December 10, 2025

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

Subject: **Comments for the December 2025 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

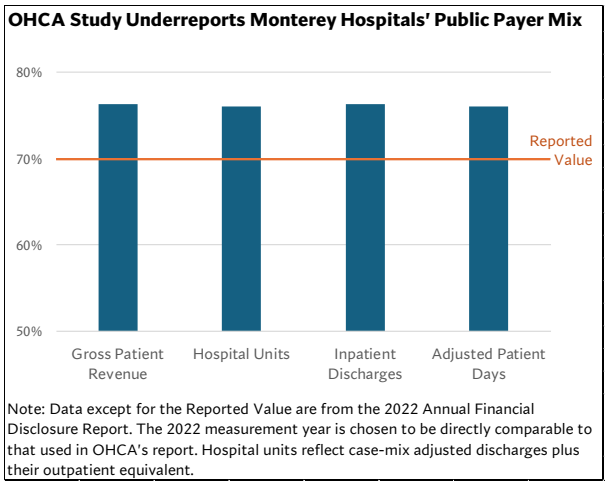
California's hospitals share the Office of Health Care Affordability's (OHCA's) goal to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of nearly 400 hospital members, the California Hospital Association (CHA) appreciates the opportunity to provide feedback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

Deeply Flawed Study on the Monterey Region Misses the Mark on Hospital Competition and Finance

OHCA was created to be a forum for focused, data-driven, and honest conversations about why health care is unaffordable for too many Californians, as well as collaboration on scalable solutions. OHCA has not fulfilled this promise. Too often, the office has reflexively emphasized a single factor (high prices), ostensibly brought about by a single cause (lack of competition), and blamed a single set of providers (hospitals). OHCA's recent report, *An Investigative Study of Hospital Market Competition in Monterey County*, is the latest example of this slanted approach. The study presents a carefully curated set of analyses that paint Monterey's hospitals as charging high commercial prices simply because they can, dismissing underlying factors driving these hospitals' prices higher than elsewhere in the state, including the Bay Area. As this analysis makes clear, Monterey County's hospital landscape is unique. This uniqueness, however, is not due to a lack of competition — in fact, the county is home to robust competition, especially given its size. Rather, Monterey's high commercial prices are explained by three factors: reimbursement shortfalls, payer mix, and the area's high cost of doing business.

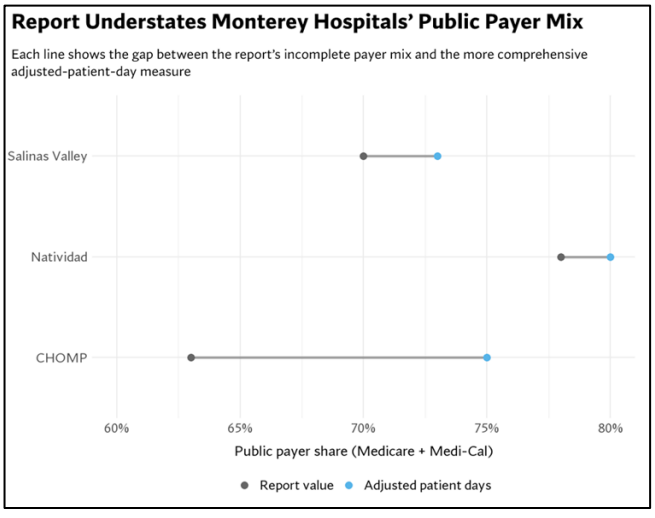
The Cost Shift Largely Explains High Commercial Hospital Prices in Monterey

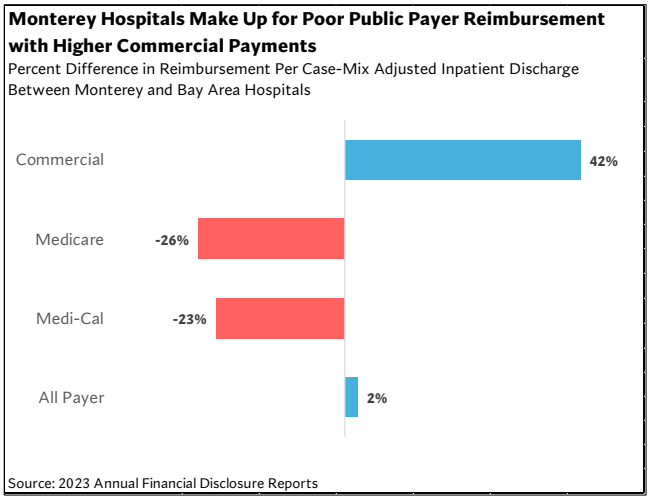
Payer mix and shortfalls in reimbursement from public payers are fundamental drivers of hospitals' financial performance. And yet, OHCA's study dismisses these issues on merely theoretical grounds and by analyzing a narrow slice of non-representative data. First, the study states that economists do not believe cost shifting exists because hospitals, in theory, are already always getting the best rates possible. In reality, hospital rate negotiations are contingent on various factors — including payments from other payers. OHCA board member Elizabeth Mitchell understands this all too well, having recently shared the following concerns with *Politico* while discussing looming federal health care cuts: "We all use the same delivery system, and if a hospital loses Medicaid coverage or other public coverage, they always seek to recoup those costs by passing them on to private coverage." Ultimately, this quote underscores hospitals' basic dilemma: make up for public payment shortfalls with higher commercial payments, or cut back on the services they provide. Monterey's hospitals are no exception.



In evaluating whether payer mix (a concept closely related to the cost shift) explains high Monterey prices, it appears the study's authors used hospital inpatient and emergency department utilization data from OHCA's parent department to show that the Monterey hospitals do not have an unfavorable payer mix. Missing from these data, however, were all non-emergency room outpatient utilization data — an omission that skews the data and renders the conclusion unreliable. The data in the study peg Monterey hospitals' average public payer mix (i.e., Medi-Cal and Medicare) at 70%. However, as the figure on the left shows, four standard measures of payer mix (all of which include all outpatient services) converge on a different, significantly higher number. The figure below shows OHCA's data was especially skewed for the Community Hospital of the Monterey Peninsula (CHOMP).

However, payer mix, as judged by patient volumes, tells only a small part of the story. The need for higher commercial payments to offset losses from public payers is not driven solely by which patients come through a hospital's doors, but also by the level of reimbursement the hospital receives from those public payers. Here, Monterey hospitals stand in stark contrast to their Bay Area peers. The figure on the next page reveals that Medi-Cal and Medicare inpatient payments for Monterey hospitals are 23% and 26% lower, respectively, than for Bay Area hospitals. On net, including commercial payments, Monterey hospitals receive all-payer inpatient payments that are just 2%





higher than Bay Area hospitals. If these hospitals instead charged Bay Area *commercial* prices, their all payer-reimbursement would be 12% lower than Bay Area hospitals'. The result: the Monterey hospitals would face hundreds of millions of dollars in losses that would force tough decisions about what services they can provide.

Clearly, cost shifting — or "cross subsidization," depending on the preferred nomenclature — is a major part of this story. The failure to place Monterey hospitals' higher commercial payments within the context of these enormous public payer shortfalls — or to ask straightforward questions as to why reimbursement is so low — calls into question the depth and balance of OHCA's analysis.

OHCA's report, and the board discussion that followed in November, did acknowledge an additional form of cross-subsidization present in Monterey County — that the hospitals' operating surpluses support local physician and outpatient practices that cannot survive independently. OHCA's report, which contains data showing that professional (e.g., physician) reimbursement is around 20% to 40% lower in Monterey compared to the Bay Area, corroborates the need for this subsidization. Without hospitals' support, attracting physicians and other health professionals to Monterey would be impossible. Ultimately, while the hospitals on their own look profitable, the health systems they sit within earn only the small margins necessary to remain financially sound and able to provide future care for the community.

Monterey Hospitals' Cost of Doing Business Is High

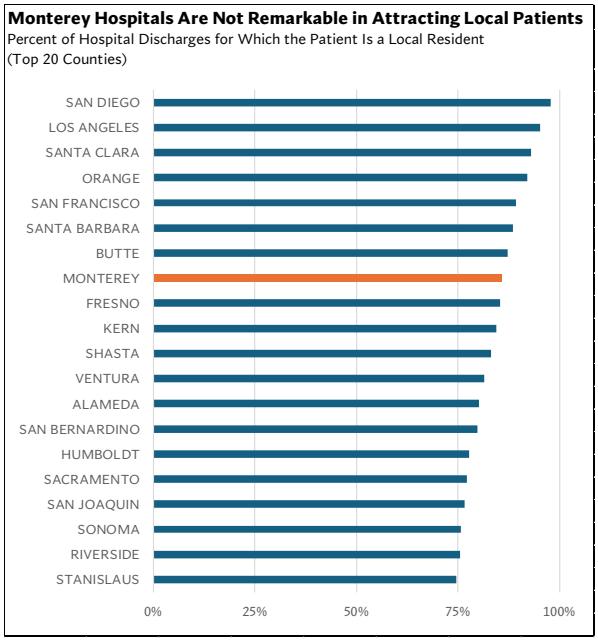
Monterey County is an expensive place to live, work, and operate a business. Coastal Monterey has some of the most expensive real estate in the entire country. Attracting workers means paying living wages — wages that are among the highest in the state. Moreover, Monterey hospitals compete with their neighbors to the north to recruit and retain physicians, nurses, and other essential staff, subjecting them to the economic forces present in **the** most expensive region in all of California (the greater Bay Area).

OHCA's study obscured these facts by selectively reporting different views of hospitals' labor costs. For example, OHCA ignored the standard assessment (hospitals' total salary and benefits costs per full-time-equivalent worker), which would have shown that the three Monterey hospitals have 5% higher per-worker costs than the study's Bay Area comparison group. The OHCA report only included salaries, not benefits, in its assessment of labor costs, and used hospital utilization to control for hospitals' varying sizes, instead of using cost per worker. Compared to all other hospitals in the state, Monterey hospitals pay a 47% premium on salaries and benefits per worker, far higher than the 13% higher all-payer reimbursement they receive.

The Monterey Hospital Market Is Highly Competitive for a County of Its Size

OHCA's study squarely blames high commercial hospital prices in Monterey on hospital market power and insurance companies' imperative to have hospitals in their network. The analysis supporting these claims is woefully insufficient — and data left out of the report paint a very different picture.

The report finds evidence of market power because Monterey residents visit Monterey hospitals in high proportions. That local residents prefer their local hospitals is an entirely unsurprising aspect of the hospital market, or any market where a service is provided in person. Moreover, the report did not even attempt to compare whether Monterey residents disproportionately tend to visit their county's hospitals, compared to residents in other areas of the state. The figure below shows Monterey is hardly unique in terms of the proportion of patient discharges attributed to county residents — and other counties are significantly higher.



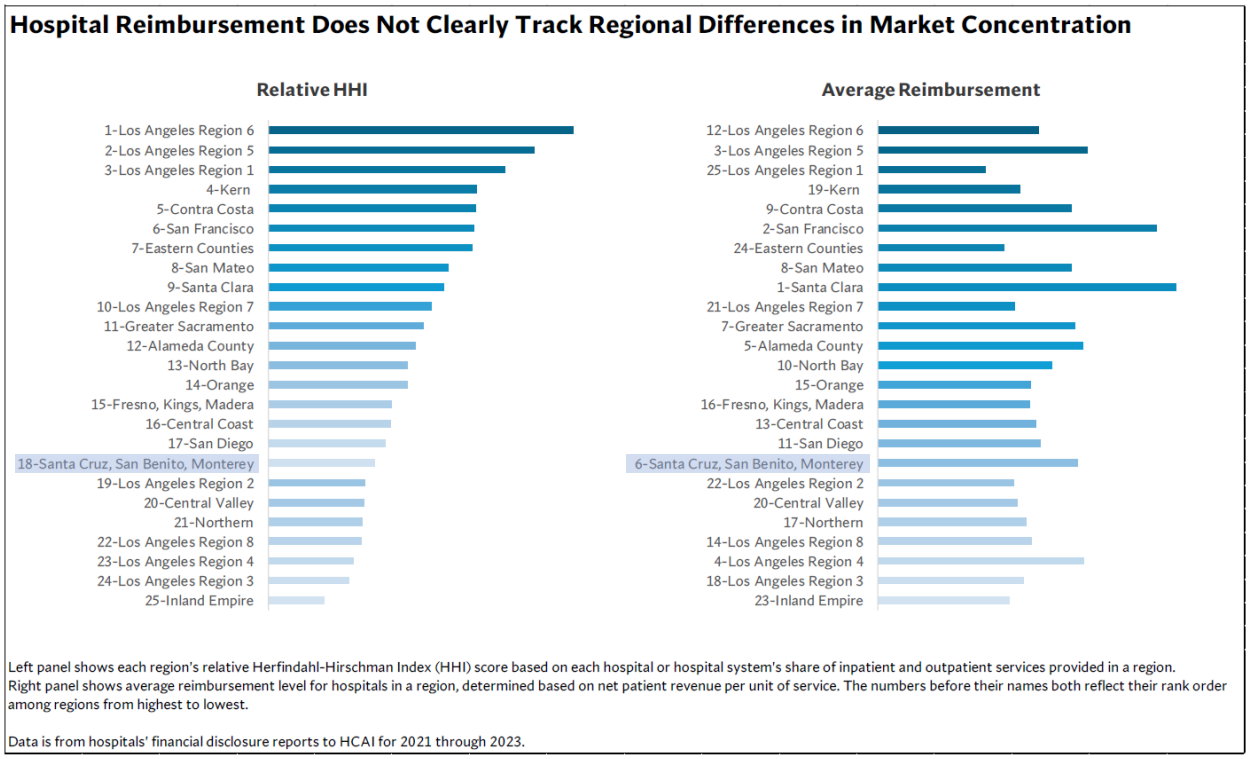
The study's second key piece of evidence is a simulated model showing that local residents have varying, and in some cases high, willingness to pay for access to the local hospitals. Simulations of human behavior must pass an extraordinarily high bar to count as evidence. Even if the model's outputs were reasonable, this constitutes zero evidence that the hospitals are in fact **exercising** their favorable market position. Ultimately, this analysis shows that local residents have reason to prefer their local hospitals, which is hardly a condition that public policy should strive to upend.

Contrary to the unsatisfying analytics used by OHCA, multiple data points show that hospital competition is relatively strong in Monterey, especially considering its size. Most simply, the county has four unaffiliated hospitals. Only two of the state's 42 counties with fewer than 500,000 residents have more than four unaffiliated hospitals. Moreover, and counter to claims by an OHCA board member at the November meeting, there is no shared hospital ownership between Montage Health and Salinas Valley Health.

Another common measure of market concentration, known as the Herfindahl-Hirschman Index (HHI), tells the same story. The graphic on the next page sorts each OHCA region (as they were originally formulated[1]) by their HHI score. Monterey, combined into a single region with Santa Cruz and San Benito, comes in just 18th among the 25 regions. As the graphic further illustrates, HHI scores for each region are not a strong predictor of average reimbursement. Even if there were a stronger connection, such a low HHI score compared to other

[1] The original OHCA geographic regions were based on Covered California regions, plus additional subdivisions for Los Angeles given its enormous size. These Los Angeles subdivisions were later removed due to administrative complexity, but their relevance to the geography of different health care markets in California remains.

regions is a clear indication that a lack of market competition is not driving higher hospital prices in the Monterey region compared to other areas of the state.



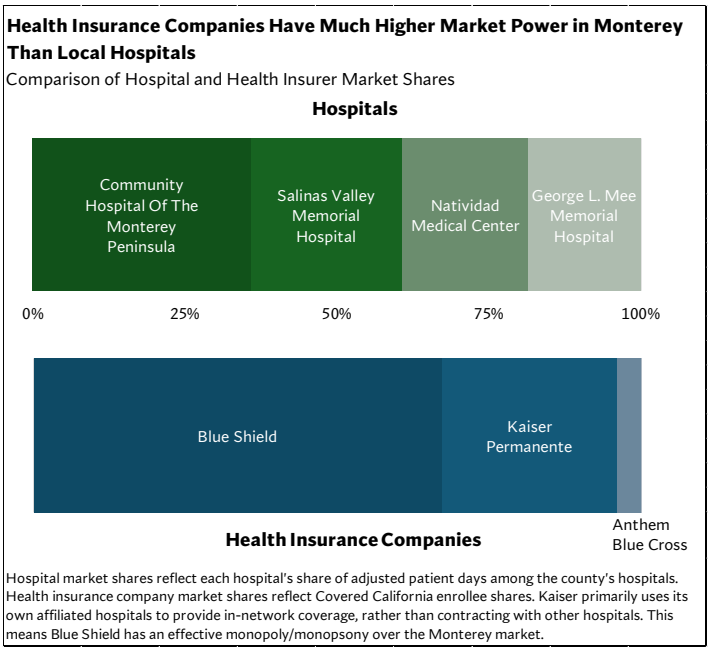
The report also echoes — without assessment or critique, which would have been appropriate —health insurance industry executives' claims that Monterey hospitals are "must haves" in their networks due to the state's network adequacy laws. OHCA provides no data to substantiate this claim, nor does it ask why the state's hospital network adequacy rules — which do not vary by county — are particularly problematic in a county with four unaffiliated and independent hospitals but not in the 33 other counties that are home to fewer hospitals.

The state's network adequacy standards are far from etched in stone, and therefore not the problem that insurance leaders allege. The state's 30-minute or 15-mile hospital travel-time standard is regularly waived for insurers that claim they cannot meet it. While data from the main regulator of commercial coverage in California, the Department of Managed Health Care, are less readily available, the state's Medi-Cal regulator publishes data on every zip code where it has waived its equivalent standard.[2] In 2024, the Medi-Cal regulator approved 647 waivers of the state's time or distance standard, meaning residents in 25% of all California zip codes have to travel farther than what is deemed safe and appropriate for in-network hospital care. In 40 zip codes, residents have to travel 75 miles or more. In one, they have to travel more than 300 miles. These data call into serious question insurance company executives' claims, but OHCA's report simply states them as fact rather than undertaking proper due diligence to confirm or debunk these claims.

[2] See the 2024 ANC Alternative Access Standards Requests report here: https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx

Ignoring Health Insurance Companies' Role in Affordability Challenges Reflects a Major Oversight

The study of competition among Monterey's hospitals and the subsequent review of the report at the November board meeting provided yet another example of how OHCA has myopically focused on one segment of the health care field and ignored other actors and drivers. At the meeting, advocates rightfully raised issue with high patient shares of cost for emergency room visits — but there was no acknowledgment that health insurance companies establish patient cost-sharing requirements, not hospitals. And while the report singles out hospital concentration as a driver of high costs — and takes the statements of other industry officials at face value — it summarily ignores and dismisses other market dynamics and the perspectives of hospital leaders themselves.



For example, while hospital market power is alleged to be the driver of high premiums in Monterey, the report does not even ask whether market power on the part of the insurance companies that set premiums is part of this problem. While comprehensive data are not readily available, those that are show that one insurer, Blue Shield, controls 67% of the Covered California market in Monterey. The next biggest insurer doesn't generally contract with unaffiliated hospitals, including those located in Monterey, meaning Blue Shield effectively has a monopoly (and monopsony) in the county. Such enormous market power on the part of a single insurer undoubtedly gives it substantial leverage in negotiations with hospitals and other providers, as well as with employers when premiums are being set. This question went unevaluated in OHCA's analysis of the Monterey market's high premiums.

Study Suffers from a Lack of Methodological Transparency and Reliability

The analysis above highlights a number of critical deficiencies, often related to what analyses were included, or excluded, from the report. In addition, in various areas, the report lacks sufficient methodological detail to allow the public to evaluate its claims. Below are several key examples:

- *Defining the Bay Area Comparison Set* – The report shows various comparisons between the Monterey hospitals and a sample of Bay Area hospitals to argue that there is no reason Monterey hospitals should be as costly as they are. However, the report provides next to no information on the inclusion or exclusion criteria that defined the Bay Area comparison set, which includes 46 out of a possible 64 general acute care hospitals. This methodological information is essential for determining whether the 46-hospital sample constitutes a reasonable comparison group.

- *Misuse of NASHP Hospital Operating Costs* – The report uses the National Academy for State Health Policy's (NASHP's) to compare cost structures between Monterey and Bay Area hospitals. However, this tool inappropriately excludes major categories of legitimate hospital expenses and therefore is unreliable.

- *Exclusion of One of Monterey's Four Hospitals from the Analysis* – The report excludes Mee Memorial Hospital from its analysis without sufficient empirical analysis to support its claim that Mee Memorial is not an integral part of the county's hospital care landscape.

- *No Modeling Details Provided for CalPERS and Covered California Analyses* – The report summarizes regression analyses performed on CalPERS and Covered California spending, but does not disclose full model specifications, analytical code, or summary statistics, making it impossible to judge the strength of the models or replicate the analysis.

- *Partial Portrayal of the Relationship between Hospital Quality and Price* – The report states "The research literature indicates little to no correlation between hospital price and quality." However, the report references a study that actually finds a significant relationship between higher prices and lower mortality under common market conditions. Other research also finds that being appropriately resourced positively affects a hospital's ability to deliver consistently high quality.[3,4]

Hospitals Urge OHCA to Acknowledge Deficient Approach and Course Correct in Future Work

OHCA's investigation of Monterey's hospital market underscored a continued lack of balance in its work, a tendency to dismiss the perspectives of entire segments of the health care field, and discomfort with acknowledging the complexity behind California's very real affordability challenges. Hospitals urge OHCA to take all necessary steps to restore faith that it is creating a fair process, with open and data-driven dialogue where all parties' voices are heard.

More Work Needed to Develop a Sound Outpatient Spending Measurement Methodology

Over the past several months, OHCA has convened a workgroup of experts to develop a methodology for measuring hospital outpatient spending. The proposed outpatient approach is conceptually similar to OHCA's planned inpatient spending approach: evaluate (outpatient) net patient revenue on a volume and resource-intensity-adjusted basis. Conceptually, the approach holds significant promise as it aims to control for growth and fluctuations in hospital service volumes, patient acuity, and service intensity. Without these controls,

[3] Beauvais, B., Richter, J. P., & Kim, F. S. (2019). Doing well by doing good: Evaluating the influence of patient safety performance on hospital financial outcomes. Health care management review, 44(1), 2–9. https://doi.org/10.1097/HMR.0000000000000163

[4] Beauvais, B., Richter, J. P., Kim, F. S., Sickels, G., Hook, T., Kiley, S., & Horal, T. (2019). Does Patient Safety Pay? Evaluating the Association Between Surgical Care Improvement Project Performance and Hospital Profitability. Journal of healthcare management / American College of Healthcare Executives, 64(3), 142–154. https://doi.org/10.1097/JHM-D-17-00208

hospitals would be at risk of being penalized for factors beyond their control, for offering costly but clinically effective services, for successfully attracting more patients, and for serving patients with higher needs.

However, major data limitations and OHCA's untested approach for intensity adjustment raise serious questions about whether the proposed outpatient model is adequate to the critical task of determining hospitals' compliance against the spending target and, ultimately, identifying which hospitals should be subject to penalties. There are two fundamental issues. First, hospitals do not report outpatient utilization data in sufficient detail to allow for the intensity of a given visit to be estimated. That's why OHCA turned to an emerging dataset, the Healthcare Payments Database (HPD), to measure hospitals' average outpatient intensity scores. The HPD, however, unlike hospitals' financial reports, is not comprehensive. Disappointingly, the HPD only included 19% of all hospital outpatient visits for commercially insured patients in 2022, and only 11% of these visits can be used to create a hospital's average outpatient intensity score. That such a limited dataset could ultimately prove representative of hospitals' outpatient experience is highly suspect, and as of today, is entirely unfounded. For this reason, OHCA's workgroup members broadly declared their discomfort with moving forward with OHCA's approach.

Second, OHCA proposes to calculate hospitals' intensity scores using weights provided by Medicare's ambulatory payment classification (APC) system. This approach has merit, particularly for common services. However, the approach breaks down for certain extremely high-cost outpatient services, such as high-cost drugs for which there is no APC weight. To prevent hospitals from being penalized for offering innovative and often curative pharmaceutical treatments and other services, OHCA must develop ancillary methodologies to exclude or otherwise control for these high-cost treatments.

Oregon's Higher Cost Growth Target Highlights Need for Review of California Spending Target

Oregon operates a spending target program, on which OHCA is closely modeled. In late 2025, Oregon's implementing agency, the Oregon Health Authority (OHA), convened a specialized workgroup composed of representatives of labor, payers and providers, academics, and consumer advocates to reassess its statewide health care spending growth target for the 2026-2030 period. The workgroup met five times and reviewed updated data on economic and health care spending trends, including per-capita health care expenditure growth and Oregon median wage growth. At the conclusion of these focused discussions, the workgroup voted 20-4 to recommend increasing Oregon's growth target from a planned value of 3% to a static 5.5% for 2026-2030. The recommended target is based on a 50/50 blend of two components 1) a five-year lookback (2020-2024) of National Health Care Expenditures per capita growth and 2) the same five-year lookback of Oregon median wage growth, grounding the target in both the reality of growth in health care costs and the aspiration to reduce health care spending growth to what people are experiencing in terms of their paychecks.

OHCA should seriously consider a similar, focused process for evaluating California's spending targets. Adopting the same recommended approach as Oregon's workgroup would result in a California statewide cost growth of 5.52%, substantially higher than currently value starting at 3.5% set by OHCA for 2026.

Following Oregon's Recommended Approach for Updating Its Spending Target Would Make OHCA's Target More Reasonable and Attainable

	U.S. NHCE	California Median Wages	Target
5-Year Average Annual Growth	5.80%	5.24%	5.52%

NHCE: National Health Care Expenditures as measured by the Centers for Medicare and Medicaid Services
California median wages are from the U.S. Bureau of Labor Statistics

Given the alignment between recent wage growth and broader health care cost pressures, Oregon's process offers a data-driven model for recalibrating spending growth targets to make them achievable and reflective of current economic forces. Hospitals urge OHCA to undertake a similar review grounded in updated wage growth, inflation, and national health care expenditure trends and update the state's targets accordingly in 2027.

Conclusion

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,

Ben Johnson
Group Vice President, Financial Policy

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