ROB BONTA
Attorney General of California
NELI N. PALMA
Senior Assistant Attorney General
EMILIO VARANINI
Supervising Deputy Attorney General
State Bar No. 163952
DAVID HOUSKA
Deputy Attorney General
State Bar No. 295918
SOPHIA T. TONNU
Deputy Attorney General
State Bar No. 330189
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3374
Fax: (415) 703-1107
E-mail: David.Houska@doj.ca.gov
Attorneys for Defendants
Office of Health Care Affordability

[EXEMPT FROM FILING FEES PURSUANT TO GOVERNMENT CODE SECTION 6103]

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

CALIFORNIA HOSPITAL ASSOCIATION, Petitioner, **v.** **OFFICE OF HEALTH CARE AFFORDABILITY, et al.** Respondents	Case No. CPF-25-519370 **RESPONDENTS' MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF DEMURRER TO PETITION FOR WRIT OF MANDATE; COMPLAINT FOR DECLARATORY RELIEF** Date: February 17, 2026 Time: 9:00 a.m. Dept: 302 Judge: The Honorable Joseph M. Quinn Trial Date: Not Set Action Filed: October 15, 2025

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES
(continued)

Page

STATUTES

OTHER AUTHORITIES

INTRODUCTION

The cost of health care is, in a word, unsustainable. The legislature, in enacting the California Health Care Quality and Affordability Act (Act), declared "[s]urveys show that people are delaying or going without care due to concerns about cost, . . . one in four people report problems paying or being unable to pay their medical bills, with two-thirds cutting back on basic household items like food and clothing to pay those bills." (Health & Saf. Code, § 127500.5(a)(9).)[1] The Act emphasized "[i]t is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal." (*Id.* at subd. (a)(1).) To achieve these goals, the Act created the Office of Health Care Affordability within the Department of Health Care Access and Information (HCAI) and established the Health Care Affordability Board (Board). OHCA, HCAI, and the Board are all named respondents in this action, along with Elizabeth Landsberg in her official capacity as the director of the office and the department (collectively "OHCA").

OHCA is charged with reporting data and developing strategies to slow growth in health care costs while maintaining quality, equity, access, and workforce stability. Chief among these is the setting of cost targets[2] for different actors in the healthcare sector. Pursuant to its statutory mandate, OHCA recently (1) set a statewide cost target; (2) established a hospital sector with cost targets equal to the overall statewide target; and (3) set lower cost targets for seven high cost hospitals. These targets serve as benchmarks for growth in annual health care spending; exceeding the cost targets can trigger scrutiny and, if there is no reasonable justification for the excess, possible enforcement action.

Petitioner California Hospital Association (CHA) claims it "enthusiastically support[s] the Legislature's goal of promoting the affordability of health care services." [Compl. ¶ 2.] However, it aggressively lobbied for higher cost targets and CHA's blunderbuss pleading—covering nearly a hundred pages—boils down to resubmitting the same arguments it presented to OHCA in public comments over the last two and half-years. Having failed to sway OHCA, CHA now comes to

[1] All further statutory references are to the Health and Safety Code unless otherwise noted.
[2] "Cost targets" is the term used in the statute. OHCA also interchangeably uses the term "cost growth targets," "spending targets," or "spending growth targets."

court for a do-over, asking the Court to effectively void all of OHCA's actions. The Court should deny this effort for two distinct reasons. **First**, not one of the roughly 400 CHA member hospitals has a concrete and particularized injury that could support standing in this action. CHA notably fails to plead that any hospital will actually exceed the cost target. Even if it had, exceeding the cost targets does not automatically create legal jeopardy for a hospital, and any enforcement action is both years away and dependent on a fact intensive, hospital specific inquiry. Nor is there any basis for the Court to allow CHA to use public interest standing to accomplish through litigation the policy aims it did not achieve through the statutory process. **Second**, CHA has failed to adequately allege an abuse of discretion by OHCA. At most CHA alleges OHCA did not fully accept the arguments and comments presented during public comment. But this does not mean there was no basis for OHCA's actions or that it failed to consider CHA's comments—it only shows OHCA ultimately accepted a different set of trade-offs than CHA would have preferred. CHA is fundamentally asking this Court to re-weigh the policy arguments presented to OHCA, substitute its judgment, and reach a different conclusion. Courts are prohibited from doing so and the petition should be dismissed.

BACKGROUND AND SUMMARY OF FACTS

I. OHCA'S CONSIDERATION OF VARIOUS STATEWIDE TARGETS AND FACTORS

Starting in March 2023, the Board spent over a year publicly deliberating and considering input on the statewide spending growth targets and associated methodology.[3] (Declaration of Sophia TonNu (TonNu Decl.), Ex. 1-2; Request for Judicial Notice (RJN), Ex. C1, C2.) This included recommendations from OHCA, input from an advisory committee of stakeholders, and multiple rounds of oral and written public comment. Consistent with its responsibility to ensure affordability for consumers and purchasers, OHCA considered historical trends and projections for economic indicators and population-based measures; historical trends in costs for Medi-Cal,

[3] § 127507, subd. (m)(1): The board shall hold a public meeting to discuss the development and adoption of recommendations for statewide cost targets, or specific targets by health care sector… The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment.

Medicare, and commercial health coverage; and potential factors to adjust future cost targets. (§ 127507, subd. (d)(1)-(3).)[4]

For the statewide cost target, OHCA published its recommendation on its website for public comment and Board review and discussion at its January 24, 2024 meeting. (TonNu Decl., ¶A-B, Ex. 7-8; RJN, Ex. B1, B2, C16, C17.) This recommendation was for a 3.0% annual spending growth target. The Board then discussed potential growth targets and advisory committee feedback at its January and February 2024 meetings. (TonNu Decl., Ex. 7-9; RJN, Ex. C16, C17, C19, C20.) Concurrently, the Board received and considered public comments on the potential targets for 45 days following the January 2024 meeting. Numerous entities and individuals, including the California Hospital Association, submitted public comments on the spending growth targets in advance of the January, February, and March 2024 public meetings. (TonNu Decl., Ex. 7-9; RJN, Ex. C15, C18, C21, C23.)

As part of these discussions, OHCA also considered historical trends and projections for multiple economic and population based indicators and historical trends in costs to establish a method of calculating the spending growth targets. (TonNu Decl., Ex. 4-10; RJN, Ex. C7, C8, C10, C11, C13, C14, C16, C17, 19, 20, 22, 24.) There was no one way to measure "affordability," and OCHA reviewed a number of metrics, including median household income, average wage growth, inflation in consumer prices, and growth in per capita health care spending in California between 2000 and 2020. (TonNu Decl., Ex. 5-7; RJN, Ex. C10, C11, C13, C14.) Consistent with OHCA's mandate to promote consumer and purchaser affordability, the Board ultimately decided to prioritize consumer affordability as reflected in the average annual rate of change in historical median household income from 2002-2022 as the basis for calculating California's statewide spending growth target. (TonNu Decl., Ex. 10-ll; RJN, Ex. C26, C27; see also § 127502, subd. (j) (singling out assessing targets' impact on affordability for consumers and purchasers of health care.)

[4] § 127507, subd. (c)(5): The health care cost targets shall: "[p]romote the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness.").

OHCA announced the final spending target at its April 2024 public meeting – a statewide cost target starting at 3.5% growth in healthcare spending in 2025; 3.5% in 2026; 3.2% in 2027, 3.2% in 2028, and finally 3.0% in in 2029. (TonNu Decl., 10-ll; RJN, Ex. C26, C27; see also Cal. Code of Regulations, tit. 22, § 97447.) Because the Board adopted a positive spending growth target, healthcare entities, including all hospitals, may meet the annual spending target while continuing to grow and expand.

II. OHCA'S CONSIDERATION OF HEALTHCARE SECTORS AND SECTOR SPENDING GROWTH TARGETS

Starting in August 2024, the Board also considered multiple healthcare sector specific spending growth targets before adopting a hospital sector target. The Board's consideration built on ongoing concerns with the contribution of hospitals to healthcare spending growth for residents both nationally and in California. (TonNu Decl., Ex. 12-13; RJN, Ex. C29, C30.) Again, the Board's public consideration included recommendations from OHCA on approaches to defining healthcare sectors and growth targets, input from the advisory committee, and multiple rounds of public comment. OHCA similarly presented information on historical trends for hospital spending, including data on historical cost trends.

The Board discussed whether defining a healthcare sector and setting sector specific targets based on geographic region, provider category, payer and/or provider by market category, and individual health care entities was advisable. (TonNu Decl., Ex. 13-15; RJN, Ex. C32, C33, C35, C36.) At the December 2024 Board meeting, OHCA noted that there was incomplete data for various market categories, including medical groups or physician organizations and for specific geographic regions in California. (TonNu Decl., Ex. 15-16; RJN, Ex. C38, C39.) Conversely, there was more complete historical hospital trends in cost data for Medi-Cal, Medicare, and commercial coverage through the annual financial disclosures from California hospitals. OHCA outlined for the Board four options: (1) wait until calendar year 2027 to establish sector specific targets; (2) define a healthcare sector for a specific region; (3) define a healthcare sector for all high cost hospitals; or (4) define a hospital sector tied to the statewide target and adjust the

statewide target for all or a specific subset of high cost hospitals within the sector. (TonNu Decl., Ex. 15-16; RJN, Ex. C38, C39.)

In January 2025, the Board chose to define a health care sector consisting of all hospitals. (TonNu Decl., Ex. 16-17; RJN, Ex. C41-42.) All Hospitals in the sector would be subject to the statewide spending growth target. In February 2024, OHCA codified a definition of the hospital sector. (See Cal. Code of Regulations, tit. 22, § 97446; TonNu Decl., ¶ D; RJN, Ex. B4.) Per statute, the Board could adjust the target (to a lower value than the statewide target) for individual hospitals within the hospital sector, as warranted to account for baseline costs in comparison to other hospitals in the sector. (§ 127507, subd. (b)(2).

III. OHCA'S CONSIDERATION OF HIGH COST HOSPITAL SPENDING GROWTH TARGETS

Due to the Board's concerns about high cost hospitals, OHCA simultaneously addressed the identification of high cost hospitals and their cost growth separately in February 2025. (TonNu Decl., ¶¶C, E, Ex. 17-18; RJN, Ex. B3, B5, C44, C45.) As these facilities would start from a significantly higher baseline, the Board considered whether these facilities should be subject to a lower growth target. (§ 127507, subd. (b)(2).)

Such high cost hospitals would be limited to hospitals that are repeat outliers on both unit and relative price measures—those who were at the 85th percentile for three out of five years relative other California hospitals. (TonNu Decl., ¶¶C, E, Ex. 17-18; RJN, Ex. B3, B5, C44, C45.) Between February and May 2025, OHCA received public feedback and comments from entities and individuals, including feedback from individual hospitals. (TonNu Decl., Ex. 17-20; RJN, Ex. C44, C45, C47, C48, C50, C53; C43, C46, C49, C52, C54.) The Board ultimately adjusted the target for the seven high-cost hospitals to a lower percentage than the statewide target. (TonNu Decl. Ex. 19-20; RJN, Ex. C50, C51, C53.)[5] All other hospitals in the sector would continue to be subject to the statewide target. (§127507, subd. (b)(2).)

[5] The seven hospitals subject to a high cost hospital spending growth target are Community Hospital of the Monterey Peninsula, Doctors Medical Center in Modesto, Dominican Hospital, Salinas Valley Memorial Hospital, Santa Barbara Cottage Hospital, Stanford Health Care, and Washington Hospital in Fremont.

IV. OHCA'S ONGOING CONSIDERATION OF SPENDING GROWTH TARGET ENFORCEMENT AND ANNUAL ADJUSTMENTS TO STATEWIDE SPENDING GROWTH TARGETS

Given the effort to develop the cost targets in the first instance, OHCA did not begin public discussion of cost target enforcement until July 2025. (TonNu Decl., Ex. 21-22; RJN, Ex. C58, C59.) Determining enforcement mechanisms and standards is a critical step because it is not necessarily illegal for a hospital to exceed the targets. Indeed, the statute specifically provides that any enforcement action must consider each entity's contribution to cost growth and the extent it has control over the applicable components of the target. (§ 127502.5, subd. (a).) The entity must have at least 45 days to respond to an initial notice and has the opportunity to provide additional data justifying its costs, including information showing reasonable factors outside the entity's control. (§ 127502.5, subd. (b)(2).) OHCA may consider good cause for exceeding the target. (§ 127502.5, subds. (a) and (i).) And even if OHCA determines a hospital has no justification, the statute provides for a multi-step process before any enforcement action can be taken. (*Id.* at § 127502.5 (describing notice, enforcement waiver, technical assistance, performance improvement plan, and an enforcement appeal process.) Public discussions on enforcement standards and procedures are expected to continue through October 2026. (TonNu Decl., Ex. A22-24, RJN, Ex. C61, C62, C64, C65.)

Critically, there is no possibility of an immediate enforcement action. The statewide target is only enforceable after a target has been established for the 2026 calendar year and after spending data from healthcare entities has been collected for the 2026 calendar year—in other words, not until sometime in 2028 at the earliest due to the lag in reporting and data collection. TonNu Decl., RJN, Ex. C8 at 5 ["Director Landsberg answered that the enforcement that would start in 2028"].)

LEGAL STANDARD

"A respondent may test the legal sufficiency of a petition for writ of mandate by demurrer." (*Committee for Sound Water & Land Development v. City of Seaside* (2022) 79 Cal. App. 5th 389, 399.) A demurrer does not admit or accept allegations in a complaint that are "contrary to law, or to facts of which a court may take judicial notice." (*City of Atascadero v. Merrill Lynch,*

et al. (1998) 68 Cal. App. 4th 445, 459). While the Court must assume that all well pled facts in the complaint are true at this stage, it does not "assume the truth of contentions, deductions, or conclusions of fact or law." (*City of Seaside*, *supra*, at p. 399 [quotation marks omitted].) Finally, where, as here, there is no reasonable possibility of curing the defects by amendment, demurrers should be sustained without leave to amend. (*Pacific Bay Recovery, Inc. v. California Physicians' Services, Inc.* (2017) 12 Cal.App.5th 200, 206.)

ARGUMENT

I. CHA LACKS BENEFICIAL INTEREST STANDING (BOTH COUNTS)

The entire petition should be dismissed because no hospital can demonstrate that it has or will be injured by OHCA. As an association not directly regulated by OHCA, CHA must establish that its individual members "would otherwise have standing to sue in their own right." (*Am Meat Inst v. Leeman* (2009) 180 Cal. App. 4th 728, 766 n11).[6] In seeking a writ of mandate, CHA must show that its individual members have a "beneficial interest" in the challenged conduct. (Code Civ. Proc. § 1086.) This means the petitioner must "have some special interest to be served or some particular right to be preserved or protected over and above the interest held in common with the public at large." (*Cal Dept of Consumer Affairs v. Super Ct.* (2016) 245 Cal. App. 4th 256, 262 [quotation marks omitted].) The standard is the same for an action seeking declaratory relief. (*Id.* at p. 261-62.) Finding a beneficial interest "is equivalent to the federal 'injury in fact' test" and accordingly, the petitioner must show "an invasion of a legally protected interest that is (a) concrete and particularized, and (b) actual or imminent." (*Limon v. Circle K Stores Inc.* (2022) 84 Cal. App. 5th 671, 696.) CHA cannot show either here because even if a hospital exceeds the cost target it does not automatically trigger liability or enforcement; any injury is entirely speculative at this juncture. Moreover, an enforcement action is likely years away—2028 at the absolute earliest—meaning any hypothetical injury is far too remote to support standing.

[6] There are two other requirements for associational standing: the litigation must be germane to the purpose of the association and neither the proceedings nor the relief requested must require the participation of individual members. (*Leeman*, 180 Cal. App. 4th at p. 766 n.11.) At this juncture, OHCA does not contest or concede that CHA satisfies the other two elements of associational standing.

A. Exceeding the cost targets does not immediately result in liability.

CHA cannot show a "concrete and particularized" injury because it cannot show that a single member hospital will actually be penalized due to the cost targets. A beneficial interest in the challenged conduct cannot be "conjectural or hypothetical." (*Dept of Consumer Affairs*, *supra*, 245 Cal. App. 4th at p. 262 [petitioner could not challenge a law where the threat of enforcement was "too conjectural for us to conclude real parties in interest have a beneficial interest that is concrete and actual"].) To determine if an interest is sufficiently concrete, the court must "consider whether plaintiffs face a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement or whether the alleged injury is too imaginary or speculative." (*Dominguez v. Bonta* (2022) 87 Cal. App. 5th 389, 413 [quotation marks omitted].) When a party challenges an agency's actions, they must show more than "a difference of opinion as to their validity." (*Pacific Legal Found. v. Cal Costal Comm'n* (1982) 33 Cal. 3d 158, 173.) A sufficiently concrete injury is particularly important in the regulatory context to prevent courts "from entangling themselves in abstract disagreements over administrative policies, and also to protect the agencies from judicial interference until an administrative decision has been formalized *and its effects felt in a concrete way by the challenging parties*." (*Id.* at p. 171 [emphasis added]; *see also Escobar v. Brewer* (D. Ariz. Aug. 31, 2010) 2010 WL 11537784, at p. *3 [no standing where "the threat of potential suit [is] wholly speculative"]; *Oregon Bankers Assn v. Oregon* (D. Or Feb 17, 2022) 2022 WL 488071, at p. *3 ["because plaintiffs' allegations only speculate, but do not adequately plead how defendants will exercise authority to enforce [the statute], the allegations are necessarily conjectural"] [quotation marks omitted].)[7]

Underscoring the degree to which this lawsuit is founded on hypotheticals, CHA has notably failed to plead that any specific hospital will in fact exceed the cost targets. But even making such an allegation would not be enough as under the statute, it is not *per se* illegal for a hospital to exceed the cost targets and an entity that does outpace the cost target is not automatically subject to sanctions. Instead, the statute provides that before initiating any kind of

[7] As the beneficial interest standard is equivalent to the federal standing test, federal cases analyzing standing are probative of the issues here. *Limon*, 84 Cal. App. 5th at 696.

enforcement action, OHCA is required to consider whether doing so would be "likely to erode access, quality, equity, or workforce stability. (§ 127502.5 subd. (a).) OHCA also must consider "the extent to which each entity has control over the applicable components of its cost target." (*Ibid.*) Moreover, as described above, OHCA must provide an individual hospital that exceeds the target 45 days to respond and provide additional information, such as reasonable justifications for exceeding the target which OHCA will consider before commencing any enforcement. (*Id.* at subds.(a) and (i).)

The threat of an actual enforcement action based on the cost targets is "too imaginary or speculative" to confer standing—there are simply too many prerequisites and possible offramps before OHCA takes action against any particular hospital. (*Dominguez*, *supra*, 87 Cal. App. 5th at p. 413 [quotation marks omitted].) If an enforcement action ever materializes, it will be based on factors and findings specific to that facility—in particular that its excess costs are within its control and can be reduced without compromising "access, quality, equity, or workforce stability." (§ 127502.5(a).) Indeed, CHA itself admits that at present the enforcement mechanism is "ill defined" and that OHCA "has not adopted rules as to how it will determine whether a hospital has exceeded the applicable target." (Compl. ¶ 5.) As CHA can only "speculate, but [] not adequately plead how defendants will exercise authority to enforce" the cost targets, they cannot show anything more than a "conjectural" injury at present. (*Oregon Bankers Assn*, *supra*, 2022 WL 488071, at p. *3.)

Pacific Legal Foundation v. California Coastal Commission, *supra,* 33 Cal. 3d 158 is particularly instructive. There, the plaintiff challenged guidelines issued by the California Coastal Commission; the guidelines laid out the standards and process for how the Commission would approve new developments. (*Id.* at p. 163.) The California Supreme Court found that the plaintiff lacked standing because they had no concrete injury. (*Id.* at p. 172.) Since the challenged guidelines would need to be applied under fact-specific conditions to specific, future developments, the plaintiff was "in essence inviting us to speculate as to the type of developments for which access conditions might be imposed, and then to express an opinion on the validity and proper scope of such hypothetical exactions." (*Ibid.*) The Court "declin[ed] to enter into such a

contrived inquiry." (*Ibid.*) The exact same logic holds true here: CHA is asking the Court to speculate as to how OHCA will determine whether a particular hospital has exceeded the cost target, whether doing so was justified under the circumstances specific to that facility, and what enforcement action it might pursue after making those findings. As in *Pacific Legal*, standing cannot rest on a multi-layer hypothetical.

B. Any enforcement action is too distant to support a beneficial interest.

Even if CHA could make out a more particularized threat of enforcement, it runs into a second problem: any such enforcement is years away at the absolute earliest. CHA acknowledges that "OHCA has not yet begun to enforce the cost targets" and that at the moment, all that has happened is a *discussion* by the OHCA board of possible enforcement procedures. (Compl. ¶¶ 82-83.) Indeed, there is no possibility of imminent enforcement because the data required for such an action won't be reported until late 2027, meaning OHCA will not be in a position to even contemplate enforcement action until early 2028. Even if OHCA instantly determines a hospital exceeded the target without reasonable justification, it would need to follow an extensive, and time consuming, process before actually commencing an enforcement action. Specifically, OHCA must (1) provide technical assistance to the facility to help it come into compliance; (2) notify the hospital and give it 45 days to respond; (3) may require public testimony on why the hospital is exceeding the cost target; and (4) may require the hospital to submit and follow a performance improvement plan. (§ 127502.5 (a)-(b).) Only after these steps are complete—and after the hospital fails to bring costs under control—can OHCA actually begin assessing penalties. (*Id.* at sub (d).) In sum, it would be impossible for OHCA to commence an enforcement action before 2028 at the absolute earliest. A beneficial interest must be based on an "actual or imminent" injury which CHA simply cannot demonstrate given this extended timeline. (*Limon*, 84 Cal. App. 5th at 696.)

II. THE COURT SHOULD NOT ALLOW PUBLIC INTEREST STANDING (BOTH COUNTS)

As CHA cannot show a concrete, imminent injury, it will likely claim that this case should proceed based on public interest standing—an exception to the general standing rules which allows litigants to bring an action to ensure the government complies with the law. (*Dept. of*

Consumer Affairs, *supra,* 245 Cal. App. 4th at p. 262 ["it is sufficient that as a citizen the plaintiff has an interest in having the laws executed and duty enforced"].) However, "public interest standing is not freely available to any party…it is an exception to, not a repudiation of, the usual requirements of a beneficial interest in the litigation." (*Ibid.*) Permitting a case to proceed pursuant to public interest standing is discretionary and "[n]o party, individual or corporate, may proceed with a mandamus petition as a matter of right under the public interest exception." (*SJJC Aviation Servs v. Cty of San Jose* (2017) 12 Cal. App. 5th 1043, 1057.) Accordingly, the Court should not allow public interest standing "if its underlying policy is outweighed by competing interests of a more urgent nature." (*Dept. of Consumer Affairs*, *supra,* 245 Cal. App. 4th at p. 262.) There are three policy considerations which weigh against public interest standing here: (1) the fact that all of CHA's arguments can be raised as defenses to a cost-target enforcement action; (2) the potential for this suit to interfere with OHCA's statutorily defined process; and (3) the fact that CHA is not acting in the public interest.

A. CHA's members will have adequate opportunity to challenge the cost targets in any possible future enforcement action.

Public interest standing is most appropriate where government misconduct would otherwise "be effectively insulated from judicial review." (*Weiss v. Cty of L.A.* (2016) 2 Cal. App. 5th 194, 206; *see also Driving Sch. Ass'n of Cal. v. San Mateo Union High Sch. Dist.* (1992) 11 Cal. App. 4th 1513, 1519 [granting public interest standing where the only parties directly injured were "unlikely to have the financial resources or the economic interest necessary to maintain the protracted litigation."].) This case is profoundly different and does not present a scenario where "an alleged right will go unaddressed and unvindicated if public interest standing is denied." (*Dept. of Consumer Affairs*, *supra,* 245 Cal. App. 4th at p. 263.) Quite the contrary—any hospital that is the subject of an enforcement action will have multiple opportunities to raise the exact same arguments that CHA does here as a defense to any enforcement action. (§ 127502.5, subd. (a).) There is no reason why CHA should be allowed an exception to the normal standing requirements when the actual parties in interest will still enjoy all of their rights and remedies if this suit is dismissed.

Moreover, it would be demonstrably superior to litigate these issues in the context of a particular hospital. "[J]udicial decision-making is best conducted in the context of an actual set of facts so that the issues will be framed with sufficient definiteness." (*Pacific Legal*, *supra*, 33 Cal. 3d at p. 314.) CHA asks the Court to find that the cost targets will compromise access, quality, equity, and workforce stability in hospitals, but does not, and cannot point to a single specific instance in which that will happen. (Compl. ¶¶ 110-111.) This kind of abstract policymaking, while always inappropriate, is particularly so here because an actual enforcement action against a specific hospital would involve a fact intensive inquiry into the finances of that particular facility. (§ 127502.5, subd. (a); *see also Dept. of Consumer Affairs*, *supra,* 245 Cal. App. 4th at p. 264 [issues should be determined when they "arise in a factual, as opposed to conceptual, context"].) Absent that clear factual foundation, CHA is merely inviting the courts to "entangle[] themselves in abstract disagreements over administrative policies." (*Pacific Legal*, *supra,* 33 Cal. 3d at p. 171.) The Court should decline.

B. Public interest standing would interfere with the statutorily defined process.

CHA petitioned the legislature when the Health Care Quality and Affordability Act was enacted. It involved itself deeply in the public comment process, commenting both publicly and in writing before and at every single Board meeting. Now, dissatisfied with the outcome, CHA cannot leverage public interest standing into a third bite at the apple. As several courts have recognized, standing should be denied where "the ready availability of court litigation will be disruptive to the administrative process and antithetical to its underlying purpose of providing expeditious disposition of problems in a specialized field." (*Dept. of Consumer Affairs*, *supra,* 245 Cal. App. 4th at p. 263; *Pacific Legal*, *supra,* 33 Cal. 3d at p. 171 [public interest standing should be denied "to protect the agencies from judicial interference until an administrative decision has been formalized and its effects felt in a concrete way by the challenging parties"].) By bringing a generalized challenge to the cost targets—rather than in the context of their application to a specific hospital—CHA seeks nothing more than a complete re-run of the rulemaking process. (Compl. at Prayer [seeking to void the cost targets].) This call to have the

Court effectively usurp OHCA's role would be disruptive. Indeed, the Legislature expressly entrusted the Board with sole discretion and authority to set the cost targets, which are exempt from the requirements of the Administrative Procedure Act. (§ 127502, subd. (n).) Further, OHCA *continues* to develop the specifics for cost target enforcement, including methodologies for determining cost overruns and enforcement procedures. (E.g., Compl. ¶¶ 5, 82-83.) As a result, OHCA would have to engage in this complex process while looking over its shoulder at this litigation; absent a concrete and immediate injury to a specific hospital, there is no countervailing justification for such interference. (*Dept. of Consumer Affairs*, *supra,* 245 Cal. App. 4th at p. 263 ["interplay between the public interest exception and challenges to administrative proceedings" are reasons to deny standing].)

C. CHA is not acting in the public interest.

OHCA is statutorily required to consider the interests of diverse—and often competing—groups in the healthcare arena including consumers, providers, and insurers. (§ 127502.5(a).) CHA by contrast is "a trade association representing the interests of hospitals in the State of California." (Compl. ¶ 27.) To be blunt, CHA is not interested in carefully balancing countervailing interests of payors and providers—it is out for itself and its members. There is nothing wrong with that advocacy, except when CHA comes into Court suddenly claiming to represent the interests of the public writ large. A plaintiff using public interest standing should represent the public interest and "where the claim of citizen or public interest standing is driven by personal objectives rather than broader public concerns, a court may find the litigant to lack such standing." (*SJJC Aviation*, *supra,* 12 Cal. App. 5th at p. 1057 [quotation marks omitted]; see also *Waste Management of Alameda Cnty v. Cnty of Alameda* (2000) 79 Cal. App. 4th 1223, 1238 [denying public interest standing to a litigant which was "pursuing its own economic and competitive interests," *disapproved of on other grounds in Save the Plastic Bag Coalition v. Cty of Manhattan Beach* (2011) 52 Cal. 4th 155, 167-68].)

To be sure, public interest standing does not require a completely dispassionate plaintiff, but the courts should not allow petitioners to use the courts to advance their own economic interests at the expense of the public. (*Save the Plastic Bag*, *supra*, 52 Cal. 4th at p. 169 [public

interest standing is "improper" where a litigant sought "to impose regulatory burdens on a business competitor, with no demonstrable concern" for the general public].) Nonetheless, that is precisely what CHA seeks to do here—promote its own narrow economic interests in revenue growth at the expense of every other actor in healthcare. Though it is just one player in a complex space filled with tradeoffs, CHA boldly asserts that "it should know what the public should want." (*SJJC Aviation*, *supra,* 12 Cal. App. 5th at p. 1058.) But its very argument—that hospitals are not being afforded enough growth which must necessarily come at the expense of payers and consumers—"confirms that its position is driven by personal objectives rather than broader public concerns." (*Ibid* [quotation marks omitted].) The Court should not grant public interest standing to such a self-interested party.

III. CHA CANNOT SHOW ARBITRARY AND CAPRICIOUS CONDUCT (BOTH COUNTS)

To show OHCA abused its discretion in setting the cost targets, it is not enough for CHA to allege OHCA acted in haste or relied on disputable information or methodologies. Rather, CHA must show that the cost targets are "fraudulent or so palpably unreasonable and arbitrary as to indicate an abuse of discretion as a matter of law." (*Cty and Cnty of San Francisco v. Cooper* (1975) 13 Cal. 3d 898, 920.) CHA must in short show that "upon no conceivable basis under all of the evidence" could OHCA justify its actions. (*Ibid.*) Furthermore, agency actions are afforded special deference as "[c]ourts exercise limited review out of deference to the separation of powers…and to the presumed expertise of the agency within its scope of authority. The court does not weigh the evidence adduced before the administrative agency or substitute its judgment for that of the agency." (*Carrancho v. California Air Resources Board* (2003) 111 Cal. App. 4th 1255, 1265 [citations and quotation marks omitted].)

CHA does not, and cannot, allege facts that come close to meeting this standard. CHA's own complaint, across 291 paragraphs and over 97 pages of allegations, demonstrates that OHCA undertook a lengthy and considered decision-making process. CHA ultimately alleges only dissatisfaction at the outcome of the process, not a plausible allegation that the process was arbitrary and capricious. In fact, the complaint does little more than regurgitate comments and arguments made by CHA's members during the rulemaking process. (e.g., Compl. ¶¶ 197-199

[describing comments and objections submitted by hospitals].) Indeed, CHA tells only its side of the story while omitting the competing considerations, data, and methodologies from non-hospitals which factored into the agency's decision making. (E.g., TonNu Decl., Ex. 5-7; RJN, Ex. C10, C11, C13, C14; Ex. 10-ll; RJN, Ex. C26, C27 [Board had to select from multiple competing measures of affordability, opted for metric which reflected individual consumer perspective; Ex. 12-13; RJN, Ex. C29, C30 [Board considered contribution of hospital costs to overall healthcare affordability].) The results—which came after nearly a year of public debate and multiple public meetings—reflected the Board's consideration of the input and concerns of almost every facet of the healthcare industry and a careful attempt to balance the need to make healthcare more affordable against other considerations. (*e.g.,* TonNu Decl., Ex. 16-17; RJN, Ex. C41-42 [hospitals account for 40% of all healthcare spending in California, justifying creation of a hospital sector].) CHA may not be pleased with the ultimate outcome, but the record only shows that their concerns were simply one set among many stakeholders; CHA cannot show that there was "no conceivable basis" for OHCA to enact the cost targets. (*Cooper*, *supra*, 13 Cal. 3d at p. 920.) Absent such showing, overturning OHCA's cost targets would require the Court to "weigh the evidence" and "substitute its judgment" for what OHCA found. (*Carrancho*, *supra*, 111 Cal. App. 4th at p. 1255.) That is not the proper role of the Court and the complaint must accordingly be dismissed.

CONCLUSION

For the foregoing reasons the Court should sustain the demurrer to the Petition and Complaint. OHCA respectfully requests that this Court:

1. Sustain the Demurrer without leave to amend
2. Award Respondent costs for defending this action; and
3. Grant such further relief as the Court deems appropriate

Dated: December 15, 2025

Respectfully submitted,

ROB BONTA
Attorney General of California
EMILIO VARANINI
Supervising Deputy Attorney General

DAVID HOUSKA
Deputy Attorney General
Attorneys for Defendants
Office of Health Care Affordability

SF2025305973