SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 2353
AUTHOR: Pacheco
VERSION: April 28, 2026
HEARING DATE: July 1, 2026
CONSULTANT: Vincent D. Marchand

SUBJECT: Health Mandates Review Program

SUMMARY: Requires the Department of Health Care Access and Information to partner with the University of California (UC) to establish the Center for Health Provider Policy Impact to assess and evaluate the impact of state and federal policies on hospitals. Requires this center, at least annually and no later than June 1st of each year to publish reports that review and analyze proposed legislation, regulations, and other policy actions affecting hospitals and health care providers. Assesses hospitals a fee of up to $3,000,000 annually to fund the expenses of the UC in implementing this bill.

Existing law:
1) Requests the University of California (UC) to establish the California Health Benefits Review Program (CHBRP) to assess legislation proposing to mandate a health insurance benefit or service, repeal a mandated benefit or service, alter a health insurance benefit design, cost-sharing, or premiums, and other health insurance topics. Requests a written report on the public health, medical, and financial impacts of the health insurance coverage mandated legislation, and essential health benefits. [HSC §127660]

2) Permits a request for an analysis by CHBRP to be made by an appropriate policy or fiscal committee chairperson, the Speaker of the Assembly, or the President pro Tempore of the Senate, who are required to forward the introduced bill to CHBRP for assessment. [HSC §127661]

3) Requires 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 by the Department of Managed Health Care and California 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 the work of CHBRP. Caps the assessment at $3.2 million, and sunsets the statute on July 1, 2033. [HSC §127662 and §127665]

4) Requires the UC, in order to avoid conflicts of interest, to develop and implement conflict of interest provisions to prohibit a person from participating in any analysis in which the person knows or has reason to know he or she has a material financial interest, including a person who has a consulting or other agreement with a person or organization that would be affected by the legislation. [HSC §127663]

This bill:
1) Requires the Department of Health Care Access and Information (HCAI) to seek to partner with the UC to develop a plan, no later than January 1, 2028, to establish the Center for Health Provider Policy Impact (Center) to assess and evaluate the impact of state and federal policies on hospitals.

2) Requires the Center to evaluate the anticipated and actual impacts of proposed policies on health care delivery, access, workforce, and system sustainability.

3) Requires the Center, at least annually, and by June 1 each year for analyses of proposed legislation, to publish reports that:
   a) Review and analyze proposed legislation, regulations, and other policy actions affecting hospitals and health care providers;
   b) Assess the impacts of those policies on public health outcomes, health care access, delivery, workforce, and system sustainability;
   c) Analyze disparities in policy impacts across regions, including rural and underserved areas; and,
   d) Identify emerging trends and policy issues likely to affect access to care, quality of care, and system sustainability.

4) Requires the Center to post all requested, initiated, and completed analyses on its website and submit all reports to the appropriate policy and fiscal committees of the Legislature and to appropriate state departments and agencies.

5) Establishes the Health Provider Impact Fund in the State Treasury to support the UC and its work in implementing this bill. Requires UC's work in providing the bill analyses to be supported from this fund.

6) Requires each hospital to be assessed an annual fee in an amount determined by HCAI through regulation and to be limited to the amount necessary to fund the actual and necessary expenses of the UC and its work in implementing this bill. Prohibits the total annual assessment from exceeding $3 million.

7) Requires HCAI to assess each hospital respectively for the costs required to fund the activities of this bill. Requires hospitals to be notified of the assessment by June 15 of each year, and requires the assessed fee to be paid on an annual basis by August 1 of each year. Requires HCAI to forward the assessed fees to the Controller for deposit in the Health Provider Impact Fund immediately following their receipt.

8) Defines "hospital," for purposes of this bill, as including a general acute care hospital, an acute psychiatric hospital, and a special hospital, as each of these are defined.

9) Sunsets the provisions of this bill on January 1, 2033.

FISCAL EFFECT: According to the Assembly Appropriations Committee, 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.

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).

PRIOR VOTES:

Assembly Floor:	56 - 1
Assembly Appropriations Committee:	12 - 0
Assembly Health Committee:	11 - 0

COMMENTS:

1) *Author's statement.* According to the author, California's hospital system is under significant financial strain. Nearly 45% of the state's hospitals operate at a deficit. In 2025 alone, financial pressure forced hospitals and health systems to lay off nearly 3,500 workers. Three hospitals closed in the last three years, and dozens more have reduced services – diminishing access to care for patients across the state. Each year, state policymakers consider hundreds of health care-related bills, regulations, and other policy proposals – often absent independent information about how each proposal will affect patient costs or access to care. To confront health care affordability, we need to understand the factors that are driving costs, including the impacts of new regulatory requirements on hospitals, their patients, and the communities they serve. This bill tasks the UC, in partnership with HCAI, with assessing and evaluating the impact of state and federal policies on hospitals, giving policymakers an objective, evidence-based foundation before making decisions that affect the health care of nearly 40 million Californians. This bill would give the Legislature a clearer picture of how policies affect hospitals – and ultimately, the people they serve.

2) *CHBRP background.* 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. Over the last 22 years, CHBRP has issued reports on approximately 248 bills and has issued other policy briefs on federal and state health insurance mandates. Legislative requests for reports per year can range between 10 and 22. 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. 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%).

3) *Prior legislation.* SB 439 (Weber Pierson, Chapter 318, Statutes of 2025) extends the authorization for funding for CHBRP, and increases the limit on the health insurance assessment that supports CHBRP's work to $3.2 million. Additionally, extended the sunset date to July 1, 2033.

   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 limit of $2.2 million to support CHBRP.

   AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests 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 AB 1996, and caps the total annual assessment on health plans and insurers at $2 million.

4) *Support.* This bill is sponsored by the California Hospital Association (CHA), which states that one way to protect hospital's ability to care for patients is to help ensure proposed policies that place new requirements on hospitals strike 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. This bill would further this goal by providing policymakers with additional, in-depth information before they make decisions on bills and other policies that could add to an increasingly unsustainable burden on hospitals. Without better informing policymakers of the costs and potential savings of new policies, along with their risks and benefits, the cumulative impact of rising expenses will continue to have devastating consequences, including service reductions, layoffs, and hospital closures. According to CHA, recent legislative mandates have added billions of dollars to hospitals' costs, which must be considered in reimbursement negotiations with payers, and ultimately are borne by families, patients, employers, and taxpayers. CHA states that through this legislation, the independent Center for Health Provider Policy Impact would be established to comprehensively analyze the impacts of pending legislation, regulations, and other policies that impose new requirements on hospitals, their patients, and communities. According to CHA, it will leverage the expertise of experienced academic researchers to perform these analyses, similar to the current review of health plan and insurer mandate legislation under CHBRP. CHA argues that these analyses would elevate consideration of costs in policy decisions, which would improve policymakers' ability to ensure that the benefits of enacted legislation and finalized regulations justify their costs. Numerous hospitals, health systems and business organizations also support this bill for similar reasons.

5) *Opposition.* Numerous labor organizations, Health Access California, Western Center on Law and Poverty, the California LGBTQ Health and Human Services Network, and many other organizations submitted a coalition letter opposing this bill. Opponents argue that the analyses created by this bill would focus on the impacts to hospitals, not Californians, and would be used to challenge hard fought existing consumer and worker laws already vetted through the legislative process, and stop future efforts to address the health care affordability crisis facing Californians. If passed, this bill would create a Center and required analyses to influence the legislative process and policy debates in favor of hospitals' interests. Opponents point out that these analyses would be conducted by the UC, which is a large and growing health system, with a clear conflict of interest to favor the hospital perspective. The state should not establish state-mandated analyses to allow perspectives of any business to influence policy debates. According to opponents, this bill relies on the false premise that laws passed in Sacramento are the reason that hospitals have to raise prices and some hospitals face financial challenges. First, hospital prices are driven by market power, and high hospital prices directly translate to higher premiums and cost-sharing for consumers. Second, California hospitals posted $11.3 billion in net income in 2024, exceeding pre-pandemic levels. While there are hospitals in financial distress, hospitals in general remain profitable, and the state and existing laws consider the hospital's financial status in implementing laws and programs.

6) *Policy comments.*
   a) *Chasing a moving target in a compressed legislative calendar.* The proponents of this bill have modeled it on the CHBRP process of analyzing new insurance mandates. Already, the compressed timeline between the bill introduction deadline and the policy committee deadline in the house of origin forces most insurance mandate proposals to be heard at the last available hearing before the deadline, so that the CHBRP analysis can be included in the policy discussion on the bill. Insurance mandate bills do not typically change as much as other legislative proposals, partly because amendments are discouraged: substantial changes could trigger a request for a revised analysis by a policy committee, which could jeopardize passage of the bill until a new revised analysis was completed. Legislative proposals impacting hospital operations are often amended in substantial ways prior to the first policy committee deadline, so any analysis based on the introduced version of a bill is likely to be outdated as soon as it is published. This bill differs from CHBRP in that the analysis is not due until June 1st, which is after the house of origin deadline. The later deadline potentially allows for some early amendments to be incorporated into the analyses, but at the cost of only the second house having the benefit of the analyses during the policy and fiscal committee hearings on the proposed legislation. Even then, amendments taken in the second house could render the analyses out of date depending on the extent of the amendments. Again, these issues exist with the current CHBRP process, but analyses of legislative proposals in the hospital space are likely to be less formulaic than insurance mandate analyses, further complicating timely completion of the analyses. The wide range of legislation impacting hospitals makes the challenge of providing a detailed impact analysis in the midst of a dynamic legislative session, with multiple opportunities to amend, especially challenging.

   b) *Much broader scope than CHBRP.* Unlike CHBRP, which as a fairly narrow mandate on what it reviews, this bill requires the center to evaluate the impacts of state and federal policies on hospitals, including "proposed legislation, regulations, and other policy actions." In addition to federal legislation and regulations, this could also be interpreted

to apply to regulations more broadly – those already adopted, in addition to those that are proposed. With only $3 million annually, which is slightly less than the $3.2 million annual budget for CHBRP, the author and committee may wish to more narrowly target legislation and regulations that are proposed in California moving forward.

c) *UC operates numerous large health systems.* As noted by the opponents, placing this center at the UC poses a question of conflict of interest. CHBRP is housed at UC Berkely, which is not one of the campuses that includes a hospital, and HCAI could choose to locate the Center at that campus or another campus without a hospital. Still, the UC as a whole is a major operator of hospitals and health systems, and frequently engages with the legislature on legislation that would affect them as a hospital operator. The Committee may wish to consider whether there is another entity that would not pose the same conflict of interest concerns.

SUPPORT AND OPPOSITION:

Support: California Hospital Association (sponsor)
Adventist Health
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 Assn
California Kidney Care Alliance
California Society of Health-System Pharmacists
Canyon Ridge Hospital
Cedars Sinai
Community Health System
Community Hospital of San Bernardino
County of Contra Costa
Cottage Health
District Hospital Leadership Forum
East Bay Leadership Council
Enloe Health
Huntington 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
Providence
Ridgecrest Regional Hospital
Saint Agnes Medical Center
Santa Monica Chamber of Commerce
Scripps Health
Sharp Healthcare

Silicon Valley Leadership Group
Stanford Health Care
Tenet Health
Torrance Memorial Health
United Hospital Association

Oppose: Alliance for Transyouth Rights
American Federation of Government Employees
Blood Cancer United
California Alliance for Retired Americans
California Federation of Labor Unions
California Federation of Teachers
California LGBTQ Health and Human Services Network
California Nurses Association
California Pan-ethnic Health Network
California Physicians Alliance
California School Employees Association
California State Council Service Employees International Union
California Teachers Association
Courage California
Engineers and Scientists of California
Gender Affirming Professionals
Health Access California
Healthy California Now
Indivisible Tri-Valley
Monterey Bay Central Labor Council
National Health Law Program
National Union of Healthcare Workers
PFLAG Danville-San Ramon Valley Chapter
PFLAG Los Angeles
Salinas Valley Federation of Teachers
Small Business Majority
Teamsters California
TransFamily Support Services
Unite Here
United Nurses Associations of California/Union of Health Care Professionals
Western Center on Law & Poverty

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