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November 22, 2011

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INITIATIVE COORDINATOR
ATTORNEY GENERAL'S OFFICE

Honorable Kamala Harris
Attorney General of California
Attn: Initiative Coordinator
Department of Justice
1300 I Street, 17th Floor
Sacramento, CA 95814

Re: Request for Title and Summary of the Fair Healthcare Pricing Act of 2012

Dear Attorney General Harris:

We hereby request your office prepare a circulating Title and Summary for the enclosed proposed initiative pursuant to Article II, Section 10(d) of the California Constitution.

Please find attached the statements required by Elections Code Sections 9001 and 9608, the name and residence address of the proponent and a check for $200.

If you have any questions, please do not hesitate to contact us.

Sincerely,

X (Signature of Proponent)

Fabunimi Sands

X (Signature of Proponent)

Tina McClain

Please contact Lance Olson with questions.

Lance Olson
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This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8, of the California Constitution.

This initiative measure amends and adds sections to the Health and Safety Code and Corporations Code; therefore, existing provisions proposed to be deleted are printed in ~~strikeout~~ type and new provisions proposed to be added are printed in *italic* type to indicate that they are new.

SEC. 1. Name

This act shall be known as the "Fair Healthcare Pricing Act of 2012."

SEC. 2. Findings and Purpose

This act, adopted by the people of the State of California, makes the following Findings and has the following Purpose:

A. The People make the following findings:

(1) Access to health care services is of vital concern to the people of this State.

(2) The State has an interest in ensuring that the people have access to affordable health care services and are not charged excessive rates for the provision of health care services.

(3) Federal data reflect that private hospitals operating in this State, on average, charge patients more than 450 percent of the actual cost of providing health care, and some private hospitals charge more than 1,000 percent of the actual cost of the care provided.

(4) Although federal law generally requires private hospitals to charge all patients the same price for each service or item, insurers and health care service plans often pay far less than the total amount charged. The result is that unreasonably high hospital charges disproportionately affect uninsured and underinsured individuals and families.

(5) Limiting private hospital charges to a maximum of 125 percent of a good faith reasonable estimate of the actual cost to the hospital of providing patient care would protect individuals and families from excessive charges while providing hospitals with reasonable returns on their investments.

(6) Allowing private hospitals that provide wholly or partially unreimbursed care to uninsured patients and patients in government programs to adjust their charges to account for losses incurred in providing such care is fair and will promote public health and welfare by encouraging private hospitals to provide such care to individuals and families in need.

(7) Existing requirements of law do not adequately deter private hospitals from charging excessively high prices for the health care they provide. Nor do existing requirements of law adequately provide standards for identifying reasonable prices private hospitals should be

permitted to charge.

B. It is the purpose of this Act to ensure that private hospitals charge patients amounts based on good faith reasonable estimates of the actual costs of providing health care, with appropriate adjustments to encourage private hospitals to provide care to uninsured patients and patients in government programs.

SEC. 3. Article 11.5 (commencing with Section 1339.611) of Chapter 2 of Division 2 of the Health and Safety Code is added, to read:

1339.611. Definitions. For the purposes of this chapter:

(a) "Actual cost" means the average "reasonable and allowable costs" that a hospital incurs per patient in providing a given service or item appearing on the hospital's charge description master.

(b) "Actual qualifying losses" means a hospital's "qualifying expenses" minus the hospital's "qualifying reimbursements." If qualifying reimbursements are equal to or greater than qualifying expenses, then actual qualifying losses are zero.

(c) "Adjusted maximum charge" means the charge for a service or item on a hospital's charge description master on the date the service or item was provided to the patient multiplied by an "adjustment factor" intended to reflect certain losses experienced by hospitals in providing health care to patients in government-sponsored programs and self-pay patients. The adjustment factor for this subdivision shall be equal to the ratio m / c, where "m" is the retrospectively adjusted maximum allowable charges for all items and services provided in the most recently concluded fiscal year, and "c" is the hospital's "total charges" in the most recently concluded fiscal year. "m" shall be calculated as the lesser of 2.25e and 1.25e(1 + q/p), where "e" is the hospital's "total patient care expenses" in the most recently concluded fiscal year; "q" is the hospital's actual qualifying losses in the most recently concluded fiscal year; and "p" is the hospital's "total private payer patient care expenses" in the most recently concluded fiscal year.

(d) "Affiliated health care service plan" means a health care service plan licensed under Section 1353 of the Health and Safety Code that in a "health system's" most recently concluded fiscal year was the primary payer for 75 percent or more of all annual inpatient discharges from hospitals that were part of the health system on the date of the discharge, excluding inpatient discharges where the primary payer was Medicare, Medi-Cal, or a County Indigent program (pursuant to Section 17000 of the Welfare and Institutions Code), where the patient was a self-pay patient (as that term is defined in subdivision (f) of Section 127400), or where the care was provided as unreimbursed charity care, as defined by the hospital's written charity care policy adopted pursuant to Section 127405.

(e) *"Charge" means the gross charges billed by a hospital for a given service or item on the hospital's charge description master.*

(f) *"Charge description master" shall have the same meaning as that term is defined in Section 1339.51.*

(g) *"Health system" means all hospitals in this State that share the same fiscal year and that satisfy both of the following requirements:*

(1) *The hospitals are owned, operated, or substantially controlled by the same person or persons or other legal entity or entities, including but not limited to by a shared corporate parent.*

(2) *The hospitals are jointly, or jointly and severally, liable, through a master indenture or other agreement or agreements, for one or more debt obligations, including but not limited to loans, leases, commercial bonds, municipal bonds, or other debt instruments owed to a third party outside the health system, if the debt obligations individually or collectively are material to any financial statement of at least one of the hospitals under generally accepted accounting principles for hospitals.*

A health system shall not include fewer than three hospitals.

(h) *"Hospital" means a hospital licensed under subdivision (a) or (f) of Section 1250. Hospital does not include children's hospitals, as defined in Section 16996 of the Welfare and Institutions Code, or public hospitals, as defined in paragraph (25) of subdivision (a) of Section 14105.98 of the Welfare and Institutions Code.*

(i) *"Individual charge adjustment factor" means a factor, "F," that shall be calculated as the lesser of 1.8 and [1 + (q/p)], where "q" is the hospital's actual qualifying losses for the most recently concluded fiscal year, and "p" is the hospital's total private payer patient care expenses for the most recently concluded fiscal year.*

(j) *"Integrated health system" means any health system and affiliated health care service plan that satisfy both of the following requirements for the full fiscal year:*

(1) *The affiliated health care service plan and the hospitals that are part of the health system are owned, operated, or substantially controlled by the same person or persons or other legal entity or entities, including but not limited to by a shared corporate parent.*

(2) *The affiliated health care service plan is jointly, or jointly and severally, liable with the health system or any one or more hospital that is part of the health system, through a master indenture or other agreement or agreements, for one or more debt obligations, including but not limited to loans, leases, commercial bonds, municipal bonds, or other debt instruments owed to a third party outside the health system, if the debt obligations individually or collectively are material under generally accepted accounting principles to any financial statement of the affiliated health care service plan, the health system, or one or more hospital that is*

part of the health system.

(k) *"Nonprofit hospital" means a hospital that is organized as, or owned and operated by, a nonprofit corporation, as defined in Part 2 or 4 of Division 2 of Title 1 of the Corporations Code, or a nonprofit foreign corporation, as defined in Section 5053 of the Corporations Code.*

(l) *"Office" means the Office of Statewide Health Planning and Development.*

(m) *"Payer" means any person or other entity that is or was legally required or responsible to make payment with respect to an item or service (or any portion thereof) provided by a hospital to a patient.*

(n) *"Primary payer" means the payer (other than the patient) who is or was legally required or responsible to make payment with respect to an item or service (or any portion thereof) before any other payer (other than the patient).*

(o) *"Qualifying expenses" means the sum of the following expenses in a hospital's most recently concluded fiscal year:*

(1) *All reasonable and allowable costs incurred by the hospital in providing care to patients where the primary payer is any federal, state, county, city, or other local government program, except the Medicare program;*

(2) *50 percent of all reasonable and allowable costs incurred by the hospital in providing care to patients where the primary payer is the Medicare program; and*

(3) *All reasonable and allowable costs incurred by the hospital in providing care to self-pay patients, as that term is defined in subdivision (f) of Section 127400.*

(p) *"Qualifying reimbursements" means the sum of the following revenues received in a hospital's most recently concluded fiscal year:*

(1) *All revenues received as reimbursements from any payer for care provided to patients where the primary payer is any federal, state, county, city, or other local government program, except the Medicare program;*

(2) *50 percent of all revenues received as reimbursements from any payer for care provided to patients where the primary payer is the Medicare program;*

(3) *All revenues received as reimbursements from any payer for care provided to self-pay patients, as that term is defined in subdivision (f) of Section 127400; and*

(4) *All revenues received as lump sum payments from any federal, state, county, city, or other local government program that are intended to defray patient care expenses, including but not limited to Medi-Cal Disproportionate Share payments, Quality Assurance Fee revenue, and revenue from California's Distressed Hospital Fund.*

(q) *"Reasonable and allowable costs" shall be determined in accordance with Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations.*

(r) *"Required refund" means, for each individual service or item provided by a hospital to an individual patient, an amount equal to all revenues received by the hospital from any source for providing that individual service or item to the patient minus the adjusted maximum charge for that service or item. If the adjusted maximum charge is equal to or greater than all revenues received by the hospital from any source for providing the individual service or item to the individual patient in question, the required refund for that individual service or item shall equal zero.*

(s) *"Revenues received" means all amounts actually received and all accounts receivable, except that accounts receivable may be discounted in accordance with a good faith reasonable estimate of bad debt. Revenues received shall be calculated in accordance with generally accepted accounting principles for hospitals.*

(t) *"Safety-net health system" means a health system that in its fiscal year concluding in 2010, or in any fiscal year thereafter, satisfied each of the following conditions:*

(1) *All hospitals in the health system are nonprofit hospitals.*

(2) *The hospitals that are part of the health system at the time of the discharge together provided 10 percent or more of the State's total number of inpatient discharges from general acute care licensed beds (as defined in regulations adopted pursuant to Section 1250.1 of Article 1 of the Health and Safety Code) where the primary payer is Medi-Cal.*

(3) *The hospitals that are part of the health system provided a combined total of 100 million dollars or more in charity care, as defined by the hospitals' written charity care policies adopted pursuant to Section 127405, measured by actual cost to the hospital of providing the charity care.*

(4) *The health system had a Medi-Cal utilization rate of 25 percent or greater. For purposes of this paragraph, "Medi-Cal utilization rate" means the ratio "Medi-Cal discharges" divided by "all discharges," where "all discharges" means the number of total inpatient discharges from general acute care licensed beds from all hospitals that are part of the health system at the time of the discharge, and "Medi-Cal discharges" means the number of all discharges where Medi-Cal is the primary payer.*

The data employed to determine whether a health system satisfies the conditions in paragraph (2), (3), and (4) shall be consistent with data reported in compliance with the Health Data and Advisory Council Consolidation Act (commencing with Section 128675) and any regulations, rules, or guidance issued under that chapter.

(u) *"Total charges" means all charges billed to any payer in a hospital's most recently concluded fiscal year.*

(v) "Total patient care expenses" means all reasonable and allowable costs incurred by a hospital in providing patient care in the hospital's most recently concluded fiscal year.

(w) "Total private payer patient care expenses" means the sum of all reasonable and allowable costs incurred by a hospital in its most recently concluded fiscal year in providing care to patients where:

(1) the primary payer is not any federal, state, county, city, or other local government program, including the Medicare program; and

(2) the patient is not a self-pay patient, as that term is defined in subdivision (f) of Section 127400.

(x) "Year," unless otherwise indicated, refers to a hospital's fiscal year for accounting purposes.

1339.612. Limitations on Charges; Required Refund for Overcharging.

(a) A hospital shall set and maintain charges for individual services and items on its charge description master based on a good faith reasonable estimate that the charges will ensure that both of the following requirements are satisfied:

(1) The hospital will not charge any person for any patient care service or item provided on or after August 1, 2014 an amount more than 125 percent of a good faith reasonable estimate of the actual cost to the hospital of providing the service or item, adjusted to account for the hospital's actual qualifying losses in accordance with this section.

(2) The hospital will not have total charges in any fiscal year ending on or after July 31, 2015, that exceed 125 percent of the hospital's total patient care expenses adjusted to account for the hospital's actual qualifying losses in accordance with this formula: The hospital's total charges shall be less than or equal to 125eF / 100, where "e" means the total patient care expenses in the fiscal year, and "F" is the individual charge adjustment factor.

(b) On or after August 1, 2014, a hospital shall not charge any person for any patient care service or item an amount more than 125 percent of a good faith reasonable estimate of the actual cost to the hospital of providing the service or item multiplied by the hospital's individual charge adjustment factor.

(c) Any hospital that has total charges in any fiscal year ending on or after July 31, 2015, that exceed 125 percent of the hospital's total patient care expenses, adjusted in accordance with the formula set forth in paragraph (2) of subdivision (a) of this section, shall have engaged in overcharging and shall, within 180 days of the end of the fiscal year, pay for each individual patient care service or item provided to each individual patient in the fiscal year the required refund defined in subdivision (r) of Section 1339.611. If one payer was charged by the hospital for the provision of a given service or item to an individual patient, the hospital shall pay the full required

refund to that payer. If more than one payer was charged for the service or item, the hospital shall divide and distribute the total required refund as appropriate among the payers.

(d) A hospital shall attest to the following statement on all billing statements made to patients and payers on or after August 1, 2014: "The charges appearing on this hospital bill do not exceed 125% of a good faith reasonable estimate of the actual cost of providing the healthcare services and items identified, adjusted in accordance with the California Fair Healthcare Pricing Act of 2012."

(e) A hospital shall not charge any payer for any patient care service or item any amount other than the charge for that service or item set forth in the hospital's charge description master.

(f) For purposes of satisfying subdivisions (a), (b), and (c), a hospital may not change its existing fiscal year unless the hospital changes its ownership or corporate structure as a result of a sale or merger.

(g) If a hospital proves in any court action that application of subdivision (a), (b), or (c) to the hospital will, in any particular fiscal year, violate due process or effect a taking of private property requiring just compensation under the Constitution of this State or the Constitution of the United States, the subdivision or subdivisions at issue shall apply to the hospital, except that as to the fiscal year in question the number "125" whenever it appears in the subdivision or subdivisions at issue shall be replaced by the lowest possible whole number such that application of the subdivision or subdivisions to the hospital will not violate due process or effect a taking of private property requiring just compensation. In any civil action, the burden shall be on the hospital to propose a replacement number and to prove that replacing "125" with any whole number lower than the proposed replacement number would, for the fiscal year in question, violate due process or effect a taking of private property requiring just compensation.

(h) The requirements of this section shall not apply to a hospital that is part of an integrated health system or a hospital that is part of a safety-net health system.

1339.613. Reporting; Public Availability of Charge Setting Methodology.

(a) Within 210 days of the end of a hospital's fiscal year ending on or after January 1, 2015, a hospital shall report the following information to the department:

- *(1) Total patient care expenses;*
- *(2) Total private payer patient care expenses;*
- *(3) Actual qualifying losses;*
- *(4) Qualifying expenses;*
- *(5) Reasonable and allowable costs in each of the categories set forth in paragraphs (1), (2), and (3) of subdivision (o) of Section 1339.611;*
- *(6) Qualifying reimbursements;*

(7) Revenues received in each of the categories reflected in paragraphs (1), (2), (3), and (4) of subdivision (p) of Section 1339.611;
(8) Total charges; and
(9) Any refund made pursuant to subdivision (c) of Section 1339.612.

(b) The department shall make the information provided pursuant to subdivision (a) available to the public upon request.

(c) The department may assess a reasonable fee on hospitals to cover any costs associated with processing the reports required by subdivision (a) or providing written notifications to hospitals pursuant to subdivision (c) of Section 1339.614.

(d) A hospital shall provide to any person within 10 business days after a request made on or after August 1, 2014, a complete description of the methodology it uses to set charges on its charge description master, including a complete description of the methodology it uses to ensure that it complies with Section 1339.612.

(e) The requirements of this section shall not apply to a hospital that is part of an integrated health system or a hospital that is part of a safety-net health system.

1339.614. Violation; Penalties.

(a) Compliance with this article shall be a condition of licensure under this chapter.

(b) The department may assess a civil penalty against a hospital that issues a billing statement that fails to comply with subdivision (d) of Section 1339.612. The penalty may not exceed $500 for each noncompliant billing statement issued by the hospital, and combined penalties may not exceed a total of $5,000 for billing statements related to the same service or item provided to an individual patient.

(c) The department may assess a civil penalty against a hospital that fails to make a report of information that complies with the requirements in subdivision (a) of Section 1339.613 and any regulations promulgated pursuant to this article. The penalty may not exceed $1,000 for each day a compliant report is delinquent after the date on which the report is due, up to a maximum of $100,000. No penalty may be assessed against a hospital under this section until 10 business days have elapsed after written notification to the hospital of its failure to file a compliant report, and no penalty may be assessed if the hospital files the required report within those 10 business days.

(d) The department may assess a civil penalty against a hospital that fails to comply with a request made by any person for information that the hospital must provide pursuant to subdivision (d) of Section 1339.613. The penalty may not exceed $1,000 for each day that the hospital fails to provide the required information, up to a maximum of $100,000. No penalty may be assessed against a hospital under this subdivision until

10 business days have elapsed after written request to the hospital by any person requesting information described in subdivision (d) of Section 1339.613, and no penalty may be assessed if the hospital provides the required information to the requesting person within those 10 business days.

(e) Penalties assessed under this section shall be due within 10 business days of their assessment, unless within those 10 business days the hospital petitions the department for reconsideration of the assessment, in which case no penalty shall be due under this section until after the department reviews and acts on the petition.

(1) The department shall promulgate regulations governing the review, acceptance, and denial of petitions filed pursuant to this subdivision.

(2) The department may assess a reasonable fee on petitioning hospitals to cover any costs associated with processing a petition made pursuant to this subdivision.

1339.615. Enforcement; Rights and Remedies.

(a) In addition to any other enforcement actions available under the law, and notwithstanding any other provision of law, the department or the Attorney General may bring or intervene in a civil action for a violation of this article for damages suffered by patients or other payers, individually or as a class; other damages; civil penalties as provided in Section 1339.614; and appropriate equitable relief.

(b) The rights and remedies provided for in this chapter shall not limit, affect, change, or repeal any statutory or common-law rights or remedies.

1339.616. The department may adopt regulations implementing this article.

1339.617. This article shall remain in effect only until January 27, 2021, and as of that date is repealed, unless a later enacted statute, which is enacted before January 27, 2021, deletes or extends that date.

SEC. 4. Section 9230 of the Corporations Code is amended to read:

9230. (a) Except as the Attorney General is empowered to act in the enforcement of the criminal laws of this state, and except as the Attorney General is expressly empowered by subdivisions (b), (c), and (d), *and Article 11.5 (commencing with Section 1339.611) of Chapter 2 of Division 2 of the Health and Safety Code,* the Attorney General shall have no powers with respect to any corporation incorporated or classified as a religious corporation under or pursuant to this code.

(b) The Attorney General shall have authority to institute an action or proceeding under Section 803 of the Code of Civil Procedure, to obtain judicial determination that a corporation is not properly qualified or classified as a religious corporation under the provisions of this part.

(c) The Attorney General shall have the authority (1) expressly granted with respect to any subject or matter covered by Sections 9660 to 9690, inclusive; (2) to initiate criminal procedures to prosecute violations of the criminal laws, and upon conviction seek restitution as punishment; and (3) to represent as legal counsel any other agency or department of the State of California expressly empowered to act with respect to the status of religious corporations, or expressly empowered to regulate activities in which religious corporations, as well as other entities, may engage.

(d) Where property has been solicited and received from the general public, based on a representation that it would be used for a specific charitable purpose other than general support of the corporation's activities, and has been used in a manner contrary to that specific charitable purpose for which the property was solicited, the Attorney General may institute an action to enforce the specific charitable purpose for which the property was solicited; provided (1) that before bringing such action the Attorney General shall notify the corporation that an action will be brought unless the corporation takes immediate steps to correct the improper diversion of funds, and (2) that in the event it becomes impractical or impossible for the corporation to devote the property to the specified charitable purpose, or that the directors or members of the corporation in good faith expressly conclude and record in writing that the stated purpose for which the property was contributed is no longer in accord with the policies of the corporation, then the directors or members of the corporation may approve or ratify in good faith the use of such property for the general purposes of the corporation rather than for the specific purpose for which it was contributed.

As used in this section, "solicited from the general public" means solicitations directed to the general public, or to any individual or group of individuals who are not directly affiliated with the soliciting organization and includes, but is not limited to, instances where property has been solicited on an individual basis, such as door to door, direct mail, face to face, or similar solicitations, as well as solicitations on a more general level to the general public, or a portion thereof, such as through the media, including newspapers, television, radio, or similar solicitations.

(e) Nothing in this section shall be construed to affect any individual rights of action which were accorded under law in existence prior to the enactment of Chapter 1324 of the Statutes of 1980.

As used in this section, "individual rights of action" include only rights enforceable by private individuals and do not include any right of action of a public officer in an official capacity regardless of whether the officer brings the action on behalf of a private individual.

(f) Nothing in this section shall be construed to require express statutory authorization by the California Legislature of any otherwise lawful and duly authorized action by any agency of local government.

SEC. 5. Amendment

Pursuant to subdivision (c) of Section 10 of Article II of the California Constitution, this act may be amended either by a subsequent measure submitted to a vote of the people at a statewide election; or by statute validly passed by the Legislature and signed by the Governor,

but only to further the purposes of the act.

SEC. 6. Severability

It is the intent of the People that the provisions of this act are severable and that if any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect any other provision or application of this act which can be given effect without the invalid provision or application.