Office of Health Care Affordability (OHCA)
A Deep Dive on Spending Targets

February 12, 2024

California Hospital Association

Questions

Online Questions: At any time, please submit your questions in the Chat box at the bottom of your screen and press enter. We will take questions at the end of the presentation.

Presenter

Ben Johnson
Vice President, Policy
California Hospital Association

Ben Johnson is CHA's Vice President, Policy, covering finance and affordability issues, including the Office of Health Care Affordability. Ben has been working in health care policy for 8 years, previously having advised the state legislature from his role at the Legislative Analyst's Office, where he was lead on issues like drug pricing, the Medi-Cal budget, single-payer financing, and health care-related taxes.

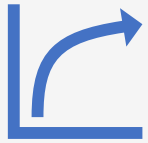
Presenter

Justin Ziombra
Group Vice President, Data Analytics
California Hospital Association

Justin Ziombra is the Group Vice President of Data Analytics at the California Hospital Association (CHA). In his role, he creates data-driven analyses to identify trends, spot opportunities, and evaluate the impact of state and federal policy changes, and translates the results of these analyses for stakeholders, elected officials and California hospitals. Prior to joining CHA, Justin was a director on the Policy and Data Analytics team at the Maryland Hospital Association and worked as a critical care registered nurse and nurse manager at The George Washington University Hospital in Washington, D.C.

OHCA's Main Objectives and Responsibilities

Increase transparency on spending and quality



Set spending targets for the health care field

Enforce compliance, including through financial penalties

Monitor and review market transactions

Establish new standards, including for quality, equity, workforce

Division of Roles and Responsibilities

California Hospital Association

Office/Director	• Establish reporting requirements • Analyze and publish reports on health care spending • Advise on and carry out progressive enforcement actions • Monitor and review market transactions
Board	• Establish spending targets and associated methodologies and adjustments • Define sectors and, as appropriate, geographic regions and individual health care entities • Approve range and scope of administrative penalties
Advisory Committee	• Provide input and recommendations on matters before the office, including data reporting requirements and spending targets

Board of Directors

Dr. David Carlisle – President and CEO of Charles R. Drew University of Medicine and Science (Governor appointee)

Dr. Mark Ghaly – CalHHS Secretary (ex officio, board chair)

Sandra Hernandez – President and CEO of CHCF (Governor appointee)

Richard Kronick – Professor, University of California, San Diego (Governor appointee)

Ian Lewis – NUHW Director of Research (Assembly appointee)

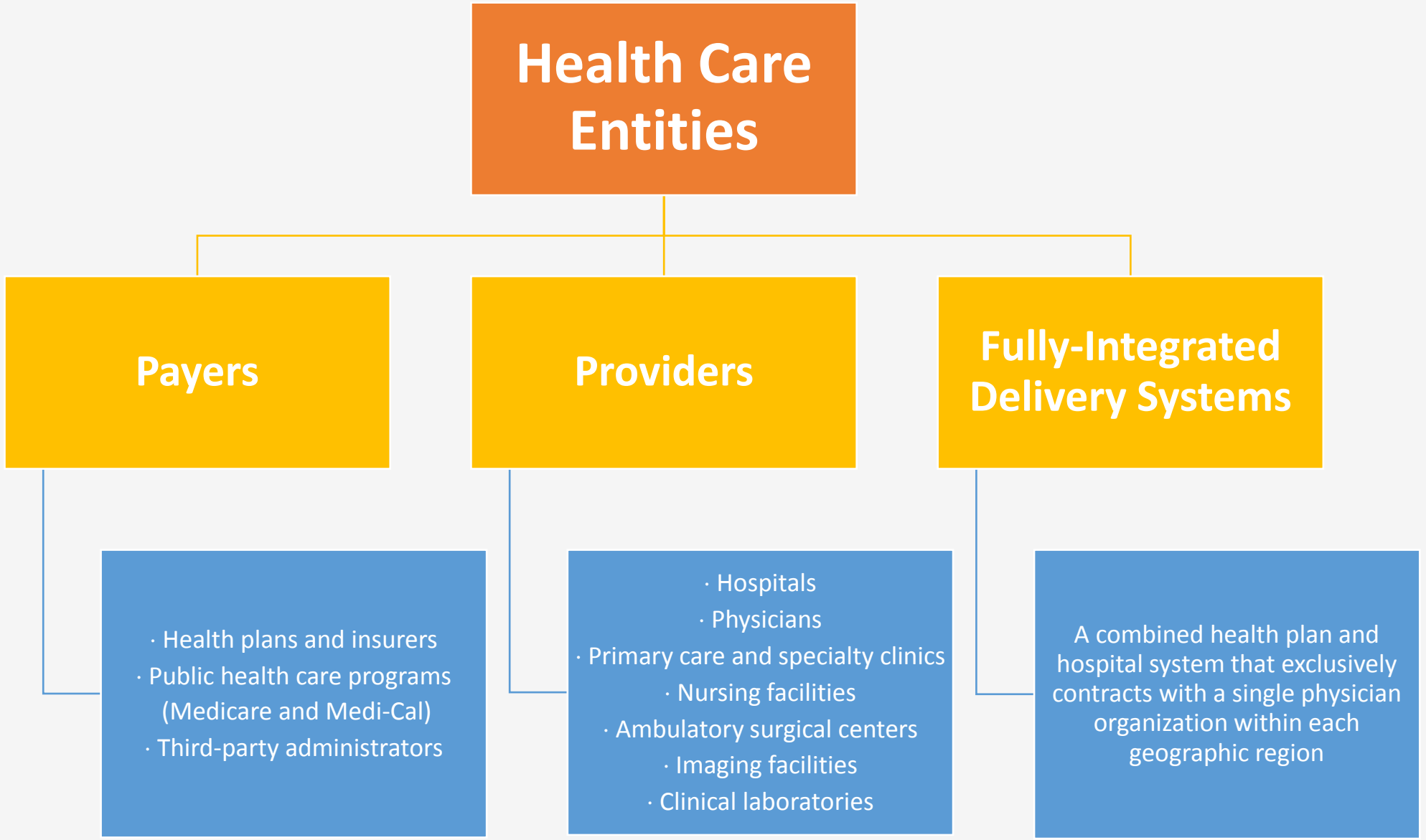
Elizabeth Mitchell – President and CEO of the Purchaser Business Group on Health (Governor appointee)

Don Moulds – CalPERS Chief Health Director (ex officio, nonvoting member)

Dr. Richard Pan – former Senator (Senate appointment)

“Health Care Entities” are Subject to Spending Targets

California Hospital Association



Exempt Health Care Providers and Suppliers

Various health care providers and suppliers are directly or indirectly exempt:

- ❑ Physician organizations with fewer than 25 physicians*
- ❑ Dentists
- ❑ Pharmacy (including manufacturers and retail pharmacies)
- ❑ Durable medical equipment suppliers
- ❑ Home health agencies
- ❑ Emergency medical transportation

*Physician organizations with fewer than 25 physicians that are determined to be high-cost outliers may have their exemption removed

These entities will not specifically be subject to reporting requirements, spending targets, or market oversight…

…However, the spending associated with exempt entities generally will be included in payers' expenditures and the revenues attributed to providers.

Data Collection and Reporting

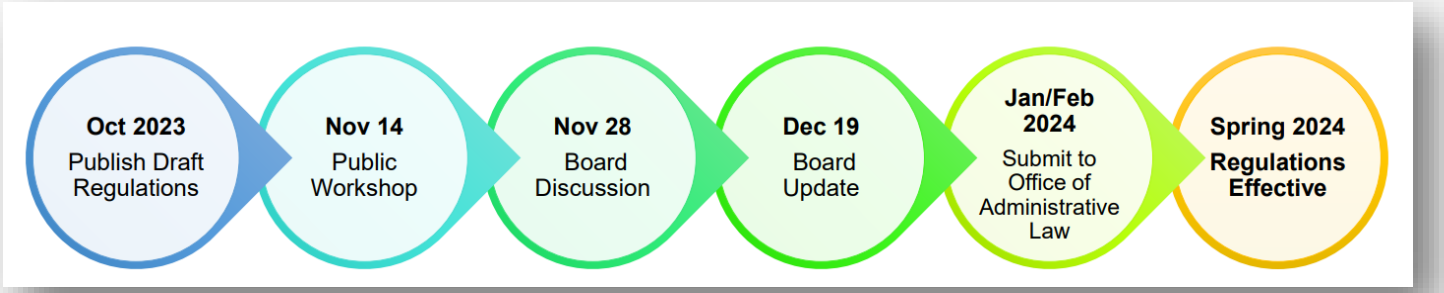
California Hospital Association

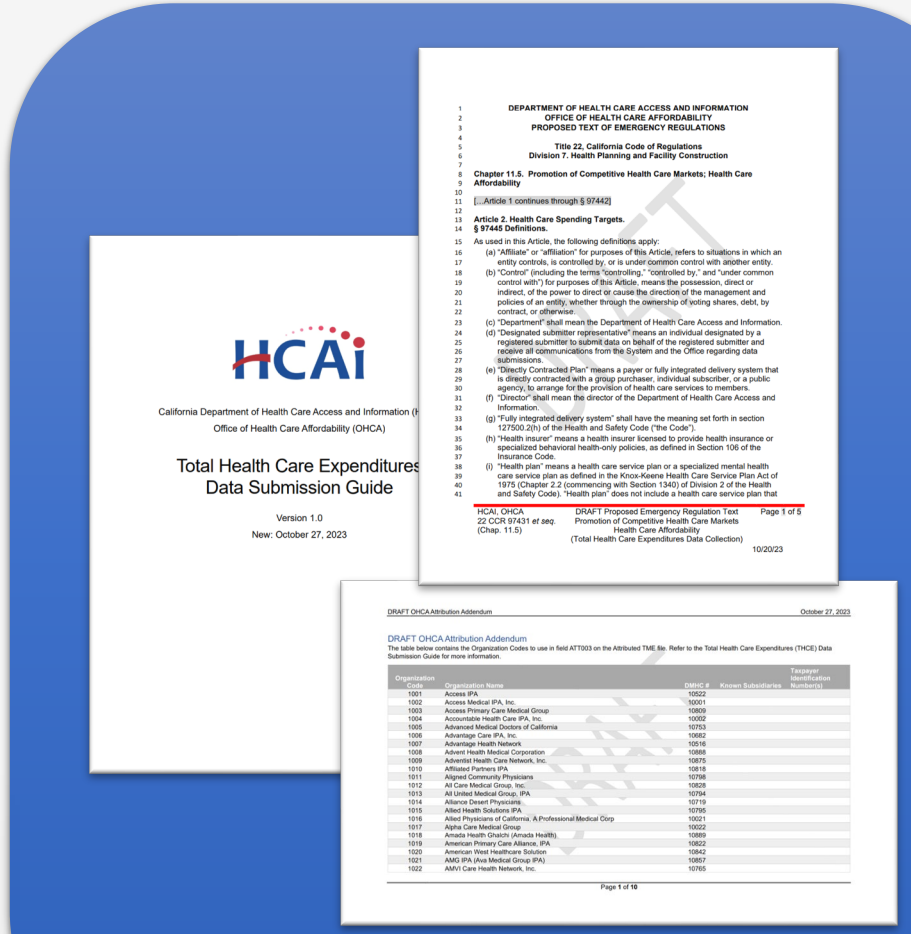
Data Collection Regulation Setting Currently in Process

Payers submit spending data on covered benefits for their members
No new reporting requirements on providers

Proposed Total Health Care Expenditures (THCE) Data Submission Emergency Regulations:

- Will govern data collection for 2022 and 2023 baseline spending analysis
- Establish the precedent for data used in assessment of entities' spending against the spending target
- Data sources:
  - Health plans and insurers for commercial and Medicare Advantage
  - DHCS for all Medi-Cal spending (at least initially)
  - CMS for Medicare fee for service
  - DMHC, DHCS, CMS, and NAIC for payer administrative costs and profits





https://hcai.ca.gov/about/laws-regulations/#health-care-affordability

OHCA Will Collect THCE Data

THCE is intended to include essentially all private and public spending in the state, including:

- Claims-based payments
- Non-claims-based payments
  - Capitation
  - Supplemental provider payments
  - Global budget
  - Other alternative payment methods
  - Salary
- Estimated patient cost sharing
- Net pharmacy spending
- Health plans and insurers' administrative costs and profits

Office will primarily collect and analyze cost data from payers (e.g., health plans), but may supplement this with data from providers and the Health Care Payments Data Program.

Data will be collected annually, starting in September 2024

Total Medical Expenditures Will be Attributed to Physician Organizations

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Total Medical Expenditures (TME)

- Equal THCE minus health plan administrative expenditures and profit
- Expenditures: defined at the payer level, *reflecting provider revenues*
- Expenditures = payment × utilization
- Payment = *allowed amount* reflecting a payer's contracted/paid amount + estimated patient share of cost
- Reporting year reflects the *service* year for which data are reported

Attribution of TME

- TME to be allocated to providers through physician organizations with at least 1,000 attributable members
- Attribution to providers based on a 3-step methodology:
  - Capitated/delegated members
  - Total cost of care Accountable Care Organizations
  - Payer-developed methodology

Per Capita Expenditures

Payers

- TME per enrolled or insured member

Providers

- TME per member attributed to the physician organization responsible for providing member's primary care

Payers and Providers

- TME calculated on a per member per month basis

TME Attribution Hypothetical Examples

Jane

Coverage – Enrolled in a United PPO
Primary Care Relationship – Primary care doctor works for a medical group within Sharp HealthCare System
Hospital Care – Delivers a baby at a Sharp hospital
Attribution – Hospital and all (health care) other spending attributed to Sharp HealthCare System

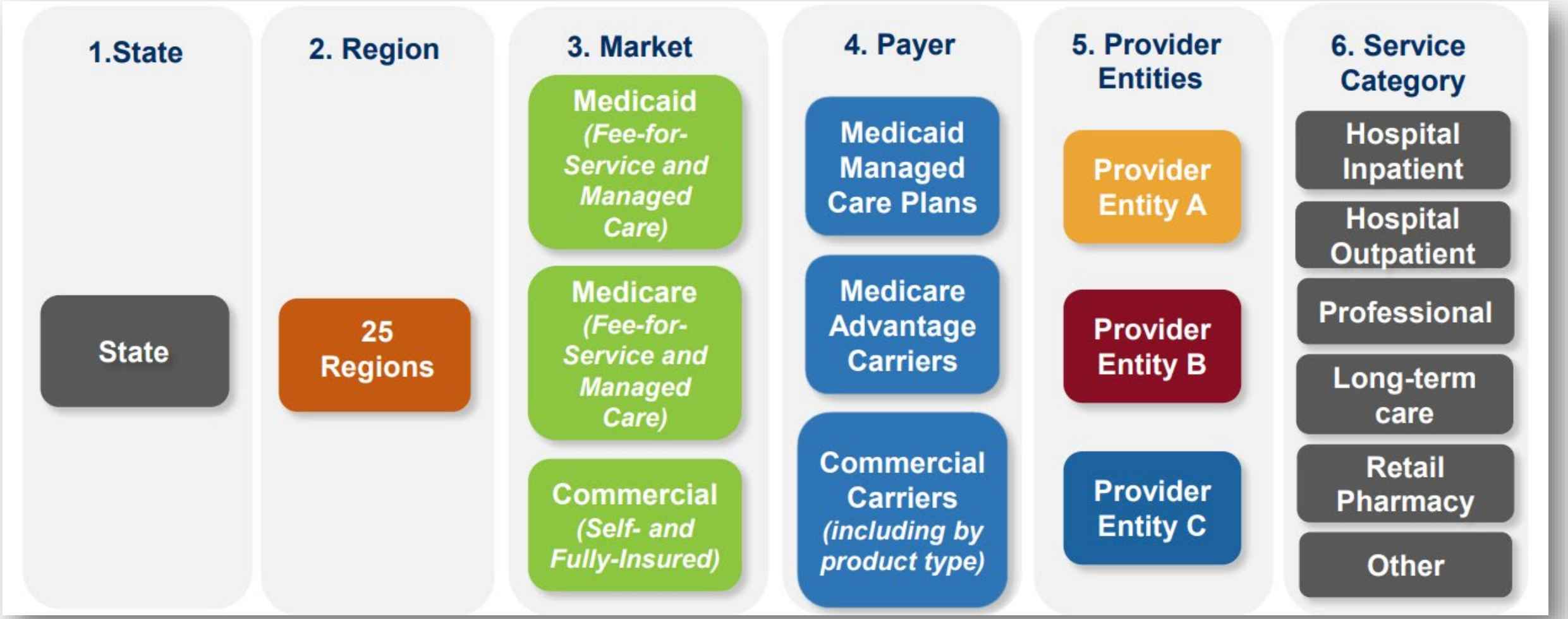
Phil

Coverage – Enrolled in an Anthem HMO
Primary Care Relationship – Assigned to a primary care doctor works for the Dignity Health Medical Foundation
Hospital Care – Receives emergency care at a Sutter hospital
Attribution – Hospital and all other spending attributed to Dignity Health System

Tom

Coverage – Enrolled in a United PPO
Primary Care Relationship – Has no established relationship with a primary care doctor
Hospital Care – Undergoes an operation at a UC hospital
Attribution – No spending is attributed at the provider level

Levels of THCE Reporting

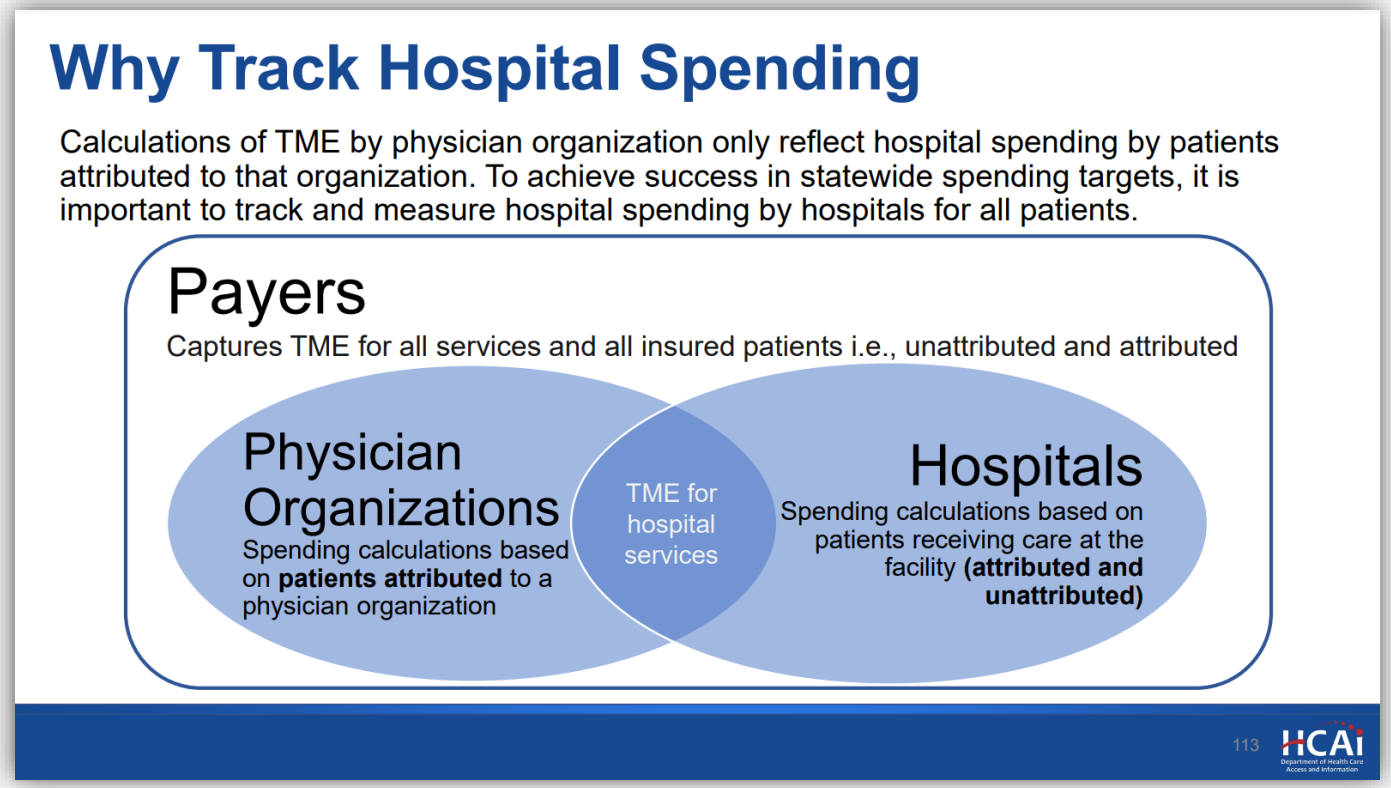


Geographic Levels of Reporting

OHCA intends to collect spending data to support geographic analysis by Covered California rating regions, except for Los Angeles County. For Los Angeles County, OHCA intends to collect data by Service Planning Areas.

Figure 16. Nineteen California ACA Rating Areas

Methodology Under Development to Assess Hospital Spending



Existing OHCA materials focus on price, rather than attributable spending

Q1 2024

Initial development of options for defining, measuring, and reporting

Q1 2024 – Q3 2025

Convene stakeholder workgroup and technical advisory panel

Q2 2024 – Q1 2025

Testing and validation of methodology

Q1/Q2 2025

Regulatory development as needed

CHA Advocacy on Data Collection

Support collecting data from payers, but requests changes to:

- Provide an opportunity to validate attributed expenditures
- Place guardrails around initial attribution methodology
- Plan for a standardized attribution methodology
- Ensure meaningful engagement with stakeholders
- Test the use of clinical risk adjustment
- Clarify how data for certain expenditures (e.g., Medi-Cal) will be collected
- Clarify how payments are defined

California Hospital Association

December 1, 2023

Megan Brubaker
Engagement and Governance Manager
Office of Health Care Affordability
Department of Health Care Access and Information
2020 West El Camino Ave., Suite 1200
Sacramento, CA 95833

Sent via email: OHCA@hcai.ca.gov

SUBJECT: **CHA Comments on the Oct. 20, 2023 Version of the Total Health Care Expenditures Data Collection Draft Regulations**

Dear Ms. Brubaker:

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) thanks the Office of Health Care Affordability (OHCA) for the opportunity to comment on the Oct. 20, 2023 version of the Total Health Care Expenditures (THCE) Data Collection draft regulations.

CHA Supports the Overall Approach of Collecting Data from Health Plans and Insurers

We believe the proposed approach of collecting the THCE data from health plans and insurers for enrolled and insured state residents makes sense. Unlike providers, health plans and insurers come the closest to having the necessary data to comprehensively identify and report the THCE of their members. By contrast, looking to providers for these data would exponentially increase the complexity of the data collection process and introduce serious data commensurability and quality issues that would undermine the spending target program.

While we support OHCA's overall approach to data collection, we have a number of concerns with the regulations and supplementary guidance, as currently proposed. Our most fundamental concerns relate to there being no process for validating the expenditures that health plans and insurers attribute to providers and essentially no rules around how health plans and insurers perform this attribution. Additionally, we remain troubled by the decision against using clinical risk adjustment, as reflected in there being no mechanism for gathering clinical risk information in the proposed regulations. Finally, we have questions and concerns with the lack of specificity around how stakeholders will be consulted when changes to the data collection regulations and guidance are being made, how these data will be

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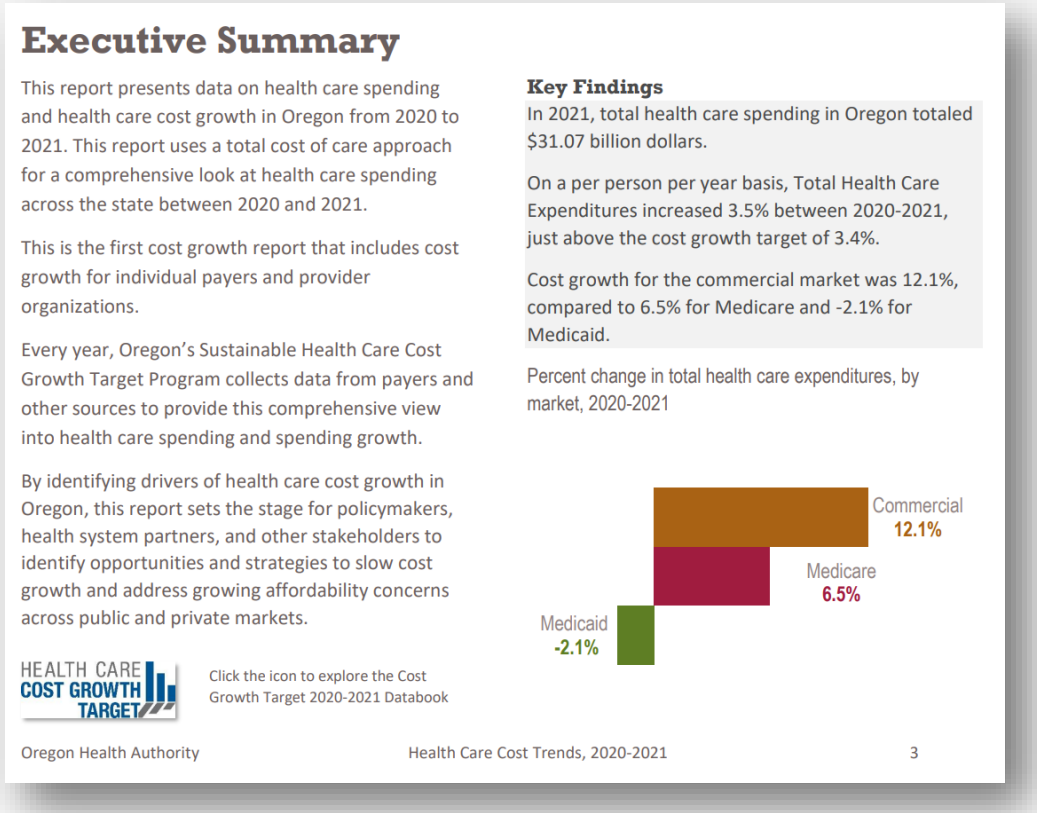
Annual Reports on Health Care Spending

California Hospital Association

Topics Covered

- Total and per capita health care expenditure growth
  - Broken down, as appropriate, by service category, geographic region, and source of funds
- Recommendations and best practices for controlling costs and improving quality and equity
- State's progress toward meeting cost target and other goals
- Drivers of cost growth
- Performance on access, quality, and equity measures
- Summaries of enforcement actions

*Not required in law, but OHCA has committed to releasing.



Executive Summary

This report presents data on health care spending and health care cost growth in Oregon from 2020 to 2021. This report uses a total cost of care approach for a comprehensive look at health care spending across the state between 2020 and 2021.

This is the first cost growth report that includes cost growth for individual payers and provider organizations.

Every year, Oregon's Sustainable Health Care Cost Growth Target Program collects data from payers and other sources to provide this comprehensive view into health care spending and spending growth.

By identifying drivers of health care cost growth in Oregon, this report sets the stage for policymakers, health system partners, and other stakeholders to identify opportunities and strategies to slow cost growth and address growing affordability concerns across public and private markets.

HEALTH CARE COST GROWTH TARGET

Click the icon to explore the Cost Growth Target 2020-2021 Databook

Key Findings

In 2021, total health care spending in Oregon totaled $31.07 billion dollars.

On a per person per year basis, Total Health Care Expenditures increased 3.5% between 2020-2021, just above the cost growth target of 3.4%.

Cost growth for the commercial market was 12.1%, compared to 6.5% for Medicare and -2.1% for Medicaid.

Percent change in total health care expenditures, by market, 2020-2021

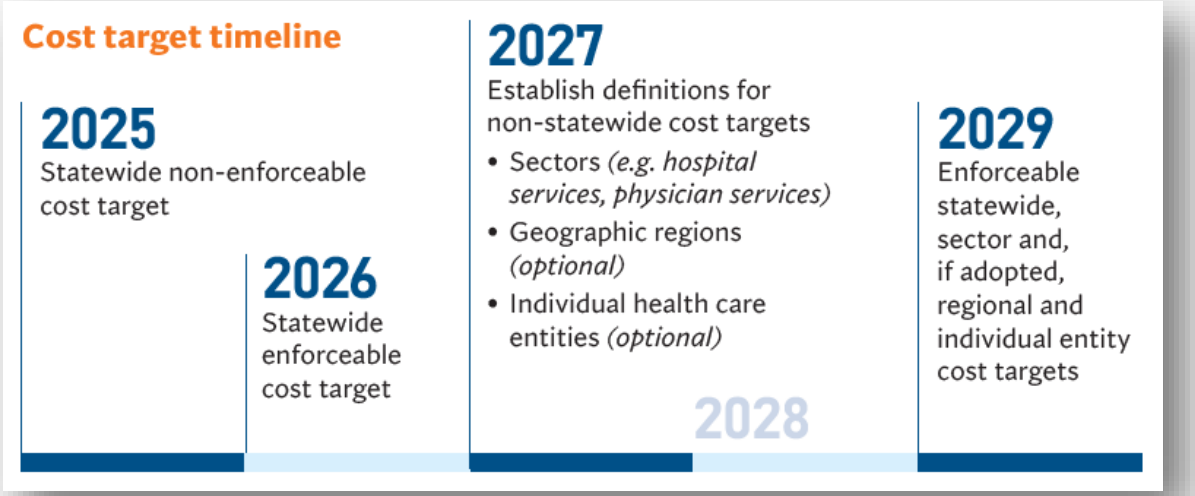
Spending Targets

California Hospital Association

Spending Targets Background

Key Statutory Requirements on Spending Targets

- Based on a **target percentage for annual growth** in per capita total health care expenditures
- **Promote affordability** and a predictable and sustainable rate of change in costs
- Set with consideration of **economic indicators** like inflation and population-based measures like aging
- Maintain **quality, equity**, and workforce stability
- Optional or required adjustments to spending targets to account for:
  - Risk of patient populations
  - Equity
  - Inflation
  - Labor costs
  - Policy changes
  - Payer mix
  - Prices of health care technologies
  - Emerging diseases
  - Growth in nonsupervisory organized labor costs
  - High-cost, low-quality health care entities



What's Behind a Spending Target?

- Based on both reimbursement and utilization levels
- Performance will be assessed based on payers' costs and providers' revenues
- Per capita:
  - For payers, measured on a per-enrollee or per-insured basis
  - For providers, initially measured on an attributed-patient basis

Spending Target Development Timeline

California Hospital Association

Dec 18
OHCA released **preliminary** recommendations for the initial statewide spending target

Jan 16
OHCA released **final** recommendations for the statewide spending target

Jan 24
OHCA board discussed staff recommendations for the spending target

Mar 11
Comment period closes for providing feedback on staff spending target recommendations

Mar 19
OHCA Advisory Committee discusses spending target recommendation

Mar 25, Apr 24, or May 22
OHCA board adopts the initial spending target

OHCA Staff Recommendation

3.0% Statewide Spending Target for 2025-2029

- To promote improved affordability, the annual per capita health care spending growth **target** percentage **should be below** the long-term [health care cost growth] trend of **5%**.
- To promote transparency and public accessibility, the basis for establishing a statewide spending target should be a **single economic indicator**.
- The methodology should rely on an indicator of consumer affordability, specifically, **median family income,** because it captures retirees and others not in the labor market.
- The methodology should **rely on historical data** over projections. Specifically, the methodology is the average annual growth in median household income in CA over for the period 2002-2022.
- Initial targets should be **set for five calendar years** to provide for sufficient planning.

Enforcement Against Spending Targets

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Pre-Enforcement Process

- Notify entities that have exceeded their spending target
- Allow entities to respond with information justifying their spending growth
- Modify findings to the extent spending growth is justified
- Report which entities have unjustifiably exceeded their target

Progressive Enforcement Process

- Provide technical assistance
- Compel entities to provide public testimony on why they exceeded their target
- Impose a performance improvement plan (PIP)
- Assess administrative penalties

2028

First enforcement actions on cost targets expected (for 2026 targets)

Massachusetts Case Study

January 2022: A PIP is imposed on Mass General Brigham after the state found:

- $293 million in cumulative commercial spending growth in excess of the target over 5 years
- Higher prices than other providers
- Inadequate cost containment strategies

September 2022: State approves PIP on Mass General, committing it to reduce annual spending by $128 million through

- Price reductions
- Reducing utilization (e.g., MRIs)
- Shifting care to lower-cost sites
- Increasing the use of APMs

CHA Advocacy on the Spending Target

California Hospital Association

CHA Advocacy, in Summary

Proposed 3% Spending Target

- ✓ Ignores external factors that influence health care costs, such as inflation and California's aging population
- ✓ Sets California apart as an outlier from other states that have struggled to meet their spending targets
- ✓ Fails to strike a balance between promoting affordability and maintaining access to high quality, equitable care

California Hospital Association

September 12, 2023

Mark Ghaly, MD
Chair, Health Care Affordability Board
1215 O St.
Sacramento, CA 95814

SUBJECT: Comments on the August 2023

Dear Dr. Ghaly:

California's hospitals share the Office of Health
patients receive high-quality, timely, equitable,
hospital and health system members, the Califor
opportunity to comment on the August 2023 pr

Draft Cost and Market Impact Revie

We appreciate the office's commitment to a rob
opportunity for stakeholder feedback on the dra
substantive concerns about the July 27, 2023 ve
raised by board members at the August Health
about the office seeking to collect too much info
transactions. A particular concern we heard fron
regulations would have on rural health care prov
have the least capacity to comply with a new an

The recent closure of Madera Community Hosp
processes come into conflict with the needed sp
severe financial distress. As the office finalizes it
(CMIR) process, we urge it to consider the poter
review even small and routine transactions; the
basic market activities; and the potential for ove
enabling statute's foundational goals of improvi

We recommend that the office reconsider its current approach of seeking maximal noticing, information submission, and timeline authority at the outset to one that focuses on the key areas of concern and clear statutory prerogatives. Then, over time and using its streamlined (emergency) rulemaking power, the office may progressively expand the scope of its market oversight functions to the extent that experience shows this is needed. Below is a summary of our central concerns and feedback.

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California Hospital Association

October 18, 2023

Mark Ghaly, MD
Chair, Health Care Affordability Board
1215 O St.
Sacramento, CA 95814

SUBJECT: Comments on the September 2023

Dear Dr. Ghaly:

On behalf of our more than 400 hospital and health
(CHA) appreciates the opportunity to comment on t
Affordability Board and Advisory Committee. We sh
commitment to improving the affordability of health
OHCA to promote affordability while addressing long

This letter provides recommendations and considera
are currently making or preparing important decision

- **Market Oversight.** We thank OHCA for the
2023, cost and market impact review (CMIR)
business transactions are not covered and est
is threatened due to provider financial instabi
additional amendments to sharpen the focus
speed up review timelines, add reasonable pr
benefits of transactions, clearly formulate the
CMIR, reduce the burden of the regulations'
confidentiality.
- **Spending Targets.** The September board and
discussions of the potential design of the spe
were missing. Board and advisory committee
targets based on economic indicators such as
below, in peer countries such as Australia, Ca
health care expenditure growth has far outpa
among peer countries with diverse health care systems indicates that drivers other than health care policy – like population aging, labor market dynamics, and technological evolution– are behind the relatively high growth in health expenditures. Ultimately, this suggests that a target that is not reflective of the underlying drivers of health care cost growth, such as one solely based

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California Hospital Association

December 13, 2023

Mark Ghaly, MD
Chair, Health Care Affordability Board
1215 O St.
Sacramento, CA 95814

Subject: CHA Comments on the Octobe
Meeting and November 30, 202
(Submitted via Email to Megan

Dear Dr. Ghaly:

On behalf of our more than 400 hospital and h
Association (CHA) thanks the Office of Healt
comment on the October Health Care Afforda
Advisory Committee meetings. In this letter,
data collection regulations and provide a num
toward setting California's first spending targ

CHA Supports Collecting Data from P

In our December 1 comment letter on the dra
proposed approach of collecting Total Health
and insurers for enrolled and insured state res
positioned than providers to comprehensively
complexity of the data collection process and
quality issues.

While we support OHCA's overall approach t
with the proposed regulations and supplemen
relate to the absence of a process for validatin
rules for how health plans and insurers must p
we fear reported THCE data will lack the trans
to support OHCA's mission.

Additionally, we remain concerned with the de
reflected in there being no mechanism for gat

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California Hospital Association

January 18, 2024

Mark Ghaly, MD
Chair, Health Care Affordability Board
1215 O St.
Sacramento, CA 95814

Subject: Urge Serious Scrutiny of the Proposed Spending Target and Significant Changes to Avoid Negative Consequences
(Submitted via Email to Megan Brubaker)

Dear Dr. Ghaly:

The Office of Health Care Affordability (OHCA) has an obligation to improve the affordability of health care **without sacrificing access to or the quality of health care**. While the office is clearly committed to the first goal, its final recommendation for California's first statewide spending target misses the mark on the second goal — putting patient care in jeopardy.

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) urges the OHCA board and advisory committee to reconsider OHCA staff's proposed 3% target for 2025-29. We specifically are concerned that the proposal:

- Fails to strike a balance between promoting affordability and maintaining access to high-quality, equitable care
- Ignores external factors that influence health care costs, such as inflation and California's aging population
- Sets California apart as an outlier from other states with spending targets

Proposed Spending Target Fails to Strike a Balance Between Promoting Affordability and Maintaining Access to a High-Quality, Equitable Health Care System

While establishment of a spending target is intended to promote affordability, that is not the only goal. State law clearly requires the spending target to be set in a manner that preserves high-quality, equitable care. OHCA's proposed spending target is:

- Incompatible with the spirit, if not the letter, of state law, as a sudden 40% drop in the growth in health care spending, in the current inflationary environment, is not achievable without serious negative consequences for patients
- Arbitrary and lacking consideration of the underlying drivers of health care costs

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OHCA Proposal Would Make California an Outlier

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California's Spending Growth Target Would Be the Lowest in the Nation Despite Higher Inflation and a Faster Growing Economy

State	Year Target Was Set	Prior Year Inflation	Average Target[1]	GSP Growth[2]	Difference (Target - GSP)	Phase-in Period (Years)[3]	Phase-in Value[3]
California	**2024**	**4.2%**	**3.0%**	**4.9%**	**-1.9%**	**0**	**0.0%**
Massachusetts	2012	3.1%	3.1%	2.5%	0.6%	6	0.5%
Nevada	2021	1.3%	3.1%	2.9%	0.2%	4	0.8%
Connecticut	2020	1.8%	3.2%	1.2%	2.0%	3	0.5%
Rhode Island	2021	1.3%	3.2%	1.3%	1.9%	4	2.7%
Washington	2018	2.1%	3.2%	4.7%	-1.5%	5	0.4%
Delaware	2018	2.1%	3.3%	0.4%	2.9%	4	0.8%
Oregon	2021	1.3%	3.4%	3.2%	0.2%	6	0.4%
New Jersey	2021	1.3%	3.5%	1.7%	1.8%	4	0.7%
Average Among Peer States		**1.8%**	**3.3%**	**2.2%**	**1.0%**	**4.5**	**0.9%**

[1] Average Target = average growth in the health care growth target 2021-23. Source: Melnick, CHCF, 2022.

[2] GSP: average gross state product for the period 2016-2019. Source: Melnick, CHCF, 2022.

[3] Phase-in value is the distance between the maximum and minimum spending target values. For all states except Rhode Island, the maximum value is the first year's value. Rhode Island revised its target upward to account for contemporary spending trends. Phase-in period is the number of years it takes for target to be reduced from its maximum to minimum value.

Melniick, CHCF, 2022: Melnick, Glenn. CHCF Issure Brief, Health Care Cost Commissions: How Eight States Address Cost Growth. April 2022.

Other States' Targets are Not Attainable

California Hospital Association

Summary of State Performance Against Their Spending Targets

	All Years				Pre-COVID-19			
	Average Performance	Average Target	Years Target Met	Years in Place	Average Performance	Average Target	Years Target Met	Years in Place
Connecticut	6.1%	3.1%	0	1			0	0
Delaware	5.3%	3.3%	1	3	5.8%	3.8%	0	1
Massachusetts	3.5%	3.4%	4	9	3.6%	3.5%	3	7
Nevada		2.8%	0	0			0	0
New Jersey		3.1%	0	0			0	0
Oregon	3.5%	3.3%	0	1			0	0
Rhode Island	1.5%	3.3%	2	3	4.1%	3.2%	0	1
Washington		3.8%	0	0			0	0
Peer State Average/Sum	**4.0%**	**3.0%**	**7**	**17**	**4.5%**	**3.5%**	**3**	**9**

OHCA Proposal Ignores External Drivers of Spending Growth

California Hospital Association

Inflation – Projected to average 3.5%
Aging – Expected to raise health care spending by $3.5 billion annually
Technology (e.g., drugs and medical supplies) – Will raise spending by $4 billion annually under current trends
Policy Changes – Decisions already made will add tens of billions of dollars in spending over next several years

Fails to Balance OHCA's Multiple Objectives

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No substantive analysis of impacts of an immediate 40% cut in allowable spending growth

No accounting for how reduced spending will lead to reduced job growth, foregone investment, and reductions in patient care

Assumes investments in equitable access (e.g., MCO tax, behavioral health infrastructure) will be offset with spending reductions elsewhere

Neglects to consider research demonstrating that lower revenues lead to lower quality

Potential Impact of a 3% Target on Revenue

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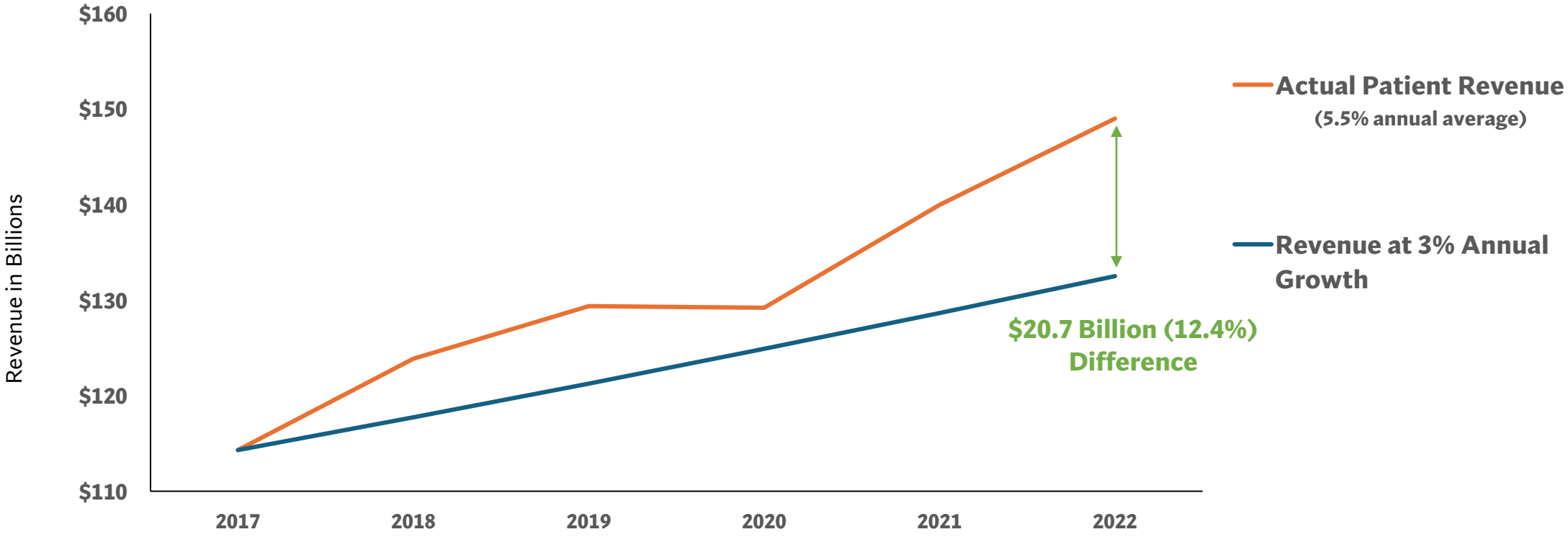
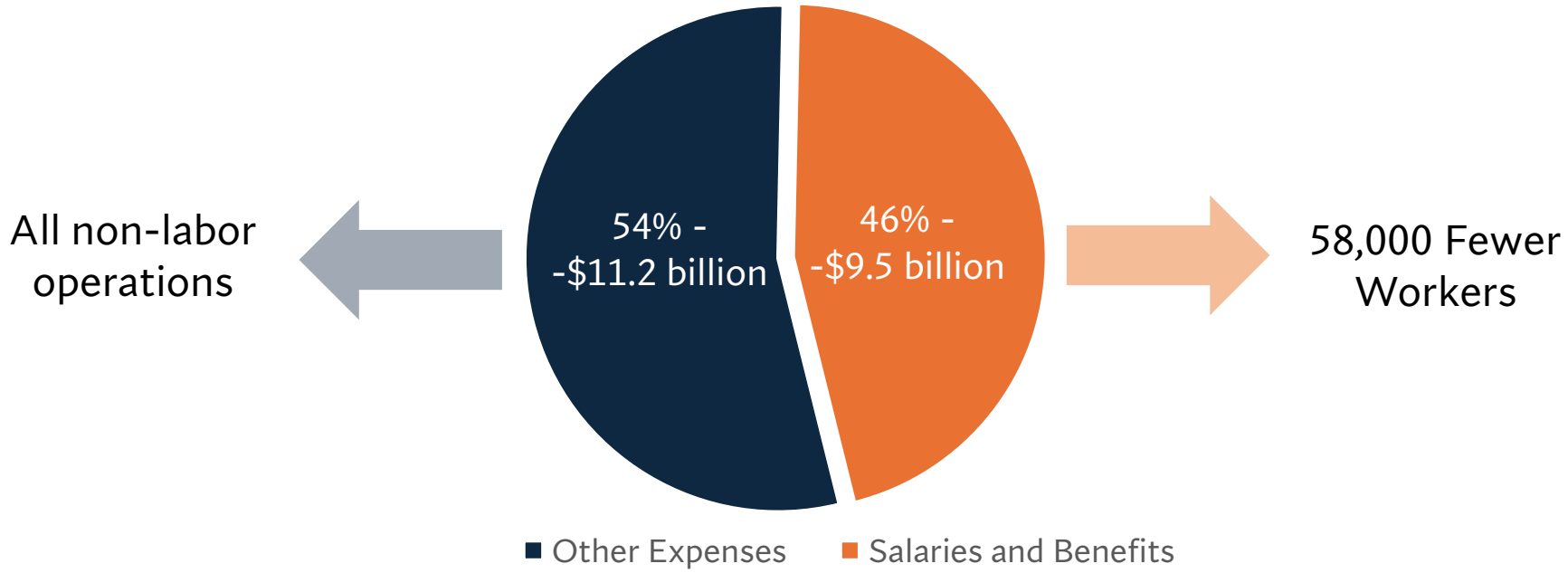
Hospital Net Patient Revenue Relative to 3% Target



Foregone Revenues Will Lead to Expense Reductions

Hospitals will not be able to reduce expenses in ways that don't impact jobs, quality, and access.

*If **$20.7** Billion Less Revenue was Matched with an Equal Reduction in Operating Expenses…*



Timeline

California Hospital Association

2024

Jan 16 – OHCA releases staff's proposed statewide spending target

Feb – OHCA finalizes regulations for data collection

Mar 11 – Comment period on spending target ends

Mar 19 – OHCA Advisory Committee meets to discuss the proposed spending target

Mar 25, Apr 24, or May 22 – OHCA board adopts the first statewide spending target

Sep 1 – OHCA collects 2022 and 2023 THCE data

2025

Jan-Dec – Non-enforceable statewide spending target in effect

Jun 1 – OHCA releases baseline report on 2022 and 2023 spending

Sep 1 – OHCA collects 2023 and 2024 THCE data

2026

Jan-Dec – Enforceable statewide spending target in effect

Jun – OHCA releases baseline report on 2023 and 2024 spending

Sep 1 – OHCA collects 2024 and 2025 THCE data

Timeline (Continued)

California Hospital Association

2027

Jan-Dec – Enforceable statewide spending target in effect

Jun 1 – OHCA releases first annual report on performance against the 2025 spending target

Sep 1 – OHCA collects 2025 and 2026 THCE data

Oct 1 – Board must define sectors

2028

Jan-Dec – Enforceable statewide spending target in effect

Jun 1 – Board must adopt spending targets by sector

Jun – OHCA releases annual report on performance against the 2026 spending target

Sep 1 – OHCA collects 2026 and 2027 THCE data

2029

Jan-Dec – Enforceable statewide and sector spending targets in effect

Jun – OHCA releases annual report on performance against the 2027 spending target

Sep 1 – OHCA collects 2027 and 2028 THCE data

Questions?

California Hospital Association

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Thank You

Thank you for participating in today's webinar.

For education questions, contact: education@calhospital.org

Appendix

Key Acronyms

CMS: Centers for Medicare and Medicaid Services

DHCS: Department of Health Care Services

DMHC: Department of Managed Health Care

NAIC: National Association of Insurance Commissioners

OHCA: Office of Health Care Affordability

Links

CHA advocacy materials can be found at: https://calhospital.org/office-of-health-care-affordability/