OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Progress Update on Office of Health Care Affordability

August 19, 2026

Vishaal Pegany, Deputy Director

HCAI

Department of Health Care Access and Information

Overview: Department of Health Care Access & Information (HCAI)

HCAI Mission

HCAI expands access to quality, equitable, affordable health care for all Californians by supporting high value delivery systems, resilient health facilities and workforces, and actionable health information and strategies.

HCAI Program Areas

Facilities: Monitor the construction, renovation, and seismic safety of California's hospitals and skilled nursing facilities.

Financing: Provide loan insurance for nonprofit healthcare facilities to develop or expand services.

Workforce: Promote a culturally competent and linguistically diverse health workforce.

Data: Collect, manage, analyze and report information about California's healthcare landscape.

Affordability: Improve health care affordability through data analysis, spending targets, and measures to advance value. Enforce hospital billing protections, and provide generic drugs at a low, transparent price.

Key Components of OHCA's Work

Slow Spending Growth

Collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by the California Health Care Affordability Board.

Focus Areas

- Statewide Spending Target
- Sector Targets
- Total Health Care Expenditures (THCE)

Promote High Value

Promote, measure, and publicly report performance on health system performance, with consideration for minimizing administrative burden and duplication.

Focus Areas

- Primary Care and Behavioral Health Investment
- Alternative Payment Model Adoption
- Quality and Equity Performance
- Workforce stability

Assess Market Consolidation

Analyze transactions that are likely to significantly impact market competition, the state's ability to meet targets, or affordability for consumers and purchasers.

Focus Areas

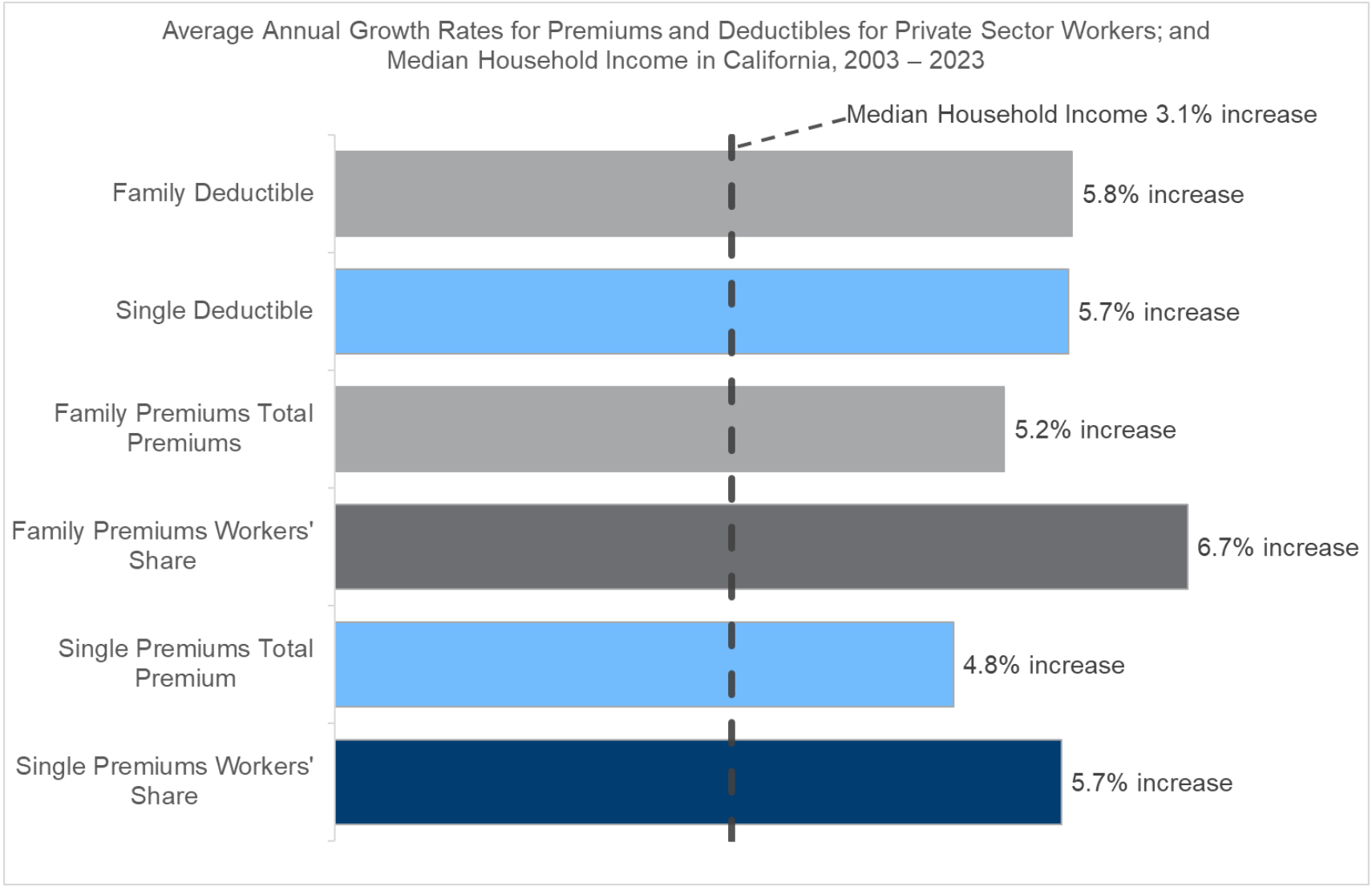
- Material Change Notices (MCN)
- Cost and Market Impact Reviews (CMIR)

Context for OHCA: State Health Care Spending Trends

2022-2023 Baseline Report

Consumer Affordability – Premiums and Deductibles Continue to Outpace Household Income Growth

Over the past 20 years, the financial burden on California workers with private coverage—driven by rising deductibles and their share of premiums—has grown faster than total premiums and median household income, highlighting a persistent affordability challenge.



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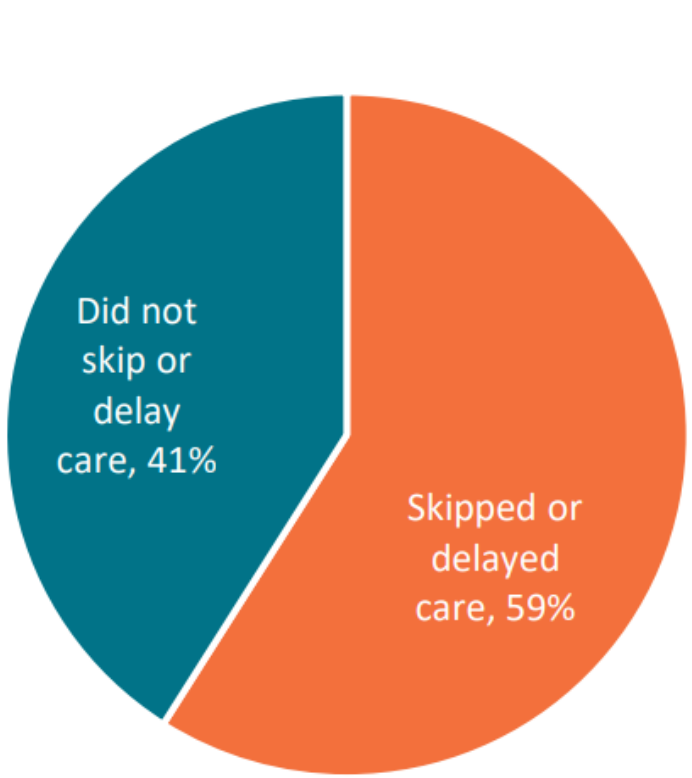
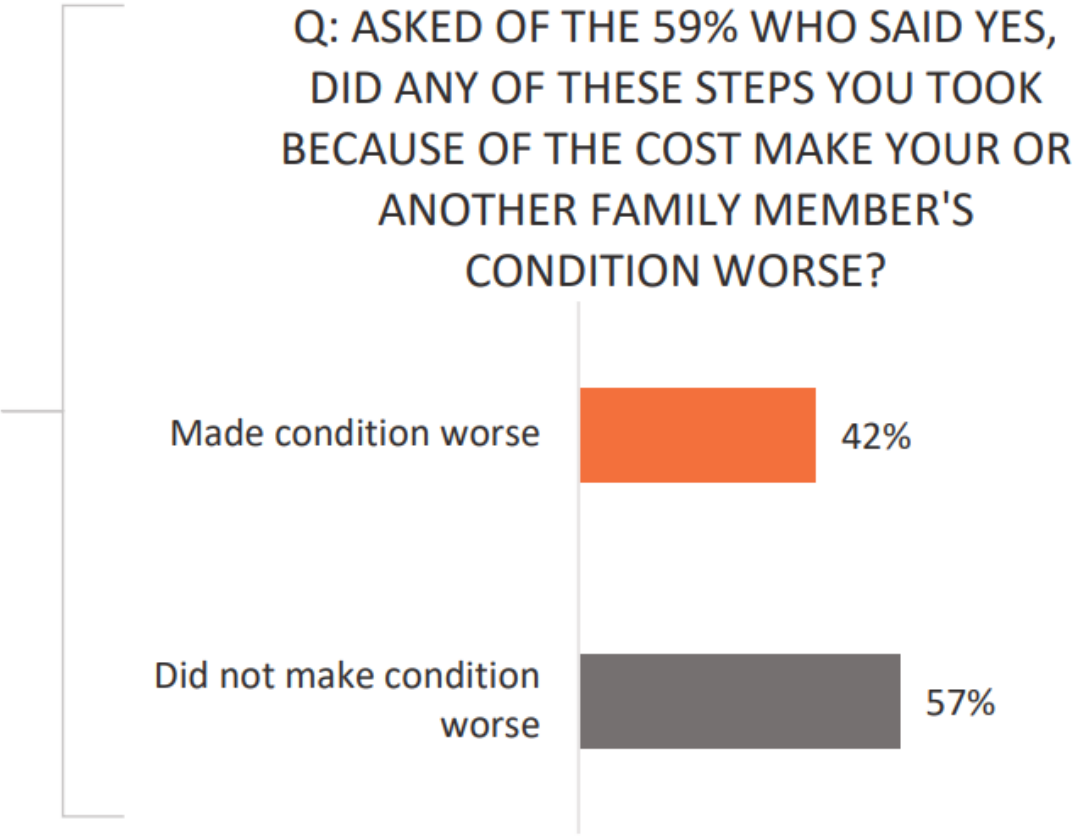
Six in 10 Californians are Postponing or Skipping Care Due to Cost

Figure 21. Six in 10 Californians Report Skipping or Delaying Care Due to Cost; 4 in 10 of Those Say Skipping Care Made Their Condition Worse





OHCA Spending Targets

Statewide Health Care Spending Target

In April 2024, the Health Care Affordability Board established a base 3% spending target for performance year 2029, based on the average annual rate of change in historical median household income growth from 2002-2022, ***signaling that health care spending should not grow faster than the income of California families***.

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

Press Release: https://hcai.ca.gov/statewide-health-care-spending-target-approval-is-key-step-towards-improving-health-care-affordability-for-californians/

Target Values for High-Cost Hospitals

Hospital*	2026	2027	2028	2029
Community Hospital of The Monterey Peninsula	1.8%	1.7%	1.7%	1.6%
Doctors Medical Center – Modesto	1.8%	1.7%	1.7%	1.6%
Dominican Hospital	1.8%	1.7%	1.7%	1.6%
Salinas Valley Memorial Hospital	1.8%	1.7%	1.7%	1.6%
Santa Barbara Cottage Hospital	1.8%	1.7%	1.7%	1.6%
Stanford Health Care	1.8%	1.7%	1.7%	1.6%
Washington Hospital – Fremont	1.8%	1.7%	1.7%	1.6%

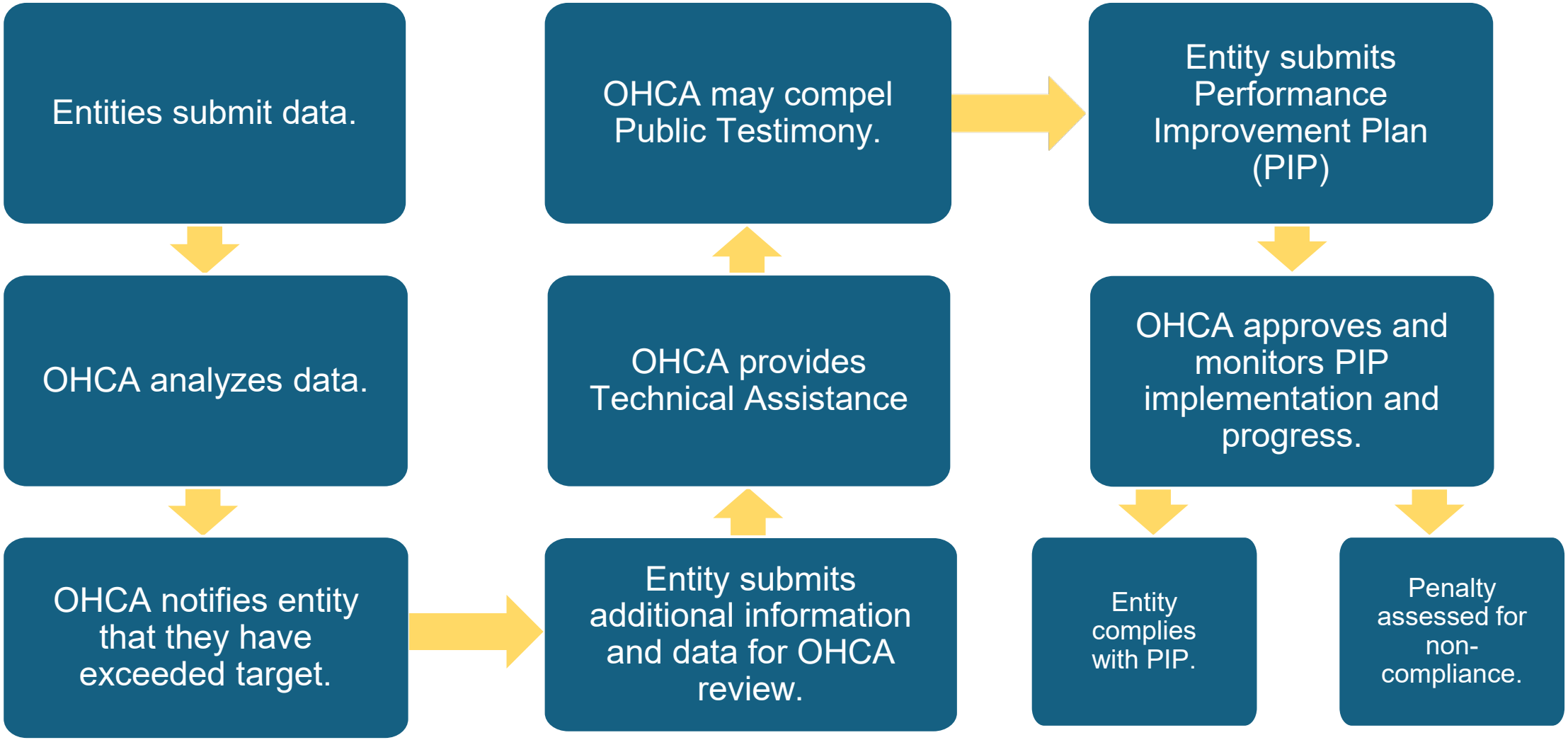
*All other hospitals in the sector and health care entities are subject to the statewide spending target.

Progressive Enforcement Overview

- The spending target will apply to health care entities, including health plans, provider organizations (with at least 25 physicians) and hospitals.
- Beginning with the Calendar Year 2026 target, OHCA can begin taking progressive enforcement action against health care entities that exceed the spending growth target.
- Progressive enforcement approaches include technical assistance, public testimony, imposing performance improvement plans, and ultimately, if warranted, assessing financial penalties.
- In 2026:
  - In August, the Spending Target Data Submission Enforcement Regulations were approved and published.
  - Upcoming: Spending Target Enforcement – Penalties, Board Vote, Regulations

See Health and Safety Code Section 127502.5 for full statutory text on OHCA's progressive enforcement process.
Note: Entities assessed a penalty may appeal an Administrative Law Judge decision.

Progressive Enforcement Process



Note: Entities assessed a penalty may appeal an Administrative Law Judge decision.

Spending Target Penalties

Spending target penalties scope, range, and justification factors are approved by the Board – OHCA aims for a vote in summer 2026.

OHCA recommended the following approach to calculating spending target penalties. Spending target penalties would be assessed when an entity fails to meet the spending target and has not complied with an approved PIP (127502.5(d)(1)). These penalties would be calculated in a two-step process.

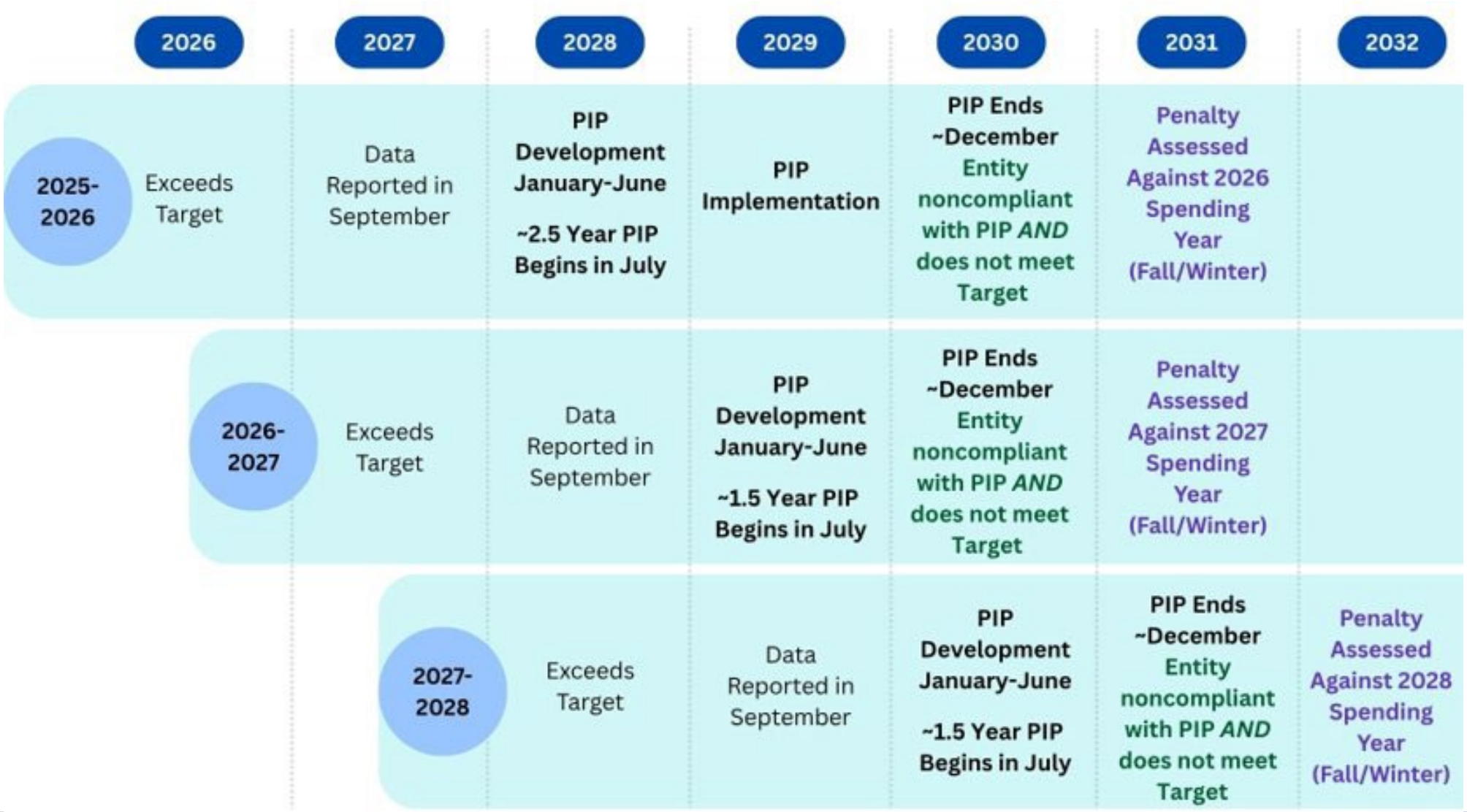
Step 1: Initially Commensurate

- Calculate penalties that are initially commensurate with the degree to which the entity exceeded the spending target.
- "Initially Commensurate" is the difference between an entity's actual spending growth and what the growth would have been had the entity met the target.
- If 2023 were an enforceable year, "initially commensurate" penalties would have ranged from $4M - $350M.

Step 2: Penalty Justification Factors

- Consider a variety of penalty justification factors that could result in an increased or decreased final penalty amount.
- Penalty justification factors listed in statute include nature, number, and gravity of offenses, the fiscal condition and market impact of the entity, and consideration of provision of nonfederal share.
- Other potential adjustment factors include input from other state agencies, other factors approved by the Board, and escalating amounts for repeated failure to meet targets.

Potential Enforcement Timeline



Health & Safety Code § 127502.5

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Procedural Penalties – Pursuant to HSC §§ 127502.5 (h)(1)(B), (C), and (E)

Recommendation

A penalty of up to $10,000 per day for:

- (h)(1)(B) Repeatedly neglecting to file a performance improvement plan with the office.
- (h)(1)(C) Repeatedly failing to file an acceptable performance improvement plan with the office.
- (h)(1)(E) Knowingly failing to provide information required by this section to the office.
- "Repeatedly" means not filing a PIP or failing to file an acceptable PIP more than once.

- Depending on the entity's compliance with the enforcement process, spending target penalties may still be issued in addition to procedural penalties identified above.
- A per day penalty prompts entities to take action to prevent penalties from continuously accruing.
- $10,000 per day aligns with other programs:
  - The California Public Utilities Commission's $5,000-$20,000 per day financial penalty for failure to submit supply and pricing information.
  - The California Department of Health Care Services has an up to $25,000 per day financial penalty for Medi-Cal Managed Care Plans that fail to implement corrective action plans. These penalties increase to $50,000 per day for second offenses and $100,000 per day for subsequent offenses.

Procedural Penalties – Per HSC §§ 127502.5 (h)(1)(D) and (F)

Recommendation

A one-time flat penalty of up to $500,000 for:

- HSC section 127502.5 (h)(1)(D) Repeatedly failing to implement the performance improvement plan.
  - "Repeatedly" means failing to implement a PIP more than once, which could mean failing to implement more than one component of a single PIP or failing to implement multiple PIPs over an extended period.
- (h)(1)(F) Knowingly falsifying information required by this section.

- Depending on the entity's compliance with the enforcement process, spending target penalties may still be issued in addition to procedural penalties identified above.
- A flat penalty is appropriate for these violations because OHCA is no longer compelling an action – the entity has already failed to implement the PIP or has already falsified information.
- A flat penalty of up to $500,000 aligns with Massachusetts' approach for entities that do not implement their PIP.

DMHC Premium Rate Review

DMHC's rate review is prospective and evaluates assumptions about projected medical costs and trends, utilization and administrative costs for the coming year.

OHCA Spending Target Enforcement

Data Collection

OHCA conducts a retrospective review of actual health care expenditure data, i.e., spending that was incurred.

Reporting

OHCA reports annual spending that occurred two years prior using data collected one year prior.

Progressive Enforcement

Begins in 2028 for the spending growth between 2025-2026.

OHCA / DMHC Feedback Loop

OHCA will consult with DMHC prior to taking enforcement.

DMHC considers the impact of targets on health care costs during rate review.

Prospective

Retrospective

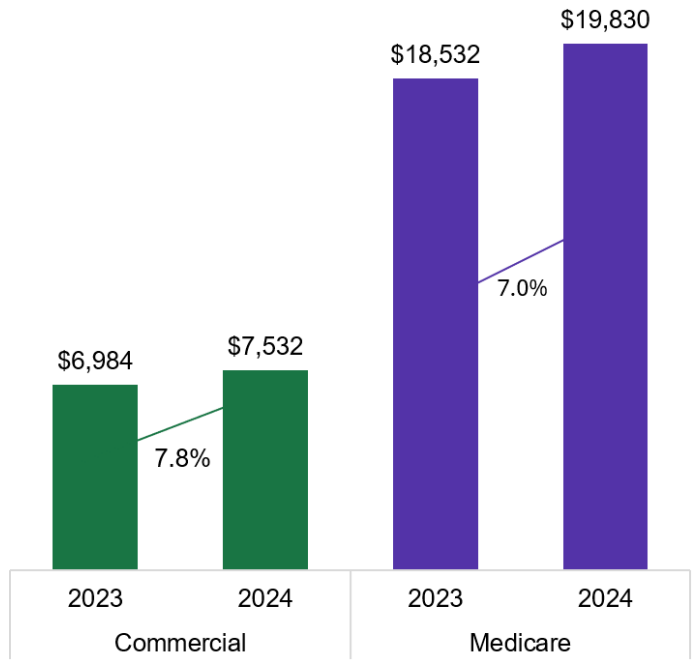
2023-2024 Commercial and Medicare Advantage Spending Overview

Commercial and Medicare TME

- Commercial Total Medical Expense (TME) was $114.2 billion in 2023 and $122.4 billion in 2024, an increase of $8.1 billion or 7.1%. TME per member per year was $6,984 in 2023 and $7,532 in 2024, an increase of $548 or 7.8%.
- Medicare TME (Medicare Advantage + Fee for Service) was $122.7 billion in 2023 and $134.2 billion in 2024, an increase of $11.5 billion or 9.4%. TME per member per year was $18,532 in 2023 and $19,830 in 2024, an increase of $1,298 or 7.0%

TME by Market
(in billions):

TME PMPY by Market



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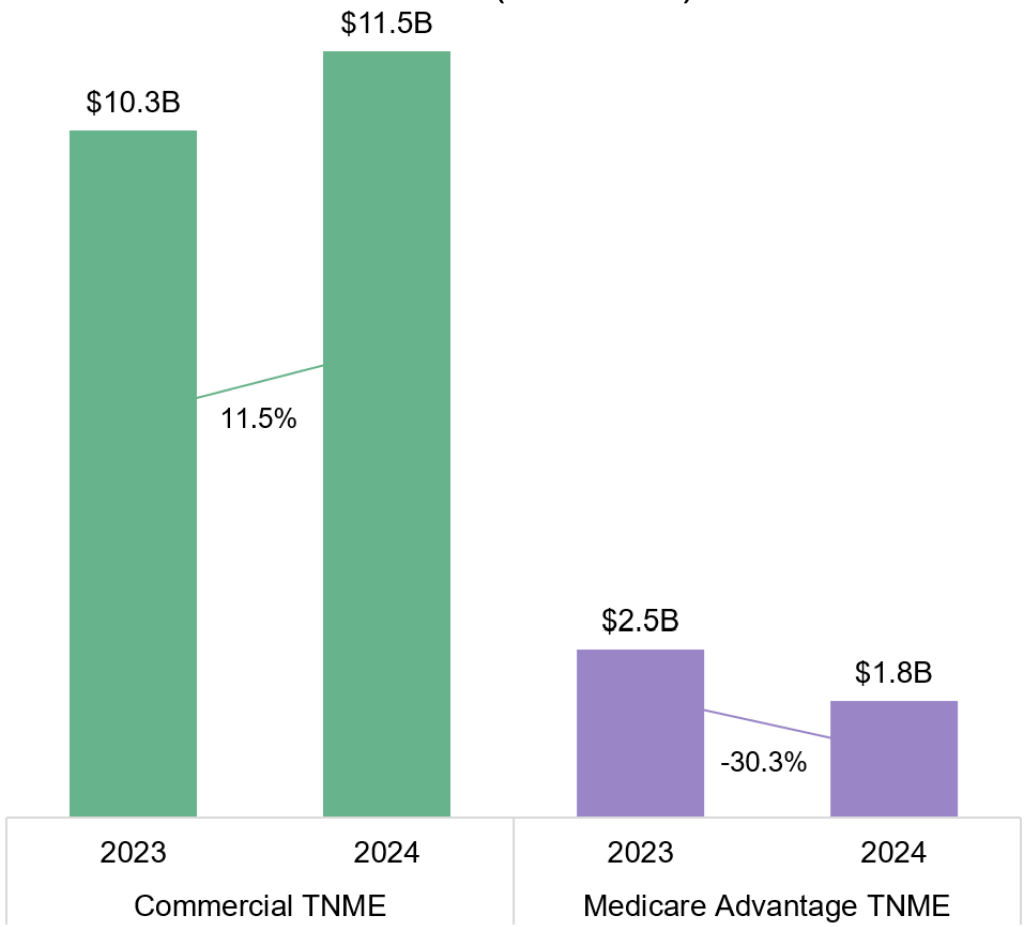
Commercial and Medicare Advantage Non-Medical Expense

- Commercial Total Non-Medical Expense (TNME) was $10.3 billion in 2023 and $11.5 billion in 2024, an increase of $1.2 billion or 11.5%.
- Medicare Advantage TNME was $2.5 billion in 2023 and $1.8 billion in 2024, a decrease of $0.8 billion or 30.3%.

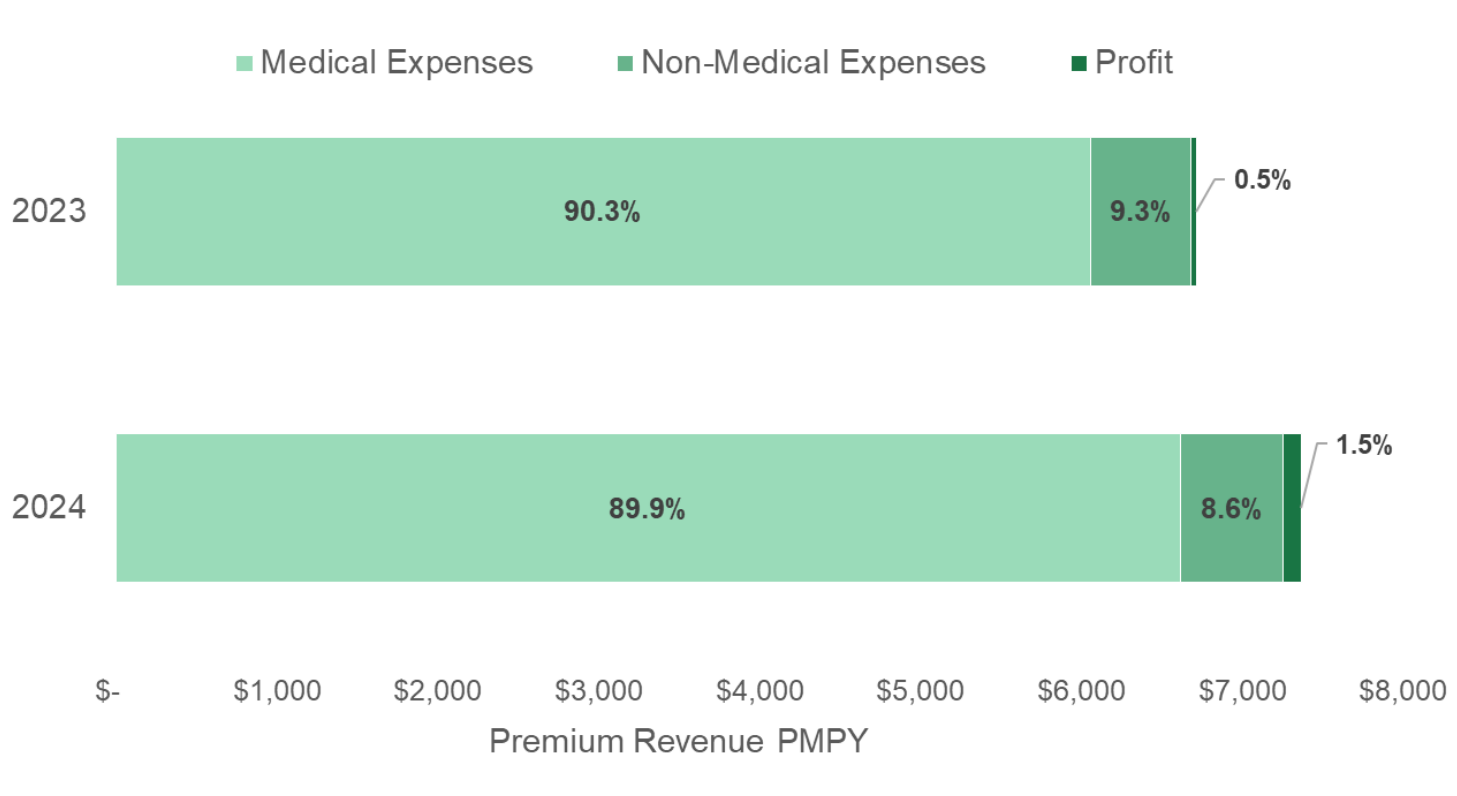
Total Non-Medical Expense by Market (in billions):



Note: The Commercial summary statistics include fully insured data reported through CCIIO MLRS and self-insured data submitted to OHCA

Use of Premium Revenue in California's Fully Insured Commercial Market

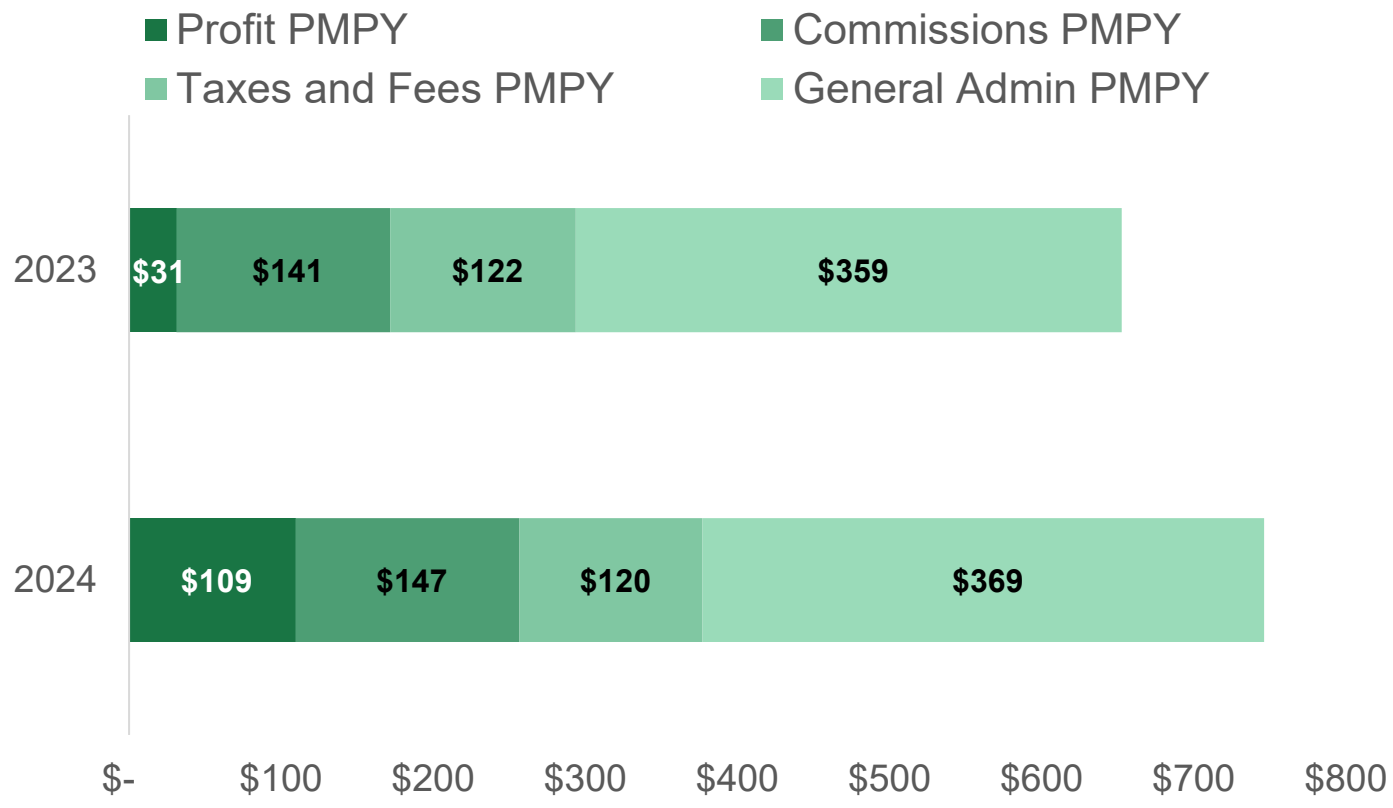
- Using CCIIO medical loss ratio filings for the fully insured commercial market in California, average premium revenue reached $7,366 per member per year in 2024, up from $6,715 dollars in 2023, reflecting an increase of $652 or 9.7%
- The share of premium revenue allocated to medical expenses declined to 89.9%, a decrease of 0.4 percentage points from 90.3% in 2023.
- The portion of premium revenue used for non-medical expenses excluding profit also declined from 9.3% to 8.6%, a reduction of 0.6 percentage points.
- Profit increased from 0.5% to 1.5% of premium, a 1 percentage point increase.



CCIIO MLR Filings 2023 and 2024 among OHCA health plan submitters. Note: Consistent with OHCA statutory definitions used for MLR reporting, quality improvement expenses are excluded.

Non-Medical Spending in California's Fully Insured Commercial Market

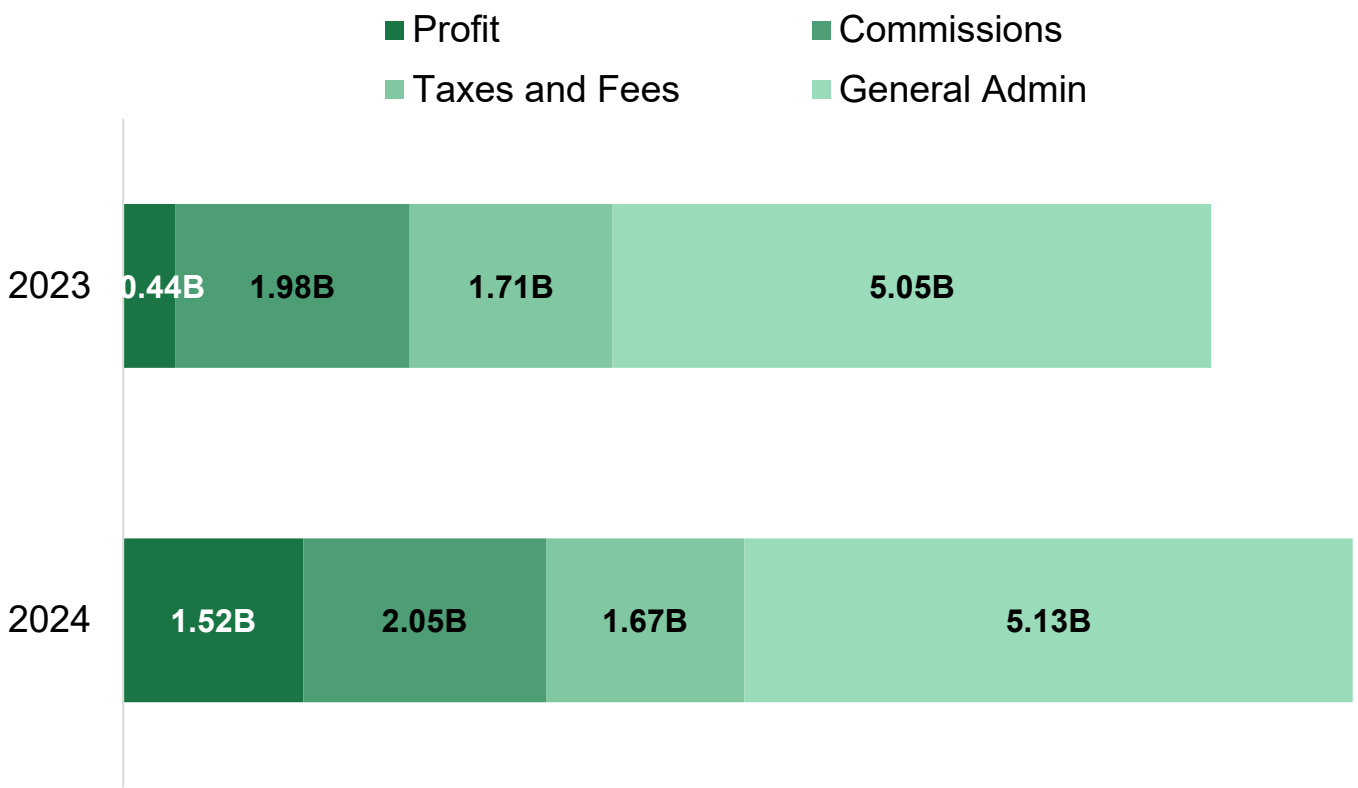
- On a PMPY basis, total non-medical expenses increased by $94 PMPY or 14.3%, rising from $653 in 2023 to $746 in 2024.
- General administrative costs remained the largest category and grew by $10 PMPY or 2.8%.
- Commissions were the second largest category and increased by $7 PMPY or 4.7%.
- Taxes and fees followed, decreasing a little more than $1 PMPY or 1.2%.
- Profits represented the smallest share but saw the largest relative increase, rising by $78 PMPY or 251.6%



CCIIO MLR Filings 2023 and 2024 among OHCA health plan submitters. Note: Consistent with OHCA statutory definitions used for MLR reporting, quality improvement expenses are excluded.

Non-Medical Spending in California's Commercial Market

- When translated into aggregate dollars across the fully insured commercial market, administrative spending components grew 1.3% from $8.74 to $8.85 billion, while profit grew 247.5% from $0.44 to $1.52 billion.



CCIIO MLR Filings 2023 and 2024 among OHCA health plan submitters.
Note: Consistent with OHCA statutory definitions used for MLR reporting, quality improvement expenses are excluded.

Payers by Market

Of the 24 payers that submitted data to OHCA in 2025, 17 offered Commercial plans and 19 offered Medicare Advantage plans.

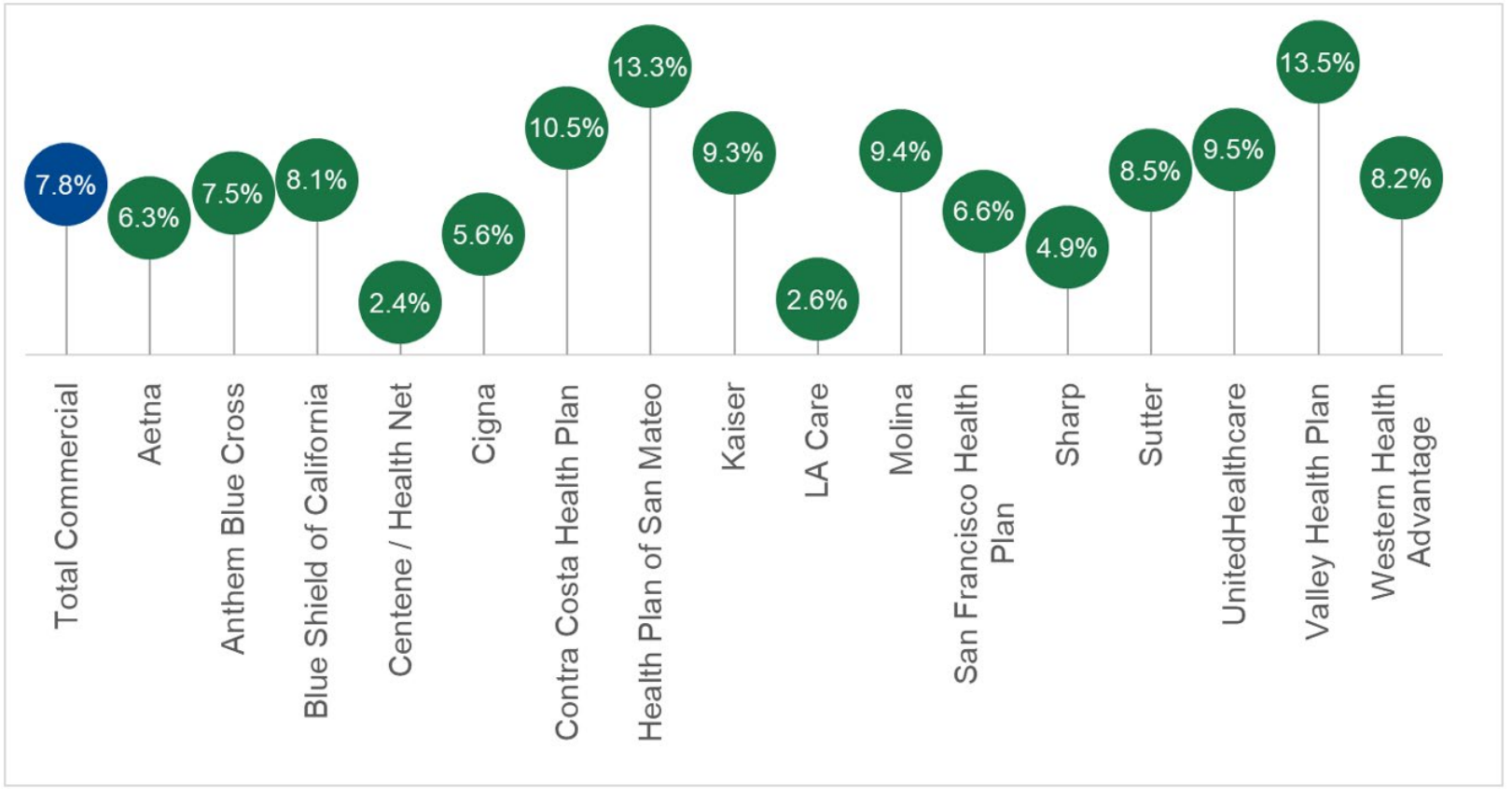
Payer	Commercial	Medicare Advantage
Aetna	✓	✓
Alignment		✓
Anthem Blue Cross / Elevance Health (Anthem Blue Cross)	✓	✓
Blue Shield of California	✓	✓
Bright Health (Universal Care)		✓
CalOptima		✓
Centene / Health Net	✓	✓
Central Health Plan of California		✓
Cigna Healthcare (Cigna)	✓	
Community Health Group		✓
Contra Costa Health Plan	✓	
Health Plan of San Mateo	✓	✓
Inland Empire Health Plan	✓	✓
Kaiser Foundation Health Plans (Kaiser)	✓	✓
Local Initiative Health Authority for Los Angeles County (LA Care)	✓	✓
Molina Healthcare of California (Molina)	✓	✓
San Francisco Health Plan	✓	
Santa Clara Family Health Plan		✓
SCAN Health Plan (SCAN)		✓
Sharp Health Plan (Sharp)	✓	✓
Sutter Health Plan dba Sutter Health Plus (Sutter)	✓	
UnitedHealthcare	✓	✓
Valley Health Plan	✓	
Western Health Advantage	✓	✓
Total payers	**17**	**19**

Commercial Market Enrollment and Spending Growth

Market Share by Enrollment:

Commercial Payers	2024 Market Share
Kaiser	42.8%
Anthem Blue Cross	15.0%
Blue Shield of CA	11.1%
UnitedHealthcare	8.6%
Aetna	7.9%
Cigna	6.9%
Centene / Health Net	3.1%
LA Care	1.43%
Sharp	0.8%
Western Health Advantage	0.7%
Sutter	0.7%
Molina	0.3%
Valley Health Plan	0.3%
Inland Empire Health Plan	0.1%
San Francisco Health Plan	< 0.1%
Contra Costa Health Plan	< 0.1%
Health Plan of San Mateo	< 0.1%
Total Members	**16,246,642**

TME PMPY growth:



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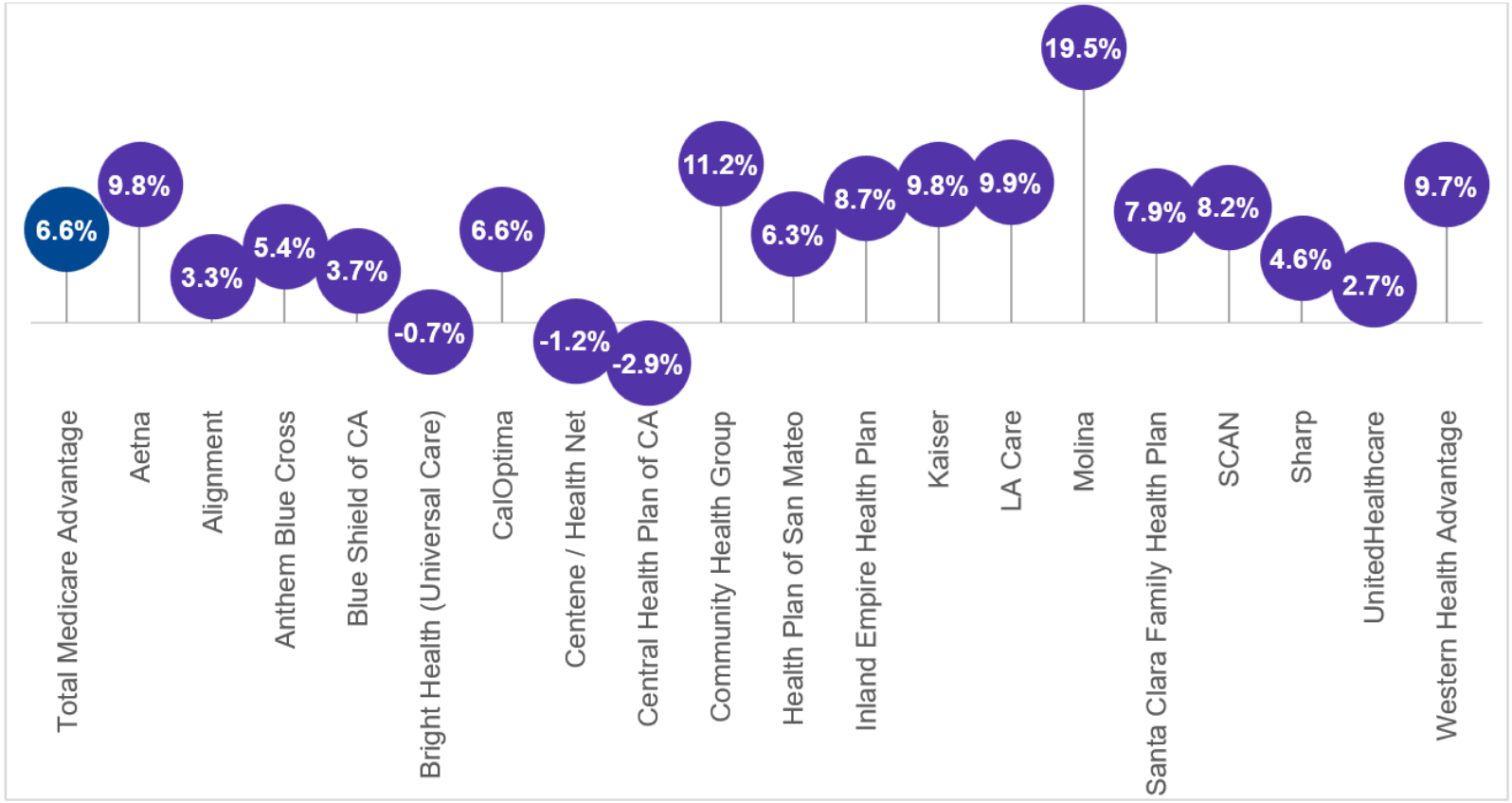
Medicare Advantage Enrollment and Spending Growth

Market Share by Enrollment:

Medicare Advantage Payers	2024 Market Share
Kaiser	42.1%
UnitedHealthcare	16.4%
Anthem Blue Cross	8.7%
SCAN	8.2%
Blue Shield of California	5.0%
Alignment	4.7%
Centene / Health Net	4.4%
Aetna	3.6%
Bright Health (Universal Care)	1.7%
Central Health Plan of CA	1.2%
Inland Empire Health Plan	1.1%
LA Care	0.6%
Molina	0.5%
CalOptima	0.5%
Sharp	0.4%
Santa Clara Family Health Plan	0.3%
Health Plan of San Mateo	0.3%
Community Health Group	0.2%
Western Health Advantage	0.1%
Total Members	**3,350,003**

TME PMPY growth:



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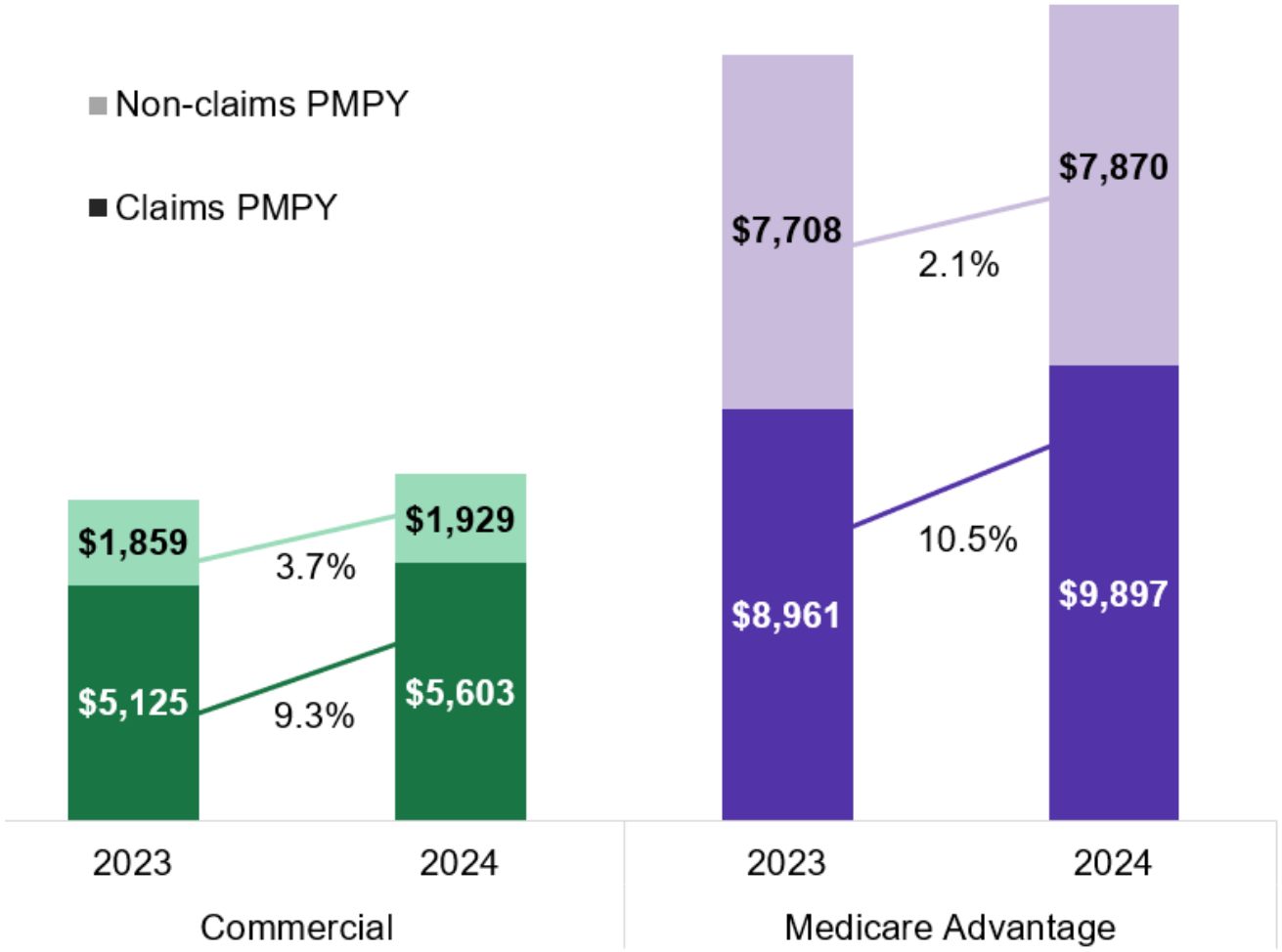
2023-2024: Claims vs Non-claims by Market

- Commercial claims spending PMPY in 2023 was $5,125 and $5,603 in 2024, an increase of $478 or 9.3%. Commercial non-claims spending PMPY in 2023 was $1,859 and $1,929 in 2024, an increase of $70 or 3.7%.
- Medicare Advantage claims spending grew from $8,961 PMPY in 2023 to $9,897, an increase of $936 or 10.5%. Medicare Advantage non claims spending PMPY in 2023 was $7,708 and $7,870 in 2024, an increase of $162 or 2.1%



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Promoting High-Value System Performance

Promoting High Value System Performance: Focus Areas

Primary Care Investment	• Define, measure, and report on primary care spending • Establish a benchmark for primary care spending
Behavioral Health Investment	• Define, measure, and report on behavioral health spending • Establish a benchmark for behavioral health spending
Alternative Payment Model Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a goal for APM adoption
Quality and Equity Performance	• Develop, adopt, and report performance on a single set of quality and health equity measures
Workforce Stability	• Develop and adopt standards to advance the stability of the health care workforce • Monitor and report on workforce stability measures

Milestones for Promoting High Value in the Health Care System

- OHCA's Alternative Payment Model (APM) standards and adoption goals were approved in June 2024.
  - OHCA will report on 2023-24 APM adoption by payers in summer 2026.
- In October 2024, OHCA's recommended benchmarks for primary care investments were approved to address historic underinvestment by shifting greater health care resources toward primary care, and to promote improved outcomes.
  - OHCA will report on 2023-24 primary care spending in summer 2026.
- OHCA adopted its Quality and Equity Measure Set in April 2025.
- OHCA is currently finalizing its approach to measuring behavioral health spending as a percent of total health care spending.
  - Data collection will begin September 2026.

Upcoming Reports

2026 Report: Promoting High-Value Health Care in California, 2023-2024*

This report will:

- Present Alternative Payment Model (APM) adoption in California for calendar years 2023 and 2024, showing members by payment arrangement and percent change across those years at the statewide level and by market
  - Show percent of members attributed to HCP-LAN Categories 3 and 4 arrangements** linked to quality by payer, line of business, and product type
- Present primary care spending in California for calendar years 2023 and 2023, showing overall spending and spending change across those two years at the statewide level and by market
  - Show percentage point change in primary care spending as a percent of total medical expense across those two years by payer, line of business, and product type
- Provide an initial assessment of APM adoption and primary care investment levels, prior to adoption and investment goals taking effect for 2024-2025 data

* Tentative report title, may change
**Category 3: shared savings/shared risk payment arrangements; Category 4: capitation and full-risk payment arrangements

Addressing Health Care Market Consolidation

Material Change Notices and Reviews

- Health care entities must provide 90-days advance notice to OHCA of a material change transaction for review. As specified in OHCA's regulations, material change transactions include mergers, acquisitions, and corporate affiliations involving health care entities.
- OHCA will determine within 60-days whether the agreement or transaction must undergo a Cost and Market Impact Review (CMIR). Waivers from a CMIR will be issued within 45 days.
- OHCA will conduct a CMIR for transactions likely to impact costs, access, quality, labor, or market concentration.
- To date, OHCA has reviewed over 40 transactions with two CMIRs currently pending.
- OHCA maintains a public list of past and ongoing material change notices and a list of FAQs. Additional questions may be submitted to CMIR@hcai.ca.gov.

AB 1415: Amends the Health Care Quality & Affordability Act

Assembly Bill 1415:

- Starting January 1, AB 1415 expands noticing requirements to additional entities:
  - Private Equity Groups and Hedge Funds.
  - Newly created business entities formed for the purpose of entering transactions with a health care entity.
  - Management Service Organizations.
  - Entities that own, operate, or control a provider, regardless of whether provider is currently operating, providing health care services, or has a pending or suspended license.
  - Defines Private Equity Groups, Hedge Funds and MSOs.
  - Authorizes OHCA to collect data and information from MSOs.

OHCA is currently developing regulations that defines the filing thresholds and requirements for MSOs, private equity groups, and hedge funds.

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Appendix

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Consideration of Spending Target During Premium Rate Review

Health and Safety Code Section 1385.035

(a) It is the intent of the Legislature in enacting this section to ensure that enrollees and subscribers benefit from reductions in the rate of growth in health care costs as a result of the establishment of the Office of Health Care Affordability.

(b) In submitting rates for review consistent with this article, a health care service plan shall demonstrate the impact of any changes in the rate of growth in health care costs resulting from the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107.

(c) In determining whether a rate is unreasonable or not justified, the director shall consider the impact on changes in health care costs as a result of the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107.

Consideration of Spending Target During Premium Rate Review

Insurance Code Section 10181.35

(a) It is the intent of the Legislature in enacting this section to ensure that insureds benefit from reductions in the rate of growth in health care costs as a result of the establishment of the Office of Health Care Affordability.

(b) In submitting rates for review consistent with this article, a health insurer shall demonstrate the impact of any changes in the rate of growth in health care costs resulting from the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107 of the Health and Safety Code.

(c) In determining whether a rate is unreasonable or not justified, the commissioner shall consider the impact on changes in health care costs as a result of the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107 of the Health and Safety Code.