



March 11, 2025

Mary Watanabe, Director  
California Department of Managed Health Care  
Sent via email: [publiccomments@dmhc.ca.gov](mailto:publiccomments@dmhc.ca.gov)

Dear Director Watanabe,

On behalf of the San Francisco Labor Council I am submitting this written comment in response to the Department of Managed Health Care's (DMHC) Public Meeting on Health Care Premium Rates and Prescription Drug Cost Transparency scheduled for March 11, 2026.

The San Francisco Labor Council represents over 100 organizations which represent and/or purchase health insurance for more than 100,000 members. We purchase coverage from Kaiser. Over the past twenty years, we have seen our premium costs increase by an average of 15%, a rate of growth that is unsustainable for workers and employers alike. These increases far outpace wage growth and place significant pressure on working families who are already struggling with the rising cost of living.

The continued escalation of premiums has contributed to the substantial profits generated by health insurance companies and enabled them to accumulate financial reserves that significantly exceed the minimum levels required by law. These reserves are largely funded by California consumers—individuals and businesses paying higher premiums, workers whose wage increases are reduced or delayed to preserve health benefits, and taxpayers who finance commercial plan participation in Medi-Cal and subsidize coverage through Covered California.

Excess reserves and profits should not be diverted toward speculative financial investments or excessive executive compensation. Instead, these funds should be used to improve patient care and reduce costs for consumers.

We urge DMHC and other state regulators and policymakers to exercise their authority to hold health plans accountable. Regulators must ensure that health plans and insurers comply with the law by clearly “demonstrating the impact” of the Office of Health Care Affordability (OHCA) cost growth targets rates including premiums, deductibles, and copayments.

Health plans must take meaningful steps to control costs and ensure that the resources generated from California consumers are reinvested into California's health care system, supporting patients, providers, and affordability, rather than further expanding corporate reserves.

Sincerely,

Kim Tavaglione  
Executive Director

March 11, 2026

Department of Managed Health Care  
980 9th Street, 5th Floor Conference Room  
Sacramento, CA 95814

**DMHC Public Meeting on Health Care Premium Rates and Prescription Drug Costs**

Good afternoon. My name is Gilbert Lara, State Government Affairs Manager for Biocom, the state's largest life sciences trade association. Thank you for the opportunity to comment on the Measurement Year 2024 Prescription Drug Cost Transparency Report. We raise three concerns about the report's methodology.

**First, health plan profits are outpacing prescription drug costs.**

Once manufacturer rebates are accounted for, prescription drugs represent 12.1% of total health plan premiums treatments that directly benefit patients. Yet the report shows that the total amount of health plan premiums going to profit increased 128.3% year-over-year, from \$1.3 billion in 2023 to \$2.97 billion in 2024. A complete affordability analysis must account for the full premium dollar, not just the portion attributable to medicines.

**Second, medical devices and non-drug products are being counted as prescription drugs.**

For example, six glucose monitoring devices appear among the 25 most prescribed brand name drugs, the highest number ever included in the report. COVID-19 vaccine administration costs are also counted as prescription drug expenses. The SB 17 statute applies to prescription drugs dispensed at a pharmacy, not devices or vaccine administration fees. These inclusions inflate the pharmaceutical sector's apparent cost burden and distort year-over-year trends. We urge the Department to exclude non-drug products from future reports.

**Third, rebate flow-through must be tracked under the new PBM framework.**

The report identifies \$3.2 billion in manufacturer drug rebates in 2024, a 16.4% increase, yet provides no visibility into whether these savings reach patients. Biocom supported SB 41 (Wiener, 2025), which prohibits spread pricing and requires rebate pass-through to health plans beginning January 1, 2026. Future reports should explicitly track rebate flow-through so policymakers can assess whether these reforms are working.

Biocom shares the Department's commitment to health care affordability. We respectfully ask that policy decisions reflect the full picture, including health plan profitability, PBM practices, and the value of innovative therapies.

Thank you.



Gilbert Lara, Government Affairs Manager  
Biocom  
[glara@biocom.org](mailto:glara@biocom.org)  
(916) 226-0601



March 17, 2026

Mary Watanabe, Director  
California Department of Managed Health Care  
980 9th Street, Suite 500

Dear Director Watanabe,

On behalf of the National Union of Healthcare Workers (NUHW), I am submitting this written comment in response to the Department of Managed Health Care's (DMHC) Public Meeting on Health Care Premium Rates and Prescription Drug Cost Transparency held on March 11, 2026.

In recent decades, health care costs have grown at a rate that is unsustainable for workers and employers alike. These increases far outpace wage growth and place significant pressure on working families who are already struggling with the rising cost of living.

The continued escalation of premiums has contributed to the substantial profits generated by health insurance companies and enabled them to accumulate financial reserves that significantly exceed the minimum levels required by law. These reserves are largely funded by California consumers—individuals and businesses paying higher premiums, workers whose wage increases are reduced or delayed to preserve health benefits, and taxpayers who finance commercial plan participation in Medi-Cal and subsidize coverage through Covered California.

In September 2025, we submitted comments to DMHC in response to Kaiser Foundation Health Plan's proposed rate increases for their small group and individual HMO health plans. We stated that Kaiser's filings with the DMHC demonstrated significant deficiencies and omissions, and the evidence they do contain makes it difficult to conclude that the rate hikes are justified. We cited concerns over Kaiser's record profitability, excessive reserves, out of state expansion, exorbitant executive compensation, and raised the issue that Kaiser's proposed increases far exceeded the Office of Health Care Affordability's statewide spending target.

We urged DMHC to investigate Kaiser's planned rate increases to determine whether they were justified and reasonable, to make its findings accessible to the public, and to seek appropriate relief for Kaiser plan participants if the Department ultimately determined that the rate increases were excessive or unnecessary.

Kaiser is not the only health plan increasing premium rates while simultaneously accumulating substantial financial reserves. The table below demonstrates the profits and tangible net equity (TNE) held by California's largest health plans.

**Table 1. Profits and TNE by California’s Ten Largest (by revenue) Health Plan in 2024**

<b>Health Plan</b>	<b>Total revenue</b>	<b>Net Income/ Loss</b>	<b>Profit Margin</b>	<b>TNE</b>	<b>Required TNE</b>	<b>Excess TNE</b>	<b>% TNE to Required</b>
Kaiser Permanente	\$120 Billion	\$12.90 Billion	10.7%	\$73.0 Billion	\$3.3 Billion	\$69.72 Billion	2,227%
Blue Shield of California	\$24 Billion	\$0.10 Billion	0.4%	\$4.4 Billion	\$0.70 Billion	\$3.70 Billion	627%
Anthem Blue Cross	\$18 Billion	\$0.79 Billion	4.4%	\$2.4 Billion	\$0.50 Billion	\$1.86 Billion	473%
Health Net of California, Inc.	\$13 Billion	\$0.49 Billion	3.8%	\$1.1 Billion	\$0.36 Billion	\$0.75 Billion	306%
LA Care	\$12 Billion	\$0.54 Billion	4.5%	\$2.2 Billion	\$0.19 Billion	\$2.02 Billion	1163%
Health Net Community Solutions, Inc.	\$12 Billion	\$0.24 Billion	2.0%	\$1.0 Billion	\$0.18 Billion	\$0.83 Billion	555%
Arcadian Health Plan, Inc.	\$9 Billion	\$0.00 Billion	0.0%	\$1.0 Billion	\$0.28 Billion	\$0.74 Billion	366%
Inland Empire Health Plan	\$8 Billion	(\$0.34 Billion)	(4.2%)	\$1.1 Billion	\$0.27 Billion	\$0.83 Billion	411%
UHC of California	\$7 Billion	\$0.17 Billion	2.3%	\$0.3 Billion	\$0.07 Billion	\$0.23 Billion	412%
Partnership HealthPlan of California	\$7 Billion	\$0.21 Billion	3.1%	\$1.5 Billion	\$0.21 Billion	\$1.24 Billion	682%

Source: California Department of Managed Health Care. (n.d.). *Health plan financial summary report*. <https://wps0.dmhc.ca.gov/flash/flash.aspx>

Excess reserves and profits should not be diverted toward speculative financial investments or excessive executive compensation. Instead, these funds should be used to improve patient care and reduce costs for consumers.

Unfortunately, health plans, including Kaiser, were able to increase premiums for 2026 by amounts that far exceeded the target set by the Office of Health Care Affordability without further investigation by DMHC. Going forward, we urge DMHC and other state regulators and policymakers to exercise their authority to hold health plans accountable. Regulators must ensure that health plans and insurers comply with the law by clearly **“demonstrating the impact” of the Office of Health Care Affordability (OHCA) cost growth targets rates including premiums, deductibles, and copayments.**

Health plans must take meaningful steps to control costs and ensure that the resources generated from California consumers are reinvested into California’s health care system, supporting patients, providers, and affordability, rather than further expanding corporate reserves.

Thank you for your attention to this critical matter.

Sincerely,

A handwritten signature in black ink, appearing to read 'SM', enclosed within a faint, light-colored circular stamp or watermark.

Sophia Mendoza  
President, National Union of Healthcare Workers