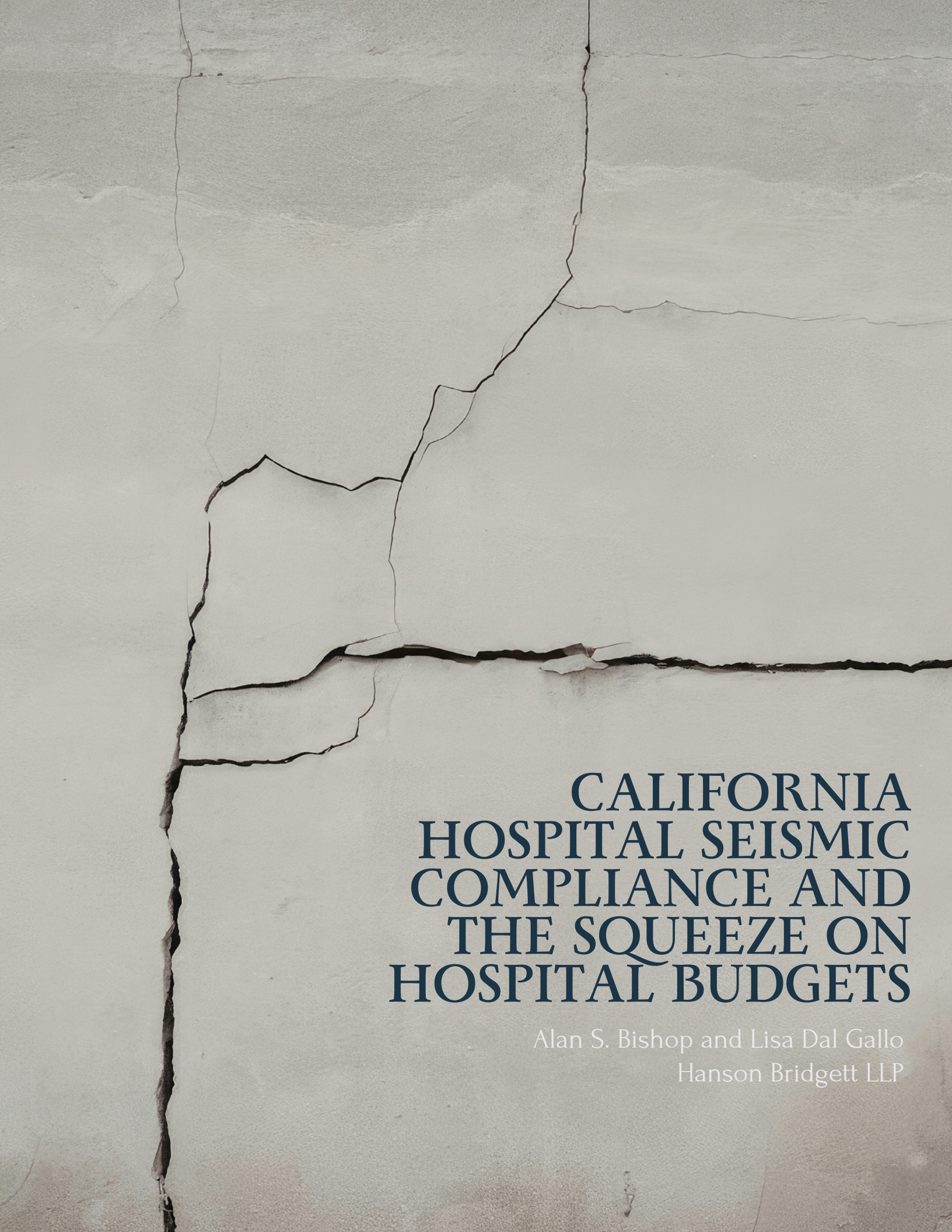

CALIFORNIA HOSPITAL SEISMIC COMPLIANCE AND THE SQUEEZE ON HOSPITAL BUDGETS

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California hospitals face a fast-approaching deadline to meet a goal developed over 50 years ago—that all acute care hospitals be structurally prepared to withstand a major earthquake and have systems allowing independent operations for 72 hours thereafter. After many years of extensions, the deadline to complete retrofits is January 1, 2030. Not all hospitals are on track, and the retrofits are particularly challenging for rural hospitals, especially in light of recent federal legislation regarding Medicare and Medi-Cal reimbursements and increased premiums for Affordable Care Act ("ACA") plans likely to drive disenrollments. Only small, rural, and distressed hospitals, as well as critical access hospitals and health care district hospitals, can seek extensions beyond the January 1, 2030 deadline.

I. The History of Hospital Seismic Legislation in California

California has been wrestling with earthquake-proofing its hospitals for over 50 years. Legislators first took action following the 1971 Sylmar earthquake, which resulted in the tragic collapse of the San Fernando Veterans Administration Hospital, killing 49 people, and the partial collapse of the Olive View County Hospital, which had only been open for 6 weeks and had to be demolished. Legislation passed in 1972 focused on earthquake-proofing new construction, not existing hospitals.[1]

Two decades later, the 1994 Northridge earthquake left multiple hospitals incapacitated and unable to treat survivors, which led to legislation focused more on existing hospitals, with a seismic compliance deadline of 2008.[2] The legislation continued to develop, with standards changed and deadlines extended multiple times.[3] Now, by January 1, 2030, all hospitals are required to satisfy specific structural criteria, called Structural Performance Category ("SPC").[4] Existing hospitals must be retrofitted to at least satisfy SPC-3, meaning that the structures may experience structural damage that does not significantly jeopardize life.[5] Hospitals must also meet non-structural criteria, called Non-Structural Performance Category ("NPC"), including storing 72 hours of clean water and generator fuel, designed to ensure that an undamaged hospital would be reasonably capable of providing services even if surrounding infrastructure fails.[6]

II. The Current Picture: Looming Deadlines and a Cash Crunch for Hospitals

Seismic retrofits are expensive. The 2019 report forecasting the cost of seismic compliance by the Rand Corporation, commissioned by the California Hospital Association, determined that already-completed SPC retrofits had cost $92 million on average per building.[7] California hospitals do not have this kind of money. To put this staggering figure in context, for 17% of hospitals, retrofitting just one building at this cost would exceed their gross revenue for an entire year.[8] And many hospitals are not breaking even. In 2023, the average operating margin for California hospitals subject to these regulations was -0.3%, and 2024 was only slightly better at 1.7%.[9]

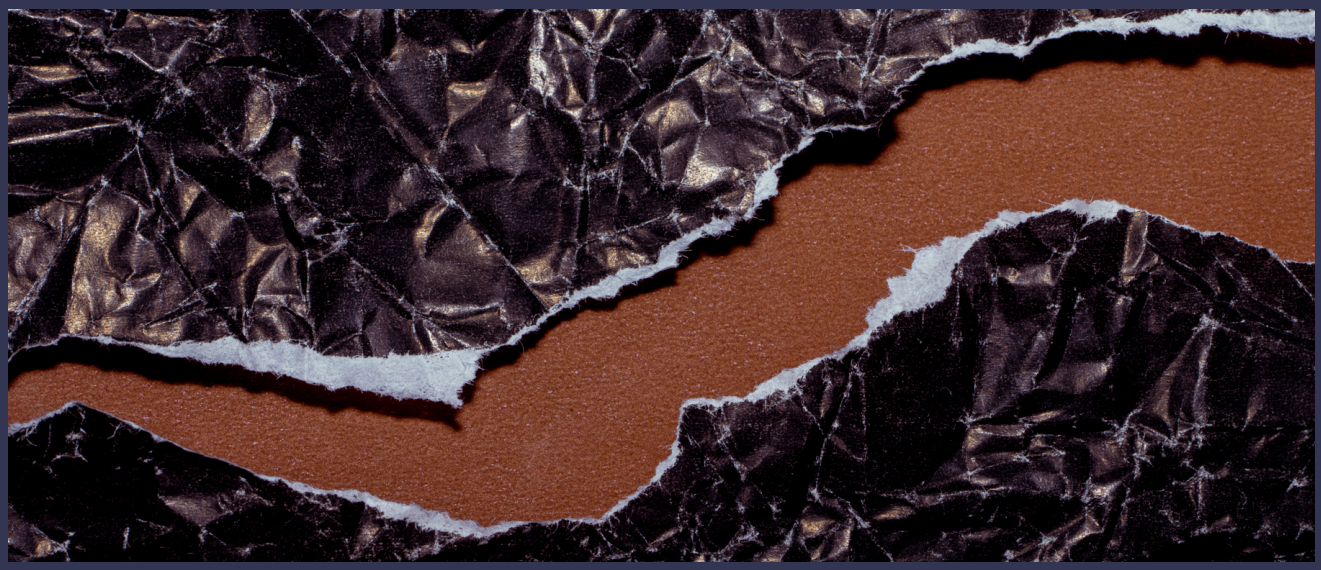
Both operating margins account for receipt of reimbursements from all sources, including Medi-Cal and Medicare.

The California Department of Health Care Access and Information ("HCAI") has not published data for 2025, but hospital operating margins are expected to decrease significantly as the "One Big Beautiful Bill" Act reduces Medicare spending and Medicaid reimbursements without reducing services demand. ACA plan premiums are also projected to rise sharply in 2026 because the Act did not extend the enhanced ACA premium tax credits, increasing the risk that more enrollees will drop coverage and that hospitals will absorb more uncompensated emergency-care costs.[10]

This cash crunch probably explains why many hospitals have lagged on seismic compliance. Current HCAI ratings continue to show hundreds of general acute care hospital buildings in operation that remain SPC-1 or SPC-2.[11] Many hospitals still have at least one SPC-1 or SPC-2 building in use.[12] Looking at both SPC and NPC, most hospitals still have at least one building not yet 2030 compliant.[13]

Many acute care hospitals are in jeopardy of ceasing acute care unless those hospitals receive an extension—an option unavailable to most hospitals under current legislation—or complete retrofits by 2030, because acute care cannot be provided in buildings that do not meet SPC-3 and NPC standards by that deadline. Governor Newsom rejected a global 5-year extension in 2024, explaining that hospitals have known about the deadline for 30 years and that any extensions "should be limited in scope, granted only on a case-by-case basis to hospitals with demonstrated need and a clear path to compliance."[14] Instead, he signed Assembly Bill 869, legislation that created narrow exceptions for recipients of the distressed hospital loan program, small hospitals, rural hospitals, critical access hospitals, and health care district hospitals, subject to additional criteria.

In the run-up to the 2030 deadline, hospitals have been required to meet multiple reporting deadlines detailing their progress toward seismic compliance. All general acute care hospitals not yet 2030 compliant were required to submit a seismic compliance plan and Assembly Bill 1882 ("AB 1882") annual services report by January 1, 2026.



The seismic compliance plan outlines details for how each building will achieve seismic compliance. Hospitals are required to submit updates if the plans change. The annual services report, due on January 1 at the end of each reporting year, requires hospitals to give an update on the SPC and NPC ratings for each general acute care building and the services being provided. On March 1, 2026, hospitals with non-compliant buildings were required to submit NPC construction documents or an explanation of the removal of non-compliant buildings from acute care services. The remaining deadlines are the annual reports for future years, plus a March 1, 2028 deadline for obtaining building permits for NPC work or ceasing acute care services in non-NPC-compliant structures.[15]

January 1, 2026, was also the Assembly Bill 869 deadline for qualifying hospitals to request an up to three-year delay of the 2030 deadline for SPC and NPC seismic compliance. HCAI issued Policy Intent Notice ("PIN") 80 outlining the policy. Requesting hospitals had to explain why the extension is needed, how the facility will achieve seismic compliance by the proposed extended deadline, and financial distress if applicable. HCAI is not rubber-stamping these requests. PIN 80 provides that the Department will review submittals within 120 days and may comment on, approve, or deny a hospital's seismic compliance plan and related delay request, and HCAI's current extension-request report reflects denials as well as approvals.[16] Under Assembly Bill 869, hospitals failing to meet their extended deadlines will be penalized $5,000 per day.

At the 2026 Healthcare Project Delivery Conference in San Diego, Randy Regier, Vice President of Real Estate, Facilities, and Construction at Hoag Hospital, encouraged hospitals to collaborate with their engineers and contractors and HCAI and emphasized that hospitals should spend more time planning to identify retrofit solutions that are lower-cost and that minimize impacts on patient care. But hospitals are running out of time. Even modest projects can take a few years to hire team members, develop initial plans, conduct a material testing and condition assessment program ("MTCAP"), complete designs and permitting, and construct.

III. Possible Approaches to Seismic Retrofits

Because the State appears unlikely to budge on the January 1, 2030, seismic compliance deadline, California hospitals will need to find a way to retrofit their existing buildings one way or another. Project delivery options for these retrofits are design-bid-build, construction management at risk ("CMAR"), design-build, or progressive design-build. While facilities and planning personnel at hospitals will inevitably lead the way on selecting a delivery method and evaluating vendors, in-house attorneys may find themselves reviewing vendor contracts for retrofit work. Having some familiarity with how these delivery methods work is critical for identifying risks and ambiguities in these contracts. Moreover, given the complexity of these arrangements, retaining outside counsel specializing in construction contracts is prudent.

Design-bid-build is the traditional process of an owner—in this case, a hospital—preparing a design and then requesting contractor bids for a firm price. Design-bid-build is not optimal for hospitals due to the complexity of a hospital project because the design is prepared in a silo without feedback from the contractor and key subcontractors regarding pricing, schedule, options, or constructability, which leads to projects coming in over budget and delayed due to redesign, which also leads to increased cost in labor and materials.

CMAR is slightly better than design-bid-build because it usually involves the general contractor in preconstruction services somewhere between schematic design and design development documents, but often a guaranteed price is not set until construction documents are issued for permit, so the general contractor is not bound by its earlier preconstruction pricing and owners may end up in the same place or only slightly better off than under a design-bid-build delivery method. As an alternative, traditional design-build places both design and construction responsibility on the owner's selected contractor and typically sets the price at procurement. Progressive design-build is a variation of traditional design-build where the final price is deferred until issuance of construction documents, which is also problematic. Private hospitals may use these delivery models by contract, but public district hospitals and private hospitals do not operate under identical procurement statutes, so counsel should confirm statutory authority for the selected delivery model in each case.[17]

Design-build can be an excellent delivery model for retrofits, or for hospitals and health care projects in general, because it creates a single point of contact, the design-builder, to manage design, permitting, and construction deadlines. Design-build with an upfront guaranteed maximum price ("GMP") is more advantageous for these projects than design-bid-build or progressive design-build because the design-builder has skin in the game to deliver the project within the GMP, giving the owner more cost certainty. Having cost certainty upfront allows for the design to be influenced by the construction budget through validation and Target Value Design, which involves design iteration with extensive contractor involvement to meet project goals within a fixed budget. If the cost of design is too high, the owner and the design-build team can pivot to alternatives while the design is still flexible and without the owner having already paid for a design it cannot afford to construct. Also, having a firm price is frequently necessary for obtaining grants or financing, including USDA Rural Development loans that rural hospitals may be eligible for. This type of design-build delivery model should be commenced with clear design criteria but still allows the client to work with the architect and contractor on design choices that fit within the GMP. The design-builder's team will work with the end-users and seek feedback with block diagramming for a functional project and regarding aesthetics, and also consider alternative equipment, structure, framing, footprint size, etc. to get the design into the owner's budget. Modoc Medical Center's project to replace its outdated hospital building from 1949 is a great example of this method of delivery. Modoc is a small rural hospital located in northeastern California. Modoc required an upfront GMP based on criteria documents, and the project was

completed on time and on budget, and received DBIA's 2021 National Award of Merit in Healthcare Facilities and ENR California's 2021 Best Health Care Project – Northern California.[18]

Progressive design-build has recently gained traction as another popular design-build method. Although progressive design-build allows the client to directly contract with the design-builder under a single contract, which allows early involvement of key consultants and trades, often the GMP is not set until the drawings are almost complete and so this delivery method is often no better than CMAR. Even when a budget or target cost is provided at the start, the owner's budget is unfortunately frequently disregarded, and the design-build team defaults into a more traditional mode of operation—designers design in a silo, and the design-builder does not procure the key trades early enough to meaningfully participate in preconstruction services during the design process. The result? The owner can still be stuck paying for a design that is too expensive to construct. Despite having hired the design and construction team together so they could collaborate, this disconnect sometimes occurs anyway because the design-builder has not committed to pricing at the time of proposal, and therefore does not have "skin in the game" and may not necessarily engage in meaningful Target Value Design throughout the design process to ensure that the design is progressing within budget and may not provide robust constructability review, rapid construction estimating, best-value recommendations, etc., often leaving the client with hard choices. As the design progresses, it becomes more inflexible and so if the project comes in over budget, it is difficult, if not almost impossible, to get it back down to cost. At this point the owner is already up the flagpole with the design-build team and essentially has four choices: 1. Increase the budget (which they may not be able to afford and may make the project infeasible); 2. Scrap the design and start over (increased cost and delays); 3. Engage in value engineering (downgrade finishes, remove certain scope, etc., which helps but often you still cannot get down to the budgeted number, and sometimes can cause construction defect claims); or 4. Terminate the design-builder and put the drawings out for hard bid under design-bid-build (but it is likely that this is only delaying the process and that the price will not be substantially different and in some cases comes in even higher).

Notwithstanding the challenges progressive design-build can pose, this approach may be an appropriate model for seismic compliance work because progressive design-build can be very responsive to the unknowns faced in seismic upgrades. To reduce uncertainty when utilizing the progressive design-build model, the design-build team should be required to lock in certain pricing upfront, such as billing rates, design fees, general conditions, general requirements, as well as contingency, bond, insurance, and fee percentages. The contract must also include a validation stage that occurs early during the design process so that a GMP is locked at the end of validation, which should occur at the end of schematic design or no later than 50% design development documents. These are only a few of the key terms that should be included, which are generally not available using standard form agreements. To avoid pitfalls, owners should consider retaining good legal counsel who understand project delivery early in the process to assist with selection of the appropriate delivery model for the project, preparation of good procurement documents, and terms and conditions for the contract depending on the circumstances.

Even with the best planning and cost control, these projects are still expensive. The State has allocated some money to help small hospitals achieve seismic compliance. The Small and Rural Hospital Relief Program offers grants and technical assistance to qualifying hospitals. The grants are for small, rural, and critical access hospitals. HCAI currently reports $55 million in grant funds available, three applications totaling more than $2.4 million under review, and grant awards totaling $5.5 million.[19]

HCAI is awarding the money incrementally on the basis of steps like initial structural evaluations, initial materials testing and condition assessment, retrofit designs, and construction costs. Amounts are paid as reimbursements after costs are incurred. Earthquake preparedness is an important goal for California health care. Unfortunately, it is also an expensive goal, and the costs are mostly being imposed on the health care industry and, ultimately, on patients. With less than four years remaining until the 2030 deadline, the current rate of compliance and the economic struggle of hospitals is not reassuring. Despite the deadlines and economics, hospitals are completing retrofits, and HCAI has been expanding its outreach to remind hospitals of the deadlines and better promote the grant funding and technical support available for small hospitals. Certainly, legislators, regulators, health care providers, and the public share the same goal of ensuring that hospitals remain safe and operational; for hospitals, however, finding the money to meet the state's seismic standards by the 2030 deadline will be no easy task.

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[13] SPC/NPC Ratings of Acute Care Hospital Buildings as of Apr. 16, 2026, HCAI, https://hcai.ca.gov/document/spc-npc-ratings-list/.

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