ASSEMBLY THIRD READING
AB 2353 (Pacheco)
As Amended April 28, 2026
2/3 vote

SUMMARY

Requires the Department of Health Care Access and Information (HCAI) to seek to partner with the University of California (UC) to develop a plan to establish the Center for Health Provider Policy Impact (Center) to assess and evaluate the impact of state and federal policies on hospitals, including health care delivery, access, workforce, and system sustainability, and would require the center to create and publish reports at least annually.

COMMENTS

California Health Benefits Review Program (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%).

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 HR 1 of 2025, 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.

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.

Arguments in 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.

Arguments in 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.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations:

1) HCAI estimates costs of approximately $500,000 General Fund in fiscal year (FY) 2026-27 for one-time vendor support for modifications to the data request portal and data transmission. HCAI estimates staffing costs in FY 2026-27 of approximately $2.44 million General Fund to support 11 positions and approximately $2.64 million General Fund in FY 2027-28 and ongoing, for a total of 12 positions. HCAI states these staff are needed to manage project activities, coordinate inter-agency agreements, and support system enhancements and technical operations; format data products and support content development; lead work evaluating the impacts of state and federal policies on health care delivery, access, workforce capacity, and system sustainability in collaboration with UC partners; conduct advanced analyses and complex data modeling; provide legal support and advice on partnership development, privacy and security requirements, and regulatory activities necessary for fee assessment and collection; manage receivables, reconciliations, ensure revenue accuracy; and ensure information security and privacy compliance, including response to potential cybersecurity or privacy incidents.

2) The UC estimates costs of approximately $3.5 million annually, to implement this bill, and notes the cost could be greater, depending on the number of reports and complexity of the analysis. The UC′s costs would be for staff to manage the center, lead the analysis work, acquire and securely store data, and perform data analytics. Other staffing needs include editing, research expertise, peer review, and subject matter expertise. The UC anticipates additional costs to include facility, infrastructure, technology, administration and the development and maintenance of new data analytics tools. This bill provides for the collection of up to $3 million per year in hospital fees to fund the UC′s work to implement this bill (Health Provider Impact Fund, which will be created pursuant to the provisions of this bill).

VOTES

ASM HEALTH: 11-0-5
YES: Bonta, Chen, Aguiar-Curry, Ahrens, Caloza, Carrillo, Johnson, Patel, Patterson, Sanchez, Sharp-Collins
ABS, ABST OR NV: Addis, Mark González, Rogers, Schiavo, Stefani

ASM APPROPRIATIONS: 12-0-3
YES: Wicks, Aguiar-Curry, Calderon, Caloza, Dixon, Fong, Krell, Pacheco, Pellerin, Sharp-Collins, Solache, Tangipa
ABS, ABST OR NV: Hoover, Mark González, Ta

UPDATED

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