January 3, 2012

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

Attention: Ms. Dawn McFarland
Initiative Coordinator

Dear Attorney General Harris:

Pursuant to Elections Code Section 9005, we have reviewed the proposed initiative (A.G. File No. 11-0082) that would place an upper limit on how much certain private hospitals may charge payers for patient care services or items.

BACKGROUND

General Care Acute Hospitals. A general acute care hospital (hereinafter referred to as a "hospital") is a health facility with a governing body that has overall administrative and professional responsibility for the facility, and a medical staff that provides 24-hour inpatient care, including the following services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary. According to the state Office of Statewide Health Planning and Development (OSHPD), there were 352 hospitals in California in 2010. This does not include general acute care hospitals operated by the federal government, such as Veterans Administration hospitals. Hospitals are licensed by the California Department of Public Health (DPH).

Hospitals vary in terms of the mix of services they offer and their capacity to treat patients. Large hospitals may have hundreds of beds and the capacity to treat large numbers of patients for a wide variety of medical conditions, while small hospitals may have only a few beds and comparatively less ability to treat patients for a wide variety of conditions. Large hospitals are mainly located in densely populated regions and are sometimes located a mile or less away from another large hospital. Small hospitals are often located in rural areas and may be the only hospital to serve a large geographic region such as a county.

Two Broad Categories of Hospitals: Public and Private. Hospitals fall into two broad categories: public and private. A public hospital is operated by the state of California, a county, a city, the University of California, a local health district or authority, or any other political subdivision of the state. A private hospital is typically operated by a corporation (both for-profit

and nonprofit). In California, about 82 percent of hospitals are private hospitals and about 18 percent are public hospitals.

Hospital Charges Vary Among Hospitals. A charge is generally the price demanded in return for the provision of a service or item. For hospitals, a charge description master, also known as a chargemaster, is a uniform schedule prepared by the hospital that lists the prices of all the services and items for which a separate charge exists. (Items could include such things as catheters, syringes, and slippers.) Each hospital has its own policy for setting prices for the thousands of different services and items on its chargemaster. Prices on the chargemaster for a service or item may be significantly higher than the cost to the hospital of providing the service or item. In California, each hospital must make a written or electronic copy of its chargemaster available to the public and submit it to OSHPD.

Most payers for hospital services and items do not pay the prices listed on the chargemaster. Instead, they negotiate discounts (sometimes as high as 70 percent or more) from the prices listed on the chargemaster, or pay based on some other payment arrangement that has been agreed to by the hospital and the payer.

Some payers, mainly uninsured persons, are billed by hospitals based on the prices listed on the chargemaster. However, hospitals are required, under state law, to offer reduced rates to uninsured patients that may have low or moderate incomes, and to establish policies that specify the qualifications patients must meet in order to be eligible for free medical care and discounted payments. These policies vary from hospital to hospital.

Hospital Revenue Streams. Hospitals receive payments from a mix of different payers, including federal, state, and local governments; commercial health insurers; and uninsured persons. Overall, charges paid by government-administered programs such as fee-for-service Medicare (Medicare is a federally funded program to provide health care to persons over 65 years of age and certain younger persons with disabilities) and fee-for-service Medicaid (Medicaid, known as Medi-Cal in California, is a joint federal and state program that provides medical goods and services to qualified, low-income persons and families) are generally lower than the charges billed to commercial health insurers and the uninsured for the same services and items. For some services and items, the charges paid by government-administered programs such as Medicare and Medi-Cal may be below the costs incurred by the hospitals to provide the services and items. It is unclear how the charges paid by other government entities such as the California Public Employees' Retirement System (CalPERS) (CalPERS provides health benefits to government employees, retirees, and their families) and commercial health insurers compare generally to the costs incurred by the hospitals to provide the services or items. The charges paid by insurers for the same items and services can differ from insurer to insurer.

PROPOSAL

This initiative places an upper limit on how much certain private hospitals may charge payers 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 August 1, 2014 and is repealed January 27, 2021.

Certain private hospitals are exempted from the application of this measure. The exempted categories are private hospitals that belong to an integrated health system or a safety-net health system, both as defined by the measure, and children's hospitals. These exemptions make up about 25 percent of all private hospitals in the state. Therefore, we find that the measure would apply currently to about 214 private hospitals.

Measure Limits Charges by Certain Private Hospitals

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

Limit on Charges May Be Adjusted Upwards Based on Various Factors. There are two ways the measure allows private hospitals to have the limit on charges that would otherwise generally apply to them under the measure adjusted upwards. First, a private hospital may have the limit adjusted upward—by up to 80 percent—by applying a formula that accounts for various fiscal factors, including whether the hospital incurred net losses in its provision of certain services or items under government-administered programs.

The second way a private hospital may have the limit on charges that applies to it adjusted upward is to 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 charges for services and items on their chargemaster, subject to the measure's charge limits that apply to them. Under the measure, hospitals may only list 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.

Refund Requirement. If a hospital's total charges for any year exceed its charge limit for all care provided that year, then the hospital must refund each overcharged payer.

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) and DPH Enforce Fair Healthcare Pricing Requirement. The 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 for Violations. 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 Requirement for Licensure. Compliance with the initiative is a condition for a hospital's licensure. A hospital that loses its license must cease operations.

FISCAL EFFECTS

Minor State Administrative Costs

Potentially Minor Costs to the AG to Perform New Duties. The AG may bring a civil action against a private hospital that violates the measure. Potential costs to the AG for these enforcement activities would therefore depend on how often the AG directly brings an action against a private hospital. While these potential costs are uncertain, they are likely to be minor.

Minor Costs to DPH. The measure imposes new processing, administrative, and enforcement workload on DPH. This increased workload would likely result in minor costs to DPH. Under the measure, DPH may assess a reasonable fee on nonexempt private hospitals to cover its processing and administrative costs to implement the measure.

Uncertain, Potentially Significant Impacts on State and Local Finances

Fiscal Impacts Depend on a Variety of Hospital-Specific Characteristics. The overall fiscal impacts to state and local governments resulting from this measure are uncertain, due in large part to a variety of factors that vary significantly from hospital-to-hospital. These factors determine how individual hospitals would be affected by the measure and what strategies they are likely to employ in response to the measure. These varying impacts on hospitals will drive the nature and extent of the measure's overall impact on state and local finances. These determining factors include:

- ***Payer Mix.*** Hospitals receive revenues from a mix of sources, potentially including state, local, and federal governments; commercial health insurers; and uninsured persons.
- ***Service Mix.*** Hospitals provide different arrays of services and items. For example, some hospitals operate emergency departments, while others do not.
- ***Existing Prices.*** Hospitals bill for services and items and these prices may vary significantly for the same service or item across hospitals and within hospitals depending on the purchaser.
- ***Market Forces.*** A hospital's ability to increase its prices for certain items and services and change the mix of items and services it provides may depend on market forces such as the level of local competition.

Hospitals' Responses to the Measure Could Vary Widely. Some hospitals may meet the charge-related requirements of the measure without making any significant adjustments to their

operations. In contrast, others may have to make significant adjustments to their service mix, payer mix, existing prices, and operating efficiencies in order to comply with the provisions of the measure. Our analysis indicates that the majority of private hospitals subject to this measure would experience a loss in revenues in meeting the requirements of this measure unless they made changes to their operations in response. Based on our analysis of 2010 data, about 20 hospitals would change from having positive operating margins to having operating losses before taking into account any strategies these hospitals might implement in response to the measure to maintain positive operating margins. To offset these losses, these impacted private hospitals could employ a mix of strategies to attempt to maintain their financial viability. (These strategies could also be applied by other private hospitals that—while not experiencing operating losses as a result of the measure—would still experience a reduction in their profit margin as a result of the measure.) Some of the strategies they could employ include:

- ***Adjust the Mix of Services and Items.*** In response to the measure, some hospitals could eliminate services and items that they currently offer and potentially add new ones. For example, a hospital might choose to eliminate services and items with low profit margins and offer new services and items with comparatively higher profit margins, subject to the hospitals' charge limit, in order to maximize profitability.
- ***Adjust the Charges for Services and Items.*** In response to the measure, some hospitals would have to adjust their charges for services and items downward in order to comply with the charge limit requirement. However, for items and services that are priced below the charge limit, hospitals could adjust the price upwards within the limits imposed by the measure.
- ***Adjust the Payer Mix.*** In response to the measure, hospitals could adjust their payer mix through efforts to increase the amount of services and items they provide to some payers and reduce the amount they provide to others. For example, a hospital might take steps to reduce the amount of services and items it provides to beneficiaries of government-funded health care and increase the amount it provides to private payers.
- ***Identify Operating Efficiencies.*** In response to the measure, hospitals may have greater incentive to seek to identify operating efficiencies in order to lower their costs for providing a service or item.

Hospitals could implement none, one, or more of the strategies identified above, or other strategies that we have not identified in response to meeting the requirements of the measure. Strategies would likely vary based on the size of the hospital and its geographic location. Some hospitals could close altogether if they were unable to meet the measure's requirements and maintain sufficient operating margins. We note that hospital closures are not unusual under current law.

The net fiscal impact to state and local governments of this measure is the accumulation of analysis of each individual hospital's response. Since an individual hospital's strategy in response to the measure's requirements would depend on that hospital's specific characteristics, the initiative's fiscal impact on state and local governments—as purchasers of hospital-provided healthcare—would vary at the individual hospital level. For instance, one hospital in a state

program's provider network may currently charge rates above the limit imposed by the measure for nearly all services and items on its chargemaster. A second hospital in the network may currently offer the state discounts for certain services utilized by a high volume of program beneficiaries. State and local government purchasers might achieve savings via reduced payments to the first hospital because the hospital would have to lower its charges in order to comply with the measure. At the same time, state and local government purchasers might have higher costs from increased payments to the second hospital, if that hospital has the ability to raise its discounted prices to offset the reductions it would make to charges above the limit established by the measure. Thus, at the individual hospital level, the measure could result in savings or costs to state and local governments. There is no way to reasonably predict how state and local finances would be affected in the aggregate without a thorough analysis of all of the hospitals subject to this measure. This analysis would include, but not be limited to, their geographic location, payer mix, service mix, charge adjustments required under the measure, and regional and statewide market forces.

Fiscal Summary

Not Possible to Provide a Reasonable Estimate Within 25-Day Timeframe. The overall fiscal impacts to state and local governments resulting from implementation of this measure are uncertain, but could potentially lead to significant costs and/or savings to state and local governments depending on the responses of individual hospitals in complying with the measure. Given the level of uncertainties surrounding fiscal impacts of this measure as discussed above, we are informing you that, in our opinion, a reasonable estimate of the net impact of this measure cannot be prepared within 25 working days from the date this proposed initiative was received.

As required by subsection (c) of Section 9005 of the Elections Code, we are informing you that it is our opinion that the measure could result in a substantial net change in state or local finances if adopted, given the magnitude of the changes proposed in this measure.

Sincerely,

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Mac Taylor
Legislative Analyst

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Ana J. Matosantos
Director of Finance