2026 California Health Care Affordability Snapshot

The Health Care Value Hub ("the Hub") is proud to launch the 2026 Health Care Affordability Policy Snapshot ("Affordability Snapshot"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other interested parties a tool to compare their state's health policies across other states. The categories examined in this resource explore a variety of policy options that impact health care affordability. Policies were examined for whether they were active, implemented to a limited degree, or not active as of May 15, 2026. Sources for this information can be found in the downloadable ***Data and Source Document*** **available on the** Dashboard **page. Definitions and descriptions for each policy category can be found in the** ***Glossary*****.**

The Hub offers support dedicated to understanding health care policy and connecting advocates and other interested parties together to help build a patient-centered, high-value health care system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Health Care Spending Benchmark	**Authority to Enforce Health Care Spending Benchmarks**	**Hospital or Primary Care Spending Oversight Entity**	**All-Payer Claims Database**	**Price Transparency Tool**	**Prescription Drug Price Transparency Reporting Requirements**
Ownership Transparency	**Cost Oversight Office or Commission**	**Health Care Financing Taskforce**	**Consolidation Transaction Notification Requirements**	**Authority to Modify or Reject Consolidation Transactions**	**Affordability Criteria Included in Transaction Review**
Restricts All-or-Nothing Contract Provisions	**Restricts Anti-Tiering or Anti-Steering Contract Provisions**	**Restricts Most-Favored Nation Contract Provisions**	**Restricts Price Secrecy and Gag Clause Contract Provisions**		

Key:

- State has passed legislation to implement these policies (dark)
- State has passed not legislation to implement these policies (light)

Dark (passed): Health Care Spending Benchmark; Authority to Enforce Health Care Spending Benchmarks; Hospital or Primary Care Spending Oversight Entity; All-Payer Claims Database; Prescription Drug Price Transparency Reporting Requirements; Ownership Transparency; Cost Oversight Office or Commission; Consolidation Transaction Notification Requirements; Authority to Modify or Reject Consolidation Transactions; Affordability Criteria Included in Transaction Review; Restricts Price Secrecy and Gag Clause Contract Provisions.

Improve Transparency and Market Oversight

Health Care Spending Oversight

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Health Care Spending Benchmark	State has active policy or program	State has established a health care spending benchmark for providers, insurance carriers, or both	California's Office of Health Care Affordability has approved a statewide health care spending target of 3.5% from 2025-2026, 3.2% from 2027-2028, and 3% for 2029 and beyond, with select high-cost hospitals pursuing separate targets set at 1.8-1.6% from 2026-2029. The target applies to health care entities including health plans, provider organizations with at least 25 physicians, and hospitals. The Office has also adopted a Primary Care Investment Benchmark with a goal of each payer increasing primary care spending by 0.5-1 percentage points per year relative to total healthcare spending and a statewide benchmark of 15% of total medical expense allocated to primary care by 2034. The state is also in the process of establishing a behavioral health spending benchmark. Of note, as of 2026 there is pending litigation against California's health care spending benchmark.
Authority to Enforce Health Care Spending Benchmark	State has active policy or program	State has established an enforcement mechanism for their health care spending benchmark(s)	Starting 2026, OHCA can take enforcement action against entities that exceed the target, including technical assistance, explanation at public meetings, performance improvement plans, and financial penalties. The office will not enforce penalties until 2028-2029. HCA does not have authority to enforce the Primary Care Investment Benchmark as a standalone requirement.
Hospital or Primary Care Spending Oversight Entity	State has active policy or program	State monitors and reports hospital spending, primary care spending, or both	California's Office of Health Care Affordability, established in 2022, monitors primary care spending. It sets statewide and sector-specific health care spending targets, appoints a Health Care Affordability Advisory Committee, approves adoption of alternative payment models, and other strategies to increase primary care and behavioral health spending.

Improve Transparency and Market Oversight

Health Care Spending Oversight

Key: ◉ State has active policy or program ◐ Policy or program partially implemented ✖ No active policy or program ○ No source or limited information found

Policy	Icon	Status as of June 2026	Summary
All-Payer Claims Database Established	◉	State has a(n) all-payer or multi-payer claims database	
Price Transparency Tool(s)	✖	State does not have a public-facing price transparency tool	
Prescription Drug Price Transparency Reporting Requirement(s)	◉	Organizations are required to report prescription drug price information to a state entity	California requires drug manufacturers to report price increases for drugs currently on the market and when introducing new drugs that exceed a specific cost threshold.

Improve Transparency and Market Oversight

Health Care Spending Oversight

Key: ● State has active policy or program ◐ Policy or program partially implemented ✖ No active policy or program ○ No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Ownership Transparency	●	State requires providers and facilities to report ownership data annually	California hospitals are required to submit annual Financial Disclosure Reports which must include the type of ownership and the name of the owner, e.g. “Kaiser Foundation Hospitals.” This information is available to the public on the California Department of Health Care Access and Information website.
Cost Oversight Office or Commission	●	State has a cost oversight office or commission	The California Office of Health Care Affordability (OHCA), established in 2022 within the Department of Health Care Access and Information, aims to address health care affordability. State law affirms a public interest in accessible, affordable, equitable, high-quality, and universal care. OHCA works to slow spending growth, promote high-value care, and assess market consolidation, while collecting and reporting cost data and enforcing spending targets set by its governing board.
Health Care Financing Taskforce	✖	State does not have a health care financing task force	While California does not have a standalone commission or task force, the state has publicly released estimates quantifying the potential impact of federal policy changes on their state Medicaid program.

Improve Transparency and Market Oversight

Consolidation Oversight

Key: ● State has active policy or program ◐ Policy or program partially implemented ✖ No active policy or program ○ No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Transaction Notification Required	●	Requires health systems or providers to notify the state of consolidation transactions	California requires health care entities provide notice of health care mergers, acquisitions, affiliations and other changes of ownership at least 90 days prior to entering into an agreement or transaction. Transactions may be referred to the Attorney General for review of unfair methods of competition, anticompetitive behavior, or anticompetitive effects.
Authority to Modify or Reject Consolidation Transactions	●	Has authority to approve, set conditions, or disapprove consolidation transactions	California law grants the Attorney General approval authority over any sale or transfer of nonprofit health care facilities.
Affordability Criteria Included in Transaction Review	●	Includes consumer affordability or price growth in review criteria, approval conditions, or both	When reviewing proposed transactions, the California Office of Health Care Affordability and Attorney General examine whether a transaction will have a negative impact on availability, accessibility of services, or quality of services in affected communities, as well as negative impact on costs for payers, purchasers, or consumers.

Improve Transparency and Market Oversight

Anti-Competitive Contract Provisions

Key: State has active policy or program · Policy or program partially implemented · No active policy or program · No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Restricts All-or-Nothing Contract Provisions	No active policy or program	No law restricting All-or-Nothing contract provisions	
Restricts Anti-Tiering and Anti-Steering Contract Provisions	No active policy or program	No law restricting Anti-Tiering or Anti-Steering contract provisions	
Restricts Most Favored Nation Contract Provisions	No active policy or program	No law restricting Most Favored Nation contract provisions	California does not ban Most Favored Nation clauses, but under Ca. Health & Saf. Code § 1371.22 if a contract between an insurer and provider includes a Most Favored Nation clause it may not apply to any to cash payments made to a provider from uninsured patients.
Restricts Price Secrecy and Gag Clause Contract Provisions	State has active policy or program	State law prohibits price secrecy or gag clause restrictions in contracts between health insurance carriers and health systems or physicians	California law prohibits contracts between health care providers, systems, and/or insurance carriers from including provisions that restrict the ability to furnish consumers or purchasers information concerning the cost of services.

Glossary

Health Care Spending Benchmarks
Health care spending benchmarks aim to limit annual health care spending growth by establishing a maximum limit, or “benchmark.” Benchmarks may examine overall spending or spending for specific hospitals or insurers. Of note, as of 2026 there is pending litigation against health care cost growth benchmarks in some states which may affect the status of these policies.

Authority to Enforce Health Care Spending Benchmarks
Some states grant oversight entities the authority to enforce health care spending benchmarks. In these states, if the benchmark is surpassed, the overseeing state entity will often collaborate with providers to curtail spending, and some states authorize the entity to mandate performance improvement plans or impose penalties. This section examines whether a state has established a benchmark, and if so, whether the state has statutory authority to enforce the benchmark.

Hospital or Primary Care Spending Oversight Entity
Health spending oversight entities monitor and track health care spending systematically, offering data and research support to ensure efficient resource use. While many states set population health priorities, few have established oversight entities with enforcement powers. This section examines whether a state has a health spending oversight entity reviewing primary care, hospital spending, or both.

All-Payer Claims Database
All-payer claims databases (APCDs) compile diverse health care data that may include health, dental, and pharmacy claims from private insurers, state employee health programs, Medicare, and Medicaid. In instances where a database includes only some of these payers, it is referred to as a multi-payer claims database. Typically created through legislation, APCDs are often subject to state oversight and regulation. However, some claims databases have been voluntarily developed by independent entities, limiting oversight.

Price Transparency Tool
A website that displays price information on healthcare services, allowing consumers to “shop” for the best price and budget for expected services. To be credited, the tool must show negotiated prices for various services and be accessible without fees, IRB approval, or legislative restrictions. Additionally, this section reviews whether a state requires prescription drug price data to be reported to a state entity and if a state has another form of price transparency regulation.

Prescription Drug Price Transparency Reporting Requirement
Prescription Drug Price Transparency Reporting Requirements enforce policies for drug manufacturers, insurers, and pharmacy benefit managers to report detailed information about how prescription drug prices are set and increased over time. They are set to promote accountability, reduce hidden costs, and give insight into rising drug costs.

Ownership Transparency
States, policymakers, and the public frequently have no clear picture of who actually owns and controls the providers delivering care to their residents. Requiring annual ownership reporting addresses this transparency gap. When states have accurate, up-to-date ownership data, they can identify consolidation trends before they become entrenched, enforce antitrust and corporate practice of medicine rules more effectively, and hold entities accountable when ownership changes lead to price increases or quality declines.

Glossary

Cost Oversight Office or Commission
To address health care affordability concerns across state populations, some states have established Cost Oversight Offices or Commissions focused on analyzing drivers of high health care costs, working with stakeholders, and creating recommendations for administrative or regulatory solutions. These groups provide broad cost oversight of entire health care systems within a state, from hospitals to insurance practices.

Health Care Financing Taskforce
In an effort to assess health care spending, some states have launched Health Care Financing Taskforces and other entities to evaluate Medicaid financing mechanisms, evaluate Medicaid spending growth, and reduce duplicative spending and inefficiencies in Medicaid program administration while maintaining access to and quality in health care.

Consolidation Transaction Notification Required
Health care consolidation refers to health care entities (i.e. doctor's offices or hospitals) joining together under a common owner through a merger or acquisition. Some states require health care systems and/or providers to notify the state of consolidation transactions.

Authority to Modify or Reject Consolidation Transactions
During health care consolidation transactions, some states have the authority to approve, modify, or deny the transactions based on their own reviews.

Affordability Criteria Included in Transaction Review
When health care entities consolidate, some states require that affordability criteria like consumer affordability or price growth be considered in approval conditions, review criteria, or both.

Restricts All-or-Nothing Contract Provisions
Anti-competitive contracting is a pattern of contracting between health care providers and insurers where one party gains unfair advantages over potential competitors. States can enact regulations that limit dominant health systems from abusing their market power in ways that increase prices. For example, All-or-Nothing contract provisions are typically applied by health systems to require plans to contract with all providers in their system or none of them, even if those providers are low-value or high-cost.

Restricts Anti-Tiering or Anti-Steering Contract Provisions
These contract provisions require insurers to place certain providers in higher tiers regardless of cost or quality (anti-tiering) and restrict directing patients to higher value care from competitors (anti-steering).

Restricts Most Favored Nation Contract Provisions
In health care, Most-Favored Nation clauses are contract terms in which a health insurance company requires a provider or health system to guarantee that no other health plan will receive the same prices at a lower price. This restriction prevents providers or health systems from offering better pricing to competitors and can lead to higher overall prices when insurers and providers work together to maintain these rates.

Restricts Price Secrecy and Gag Clause Contract Provisions
Gag clauses are contractual provisions that prevent providers and insurers from disclosing prices, including negotiated rates, to patients, employers, or plan sponsors. These provisions can limit price transparency and make it harder for patients, self-funded employers, and policymakers to identify where health care markets are not functioning effectively. Congress passed the Consolidated Appropriations Act of 2020, which prohibits most gag clauses in health insurance contracts.