LAO

December 18, 2015

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. 15-0101) that would place an upper limit on gross charges for patient care services or items set by certain private hospitals.

BACKGROUND

California Hospitals

There are two main types of hospitals operating in California:

- ***Public Hospitals.*** There are 65 hospitals operated by counties, the University of California, health care districts, cities, or other political subdivisions of the state.
- ***Private Hospitals.*** There are 290 hospitals owned and operated by nonprofit or for-profit entities.

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 Payers

Public 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.

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- ***Medi-Cal.*** In California, the federal-state Medicaid Program is known as Medi-Cal. This program currently pays over $18 billion from the state General Fund to provide health care benefits to nearly 13 million low-income persons. 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). The percentage of Medi-Cal costs paid by the federal government currently ranges from 50 percent to 100 percent, depending on the type of enrollee and/or service. Later we describe Medi-Cal payments for hospital services in greater detail.

Two Main Delivery Systems. 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 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.

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.
- ***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.
- ***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 Payers

Private payers mainly consist of commercial health insurers that provide coverage to members of employer groups, organizations, or individuals who purchase health insurance. These insurers receive a payment known as a premium in exchange for covering an agreed-upon set of health care services. In most cases, government agencies contract with health insurers to provide health benefits for their employees, retirees, and their family members.

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. Together, state and local governments pay

roughly $20 billion annually for employee and retiree health benefits. As mentioned earlier, these health benefits are typically provided by commercial health insurers.

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 billing purposes. (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.

For each entry, the chargemaster lists a 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. State law requires every hospital to make a copy of its chargemaster available to the public and submit it to the Office of Statewide Health Planning and Development (OSHPD).

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

Most third-party payments for hospital services have moved away from gross charges as a basis for setting payments, as discussed in detail below. (Gross charges, however, may 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 Contract With Hospitals in Their Networks . . . Health insurers that provide 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 the methods used to calculate payments for covered services—are generally governed by multiyear contracts negotiated between the payer and the hospital. When structuring contracts, private payers 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 methods 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 billed by the hospital. 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 billed 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 billed.
- ***Capitation.*** A fixed payment per patient, per month regardless of the level of services used or gross charges billed 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.

Contracts Often Include* Lesser-Of *Provisions That Reference Gross Charges. Within contracts 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 billed 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 for services. This is because gross charges are generally recognized by payers to be highly inflated.

Gross Charges 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 gross charges to the payer. The payer then typically negotiates ad hoc with the noncontracted hospital, usually agreeing to pay 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. This may indirectly strengthen a hospital's bargaining position and ability to command higher fixed payments as a contracted provider.

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. Since 2009, the Legislature has passed four successive laws to impose such a fee on certain private hospitals. Though each of these laws contains a sunset date, the Legislature has consistently enacted legislation to immediately extend or replace the expiring fee. The legislation authorizing the current fee becomes inoperative on January 1, 2017. Most of the revenues collected through the fee 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 are used to draw down federal funds.

State Receives Portion of Net Benefit From Fee. A certain portion of the fee revenue offsets 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 equals 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, 2017. Private children's hospitals are exempted from the application of this measure. Therefore, we find that the measure would apply currently to 282 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 Department of Public Health (DPH) is responsible for collecting these reports and making them available to the public upon request.

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. 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 Employee and Retiree Health Benefits, 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 billed—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 contracts that stipulate that payers will remit, and hospitals will accept, the lesser of the negotiated fixed payments and billed 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, billed 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 hospital 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 2014. Our analysis of this data suggests that had the measure been in effect in 2014, 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 employee and retiree health benefits, a 10 percent to 15 percent decrease would translate into several hundreds of millions of dollars annually in reduced spending on hospital services for public employees of state and local governments.

Actual Amount of Net Savings to Government Employers Highly Uncertain. Although the above figure serves as a rough reference point for estimating the annual savings to state and local governments related to employee and retiree health benefits, it is 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 2014 data. Second, this figure does not incorporate individual responses to the measure from insurers and hospitals that could serve to offset government savings. These factors would generally offset total government savings related to employee and retiree health benefits by an unknown degree.

Some Portion of Savings Would Likely Be Retained by Health Insurers. Health insurers that contract with government employers to provide 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. Impacted hospitals could employ a variety of contracting and operational strategies to mitigate these losses. Below, we list some of the strategies that hospitals could employ, and which would reduce the overall amount of government savings related to employee and retiree health benefits by an unknown degree.

Hospital Response 1: 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 contracts. Deleting these provisions would potentially allow some hospitals to receive contractual payments above statutorily capped gross charges. The ability of individual hospitals to obtain such concessions from their contracted payers is highly uncertain. For example, most insurers may be initially unwilling or reluctant to give up the negotiating leverage afforded by *lesser-of* provisions. However, as described earlier, insurers need to build and maintain provider networks that satisfy both regulatory requirements and market demand. In some cases, insurers might be convinced that the benefits of keeping certain hospitals within their networks outweigh their costs of paying those hospitals at or above gross charges.

Hospital Response 2: 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. Under current law, gross charges rarely affect actual payment amounts under contracts, 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 billed 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 employee and retiree health benefits.

Hospital Response 3: 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. Unlike contracts based on per-diem or case-rate payments, capitation-based contracts generally do not reference *lesser-of* provisions. 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, to maintain some of their revenue that would otherwise be reduced under *lesser-of* provisions. The legal and practical ability to shift to capitation would vary from hospital to hospital.

Loss of Fiscal Benefits Related to Quality Assurance Fee

Under current law, the hospital quality assurance fee expires before this measure takes effect. However, the Legislature has extended the fee three times since its initial enactment and—in the current version of the fee—has established some parameters for future fees that are authorized after 2016. If the Legislature chooses to continue this practice of extending the fee to raise similar amounts of funds for similar purposes, then state and local government net savings through lower spending on employee and retiree health benefits (as outlined above) could be partially or fully offset. This is due to the possible need to downsize any future 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 current 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 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 insurers. 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, including (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.)

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 employee and retiree health benefits spending on hospital services, potentially up to several hundreds of millions of dollars annually, offset to an unknown degree by various responses by insurers and hospitals.
- To the extent the Legislature continues to extend a current limited-term fee on certain private hospitals, the measure would likely decrease fee revenues available to (1) offset state costs for children's health coverage and (2) support state and local public hospitals.

Sincerely,

for Mac Taylor
Legislative Analyst

for Michael Cohen
Director of Finance