

December 19, 2013

Hon. Kamala D. Harris
Attorney General
1300 I Street, 17th Floor
Sacramento, California 95814

Attention: Ms. Ashley Johansson
Initiative Coordinator

Dear Attorney General Harris:

Pursuant to Elections Code Section 9005, we have reviewed the proposed statutory initiative (A.G. File No. 13-0041) that would place an upper limit on gross charges for patient care services or items set by certain private hospitals.

BACKGROUND

California Hospitals

A general acute care hospital (hereafter referred to as “hospital”) must be licensed by the state Department of Public Health (DPH) to operate in California. According to the Office of Statewide Health Planning and Development (OSHPD), there were 460 hospitals operating in California in 2013. These hospitals fall under two broad categories:

- **Public Hospitals.** These are 67 hospitals operated by counties, the University of California, health care districts, cities, or other political subdivisions of the state.
- **Private Hospitals.** These are 393 hospitals owned and operated by nonprofit or for-profit entities.

Payers of Hospital Services

Hospitals receive payments for their services from patients and third-party payers. Third-party payers pay hospitals (the second party) for services delivered to patients (the first party). Third-party payers generally fall under two broad categories: public payers and private payers. Below, we describe the third-party payers that account for the greatest volume of patients treated and amount of revenues received by private hospitals.

Public Third-Party Payers. Public third-party payers consist of federal, state, and local government programs that provide health care benefits to certain eligible populations. The two largest public payers for hospital services in terms of patient volume and spending are:

- **Medicare.** This is the federally funded program that provides coverage to most individuals 65 and older and certain younger persons with disabilities.
- **Medi-Cal.** In California, the federal-state Medicaid Program is known as Medi-Cal. This program currently provides health care benefits to about eight million low-income persons who meet certain eligibility requirements for enrollment in the program. The costs of the Medicaid Program are generally shared between states and the federal government, and the federal government's contribution toward reimbursement for Medicaid expenditures is known as federal financial participation (FFP). In general, the percentage of Medi-Cal costs paid by the federal government is set at 50 percent. (This percentage will increase for the Medi-Cal expansion population under federal health care reform.) Later we describe Medi-Cal payments for hospital services in greater detail.

Medi-Cal and Medicare provide health care through two main systems: fee-for-service (FFS) and managed care. In the FFS system, a health care provider receives an individual payment for each medical service delivered to a beneficiary. (In a hospital setting, an individual "service" may consist of an inpatient day, an entire hospital stay, or specific procedures and items.) In the managed care system, the public payer generally contracts with managed care plans to provide health care for beneficiaries enrolled in these plans. Managed care enrollees may obtain services from providers—including hospitals—that accept payments from the plans. The plans are paid a predetermined amount per enrollee, per month (known as a capitation payment) regardless of the number of services each enrollee actually receives.

Private Third-Party Payers. Private third-party payers mainly consist of employers and commercial health insurance companies that provide coverage to members of employer groups, organizations, or individuals who purchase health insurance. In many cases, commercial health insurance companies receive a payment known as a premium—from employers on behalf of their employees, or from individuals or other sources—in exchange for coverage of an agreed-upon set of health care services. In other cases, large employers may self-fund their health plans instead of paying premiums to health insurance companies, thereby assuming direct financial risk for the cost of covered health care services. Employers that provide self-funded plans to their employees usually contract with health insurance companies to administer their plan benefits on a day-to-day basis. Government agencies provide employer-sponsored health insurance—a form of private-payer coverage—for their employees, retirees, and their family members. Because these benefits are generally provided and/or administered by commercial health insurance companies as typical employer-sponsored insurance plans, payments from plans that cover public employees—including payments to hospitals—are broadly similar (in both amount and structure) to payments from plans that cover private sector employees.

Private Third-Party Payers May Cross-Subsidize Public Third-Party Payers. As described later, different payers use a variety of payment methods and often pay different amounts for the same hospital service. Payments from public payers are often below hospitals' average costs for providing services, while payments from private payers are often above average costs. (Average costs are costs that can be directly linked to each item and service provided by hospitals, such as labor and supplies used to treat a patient, plus some portion of fixed overhead costs spread

among all services, such as utilities and administration.) Payments received from private payers that are above hospitals' average costs for providing services may help the hospital offset costs related to uncompensated care and public payments that are below hospitals' average costs. In this manner, private payments may cross-subsidize some unprofitable services that are more heavily used by patients who are uninsured or covered by public programs. Thus, a hospital's payer mix is important for the hospital's financial position and mix of services provided.

Chargemaster Lists “Gross Charges” for Services and Items

A chargemaster is a file system used and maintained by each hospital to inventory and record services and items provided to patients. Specifically, the chargemaster includes an entry for every individual service and item that is provided at the hospital and recognized by payers for the purposes of billing and payment determination. (Billing refers to the process of submitting claims, invoices, and other required documents to third-party payers and patients to obtain payment for services rendered.) Examples of services that appear on a chargemaster are laboratory tests and x-rays, and examples of items that appear on a chargemaster are medications and medical instruments.

Chargemasters typically contain thousands of entries corresponding to services and items. The size and format of chargemasters, and the services and items included in them, may differ from hospital to hospital. Despite this variation, every hospital's chargemaster contains two data elements associated with each item or service as follows:

- **Codes.** The first data element is a set of codes that describe the type of service or item provided. These codes are based on classification systems that are externally developed and standardized across the medical profession and health insurance industry.
- **Gross Charges.** The second data element is the gross charge, which is the list price for a service or item. Gross charges are internally set by the hospitals and generally can be increased or decreased at a hospital's discretion. The federal government requires hospitals to apply the same uniform schedule of gross charges when billing for care provided to all patients, regardless of the expected source or amount of payment.

Role of Chargemaster in Hospital Billing of Third-Party Payers. State law requires every hospital to make a copy of its chargemaster available to the public and submit it to OSHPD. The chargemaster is linked to the hospital's billing system and is used to generate claims to third-party payers. By reviewing a claim's listing of codes for each service or item provided to a patient—which is derived from the chargemaster—the payer ascertains whether these billed services and items were medically necessary, properly documented, and covered under the patient's health benefits. Based on this information and the payer's specific arrangement with the hospital, the payer determines whether to remit payment for all or part of the claim. Thus, through its coding content, the chargemaster supports the hospital's compliance with laws, regulations, and payer specifications related to billing and documentation. In contrast, as discussed immediately below, the claim's listing of accrued gross charges for each service or

item provided to the patient—also derived from the chargemaster—is *frequently irrelevant* for determining the actual amount of payment due under third-party payer arrangements.

Gross Charges Seldom Systematically Reflect Hospitals’ Costs. Each hospital has its own policy for setting gross charges, and currently there are no state or federal restrictions on how high gross charges may be set individually or in aggregate. Recently, gross charges have been observed to (1) vary greatly across different hospitals for the same services and items, (2) imply markups that are many times above the operating expenses incurred by hospitals, and (3) demonstrate a wide range of markups for different services and items within the same hospital. While there are no definitive explanations for hospitals’ varying markup policies across gross charges, in some cases they may reflect certain hospital-specific pricing strategies discussed later in this analysis.

Most Hospital Payments Are Not Directly Based on Gross Charges

Hospitals’ gross charges have been likened to automobile “sticker prices” or hotel “rack rates” due to some perceived similarities in that the list prices are significantly higher than the payment sellers expect to ultimately receive from most buyers. However, these analogies imply that consumers or their agents eventually negotiate and pay some percentage discount that is based off of the original list prices. In contrast, most third-party payments for hospital services have increasingly moved away from using gross charges as a basis for setting payments, as discussed in detail below. (Gross charges, however, may form the basis for some payments to hospitals from uninsured patients, as well as have an indirect effect on payments negotiated between private payers and hospitals, as discussed later.)

Public Payers Set FFS Hospitals’ Payments Without Reference to Gross Charges. Private hospital payment mechanisms under the FFS systems for Medicare and Medi-Cal are complex. The amount and structure of these payments are governed by federal and state laws and regulations and administered by government agencies. Generally, the following characteristics apply: (1) the payments are usually not based on hospitals’ gross charges, and (2) any hospital that elects to participate in the government program must accept the predetermined FFS amount as payment in full. That is, the hospital may not seek additional reimbursement from the patient or other payers.

Public and Private Managed Care Payments to Hospitals Similar in Structure. Hospital payments from managed care plans that contract with public payers are broadly similar in structure—though not necessarily in amount—to hospital payments from private payers, which are described in detail below.

Private Payers Recruit and Contract With Hospitals in Their Networks. . . . Health insurance companies that provide and/or administer health benefits for large employers (including state and local governments) must demonstrate adequate coverage of health care services within a defined geographical region to meet both state regulatory requirements and market demand from their customers and members. Thus, these private payers build and maintain networks of contracted providers, including hospitals, to furnish services for their members.

Private payers often: (1) refer their members to contracted providers within their networks for obtaining services, and (2) do not cover out-of-network services delivered by noncontracted

providers, other than emergency services. As a result, it is often in a hospital's interest to be included in a large payer's network. This may help ensure that the hospital does not lose business to competitors who are already in the network. In addition, the hospital is more likely to receive direct and timely payments from a private payer through participation in the payer's network.

... And Negotiate Fixed Payments That Are Not Based on Gross Charges. The terms and conditions for a hospital's participation in a private payer's network—including coverage of medically necessary services, billing requirements, and methods used to calculate payments for covered services—are generally governed by multiyear contracts negotiated between the payer and the hospital, also known as participating provider agreements. When structuring participating provider agreements, private payers intentionally and often successfully use their purchasing clout to avoid contract payments to hospitals that are based on gross charges (such as discounted charges). This is because under current law, payers have little if any control over how much or how often a hospital will increase its gross charges. Instead of payments based on gross charges for each service or item, most contracts establish payment methodologies that involve predetermined amounts (known as flat or fixed payments) paid to hospitals for treating the payer's members, regardless of the costs incurred or gross charges accrued by the hospital during treatment. Common methods of fixed payments to contracted hospitals include:

- *Per Diem.* A fixed daily payment that varies neither with the level of services received by the patient, nor the gross charges accrued during the patient's stay or visit.
- *Case Rate.* A fixed payment based on diagnosis or procedure, regardless of the length of stay or gross charges accrued.
- *Capitation.* A fixed payment per patient, per month regardless of the level of services used or gross charges accrued by the patient.

Fixed Payments Vary by Hospital and Payer. Rather than deriving from gross charges, fixed payment amounts are usually a function of each party's relative ability to obtain favorable payment terms through the negotiating process. For example, a payer that provides coverage for many employers and members in a region may be able to negotiate lower fixed payments in exchange for referring an expected volume of patients to the hospital. Because individual hospitals and private payers often manage a multitude of contracts, there may be many instances in which a payer pays—and a hospital receives—many different payment amounts for the treatment of comparable patients.

Contract Payments—Not Gross Charges—Are Usually Considered Payment in Full. By accepting the terms of the contract with the payer, the hospital generally agrees to recognize the fixed payment amount, rather than gross charges, as payment in full. (Under most contracts, there are limited exceptions to this rule that we describe shortly.) In practice, although the hospital initially posts accrued gross charges to a patient's account as part of the billing process, the hospital subsequently reduces the account through a "contractual adjustment" so that the resulting "allowed" or "approved" amount—that is, the fixed payment according to the contract—is recognized as payment in full. Thus, while two patients in the same hospital that receive the exact same services and items will accrue the same gross charges, their final

payments due (1) may differ widely if they are covered by different payers who have negotiated different contracts with the hospital, and (2) typically bear no direct relationship to the gross charges originally posted to the accounts.

Contracts Often Include Lesser-Of Provisions That Reference Gross Charges. Within participating provider agreements that are structured around per-diem or case-rate payments, it is standard industry practice to include certain provisions (hereafter referred to as *lesser-of* provisions) formally stipulating that payers will remit, and hospitals will accept, the lesser of negotiated fixed payments and accrued gross charges as payment in full. Although such provisions are commonplace, under current law they have little if any practical effect on (1) the development of fixed payment amounts through contract negotiations and (2) actual payments on claims within each contract period. This is because at the negotiation stage, individual gross charges are generally recognized by both parties to be highly inflated, while accrued gross charges on submitted claims usually exceed the applicable fixed payment amount under the contract.

Gross Charges May Directly Apply to Payments Within Limited Contract Situations. . . While the majority of contract payments from private payers to hospitals are fixed without reference to gross charges (as outlined above), gross charges may form the basis of other payments under certain situations outlined by the contract. For example, some outpatient services may be paid according to discounted gross charges. Also, if a hospital's costs for treating a particular patient substantially exceed a predefined threshold, its contracts may allow for incremental payments above the threshold based on gross charges. To limit their exposure to gross charges, payers often seek to limit or eliminate such "outlier payments" in their contracts, and may demand "hold harmless" provisions stating that if a hospital increases its gross charges, the payer will not pay more in aggregate than it otherwise would have.

. . . And May Have Indirect Effect on Contract Negotiations. When a patient receives care from a hospital outside of his or her plan provider network, the noncontracted hospital bills the accrued gross charges to the payer. Without the benefit of a predetermined fixed payment, the payer typically engages in ad hoc negotiations with the noncontracted hospital, which usually end with agreement on some percentage discount off of the gross charges. Thus, some hospitals may perceive advantages to setting gross charges with higher markups for services and items that are more likely to be used out-of-network, such as those provided in the emergency department. Furthermore, in certain instances, high markups on gross charges may indirectly strengthen a hospital's bargaining position and ability to command higher fixed payments as a contracted provider.

State and Local Governments Pay for a Substantial Amount of Hospital Services

Medi-Cal Hospital Payments. Nearly all private hospitals in California currently receive at least one of three types of payments Medi-Cal makes to pay for services for patients:

- ***Direct Payments.*** Direct payments are payments for services provided to Medi-Cal patients through FFS. The state currently spends nearly \$2 billion in General Fund monies annually on direct payments to private hospitals.

- **Managed Care Payments.** Managed care payments are payments from Medi-Cal managed care plans to hospitals for services provided to Medi-Cal patients enrolled in these plans. In recent years, plans used roughly \$1.5 billion in General Fund support to reimburse private hospitals for services provided to Medi-Cal patients.
- **Supplemental Payments.** Supplemental payments are made in addition to direct payments. The state generally makes these payments to hospitals periodically on a lump-sum basis, rather than individual increases to reimbursement rates for specific services. (Supplemental payments are generally used to provide additional revenues to certain hospitals to help subsidize the cost of uncompensated care and partially backfill Medi-Cal direct and managed care payments that are below hospitals' cost.) Private hospitals receive about \$400 million in General Fund support from these supplemental payments.

Health Benefits for State and Local Government Employees and Retirees. The state, California's two public university systems, and many local governments in California pay for a large portion of health costs, including hospital services, for their employees and related family members and for some of their retired workers. For example, the California Public Employees' Retirement System currently offers 11 health plan options (including three self-funded plans) to public workers and retirees, at a cost of about \$3 billion annually to the state. Together, state and local governments pay roughly \$20 billion annually for employee and retiree health benefits. As mentioned earlier, employee and retiree health benefits are typically provided and/or administered by commercial health insurance companies.

Hospital Quality Assurance Fee

Federal Medicaid law permits states to (1) levy various taxes, fees, or assessments on health care providers and (2) use the proceeds to draw down FFP to support their Medicaid programs and/or offset some state costs. Current state law imposes a fee known as a quality assurance fee on certain private hospitals beginning January 1, 2014. The legislation authorizing the fee becomes inoperative on January 1, 2017. Most of the revenues collected through the fee will provide the nonfederal share of (1) certain increases to capitation payments that Medi-Cal managed care plans are required to pass along entirely to private and public hospitals and (2) certain supplemental payments to private hospitals. Both types of payments receive FFP, so the fee revenues will be used to draw down federal funds.

State Receives Portion of Net Benefit From Fee. A certain portion of the fee revenue will offset General Fund costs for providing children's health care coverage, thereby achieving General Fund savings. Specifically, the annual amount of moneys used to offset General Fund costs for children's health care coverage will equal 24 percent of the "net benefit" to hospitals from the assessment of the fee, hereafter referred to as net benefit. Net benefit is defined as total fee revenue collected from hospitals in each fiscal year, minus the sum of the following fee-funded payments:

- Fee-funded supplemental payments and direct grants.
- Fee-related capitation increases for hospital payments.

PROPOSAL

This measure places an upper limit on certain private hospitals' gross charges for patient care services or items, requires these hospitals to file reports with state agencies, and imposes penalties for failure to comply with the measure's provisions. This measure goes into effect on July 1, 2015. Private children's hospitals are exempted from the application of this measure. Therefore, we find that the measure would apply currently to about 385 private hospitals.

Measure Limits Gross Charges Set by Certain Private Hospitals

Limit on Gross Charges Based on Hospitals' "Actual Costs." The measure generally limits a private hospital's gross charges to individual persons and third-party payers, such as insurers, to 125 percent of the hospital's good faith reasonable estimate of its actual costs for a service or item. The measure requires private hospitals' estimates of actual costs to be consistent with what is an allowable and reportable cost under federal regulations. The measure provides that the 125 percent limit on gross charges may be adjusted upward according to the hospital-specific factors discussed below.

Limit on Gross Charges May Be Adjusted Upwards Based on Various Factors. There are two ways the measure allows private hospitals to have the limit on gross charges that would otherwise generally apply to them under the measure adjusted upwards.

- A private hospital may have the limit adjusted upward—up to 225 percent of costs—by applying a formula that accounts for various fiscal factors, including whether the hospital incurred net losses in its provision of care for patients who are uninsured or covered under certain government programs.
- A private hospital may have the limit on gross charges that applies to it adjusted upward if it can prove in court that the limit would prevent the hospital from realizing a reasonable return on its investments.

Private Hospitals Must Revise Chargemasters. Hospitals subject to the measure must set and maintain their gross charges for services and items on their chargemaster, subject to the measure's limits. Under the measure, hospitals may only list gross charges that comply with this limit on their chargemasters. A hospital must attest on all billing statements that it has not charged any patients or payers above this limit.

Limit on Total Gross Charges and Refund Requirement. If a hospital's total gross charges to all payers (as limited by the measure) for any year exceed its total patient care expenses incurred that year (again defined as reasonable and allowable costs under federal regulations), then the hospital must refund each payer an amount equal to the actual revenues received by the hospital from that payer for patient care services, minus the capped gross charges for those services.

Reporting Requirements. The initiative requires a hospital to submit an annual report containing the revenues and costs used to determine its charge limit for the year. The DPH is responsible for collecting these reports and making them available to the public upon request. The DPH may assess fees on hospitals to cover the total costs of processing the reports.

Enforcement by State Departments and Penalties for Noncompliance

The Attorney General (AG) or DPH may bring any action available under the law against a private hospital for violating the requirements of this measure. These actions can be brought directly by the AG or by the AG on behalf of DPH. The DPH may assess penalties against hospitals for billing statement violations (failing to properly attest to the charge limit on a billing statement) and reporting requirement violations. Compliance with the measure is a condition for a hospital's licensure. A hospital that loses its license must cease operations.

FISCAL EFFECTS

This measure could have two major fiscal effects on state and local governments. The first effect would result in state and local government savings—although these savings would be offset in part by a variety of other factors—while the second effect would result in state and local government costs. We provide a wide range for the savings associated with the first effect, which are subject to substantial uncertainty. The costs associated with the second effect are subject to even greater uncertainty. Therefore, we are unable to predict whether the combined effects of the measure would result in net savings or costs for state and local governments.

No Immediate Impact on Medi-Cal Direct FFS and Managed Care Payments

Under Medi-Cal, both direct FFS payments to private hospitals and managed care payments funded by the General Fund are typically below hospitals' costs. Therefore, it is unlikely that the measure would create any immediate requirements for the state to alter the amount or structure of these payments. However, as discussed later, the measure could significantly impact the supplemental payments and increased managed care payments available under the hospital quality assurance fee.

Savings to Governments Related to Public Employer-Sponsored Health Insurance, Offset in Part by Various Factors

Measure Would Cap Hospitals' Gross Charges Below Current Payments Received From Private Payers. . . We estimate that on average, hospitals currently receive net patient care revenue from private payers that is higher than the total amount of gross charges they would be allowed to bill these payers under the measure. The measure formally regulates only gross charges set—and not actual payments received—by hospitals. Nonetheless, the practical effect of the measure's limit on gross charges would be to reduce private payments to hospitals, through the mechanisms described immediately below.

. . . Making Gross Charges Relevant and Favorable to Private Payers. . . As mentioned earlier, it is standard industry practice to include provisions in participating provider agreements that stipulate that payers will remit, and hospitals will accept, the lesser of the negotiated fixed payments and accrued gross charges as payment in full. As long as such provisions remain intact, the measure would likely alter the contracting environment to strengthen the bargaining position of private payers relative to hospitals. This is because in many cases, accrued gross charges would switch from being higher than current contract payments to lower than such payments.

Specifically, in accordance with these *lesser-of* provisions, hospitals would be limited to receiving payments at or below capped gross charges. Moreover, the cap on gross charges would generally weaken the bargaining position and ability of certain hospitals—such as those located in less competitive markets—to command contract payment levels with relatively high markups. Due to (1) the newfound relevance of *lesser-of* contract provisions, and (2) the overall shift in leverage to private payers in contract negotiations, these payers would likely reduce their spending on hospital services in the following ways:

- In the short term, payers would scrutinize submitted claims and frequently pay capped gross charges, rather than higher fixed payment amounts, under the terms of their current contracts.
- In future contract negotiations, payers would likely use expected gross charges as a reference point for deriving lower fixed payment amounts to hospitals.

... And Reducing Spending on Hospital Services Used by Public Employees. In an effort to obtain a range of reductions in spending on hospital services that could result from the above effect, we examined hospital annual financial data reported to and published by OSHPD in 2012. Our analysis of this data suggests that had the measure been in effect in 2012, total permissible gross charges (under the measure's definition) for hospital services provided to privately insured patients would have been roughly 10 percent to 15 percent below the actual amount of payments that hospitals received for these services. Assuming that spending on hospital services currently constitutes about 30 percent of the total cost of public employer-sponsored health insurance, a 10 percent to 15 percent decrease would translate into roughly \$600 million to \$900 million in reduced spending on hospital services for public employees in the state—between around \$100 million to \$150 million less spending on hospital services for state employees and retirees, and between around \$500 million to \$750 million less spending on hospital services for local government employees and retirees.

Actual Amount of Net Savings to Government Employers Highly Uncertain. Although the above figures serve as a rough reference point for obtaining a range of annual savings to state and local governments related to public employer-sponsored health insurance, they are subject to considerable uncertainty and potential offsets. First, actual savings in future years would depend on the base level of hospital spending that would have occurred absent the measure in those years. These base spending levels could be significantly higher or lower than the level of spending observed in the 2012 data. Second, these figures incorporate neither individual responses to the measure from insurers and hospitals that could serve to offset government savings nor potential General Fund pressures to increase Medi-Cal hospital payments as a result of the measure. These factors would generally offset total government savings related to employer-sponsored insurance by an unknown degree.

Some Portion of Savings Would Likely Be Retained by Insurance Companies. Health insurance companies that contract with government employers to provide and/or administer health benefits would likely retain some portion of savings from reduced hospital spending as profits or net income, although a greater portion of savings to self-funded plans would accrue directly to employers. The relative apportionment of savings between government employers and insurers would depend on employers' ability to exert competitive pressure on insurers—for

example, by only offering benefits from plans that pass along some savings through lower premiums. The extent to which this would occur is unknown.

Behavioral Responses by Hospitals Could Reduce Amount of Government Savings. Many hospitals could experience a loss in revenues and net income in meeting the requirements of this measure, with the possibility that some hospitals could switch from having positive operating margins to having operating losses. Impacted hospitals could employ a variety of contracting and operational strategies to mitigate such reductions in their operating margins and, if applicable, to maintain their financial viability. Some of the strategies that hospitals could employ—and which would reduce the overall amount of government savings through public employer-sponsored insurance—include:

- ***Pursue Court Actions to Increase Permissible Gross Charges.*** As described earlier, the measure allows the limit on a hospital's gross charges to be adjusted upward if the hospital is able to prove in court that its default limit under the measure would prevent the hospital from realizing a reasonable return on its investments. It is possible that some hospitals—such as those threatened by financial hardship or closure under the measure—could successfully pursue such court actions to raise their permissible gross charge limits from what they otherwise would be under the measure. To the extent that these hospitals are able to legally maintain their gross charges at or above their current contract payment levels, they would continue to receive their current payments without the measure operating to reduce them.
- ***Renegotiate Contracts to Remove Lesser-Of Provisions.*** During new or renewed contract negotiations with private payers, some hospitals may request to delete *lesser-of* provisions from their participating provider agreements. Under such contract revisions, fixed payments would no longer be constrained by capped gross charges (that is, payers would agree to pay hospitals the entire contract amount for each patient treated, even if that amount exceeded the accrued gross charges). The ability of individual hospitals to obtain such concessions from their contracted payers is highly uncertain. For example, most private payers may be initially unwilling or reluctant to give up the negotiating leverage afforded by *lesser-of* provisions. However, as described earlier, payers need to build and maintain provider networks with adequate coverage. Therefore, it is possible that certain hospitals could successfully convince payers that without receiving contract payments that are above permissible gross charges, these hospitals would lose the ability to remain open or provide necessary services—in turn jeopardizing the payers' ability to meet requirements for adequate coverage in their networks.
- ***Increase Volume and Intensity of Services Provided.*** The measure could introduce incentives for some hospitals to increase their average costs for treating patients covered by private payers. Some studies have suggested that hospitals may vary the amount and type of services provided to patients with similar clinical profiles, depending on the expected source of payment. Under current law, gross charges rarely affect actual payment amounts under participating provider agreements, thus providing incentives for hospitals to minimize their costs per treated patient and

maximize their net income from receiving fixed contract payments above these costs. In contrast, under the measure, a hospital would maximize revenue—and in some cases, net income—from treating a privately insured patient by providing services up to the point where accrued gross charges equaled the highest allowed contract payment. To the extent such behavior occurs, hospitals' operating expenses could grow at a faster annual rate than they would have grown at absent the measure. Any higher costs would likely be passed along to state and local governments through increased premiums for public employer-sponsored health insurance.

- ***Move to Capitation Payments That Disregard Gross Charges.*** Under agreements structured around per-diem and case-rate payments, hospitals only earn revenues when they actively provide services (for example, when they admit patients for inpatient care or treat patients who visit their outpatient departments). In contrast, under capitation-based contracts, hospitals are paid a fixed payment per patient, per month regardless of whether these patients actually utilize any hospital services. Thus, unlike contracts based on per-diem or case-rate payments, capitation-based contracts generally do not reference *lesser-of* provisions (otherwise, the hospital would be unable to receive capitation payments for patients who do not use any services and do not accrue any gross charges in a given month). In response to the measure, some hospitals that are currently paid based on per-diem or case-rate methods may attempt to restructure their contracts and operations to instead be paid through capitation, in an effort to maintain some of their revenue and income that would otherwise be reduced under *lesser-of* provisions. The ability to shift to capitation would vary from hospital to hospital, and would generally depend on: (1) payers' willingness to enter into these capitation-based contracts, (2) the hospital's ability to bear a greater level of financial risk for an entire patient population (not just per treated case), and (3) the hospital's ability to form partnerships with and/or acquire physician groups and other nonhospital providers, which may be both legally and practically necessary to implement payer arrangements based on capitation.

General Fund Pressure to Increase Medi-Cal Hospital Payments Could Reduce Savings. Hospitals must eventually earn revenues above their total operating expenses to maintain their operations, access capital markets, and build sufficient reserves. It is possible that the measure could reduce the ability of some hospitals to remain financially viable, and/or use private payments to cross-subsidize unprofitable services that are used more heavily by Medi-Cal patients. This could create greater pressures for additional General Fund spending to maintain Medi-Cal beneficiaries' access to such services—and to private safety-net hospitals in general—than would otherwise occur. For example, a 5 percent increase in General Fund support in Medi-Cal hospital payments would translate into roughly \$150 million in increased state expenditures. The extent to which the measure would create pressures to increase General Fund spending on Medi-Cal hospital payments is highly uncertain, depending on a number of factors such as the future availability of various sources of funding for hospital services (including federal funding).

Summary of Range of Savings—and Potential, Uncertain Offsets—Related to Public Employer-Sponsored Health Insurance. After taking into account all of the factors outlined

above, we estimate that by reducing plan payments to hospitals for services used by public employees, the measure could save (1) between tens of millions of dollars to the low hundreds of millions of dollars annually for the state, and (2) in the hundreds of millions of dollars annually for local governments. However, these potential savings would be offset to an unknown degree by various responses by insurers and hospitals, as well as possible pressures to increase General Fund spending on Medi-Cal hospital services.

Loss of Fiscal Benefits Related to Quality Assurance Fee

State and local government net savings through public employer-sponsored health insurance, as outlined above, could be partially or fully offset within the first few years of the measure taking effect, due to the possible need to downsize the hospital quality assurance fee program—and with it, the state’s and public hospitals’ share of the net benefit—to meet certain federal Medicaid payment requirements. These requirements are complex and the magnitude of their fiscal implications is highly uncertain. We briefly summarize their most salient aspects below. We note, for example, that a 25 percent reduction in net benefit from the fee would result in a loss of around \$200 million in revenues that offset state costs for children’s health coverage—enough to potentially negate savings from lower state employee health premiums.

Loss of Benefits to State and Public Hospitals From Fee-Related Capitation Increases. A large portion of the revenue from the hospital quality assurance fee provides the nonfederal share of certain increases to capitation payments to Medi-Cal managed care plans, up to the maximum amount permitted by federal law. The maximum amount depends on an assessment from qualified actuaries that the proposed capitation payments reflect “reasonable, appropriate, and attainable” costs to plans from making payments to providers, including hospitals. It is our understanding that the actuaries’ assessment typically includes comparisons to payments from commercial health insurance companies. Thus, by reducing hospital payments from private payers as described earlier, the measure would likely lead to (1) a lower actuarial assessment of the maximum amount of permissible capitation payments, (2) a corresponding decrease in fee-related capitation increases, and (3) reduced net benefit under the fee program. This would result in a negative fiscal impact on the state and units of government that operate public hospitals, although the level of this impact is highly uncertain. (Under current law, the amount of net benefit from fee-related capitation increases is roughly \$1 billion annually, translating into (1) about \$250 million annually in revenues that offset state costs for children’s health coverage and (2) about \$100 million annually in fee-funded managed care payment increases for public hospitals.) Although the legislation authorizing the fee would become inoperative on January 1, 2017, we note that over the past several years, the Legislature has renewed this fee before it expired.

Medi-Cal FFS Overpayments May Result in Fee-Related Refund Requirements. Federal law prohibits FFP for any Medicaid FFS payments to an individual hospital that exceed that hospital’s “customary charges” to the general public. From the federal perspective, the relevant comparison is between the following two amounts:

- ***Medi-Cal FFS Payments***—The sum of both direct and supplemental payments to the hospital, including the nonfederal share that is funded through sources other than state general funds, such as provider taxes.

- **Customary Charges**—Total billed for services provided to Medicaid patients.

It is likely the federal government would view hospitals' uniform schedules of gross charges as a key reference point for determining customary charges. It is also possible that total Medi-Cal FFS payments to some hospitals—including hospital fee revenues used as the nonfederal share—are greater than these hospitals' costs for treating Medi-Cal patients. By reducing permissible gross charges at many hospitals, the measure also creates the risk that total Medi-Cal payments to certain hospitals would be found to be in violation of the customary charge ceiling. This could potentially trigger a requirement for hospitals and the state to refund some portion of fee-funded FFP to the federal government. To the extent this scenario occurs under the measure, it would generally lead to lower net benefits to hospitals under the fee program, and thus lower fiscal benefits to the state and to public hospitals, although the amount of reduction is highly uncertain.

Summary of Fiscal Effects

We estimate that the measure would result in the following major fiscal impacts:

- State and local government savings associated with reduced government employer-sponsored health insurance spending on hospital services, potentially ranging from the mid- to high-hundreds of millions of dollars annually, offset to an unknown degree by (1) various responses by insurers and hospitals and (2) possible pressures to increase General Fund spending on Medi-Cal hospital services.
- Uncertain but potentially significant state and local government costs over the next few years, due to likely decreased revenues from existing limited-term fees on certain private hospitals to (1) offset state costs for children's health coverage and (2) support state and local public hospitals.

Sincerely,

Mac Taylor
Legislative Analyst

Michael Cohen
Director of Finance