Date of Hearing: April 21, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2353 (Pacheco) – As Amended March 16, 2026

SUBJECT: Health Mandates Review Program.

SUMMARY: Requests the University of California (UC) to establish the Health Mandates Review Program to assess legislation proposing to mandate new or additional services or activities for a designated provider, beginning no later than January 1, 2028. Specifically, **this bill**:

1) Requests the UC to establish the Health Mandates Review Program to assess legislation proposing to mandate new or additional services or activities for hospitals beginning no later than January 1, 2028.

2) Requires the appropriate policy or fiscal committee within the legislation's house of origin to request that the Health Mandates Review Program assess legislation if the legislation is expected to affect the operations of a majority of the state's hospitals, or a majority of hospitals within a recognized class of hospitals, by requiring hospitals to hire new staff or otherwise increase workforce costs, purchase or lease new equipment, make physical alterations to their facilities, or provide additional discounted or charitable care.

3) Requests the Health Mandates Review Program, after receiving a request made by the Legislature, to provide a written analysis of the legislation to the appropriate policy and fiscal committees of the Legislature not later than 72 hours before the legislation is to be heard in the relevant fiscal committee of the house of origin, or in a manner and pursuant to a timeline agreed to by the Legislature and the Health Mandates Review Program.

4) Requests that the written analysis include an analysis of the following impacts:

    a) To the extent applicable and feasible within the timeframe for the request, hospital care delivery impacts, including all of the following:

        i) The extent to which the proposed mandated service or activity is generally recognized as effective in the screening, diagnosis, treatment, or prevention of a condition or disease, as demonstrated by a review of scientific and peer-reviewed literature;

        ii) The extent to which the proposed mandated service or activity is generally currently utilized by hospitals; and,

        iii) The results of research demonstrating the efficacy of the proposed mandated service or activity compared to alternatives, including not providing the service or activity.

    b) To the extent applicable and feasible within the timeframe for the request, public health impacts, including both of the following:

        i) The impact of the mandated service or activity on the health of patients and the community, including the reduction and prevention of disease and disparities in health outcomes, premature death, and economic loss associated with disease; and,

ii) The results of any research demonstrating the efficacy of the activity or service compared to alternatives, including not providing the activity or service.

c) Financial impacts, including all of the following:

i) The extent to which the mandate will affect the cost of providing and administering hospital services or affect the cost of providing uncompensated care;

ii) The extent to which the proposed mandated service or activity may affect access to currently available health care services or affect the financial stability of hospitals;

iii) The extent to which the mandate will increase or decrease the utilization of hospital services or will be a substitute for, or affect the cost of, services at other sites of care;

iv) Impacts on the cost of health care for patients, purchasers, and payers, including commercial payers, the Medi-Cal program, and the federal Medicare Program; and,

v) The total effect on the cost of health care services resulting from the proposed mandated service or activity compared to the total cost of health care in California.

5) Requests, to the extent feasible and applicable, that the written analysis separately identify impacts for different recognized classes of hospitals and for the major payer categories of the Medi-Cal program, the federal Medicare Program, and commercial payers.

6) Permits the Health Mandates Review Program, to prepare the written analysis provided, to make and execute contracts and interagency agreements consistent with its duties.

7) Prohibits an independent review board process by the state for full data access to all claims payer database and hospital discharge data.

8) Requests, on or before December 31 of each year, and no sooner than following the completion of an analysis, that the Health Mandates Review Program publish a summary of legislation analyzed by the Health Mandates Review Program enacted in the same year that mandates new or additional services or activities, as well as their impacts on cost if a written analysis was conducted.

9) Requests the Health Mandates Review Program to convene a workgroup of members with relevant expertise in hospital finance or operations to advise on the development and implementation of the program.

10) Defines “legislation proposing to mandate new or additional services or activities” as a proposed statute that requires hospitals to offer or provide specific services or perform specific activities that have not previously been required. Including changes to existing requirements that are expected to increase the cost of providing existing services or performing existing activities.

11) Establishes the Health Care Mandates Fund to support the UC and its work in implementing the program. Annually transfers an unspecified amount of money from the California Health Data and Planning Fund to the newly established Health Care Mandates Fund.

EXISTING LAW:

1) Requests the UC to establish the California Health Benefits Review Program (CHBRP) to assess legislation proposing to mandate a benefit or service or to repeal a mandated benefit or service, and to prepare a written analysis with relevant data on public health, medical and financial impacts, as defined. [Health and Safety Code (HSC) § 127660]

2) Defines "legislation proposing to mandate a benefit or service" as a proposed statute that requires a health plan or a health insurer, or both, to do any of the following:

   a) Permit a person insured or covered under the policy or contract to obtain health care treatment or services from a particular type of health care provider;

   b) Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition; or,

   c) Offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service. [*Ibid.*]

3) Establishes in the State Treasury the Health Care Benefits Fund to support UC and its work in implementing CHBRP. [HSC § 127662]

4) Requires, for the 2022–23 to 2025–26 fiscal years, inclusive, each health plan, except a specialized health plan, and each health insurer offering health insurance, to be assessed an annual fee in an amount determined through regulation. Requires the amount of the fee to be determined by the Department of Managed Health Care and the Department of Insurance in consultation with the UC and to be limited to the amount necessary to fund the actual and necessary expenses of UC and its work in implementing the CHBRP-related provisions. [*Ibid.*]

5) Prohibits the total annual assessment on health plans and health insurers from exceeding $3.2 million dollars. [*Ibid.*]

6) Sunsets the CHBRP and its related financing and operational provisions on July 1, 2033. [HSC § 127665]

7) Establishes the Department of Health Care Access and Information (HCAI) in the California Health and Human Services Agency to expand equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs. [HSC § 127000, *et seq*.]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, hospital care in California is under threat. The author states that nearly 45% of the state's hospitals operate at a deficit, financial strain forced hospitals and health systems to lay off nearly 3,500 workers in 2025, three hospitals closed in the last three years, and dozens more have reduced services. The author continues that each year, state policymakers consider hundreds of health care-related bills –

often absent independent information about how each proposal will affect patient costs or access to care. The author argues that to confront health care affordability, we need to understand the factors that are driving costs, including the impact of new regulatory requirements on hospitals. The author continues that this bill tasks an independent agency with reviewing legislation that places additional requirements on hospitals, so that lawmakers understand the cost and patient impact before making legislative decisions. The author concludes that this bill gives the Legislature a clearer picture of how policies affect hospitals – and ultimately, the people they serve.

2) BACKGROUND.

a) CHBRP. CHBRP was created by AB 1996 (Thomson), Chapter 795, Statutes of 2002 with the intent to provide current, accurate data and quality information on both the quality and cost of proposed legislation for the purpose of determining whether certain mandated health insurance benefits should be part of the basic health insurance benefit package, enabling the Legislature to be better informed when making decisions on mandated benefit legislative proposals.

According to CHBRP, a team of analytic staff at UC Berkeley works with a task force of faculty and researchers from several campuses of the UC, as well as actuarial consultants to complete each analysis during a 60-day period, usually before the Legislature begins formal consideration of a mandate bill. CHBRP indicates that a strict conflict of interest policy ensures that the analyses are undertaken without financial or other interests that could bias the results. A National Advisory Council, made up of experts from outside the state of California and designed to provide balanced representation among groups with an interest in health insurance benefit-related legislation, reviews draft analyses to assure their quality before they are transmitted to the Legislature. CHBRP indicates that each analysis summarizes sound scientific evidence relevant to the proposed legislation but does not make recommendations, deferring policy decision-making to the Legislature.

Over the last 22 years, CHBRP indicates it produced nearly 300 analyses in addition to dozens of supporting publications to assist policymakers in understanding the impact of proposed legislation. Legislative requests for analyses vary by year, and can range from between 10 and 22. CHBRP indicates it aims to have the capacity to complete between 12 to 15 bill analyses per year. CHBRP also indicates the cost of each analysis varies significantly, and depending upon the complexity of the bill, actuarial costs generally range from $15,000 to $70,000 or more, most of which are $45,000 and up. CHBRP's expenses include staff salary and benefits (42%), operational expenses such as training, rent, travel, information technology (4%), faculty and researcher task force (28%), actuarial costs (19%- 28%), editors, contractors, librarians, and content experts (3%-6%), and National Advisory Council Honorariums (1%).

b) Peterson-Milbank Program for Sustainable Health Care Costs. The Peterson-Milbank Program published a study in September of 2025 titled "Separating the Haves from the Have-Nots: State Options for Targeted Application of Hospital Affordability Policies," which notes that states pursuing health care affordability strategies face major pushback from hospitals and their lobbying groups. The study acknowledges that certain increase in uncompensated care in the coming years (resulting from people losing their insurance due to the terms of federal HR1, recently passed and signed into law) will

increase financial pressures. Hospitals argue that these policies will have disastrous financial impacts for them and that this legislation could force them to make service cuts or even close facilities, endangering patient access to care. However, these arguments mask a critical truth: Not all hospitals and health systems are in the same financial position. Rather, the hospital industry is characterized by a mix of what the study coauthors have referred to as haves and have-nots. Some hospitals and health systems (the haves) retain large reserves and strong market power, and others (the have-nots) are financially precarious. The haves are often large and/or located in high-income communities, whereas the have-nots are often small and/or located in low-income communities. Historical information suggests that high-asset hospitals grow their assets particularly through nonpatient care activities, using their wealth to generate more funds, while low-asset hospitals are likely to stay asset-poor.

The study notes that while the hospital industry has faced serious challenges since 2020 and, in particular, experienced widescale losses in fiscal year (FY) 2022 as federal pandemic relief programs ended and stock market swings decreased investment portfolio values. Though industry-wide financial performance has improved since then, with gradual recovery starting in late FY2023 and continuing in FY2024, some hospitals continue to struggle. However, these challenges have not been felt evenly. While some hospitals and systems have seen degradation of their finances (e.g., poor margins, low liquidity, and downgraded credit ratings), others have maintained robust financial health, maintaining significant reserves and high credit ratings.

3) **SUPPORT.** The California Hospital Association (CHA) is sponsoring this bill, stating that protection for hospitals' ability to care for patients is needed now, more than ever. CHA continues that one way to do that at the state level is to help ensure proposed legislation that places new mandates on hospitals strikes the right balance of providing meaningful benefits to patients, health care workers, and communities without reducing access to vital services or, in the worst cases, jeopardizing a hospital's viability entirely. CHA states that this bill would further this aim by providing legislators with additional in-depth information before they make decisions on bills that could add to an increasingly unsustainable burden on hospitals. CHA argues that without enhanced clarity of the costs, cost savings, risks, and benefits of new hospital mandates, the cumulative effect of rising costs will result in devastating consequences such as service reductions, layoffs, and hospital closures — leaving more Californians in health care "deserts," unable to access the lifesaving and life-changing care they need and deserve. CHA continues that labor costs — the largest share of hospital spending on care — have increased 51% since 2019, more than twice the rate of general inflation. CHA states that regulation plays an important role in protecting the safety, quality, and accessibility of hospital care, as well as the safety of the invaluable health care workers who make care delivery possible. However, CHA believes that any new regulations must be considered in light of current pressures and the objective impact that new mandates would have on our ability to sustain access to affordable care.

4) **OPPOSITION.** Health Access California opposes this bill, stating that this bill warps CHBRP's purpose by requiring an analysis of the impacts on the hospitals' finances – using state resources to influence public policy in service of private actors in the health care system. Health Access continues that this bill would propose a hospital impact analysis by CHBRP, which is housed at the UC. Because the UC is a major health system, one of the largest in California, this jeopardizes the independence of the analysis. Health Access

California notes that the current legislative intent for CHBRP is to analyze to the impacts of proposed legislation for consumers, not hospitals. Health Access California states that hospitals are a primary driver of consumers' health care costs and nearly 75% of consumers owe some or all of their medical debt to a hospital. Health Access California continues that while keeping hospitals open is critical to consumer access, the state has existing tools to address these concerns. Health Access California notes that California already collects information about the financial status of hospitals through HCAI and is monitoring the impacts of H.R. 1. Health Access California states that despite arguments to the contrary, consumers, not hospitals, will bear the brunt of the negative effects of H.R. 1. Health Access California concludes that at a time when consumers are losing coverage and health care costs are rising, this bill requires an analysis of legislation that would improve access to health care and prevent consumers from being crushed by hospital debt. But that analysis would focus on hospitals' finances, not the needs of Californians – and put a thumb on the scale on the side of the same hospital actors responsible for today's high costs.

SEIU California (SEIU) is also opposed to this bill. SEIU states that this bill is framed as an affordability measure, but in practice it risks becoming a new procedural tool to slow or weaken legislation meant to protect patients, workers, and communities. SEIU continues that the stated premise for the bill is that hospitals face costs due to mounting regulatory burdens, yet statewide data show that California hospitals as a whole posted $11.3 billion in net income in 2024, with profits exceeding pre-pandemic levels. SEIU argues that this matters because the core narrative behind this bill does not match the broader financial reality. While some facilities are financially distressed, SEIU notes that the sector overall has regained strong profitability, making it inappropriate to create a special new review process built around the assumption that additional hospital standards are inherently unaffordable. SEIU states that nothing in this bill guarantees that consumers will benefit from this added review layer. SEIU continues that this bill does not require hospitals to justify existing price growth, does not ensure savings are passed on to patients or purchasers, and does not demonstrate that delaying or discouraging new hospital standards will reduce premiums, deductibles, or out-of-pocket costs or improve the quality of patient care. SEIU concludes that this bill risks shifting the policy conversation away from accountability for excessive hospital pricing and toward a process that could make it harder to enact protections for patients, workers, and communities. California should not create a special policy step for hospitals—especially one housed in a university system that itself runs major hospitals—without clear evidence that consumers and patients will see measurable benefits.

5) PREVIOUS LEGISLATION.

a) SB 439 (Weber Pierson), Chapter 318, Statutes of 2025, extends the operation of CHBRP through July 1, 2033. Extends the continued assessment of the annual charge on health plans and health insurers for the purpose of funding CHBRP for the 2026–27 to 2032–33 fiscal years, inclusive. Increases the maximum allowable total annual assessment on health plans and health insurers from $2.2 million to $3.2 million. Removes an obsolete reference to the Healthy Families Program.

b) AB 1082 (Waldron) Chapter 592, Statutes of 2021 extends the assessment on health plans and insurers that supports CHBRP to July 1, 2027, and increases the annual cap on the health plan and insurer assessment by $200,000 (for a total annual assessment amount of $2.2 million) to support CHBRP.

c) SB 406 (Pan) Chapter 302, Statutes of 2020, among other provisions, extends the CHBRP assessment and sunset date to July 1, 2022.

d) AB 114 (Committee on Budget) Chapter 38, Statutes of 2017, extends the CHBRP sunset date to July 1, 2020.

e) SB 125 (Hernández) Chapter 9, Statutes of 2015, among other provisions, extends the sunset date of CHBRP to June 30, 2017 and makes changes to its analyses and timelines.

f) SB 1465 (Committee on Health) Chapter 442, Statutes of 2014, among other provisions, extends the sunset date by six months, to December 31, 2015.

g) AB 1540 (Committee on Health) Chapter 298, Statutes of 2009 extends the CHBRP sunset date to June 30, 2015.

h) SB 1704 (Kuehl) Chapter 684, Statutes of 2006 extends the CHBRP sunset date to January 1, 2011 and adds within the scope of legislation bills that would propose to repeal a mandated service or benefit, that if enacted, would become effective on or after January 1, 2008.

i) AB 1996 (Thomson) Chapter 795, Statutes of 2002 establishes CHBRP by requesting UC to assess legislation proposing a mandated benefit or service, and to prepare a written analysis with relevant data on the public health, medical and economic impact of proposed health plan and health insurance benefit mandate legislation. Requires, for fiscal years 2002-03 to 2005-06, health plans and insurers to be assessed an annual fee in an amount determined through regulation to fund the actual and necessary expenses of UC in implementing this bill, and capped the total annual assessment on health plans and insurers at $2 million. Repeals the provisions of the bill on January 1, 2007.

6) **POLICY COMMENTS.** It should be noted that CHBRP was created by the legislature, for the legislature, when a gap in the body's ability to thoroughly analyze the impacts of bills mandating the coverage of new health benefits was identified. CHBRP's scope was broadened after the Affordable Care Act significantly shifted the insurance market, but their scope is still focused and purposefully narrow. This committee reviews dozens of bills each year that impact health insurers – detailing what benefits they must cover, adding and altering licensure requirements, establishing consumer protections and standards, setting requirements on how they manage contracts and relationships with providers, etc. CHBRP's current mandate is so clear that the committee only sends a fraction of introduced bills to the program for review. Furthermore, CHBRP's reports analyze and detail impacts of new benefit mandates through a lens that's meant to meaningfully inform public policy decision-making. As a policy committee, this committee relies on CHBRP's analysis of the medical effectiveness of the services being considered, short-and long-term public health impacts of changing benefit design, and impacts to consumer premiums and out-of-pocket costs. These are incredibly important factors to consider when weighing the **public** benefit of changing benefit design. Notably, the impact to the bottom line of insurance companies is not a factor that is considered.

   In contrast to CHBRP's origins and current focus, this bill is being pursued by an industry, requesting reports that detail the impact of bills on that industry. As drafted, it would subject **every single bill** that impacts a hospital to CHBRP's review. This insinuates that to date the

legislature has been inadequately analyzing and voting on bills that range from labor standards, building standards, care standards, and more. It also assumes that CHBRP could easily build statistical models, access meaningful data, and translate the same detailed reports that they do for a narrow set of insurance benefit bills to this drastically broad range of issues. CHBRP's reports on proposed legislation, as drafted under this bill, would primarily focus on the financial impacts to hospitals without thoroughly weighing the impact to public health, health care access, or health outcomes. For example, if there were a bill on staffing ratios aiming to ensure that patients have adequate access to providers when they're hospitalized, the analyses under this bill would primarily focus on how much the proposed staffing ratio would cost as opposed to what it would mean for the quality of care and health outcomes for patients.

As raised by the opposition, there are also significant concerns with conflicts of interest. CHBRP is currently housed under the UC. UC Health manages academic health centers and children's hospitals that treat patients across the state. Tasking an entity that has significant financial investment in the analyses being produced would create ongoing questions on integrity and bias. There are also significant concerns that this bill could establish a slippery slope. If one line of business can pass a bill to require additional layers of analyses on proposed legislation that impacts them, what's stopping other businesses from following suit? Does the legislature truly need multiple, formal, in-depth analyses on every bill that impacts oil? Car manufacturers? Software companies?

The crux of the argument from the sponsors of this bill is that hospitals are going through a tough time and that needs to be considered as new legislation is proposed. There is no denying that the entire health care system, including hospitals, is at a moment of crisis. The question is whether the state needs to establish and fund additional analyses, which as noted above cost $15,000 to $70,000 a piece, to make such considerations on every single bill that impacts hospitals. Is it not within the realm of responsibility for hospitals, or the association that represents them, to do such research on how policies impact them and bring that information to the legislature for consideration? If they aren't capable of presenting impact on their industry to the legislature, are there other options to pursue? Such as establishing their own version of the UC Labor Center or other independently funded and established research arm to do that work?

7) **AMENDMENTS.** To address some of the concerns raised on conflict of interest and scope, the committee is proposing to strike the current contents of the bill and insert the following amendments:

   a) Require HCAI to seek to partner with UC to establish a Center for Health Provider Policy Impact to assess and evaluate the impact of state and federal policies on hospitals.

   b) Require the Center to evaluate impacts of proposed policies on healthcare delivery, access, workforce, and system sustainability, as specified.

   c) Require the Center to publish reports and submit to the legislature.

   d) Permit the legislature to request reports on certain legislation.

   e) Require hospitals to be assessed by HCAI to fund the work of the Center.

REGISTERED SUPPORT / OPPOSITION:

Support

California Hospital Association (sponsor)
Adventist Health
Alliance of Catholic Health Care
Association of California Healthcare Districts
Barstow Community Hospital
Bear Valley Community Hospital
California Association of Health Facilities
California Chamber of Commerce
California Children's Hospital Association
California Society of Health-system Pharmacists
Canyon Ridge Hospital
Cedars Sinai
Community Health System
Community Hospital of San Bernardino
Contra Costa County
Cottage Health
Cottage Health
Dignity Health
District Hospital Leadership Forum
Enloe Health
Huntington Health
John Muir Health
Kaiser Permanente
Kindred Hospitals
Marshall Medical Center
Mayers Memorial Hospital District
Memorialcare
Modoc Medical Center
Pih Health
Pomona Valley Hospital Medical Center
Prime Healthcare
Private Essential Access Community Hospitals
Rady Children's Health
Rady Children's Hospital
Ridgecrest Regional Hospital
Saint Agnes Medical Center
Scripps Health
Sharp Healthcare
Silicon Valley Leadership Group (SVLG)
Stanford Health Care
Tenet Health
Tenet Healthcare Corporation
Torrance Memorial Health
United Hospital Association

Opposition

Blood Cancer United, Formerly the Leukemia & Lymphoma Society
California Federation of Labor Unions, AFL-CIO
California Nurses Association
California Pan - Ethnic Health Network
California Physicians Alliance
California State Council of Service Employees International Union
California Teachers Association
CFT – a Union of Educators & Classified Professionals, AFT, AFL-CIO
Courage California
Health Access California
Indivisible Tri-valley
National Health Law Program
Western Center on Law & Poverty

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