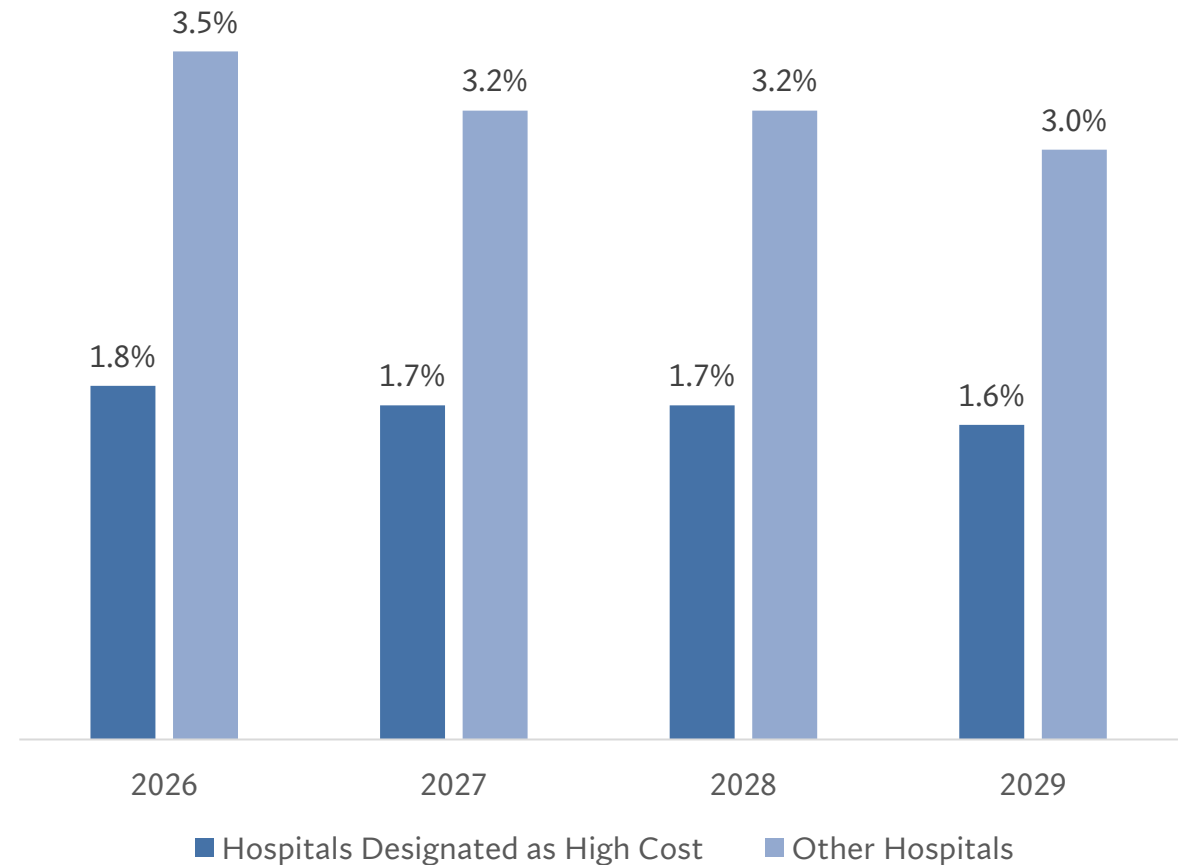
Certain Hospitals Subject to Lower Targets

Hospitals designated as high cost*

Community Hospital of the Monterey Peninsula	Monterey
Doctors Medical Center – Modesto	Stanislaus
Dominican Hospital	Santa Cruz
Salinas Valley Memorial Hospital	Monterey
Santa Barbara Cottage Hospital	Santa Barbara
Stanford Health Care	Santa Clara
Washington Hospital – Fremont	Alameda

*Designations could change on annual basis

Hospital Sector Targets



High-Cost Hospital Designation Update

No changes yet, but a reassessment is expected in the next months, and every hospital's data affects the outcome

Where it stands

No updates to the designation methodology or list

OHCA board will reassess designations this fall or early winter

Reassessment to include consideration of resubmitted financial data

Why it matters

1.8% starting target, about half the statewide rate

Designation: above the 85th percentile on commercial-to-Medicare PTCR *and* IP commercial NPR per CMAD in 3 of 5 years (2018–2022)

Based on frozen AFDR data that do not reflect resubmissions. Because the threshold is relative, a correction anywhere moves the line for everyone.

What to do now

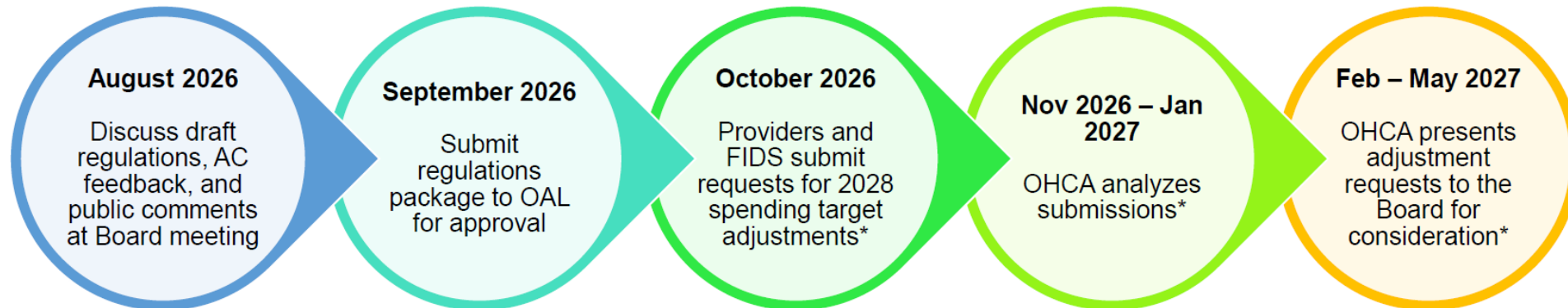
Watch for an updated list and prepare to advocate

Review your AFDR data carefully, especially payer allocation of revenue

PTCR = Payment to cost ratio; IP = inpatient; NPR = net patient revenue; CMAD = case-mix adjusted discharge; AFDR = Annual Financial Disclosure Report.

NOLA | A prospective, upward adjustment to the spending target for providers to account for growth in their non-supervisory organized labor costs

- Involves submitting projected expense data to OHCA to request the adjustment
- OAL approved the NOLA regulations on October 12, 2026
- Requests are due by November 16, 2026, for 2028 enforcement year adjustment



Source: August 2026 OHCA Board meeting slides, dates are subject to change

*If regulations are approved by the Office of Administrative Law (OAL). FIDS=Fully Integrated Delivery System.

Link to [final regulations and documentation](#).

Hospital Spending Measurement

OHCA Spending Target

Providers (including hospitals)



Applies to revenues



Not expenses (e.g., labor, supplies, drugs, facilities)

VS

Payers



Applies to expenses (medical and non-medical)



Not revenues (e.g., premiums)

Providers and Payers Are Measured Differently

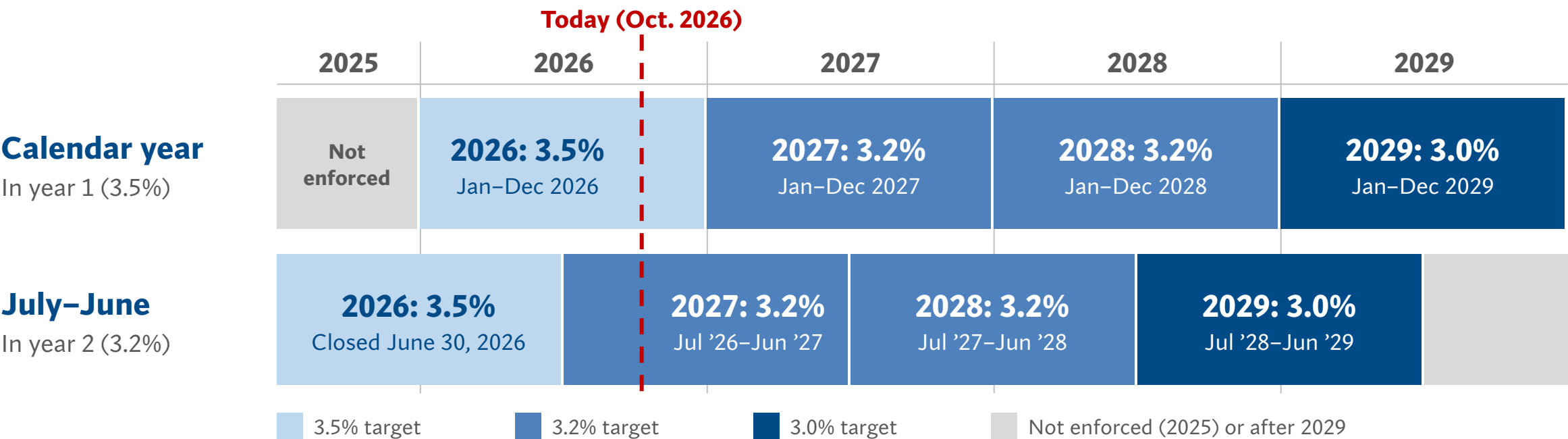
In Sum: Hospitals are measured on volume and acuity-adjusted revenue from their own filings; payers and physician groups on per-member spending that payers report about a year sooner

	Hospitals	Payers	Physician Organizations
What is measured	Net patient revenue (NPR) Payments received from payers and patients	Total health care expenditures Medical and non-medical expense (admin & profit) measured separately	Attributed TME All medical spending for attributed members, including care outside the group
Unit of measure	Per acuity-adjusted discharge (IP) or visit (OP)	Per member per year	Per attributed member per year
Adjustment	Volume + acuity Case mix index (IP); average visit intensity (OP)	Enrollment only No acuity or risk adjustment	Enrollment only Reported by age and sex; no acuity or risk adjustment
Data source	Hospital-submitted AFDR Plus, HCAI discharge data (CMI) and HPD (OP intensity)	Payer-submitted Total Health Care Expenditures (THCE) data	Payer-submitted Physician organizations do not submit their own data
Data available 2026 performance year	~Late 2028, reported 2029 Complete AFDR posts ~1.5 years after year end (2024 data: Sep. 2026)	Late 2027, reported 2028 Payers report the following year	Late 2027, reported 2028 Payers report the following year

Source: HCAI, Draft Spending Target Performance Measurement Manual (Oct. 8, 2026), Sections 2–4. AFDR = Annual Financial Disclosure Report; CMI = case mix index; HPD = Health Care Payments Database; IP = inpatient; OP = outpatient; TME = total medical expenditure.

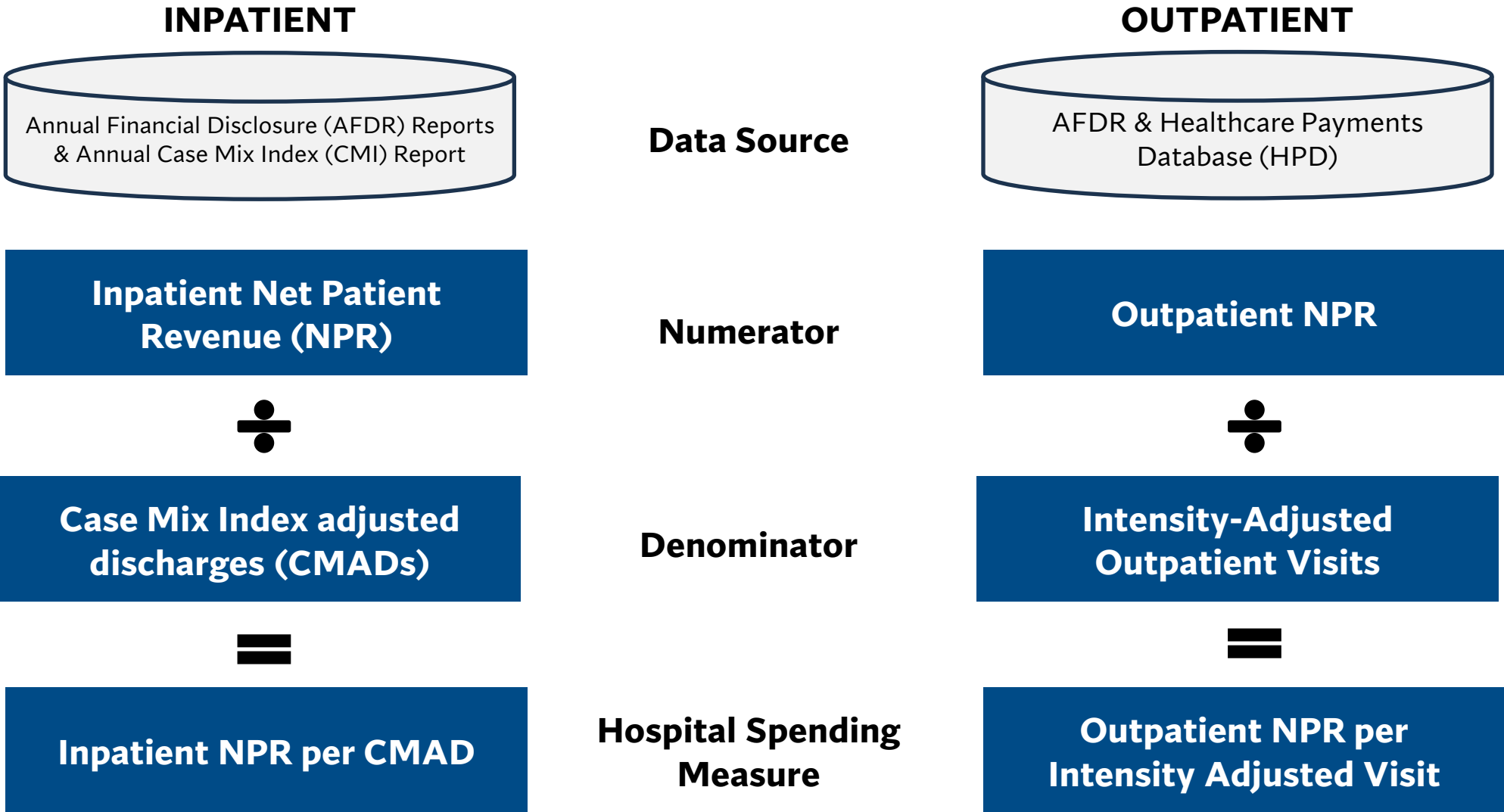
Hospital's Enforcement Year Is Their Fiscal Year

July–June hospitals are already past the 3.5% year and into year two at 3.2%



Enforcement year = the fiscal year that ends in that calendar year. A July–June hospital's 2026 year (3.5%) ran July 2025–June 2026 and is already closed. Today it is being measured against 3.2%, and the target only goes down from here.

How OHCA Will Assess Hospital Spending



Numerator and denominator will be calculated separately for commercial, Medi-Cal, and Medicare

No self-insured data

Missing intensity weights

Visits that don't match with hospital-reported data

Payer-reported data from the HPD has major flaws

Intensity adjustment will **not** fully capture the complexity of all outpatient cases

2022 Fiscal Year Comparable Hospitals	Commercial	Medicare	Medi-Cal
Outpatient visits in Hospital Financial Reports among hospitals found in HPD	15.2 million	15.8 million	15.3 million
December 2025: Outpatient visits in HPD with APC weights	1.7 million	6.7 million	3.8 million
<i>% of Hospital Financial reported visits</i>	11.2%	42.7%	24.8%
April 2026: Outpatient visits in HPD with APC weights	3.0 million	6.9 million	5.2 million
<i>% of Hospital Financial Reports reported visits</i>	20% (+9.8 pp)	44% (+1.3 pp)	34% (+9.2 pp)

In draft regulations, OHCA proposed three instead of six measures for hospitals

How it works – Commercial Example

Inpatient growth 4.5% × 45% of NPR	2.0%
Outpatient growth 2.5% × 55% of NPR	1.4%
Combined commercial growth	3.4%

Inpatient and outpatient growth are calculated separately, then weighted by each service line's share of that payer's net patient revenue in the base year.

Would align to measurement structure used by OHCA for payers and physician organizations

What it means

CHA ANALYSIS

Separately, either measure can trigger enforcement. Combining substantially reduces exposure.

Hospitals above 3.5%, any payer line

Above on IP or OP

326 (92%)

Above on combined measure

294 (83%)

32 fewer hospitals over the target, a 10% reduction

How OHCA Will Assess Spending Against the Targets

How Compliance With the Spending Targets May Be Measured

Illustrative Example

	2025-2026	2026-2027	2027-2028	2028-2029
Spending Target*	3.5%	3.2%	3.2%	3.0%
Hospital Spending Growth (Inpatient and Outpatient Combined)				
Commercial	4.2%	2.9%	-1.3%	6.0%
Medicare	2.0%	4.4%	3.1%	-0.4%
Medi-Cal	6.0%	-5.3%	2.2%	1.6%
All Payer	4.1%	0.7%	1.3%	2.4%

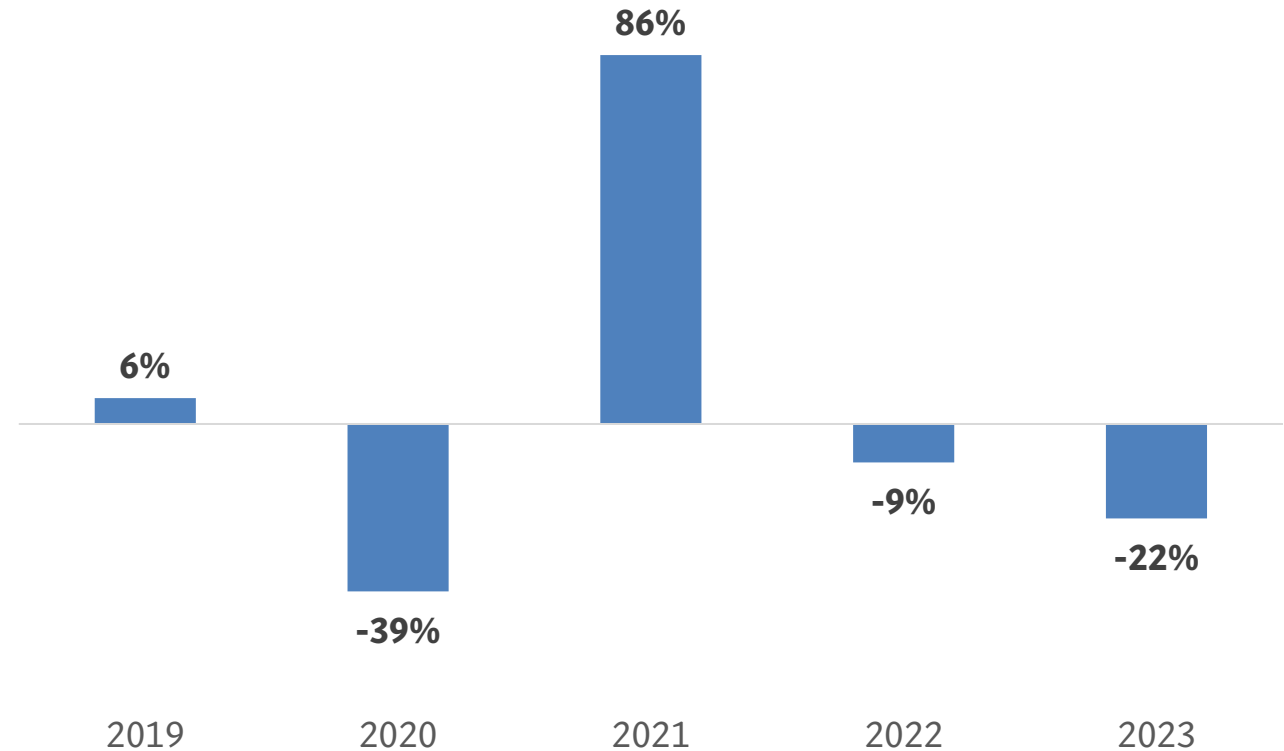
■ Potential violation of the spending target

*Displays the statewide target, applicable to all hospitals except those designated as "high-cost."

Untested measurement approach

- 1 Extraordinary volatility
- 2 Incomplete data
- 3 Three distinct assessments

Annual growth in commercial inpatient spending *Anonymous hospital*



Most Hospitals Likely to Miss Their Target in Any Given Year

167

hospitals would have violated a 3.5% spending target in 2023 on their commercial lines

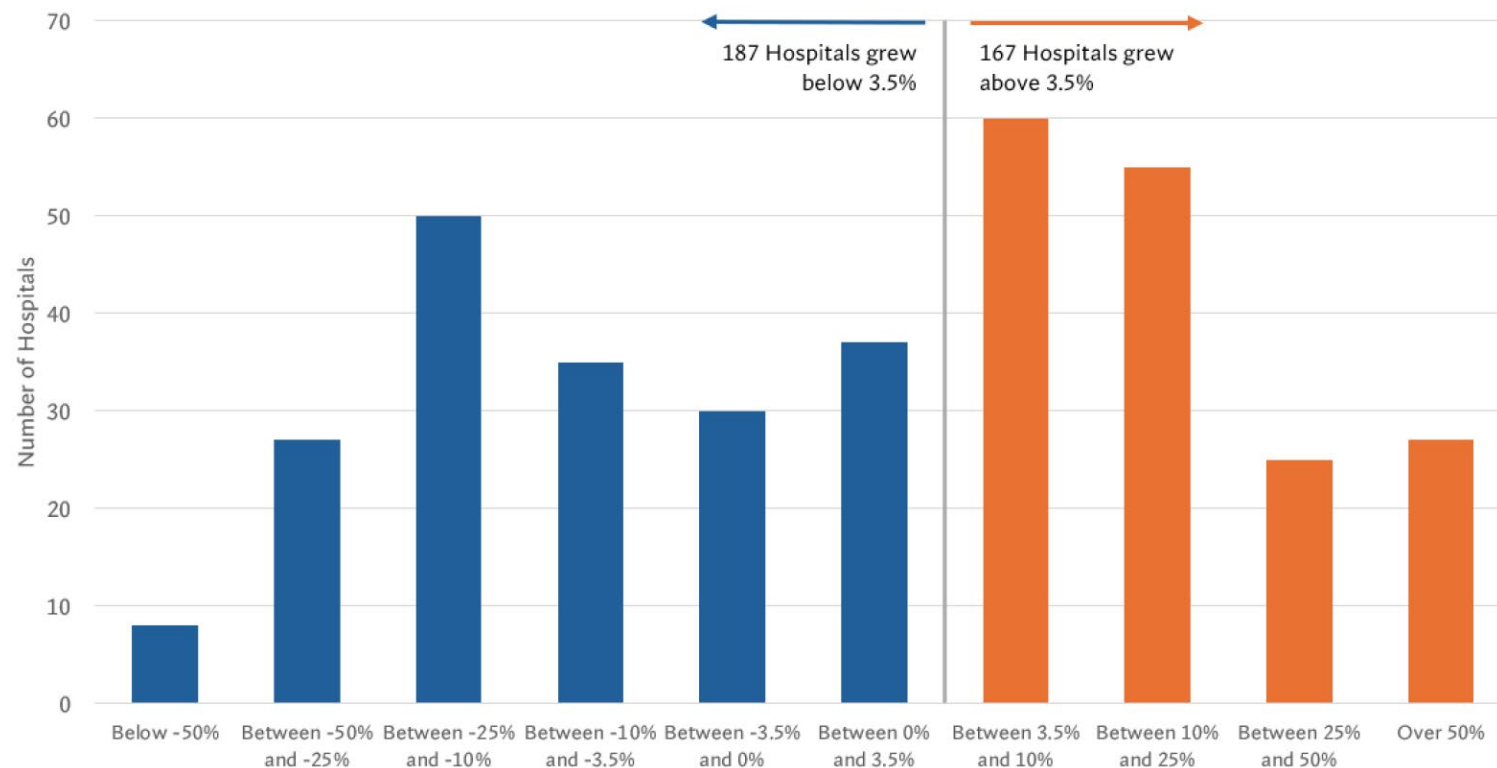
Dozens

of hospitals had measured spending growth greater than 50% or less than -50%

83%

of hospitals would have violated a 3.5% spending target in 2023 for at least one payer line

Hospital Spending Growth Under OHCA's Methodology Is Extraordinarily Volatile



Note: 2023 commercial spending growth rates for combined inpatient and outpatient services derived from OHCA's Hospital Measurement Combined Dataset 2022-2023.

OHCA acknowledges the data problem but proposes no fix before enforcement begins

Drivers OHCA identified

- Prior-year contractual adjustment true-ups
- Changes in consultants or methods
- IP/OP allocation errors
- Very low payer volumes

Other likely drivers

- Cost settlements
- Utilization and revenue misallocations

Not addressed by any of OHCA's proposed responses

OHCA's response

Hospitals can explain swings in the 45-day window after notice

Possible minimum volume thresholds

In the future: Changes to HCAI financial data collection (Annual Financial Disclosure Report)

Why it falls short

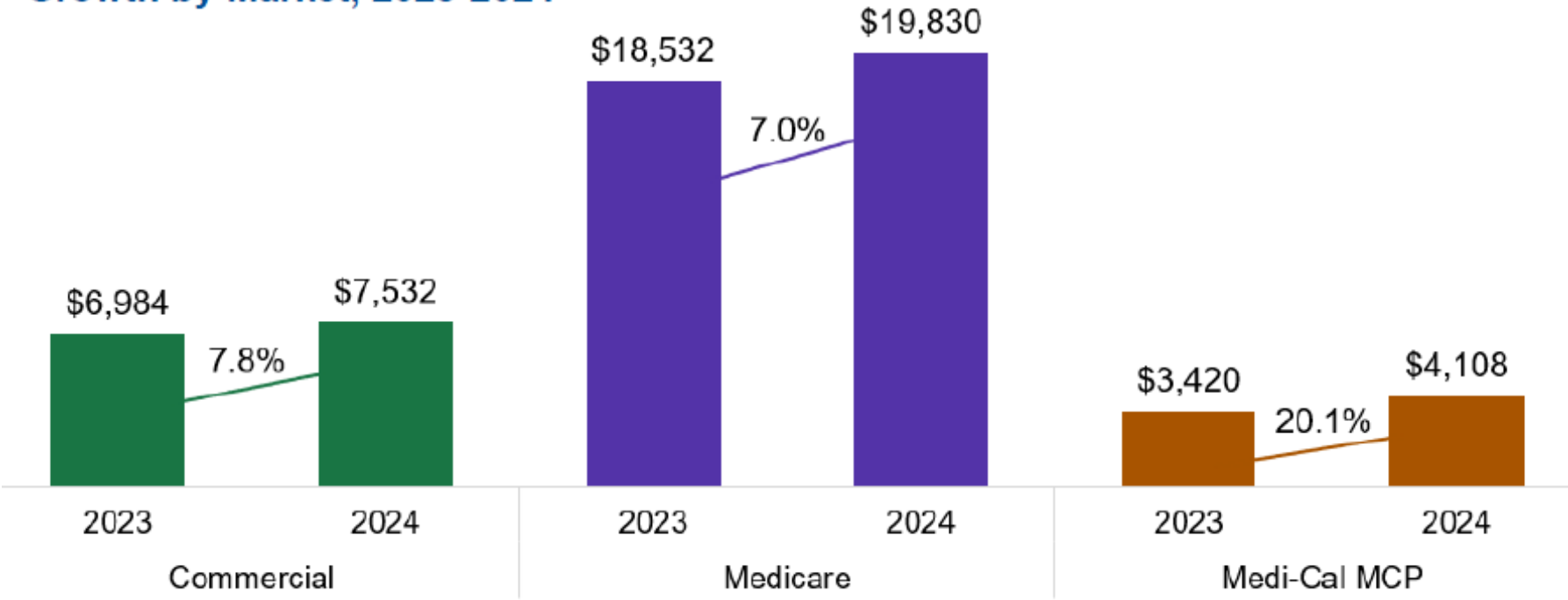
Burden falls on hospitals after they're flagged; errors stay in the public record

Helps low-volume cases only; Many hospitals have thousands of discharges or visits

Exploratory and long-term; not in place for early enforcement years

Overview: Spending per member grew far above 3.5% in every market

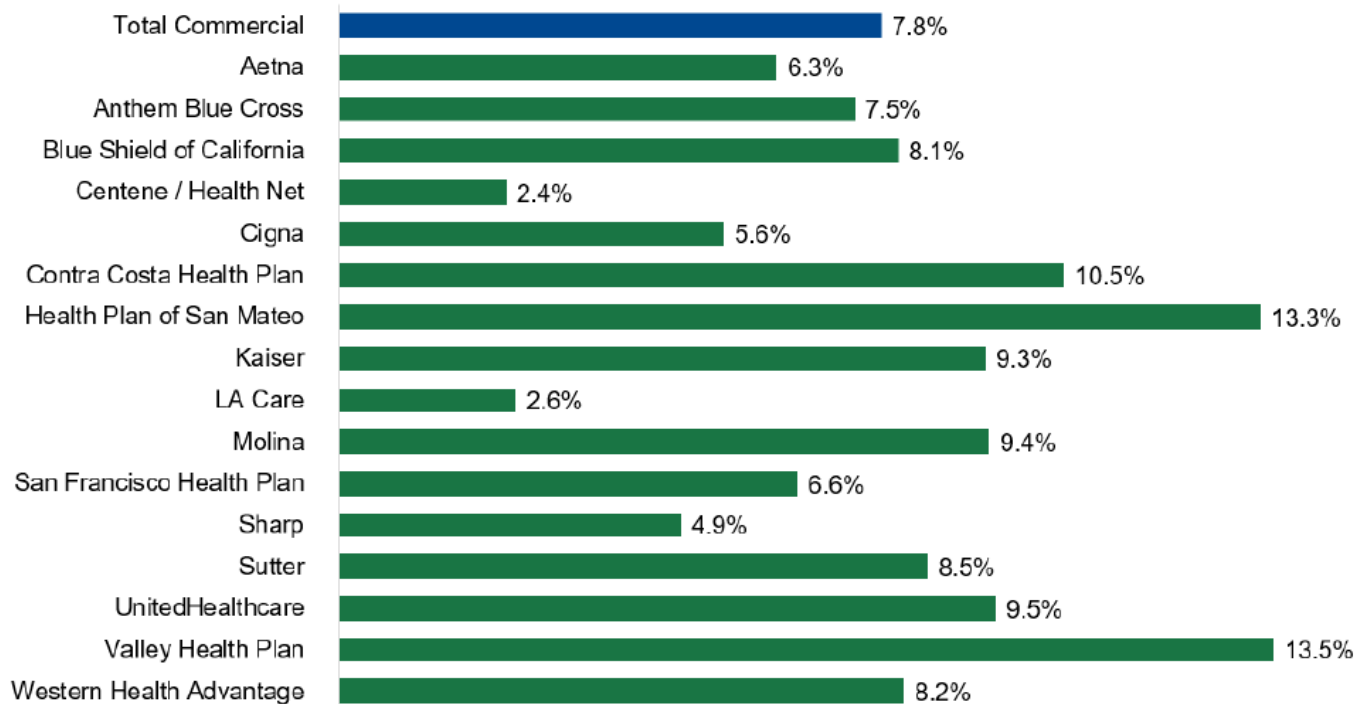
Figure 7. Total Medical Expense Per Member Per Year Spending and Spending Growth by Market, 2023-2024



Note: TME includes total spending on medical services and does not include total non-medical expense (TNME). Medicare includes both Medicare FFS (includes dual eligibles) and Medicare Advantage (includes duals and D-SNPs). Medi-Cal Managed Care does not include spending from Managed Care Organization (MCO) Tax, pass-through payments, or Medi-Cal FFS. D-SNP = dual eligible special needs plans; FFS = fee-for-service [Link to report](#)

Nearly every payer grew faster than 3.5%, and spending levels vary ~3x

Figure 15. Commercial Payer Total Medical Expense Per Member Per Year Spending Growth, 2023-2024



Commercial:

- 14 of 16 payers grew faster than 3.5%
- 2024 PMPY ranged from \$3,964 to \$11,268.

Medicare Advantage:

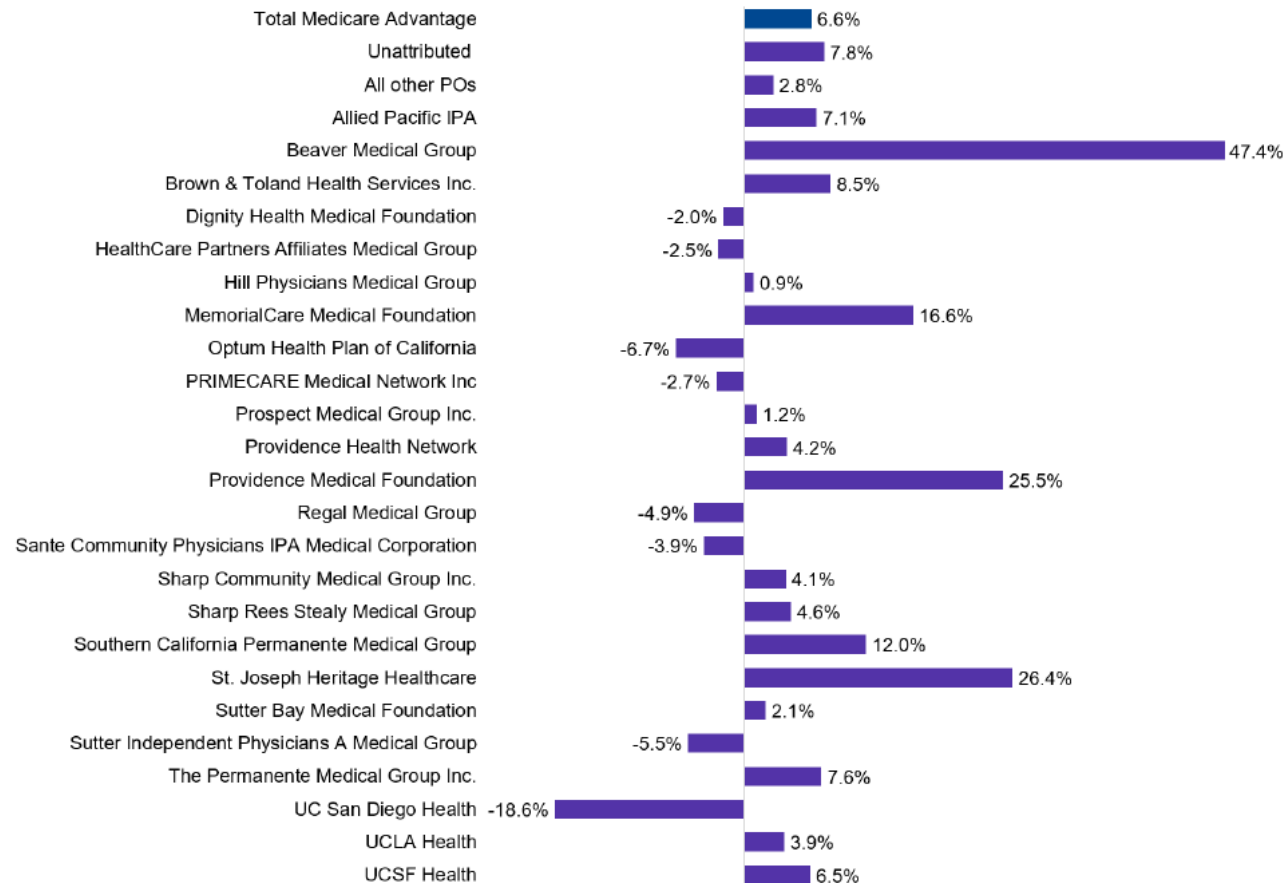
- 14 of 19 payers grew faster than 3.5%
- Growth ranged from -2.9% to +19.5%
- 2024 PMPY ranged from \$10,644 to \$35,256.

Medi-Cal managed care:

- 21 of 22 plans grew faster than 3.5%, most by double digits.

Most physician groups grew faster than 3.5% in Commercial, while Medicare Advantage results were far more mixed

Figure 23. Medicare Advantage TME PMPY Spending Growth by Selected Physician Organizations, 2023-2024



Commercial:

- 19 of 27 groups grew faster than 3.5%
- Growth ranged from -1.0% to 14.4%
- 30% of members couldn't be attributed to any group; their spending grew 7.1%

Medicare Advantage:

- 13 of 24 groups grew faster than 3.5%, and 8 declined.
- Growth ranged from -18.6% to +47.4%
- 14% of members were unattributed; their spending grew 7.8%

Inpatient hospital spending grew slowest of any commercial service category

Figure 26. Total Medical Expense Per Member Per Year Spending Growth by Market and Category, 2023-2024

Category	Commercial	Medicare Advantage	Medicare FFS
Hospital inpatient	5.0%	9.7%	6.8%
Hospital outpatient	12.4%	16.9%	11.6%
Professional	8.6%	15.0%	16.2%
Long-term care	8.1%	13.6%	10.7%
Pharmacy (gross of rebates)	11.9%	5.9%	-6.7%
Other	8.6%	13.9%	12.0%
Capitation	3.4%	2.0%	-
Non claims, non capitation	38.7%	9.3%	-
Total (gross of rebates)	7.8%	6.6%	7.7%

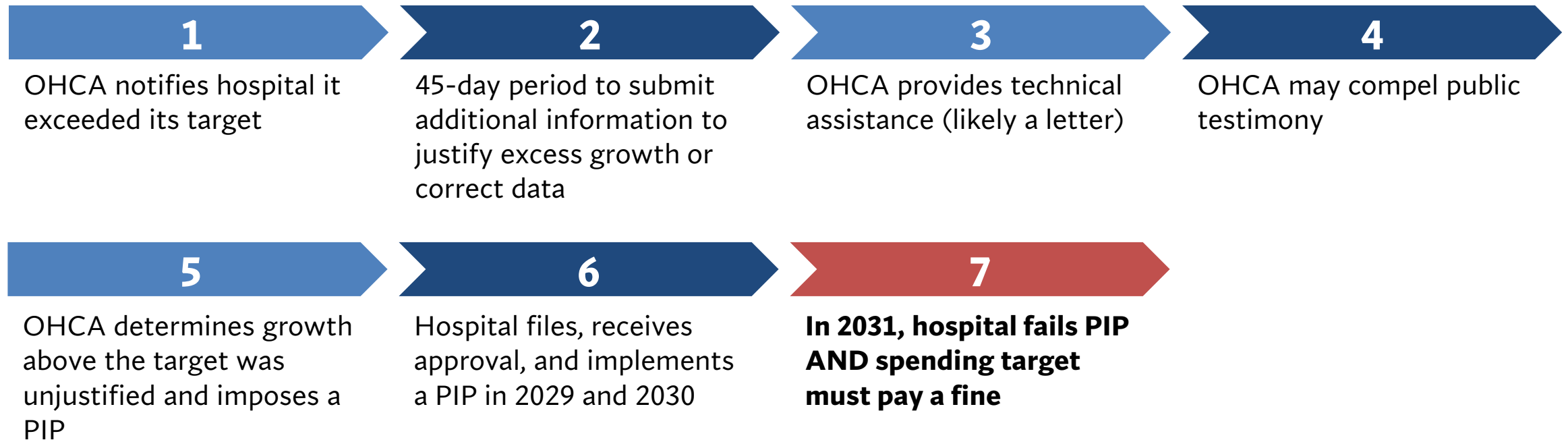
Note: Medicare FFS did not provide capitation, non-claims, or pharmacy rebate payments
FFS = fee-for-service. PMPY = Per member per year.

- **Commercial inpatient:** +5.0% PMPY, the lowest of any claims category
- **Commercial outpatient:** +12.4% PMPY and the largest dollar contributor (\$173 of the \$548 increase). This pattern is consistent with care shifting to lower-acuity settings
- **Combined commercial hospital spending:** grew 8.6% PMPY, below total claims at 9.3%
- **Pharmacy:** grew 11.9% and was the #2 dollar driver (\$135)

Progressive Enforcement Process

The Road to a Penalty

Scenario: In 2029, OHCA determines a hospital exceeded its 2026 spending target

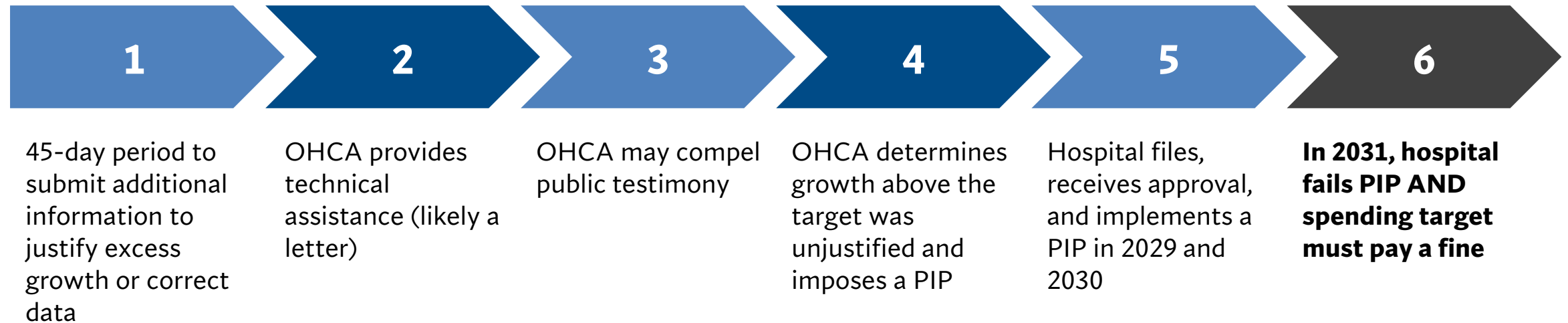


Timing: OHCA indicated at the August 2026 board meeting the earliest penalties would be in 2030, more likely 2031, for 2026 enforcement year

Progressive Enforcement Process

The Road to a Penalty

In 2029, OHCA determines a hospital exceeded its 2026 spending target



Timing: OHCA indicated at the August 2026 board meeting the earliest penalties would be in 2030, more likely 2031, for 2026 enforcement year

PIP = performance improvement plan

Potential Enforcement Considerations

OHCA's current list

Population characteristics

High-cost patient outliers

High-cost drugs

Entity baseline costs

Historical spending growth

Impact on consumer access and affordability

Investments in primary and preventive care

Changes in state and federal law

Acts of God or catastrophic events

Non-supervisory organized labor costs

Amount of entity's excess spending growth

Entity's actions that impair or impede enforcement

Any other reasonable cause

CHA recommended additions

- + Macroeconomic trends (e.g., inflation, tariffs, supply chain shocks, cost of living variation)
- + **All** labor costs
- + Payer mix
- + Investments in specialty care
- + Provider financial distress
- + Changes in service offerings
- + Payment settlements & other factors driving revenue volatility

- Imposed at the **discretion** of the director
- Defined as **action plans** entities implement to come into compliance with spending targets
- Content **developed by entities, approved by director** with input from the board
- May not be approved if likely to **erode access, quality, equity, or workforce stability**
- Significant administrative resources required to complete and implement

Strategy examples

Rate reductions

**Service
reductions**

**Move services
out of the
hospital**

**Adopt
alternative
payment
methodologies**

Performance Improvement Plans (PIPs)

OHCA's draft PIP Guidance contains nine sections (A-I) and one appendix

Section A: Introduction

Section B: Submission Instructions

Section C: Extension Requests

Section D: PIP Content Requirements

Section E: Evaluation of PIP Proposal

Section F: Progress Reports

Section G: Final Progress Report

Section H: Evaluation of Final Progress Report

Section I: OHCA Contact Information

Appendix A: PIP Attestation

Section D: 10 required content elements

Most of the work in an initial PIP lives in Section D

1

Contacts

2

Brief Summary

3

Reasons for spending growth

4

Goals, activities, milestones
(SMART)

5

Affordability for Consumers and
Purchasers

6

Assessment Plan

7

Balancing Measures

8

Sustainability

9

Other State Agencies

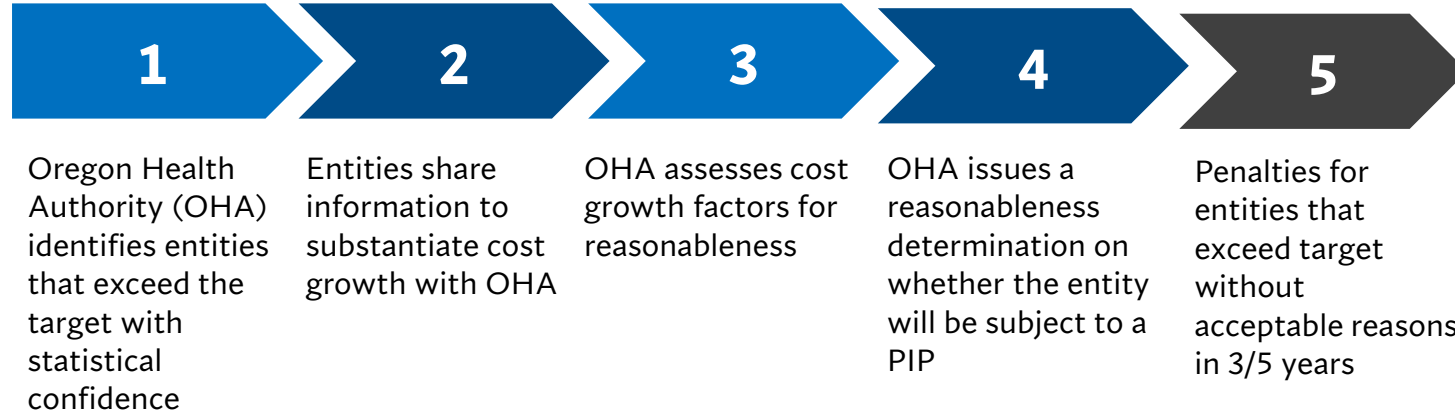
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PIP Implementation Timeline

SMART = Specific, Measurable, Attainable, Relevant, Time-bound

Oregon's Enforcement Process

Progressive Enforcement Process for Entities that Exceed Target



Oregon's List of Acceptable Reasons for Cost Growth

- Changes in mandated benefits
- New drugs, treatments, and devices
- Changes in taxes or other administrative factors
- Acts of God (disasters, pandemics)
- Changes in federal, state, or local law that increases costs
- Health equity investments
- Macroeconomic factors (inflation, supply chain/labor shortages)
- Total compensation for frontline worker
- High-cost patient outliers
- Any other reasonable cause

OHA's list of acceptable reasons is additive; new acceptable reasons are applied prospectively, unless otherwise specified.

OHA assess payers and provider organizations. Oregon's cost growth target for 2021-2025 is 3.4%; 2026-2030 is 3.75%.
Source: OHA CGT program documents

Growth deemed reasonable

2021-22 measurement year

25/28

entities' growth deemed reasonable

3 not reasonable: 2 payers and 1 provider organization

2022-23 measurement year

66/71

entities' growth deemed reasonable

5 not reasonable: 3 payers and 2 provider organizations

First ever PIP requirement for 2022-23 measurement year.

Penalty Structure

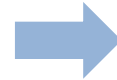
Enforcement penalties for failing the PIP and associated spending target: a two-step calculation

STEP 1

“Initially commensurate” penalty



Dollar difference between actual and allowed growth under the target (the blue segment)



STEP 2

Adjustment



Adjustments to decrease or increase the initial amount, from 0% up to 125%, based on penalty justification factors

Spending Target Penalty Example Calculation

For each payer, inpatient and outpatient penalties are calculated separately, then added together

Inpatient

Per case-mix adjusted
discharge 2022-23

Allowed  \$20,700

Actual  \$22,000

\$1,300 over target

× 5,000 case-mix adjusted
discharges in 2023

+\$6.5M

Outpatient

Per intensity-adjusted visit
2022-23

Allowed  \$1,035

Actual  \$990

\$45 under target

× 40,000 intensity adjusted
visits in 2023

-\$1.8M

Combined penalty

Before applying Step 2
justification factors

\$4.7M

Outpatient growth below target
reduces the inpatient penalty

Without the offset: **\$6.5M**

Penalty can't go below \$0

Illustrative hospital, 3.5% target. Calculated separately for commercial, Medicare and Medi-Cal; payers do not offset each other. Allowed = 2022 amount × 1.035. Based on formulas in OHCA's Draft Spending Target Performance [Measurement Manual](#) (Oct. 8, 2026), Sec. 5.3.

Penalties for failures in the PIP process itself

Accrues daily

Up to **\$10,000** per day

 until resolved

Applies to:

Repeatedly failing to file a PIP

Repeatedly failing to file an acceptable PIP

Knowingly failing to provide required information

One-time

Up to **\$500,000**

 flat penalty

Applies to:

Failing to implement a PIP

Knowingly falsifying required information

Approved by the OHCA Board August 26, 2026; subject to final regulation approval. Approved without addressing hospital data concerns.
Procedural penalties are subject to the same justification factors as spending target penalties.

Penalty Justification Factors Approved by Board Vote

Penalty justification factors

Apply to both spending target penalties and procedural penalties

Approved by OHCA Board at August 26, 2026, board meeting, still subject to final regulation approval

01 Nature, number, and gravity of the offenses

02 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.

03 The market impact of the entity.

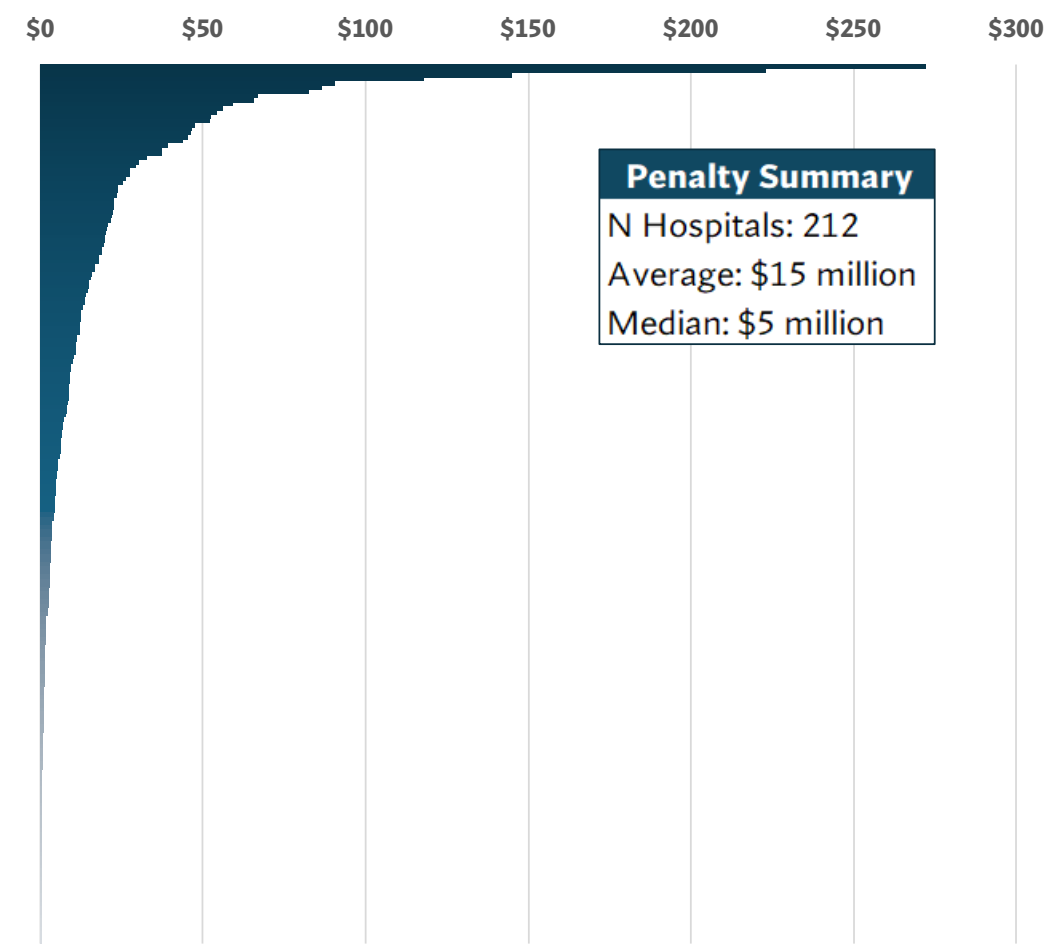
04 The related provision of nonfederal share associated with Medi-Cal reimbursement.

Per draft regulations, entities may contest the penalty by submitting a notice of appeal, along with any supporting documents, within 30 calendar days from the date of notice of the penalty.

OHCA Seeking Exorbitant Penalties

OHCA Penalty Structure Could Impose Penalties in the Hundreds of Millions of Dollars

Penalty Amount (in Millions) per Hospital



Note: Penalties calculated based on difference between actual spending growth and allowable growth under a 3.5% target assumed applicable in 2023. Analysis only includes hospitals with fines over \$1,000.

\$100M+

Penalties could start in the **hundreds of millions of dollars** for larger hospitals—and adjusted upward

100+

For over 100 hospitals, the starting penalty amounts would **exceed their 3-year cumulative operating earnings**

20x

Starting penalty amounts are **20x higher than the next closest state's**

What information will be made public?

Step in Enforcement Process	What will be publicly shared
End of 45-day period for submitting additional data and information	1. A list of entities that exceeded the target and by how much* 2. TA letter templates (no entity specific details) *This list will be shared publicly regardless of whether OHCA decides which entities will move forward in the progressive enforcement process
Public testimony	Public testimony (no confidential information)
Performance improvement plan (PIP) implementation	1. List of entities required to implement a PIP 2. PIP Proposals (no confidential information) 3. Approved PIPs (no confidential information) 4. Summaries of PIP compliance
Assessment of penalties	A list of entities with penalties and any funds returned to consumers

TA = Technical Assistance

OHCA's Estimated Enforcement Rulemaking Timeline

October 2026



Informal comment period on draft enforcement regulations; comments due October 30

November 2026



Comments on draft regulations reported at OHCA Board meeting; OHCA to prepare and submit regulations to Office of Administrative Law + formal comment period

December 2026



Enforcement regulations become effective

01

Hospital Spending Growth Measurement

Control volatility and account for all payers and all services when assessing compliance against the targets

02

Enforcement Decisions

Transparent, standardized, and fair process to avoid enforcement for justifiable spending growth

03

Performance Improvement Plans

Strategies are developed by entities, not prescribed by OHCA, and good-faith efforts to improve are recognized

04

Financial Penalties

Reasonable, predictable penalties that gradually increase for noncompliance and account for entities' individual circumstances

Hospital Field Has Activated, Sustained Engagement Needed

150

hospitals

Organizations representing nearly 150 hospitals urged OHCA's board to reject draconian penalties

“ *Let me be direct: The penalty framework before you will not make health care more affordable, it will make it less available.*

“ *When my daughter got her appendix out... I counted 11 staff members that saw her before surgery. Those are people who may or may not have jobs if we are further penalized by our state and federal government.*

100

members

pressed OHCA for answers and changes at a July hospitals-only enforcement workshop

“ *Published data shows +23% commercial inpatient and -45% Medi-Cal outpatient. I've been negotiating contracts for over 14 years and never have exceeded the low single digits. Does OHCA believe its own methodology is mathematically sound?*

“ *We know that labor is 60-65% of a hospital's costs and there's this presumption that because OHCA has in their tenets lower health care costs, but also workforce stability, that labor cannot be touched.*

What Hospitals Can Do to Plan for OHCA

1

Ensure future AFDR filings are accurate

- 1st enforceable spending target applies to the growth in spending between reporting years 2024-25 and 2025-26
- Net patient revenue and discharge and visit volume data elements

2

Track internal data for justifiable spending growth

- E.g., impacts of fed/state policies, drug costs, *all* nonsupervisory labor cost growth, etc.

3

Watch out for changes to the high-cost hospital designations coming this fall

4

Consider asking OHCA for a nonsupervisory organized labor adjustment (NOLA)

- Providers submit request by November 16 this year, by end of October in future years
- Regardless document any increases in all labor costs

5

Join CHA in advocating for fair and transparent enforcement rules by October 30

- [CHA Alert](#) on Enforcement Regulations

CHA vs. OHCA Litigation Update

CHA vs. OHCA Spending Target Litigation Update

February

SF Superior Court sides with OHCA that CHA lacks standing, but grants leave to amend

June

CHA files amended petition detailing adverse impacts from OHCA from seven member hospitals and CHA itself

September

Judge rules that the case may proceed

- OHCA's request to dismiss the case on standing denied
- CHA sufficiently alleged that harm from OHCA's challenged actions is occurring now, even before penalties

SUPERIOR COURT OF THE STATE OF CALIFORNIA COUNTY OF SAN FRANCISCO	
CALIFORNIA HOSPITAL ASSOCIATION,	Case No. CPF-25-519370
Petitioner,	RESPONDENTS' REPLY IN SUPPORT OF DEMURRER TO SECOND AMMENDED VERIFIED PETITION FOR WRIT OF MANDATE; COMPLAINT FOR DECLARATORY RELIEF
v.	Date: September 9, 2026
OFFICE OF HEALTH CARE AFFORDABILITY, et al.	Time: 9:00 a.m.
Respondents.	Dept: 302
	Judge: The Honorable Joseph M. Quinn
	Trial Date: Not Set
	Action Filed: October 15, 2025

CHA vs. OHCA Spending Target Litigation Update

What's next?

- Proceed to the merits of CHA's challenge
 - Establishment of spending targets, hospital sector, and high-cost designation as contrary to state law and select constitutional provisions
- OHCA to file formal answer (deadline TBD)
- Hearing likely in the first half of 2027 and a decision expected shortly thereafter (but likely appeal)

Relief sought

Invalidate existing targets and force OHCA back to drawing board

“

Petitioner has adequately pled a beneficial interest in OHCA refraining from adopting arbitrary cost targets and resultant harms, including impacts on hospital budgets, staffing, services, and other operational expenditures...The enforcement period began January 1, 2026. The hospitals' operational harms flow from the existence of the allegedly arbitrary target rates and does not require an enforcement action resulting in penalties.

— **September 10 order**

CHA's OHCA Advocacy Strategy

Protecting Access Is a Top Priority for Californians

Californians prioritize protecting access to high-quality care when asked which statements come closer to their opinions:

Protect Quality Care

It is most important to me to have high-quality care at California hospitals, even if that means that hospital spending may increase

81%

It is most important to me to limit hospital spending in California, even if that means a reduction in the quality of care

9%

Protect Access to Care

It is most important to me to have convenient access to nearby hospital care and shorter wait times, even if that means hospital spending may increase

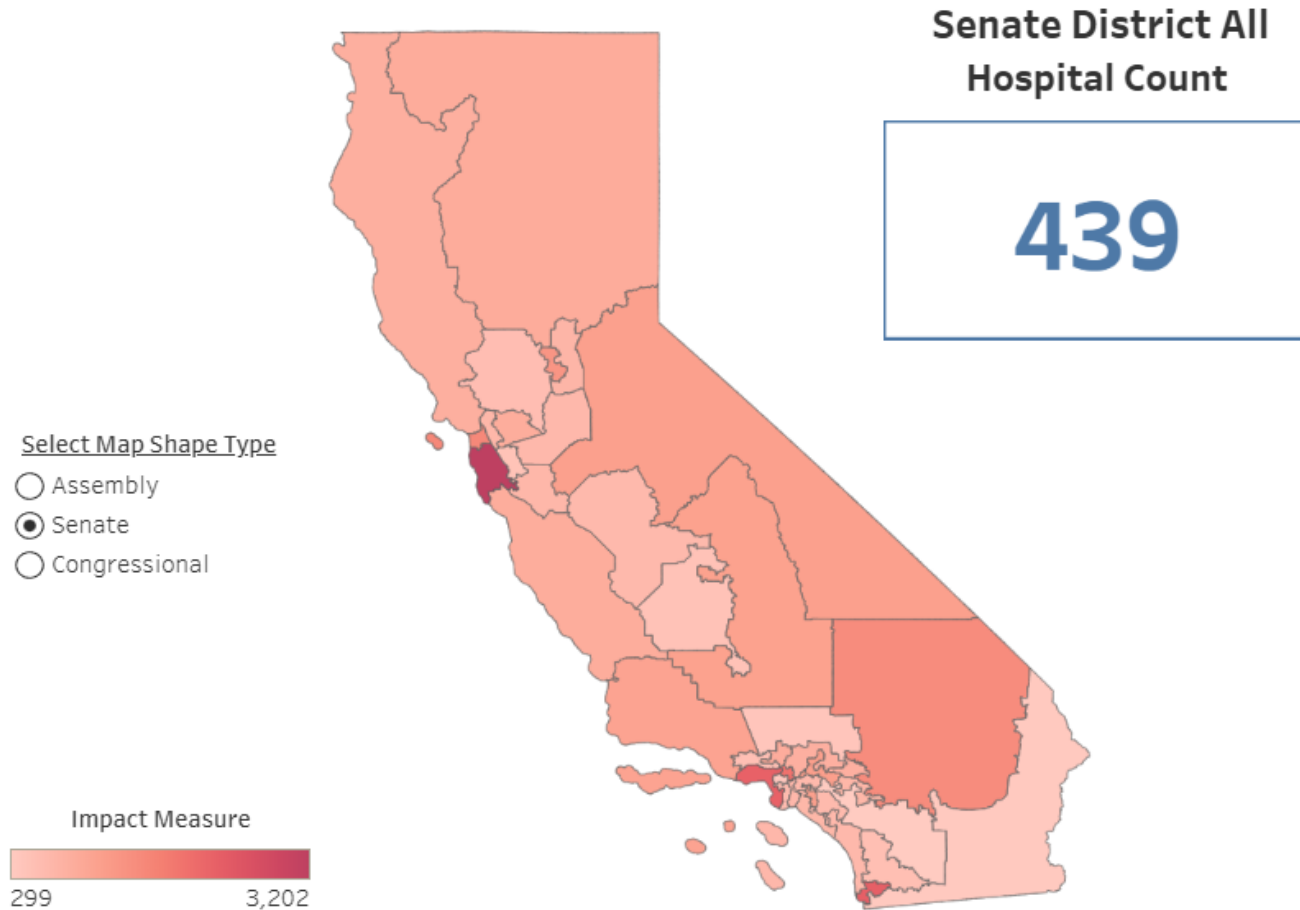
76%

It is most important to me to limit hospital spending in California, even if that means fewer hospital services in my community and having to drive further or wait longer...

11%

Source: Fairbank, Maslin, Maullin, Metz & Associates (FM3) interviewed 837 California voters in the summer 2025 to understand their views on health care affordability and access.

Making a Bad Situation Worse – Lost Jobs



Health care job losses

3,300

Already shed in California in 2025

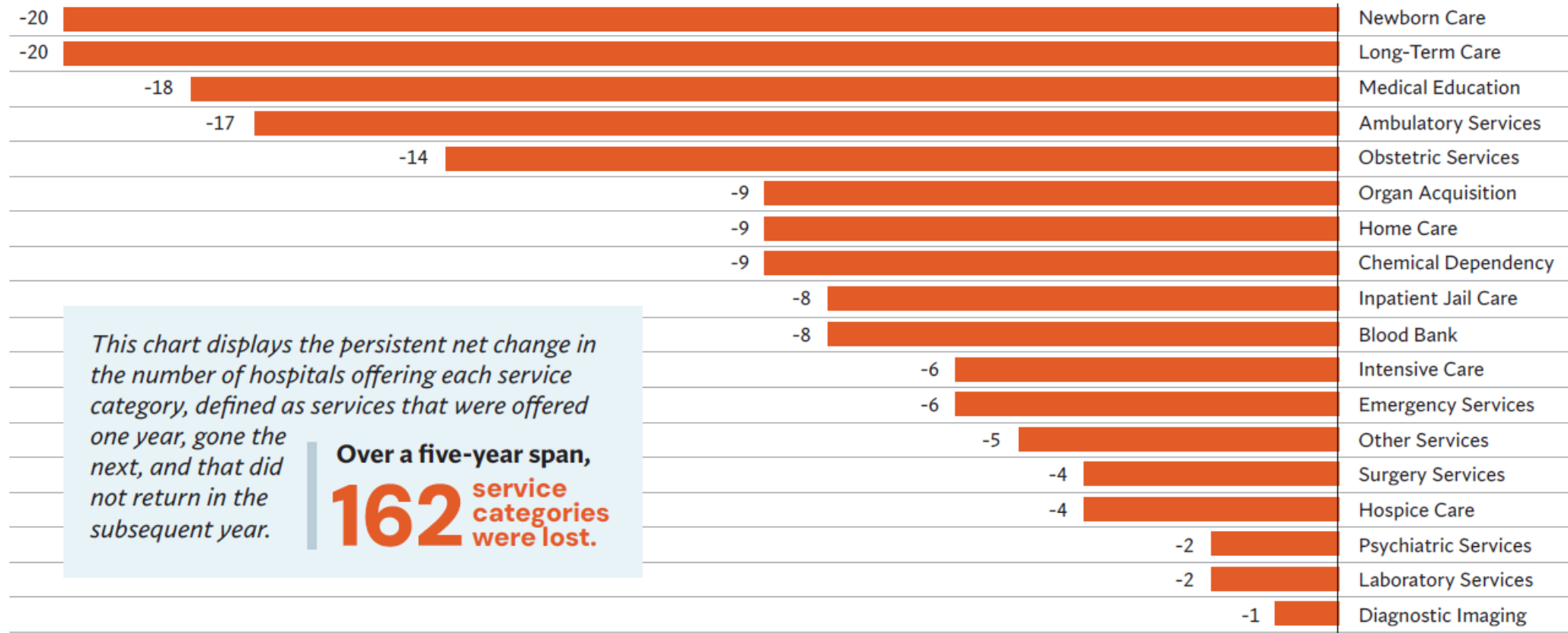
39,000

projected lost by 2029 under OHCA's
spending targets

Source: CHA projected losses in revenue, jobs, and economic activity by the end of 2029 resulting from OHCA's spending targets. These losses reflect the gap between allowable revenue growth and projected cost growth. More information available upon request.

Making a Bad Situation Worse – Service Line Closures

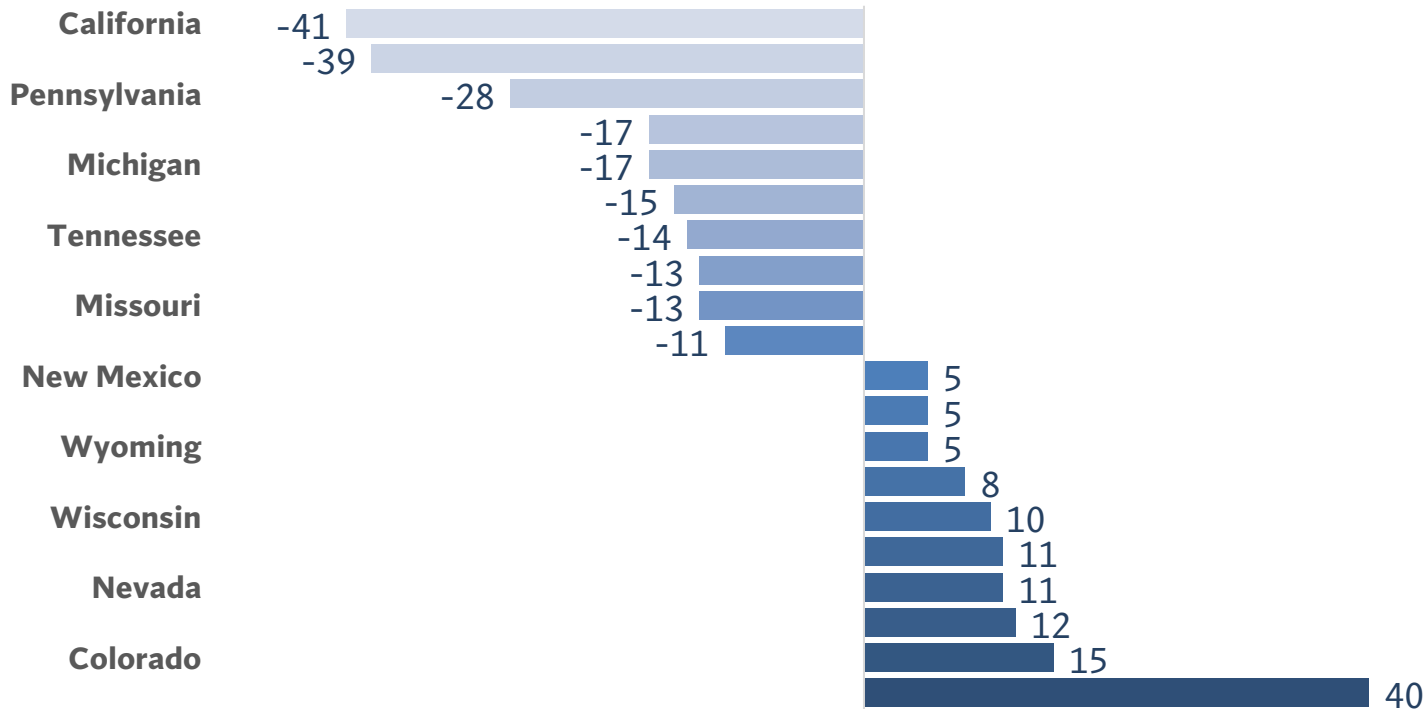
Hospitals Reduced Their Service Offerings from 2017 to 2022



Making a Bad Situation Worse – Hospital Closures

Net Hospital Closures by State Over the Last 20 Years

Top/Bottom 10 States



Closures Source: Health Care Affordability Lab at Yale. Hospital Closures Guide.
<https://markets.healthcareaffordabilitylab.org/closures-explorer/usa?indicator=closure>

TODAY

44%

of hospitals are operating at a loss

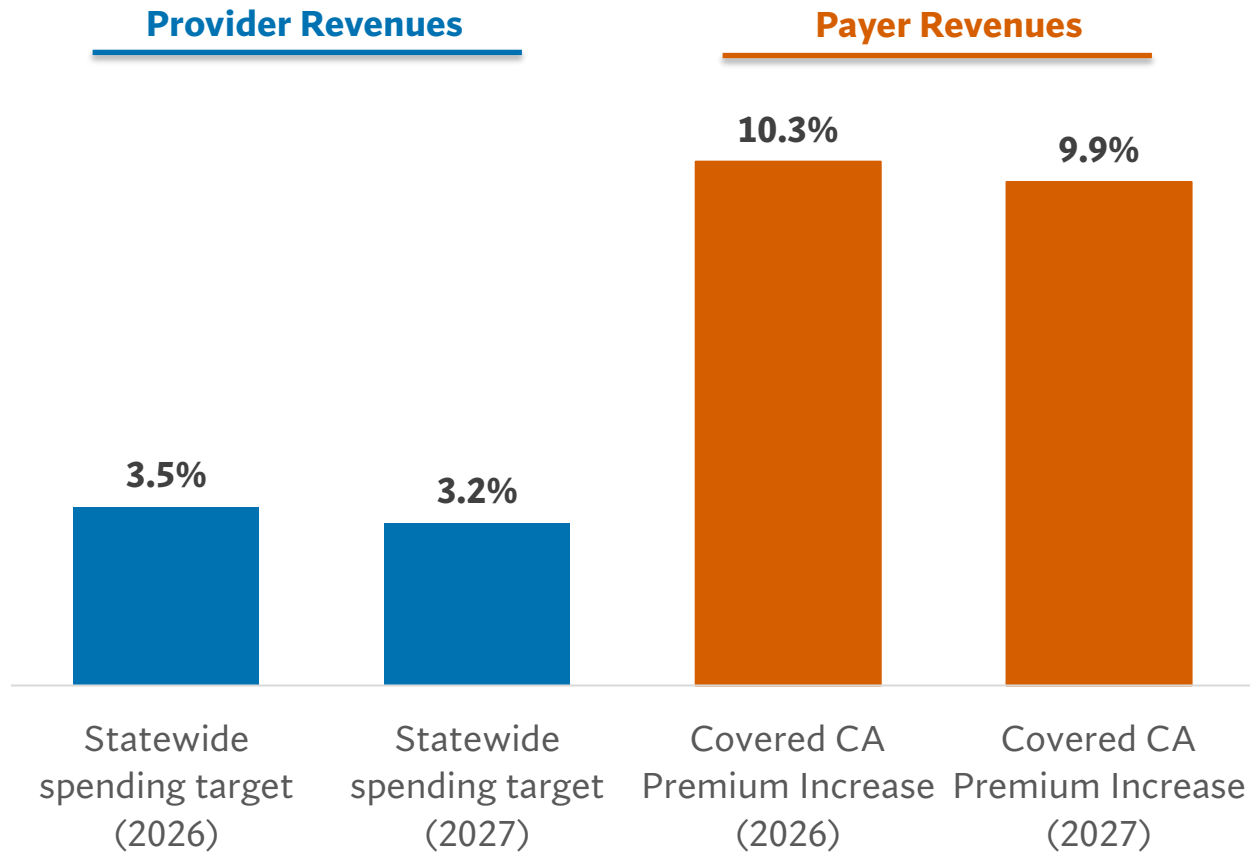
BY 2029

80%+

will be under OHCA's targets, absent drastic cost-cutting interventions

OHCA's Impact on Affordability

The Target Caps Spending. It Does Not Cap Premiums.



OHCA spending targets apply to **provider revenues, payer expenditures**

Legislative letter:

26

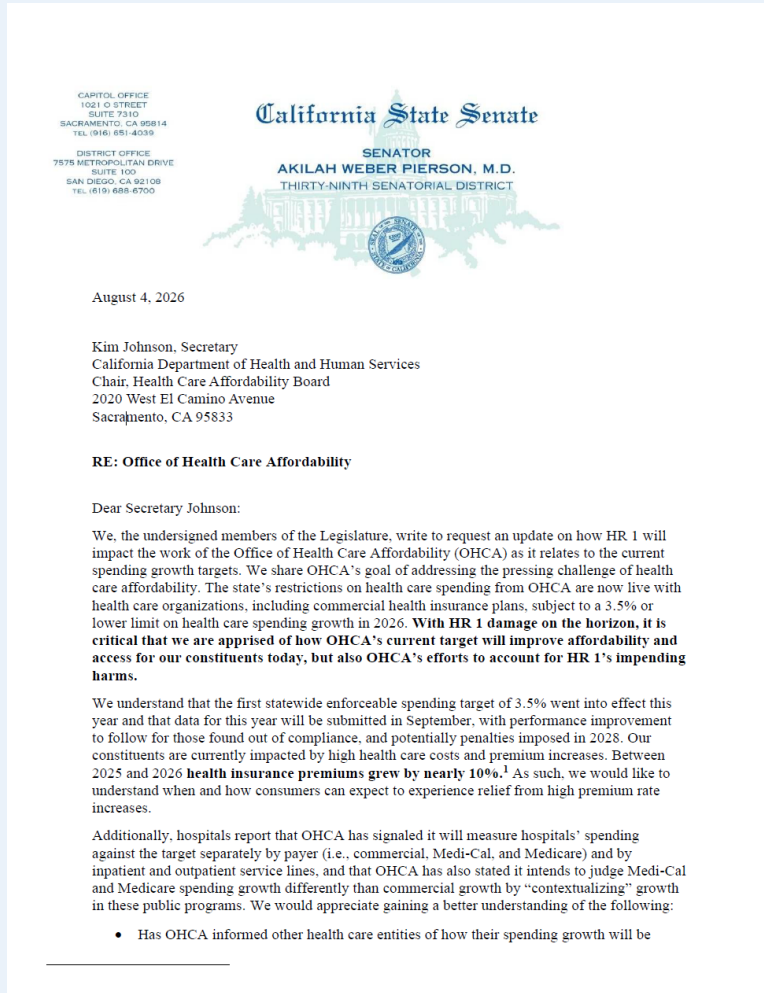
bicameral and bipartisan legislators
signed

Aug 4

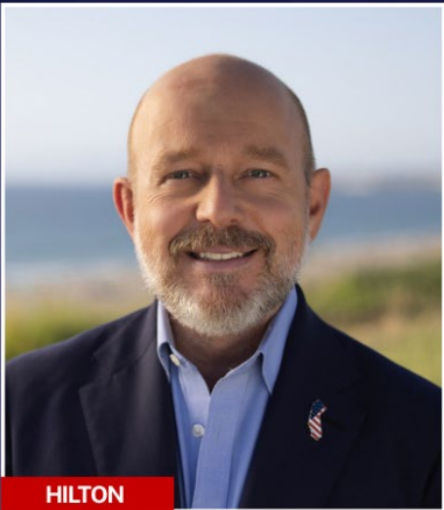
sent to the OHCA Board, 2026

Asking the OHCA Board:

- ? How is OHCA protecting access in the face of the One Big Beautiful Bill Act?
- ? Why are penalties 20x higher than the next highest state's?
- ? How will OHCA protect all workers, regardless of representation?



New Governor New Opportunities



Priority reforms

- ✓ Recognize hospital expenses within the spending targets
- ✓ Create a fair and collaborative enforcement process
- ✓ Promote real affordability, not just provider cuts
- ✓ Bring new voices to the table

Questions?