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Issue Backgrounder

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House Bill 09-1293: Tax Sick People to Create a Hospital Slush Fund

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Note: the Fiscal note numbers referenced in this bill are from the March 18, 2009 Fiscal Note. The bill language refers to the unofficial preamended version of the bill as of March 20, 2009. For the purposes of this analysis, the main difference between the preamended version and the introduced version is that the limits of the buy-in program for the disabled were increased from 400 percent of the Federal Poverty Level to 450 percent of the Federal Poverty Level.

The Bill in Brief:

- Adds a tax of as much as 5.5 percent (the tax is called a "fee" in the bill) to every patient's hospital bill. The potential revenue raised from the patient tax could cost Colorado's citizens more than $573,000,000 a year in higher health care costs.
- Attempts to evade the plain language of TABOR by calling a tax a fee.
- Requires hospitals to mislead patients about the tax. The bill specifically prohibits hospitals from listing the tax as a line item on patient bills.
- Significantly expands medical assistance programs without a stable funding base. In some cases, people with median household earnings or income will be eligible for Medicaid.
- Will increase private health insurance premiums and, potentially, the Medicare cost-sharing amounts paid by the elderly.
- Reimburses hospitals for 100 percent of hospital determined costs without adequate oversight.
- Stops general fund appropriations to hospitals from going below their 2008 levels without being "made up."
- Earmarks payments for an unspecified "group facilitator."

More detail:

I. **Freezes general fund appropriations for hospital reimbursements** at the level in place for the fiscal year commencing July 1, 2008. The general fund appropriation can be reduced only if the same percentage reduction is made for all other providers.

(1) This implicitly assumes that the current ratio between state reimbursement for services rendered by hospitals and by other providers is optimal and that changes in technology or health care delivery systems organizations and staffing will have no effect on the proper ratio in the future.

(2) It has the potential to seriously exacerbate health care access problems for Colorado patients on state medical assistance programs.

(3) The bill makes reimbursement even less transparent by specifying that an unspecified "index" of average percent-

age change in reimbursement rates shall be used to decide whether general fund appropriation for hospital reimbursement has been reduced more than for other providers. The bill does not explicitly specify the index or average to be used. It leaves specification of the index up to the State Board in consultation with the Advisory Board the bill creates.

II. **Taxes hospital inpatient and outpatient services** and puts the money into a new fund. The bill calls this new tax a "fee."

(1) The federal government, other states, and the rest of the world refer to this bill's "fee" as a provider tax. Calling this tax a fee looks like an attempt to evade TABOR requirements.

(2) The current federal limit on the kinds of provider taxes proposed here is 5.5 percent of total taxpayer revenue. The bill proposes a tax on hospital patient revenue, not on total hospital revenue. Patients, not hospitals, will ultimately end up paying this tax in the same way that customers, not corporations, end up paying corporate taxes.

(3) A tax that increases the cost of hospital care will increase the cost of health insurance. It will also increase the cost of Medicare copays. This harms the elderly.

III. **Stipulates that hospitals may not show the amount of the tax on their billing statements.** The exact wording at the top of page 9 line 6 is

(f) A HOSPITAL SHALL NOT INCLUDE ANY AMOUNT OF THE PROVIDER FEE AS A SEPARATE LINE ITEM IN ITS BILLING STATEMENTS.

IV. **Stipulates that records used to calculate the tax are not subject to public examination:** the bottom of page 8 (line 23) says (emphasis added)

(1) (III) THE STATE BOARD, IN CONSULTATION WITH THE ADVISORY BOARD, SHALL PROMULGATE RULES ON THE REPORTS THAT HOSPITALS SHALL BE REQUIRED TO SUBMIT FOR THE STATE DEPARTMENT TO CALCULATE THE AMOUNT OF THE PROVIDER FEE. NOTWITHSTANDING THE PROVISIONS OF PART 2 OF ARTICLE 72 OF TITLE 24, C.R.S., *INFORMATION PROVIDED TO THE STATE DEPARTMENT PURSUANT TO THIS SECTION SHALL BE CONSIDERED CONFIDENTIAL AND SHALL NOT BE DEEMED A PUBLIC RECORD.* NONETHELESS, THE STATE DEPARTMENT, IN CONSULTATION WITH THE ADVISORY BOARD, MAY PREPARE AND RELEASE SUMMARIES OF THE REPORTS TO THE PUBLIC.

(2) Due to the inability to examine the records used to determine costs, transparency, accountability, and oversight over the determination of these taxes will be limited.

(3) Hospitals have a record of manipulating their accounting systems to maximize revenues. In many cases, uncompensated care costs have been calculated as the difference between a hospital's chargemaster price and the price paid, even though the chargemaster price may have little to do with actual costs. This means that hospital claims about uncompensated care costs are unreliable.

(4) Hospital bills are unreliable. They are sufficiently inaccurate that a whole industry—medical bill review—has grown up to examine hospital bills for error. Civil rights groups like Consejo de Latinos Unidos have had to organize to help cash payers resist hospital price gouging.

V. **Allows the State to apply different tax rates at different hospitals.** Exempts certain hospitals, and payers, from the tax.

(1) This provision creates the potential for an inefficient use of health care resources. If political considerations result in a more efficient hospital being taxed more heavily than a less efficient one, patients and third-party payers could select the less efficient hospital because it costs them less. This would increase total health system costs.

(2) Putting favorable treatment into statute opens the door for corruption, influence peddling, and the inappropriate use of government influence over private health care providers.

VI. **Creates the Hospital Provider Fee Oversight and Advisory Board.** The Board advises the State on the appropriate collection and use of the provider tax.

(1) Out of 11 members of the board, 4 must be hospital employees and 1 a representative from a hospital organization. Two appointees must be employees of the State department that will implement, administer, and have its budget enlarged by this provider tax.

(2) The composition of the advisory board makes it likely that it will be controlled by people favorably disposed to hospitals. As a result, this bill increases the influence of a private interest group by giving it a statutory advisory role within state government.

(3) In general, hospitals have a poor record of treating patient finances with consideration or respect. They also have a poor record of cost transparency.

(4) The Advisory board advises on the tax. The tax is a percentage of patient billings. Hospitals receive grants from the pool of tax revenues. The existence of the tax and the direction of the funding from it gives hospitals a clear incentive to inflate patient billings.

(5) Allowing the Advisory Board to suggest policy on the basis of secret records suggests that those in favor of this bill have little concern about increasing health care costs or the people who are hospitalized and may end up paying for greatly inflated charges.

(6) The Board recommends how the taxes will be collected, gives opinion on legislation affecting the taxes, recommends changes in the provider taxes, recommends how revenues should be divided among hospitals, and recommends changes in Medicaid program reimbursement. It must also prepare a report.

VII. **Hospitals before people. If provider tax funds are insufficient to fund hospitals, then people enrolled in the Medicaid/CHP expansions either must be cut from the rolls or suffer reduced benefits.**

(1) Enrolling people in medical assistance programs without stable funding is not good policy. People often disrupt existing arrangements to take part in government programs if they believe that government programs will cost them less. For example, an estimated 60 percent

of children enrolled in SCHIP programs previously had private insurance. Private arrangements are not easy to reconstruct if a government program is cut, especially for the disabled.

(2) Medical assistance benefits are very difficult to cut once in place. In Tennessee, proposed TennCare cuts resulted in years of legal challenges.

(3) Provider taxes may make treatment in Colorado less attractive than similar treatment in other states or countries.

(4) Funding hospitals means making hospital provider reimbursement and quality incentive payments.

VIII. **Uses of the money obtained from the tax on patients.** The money from the patient tax can be used for a variety of purposes, including Medicaid expansion. Note that Medicaid expansion cannot be funded unless hospital costs, state administrative expenses, payment for implementing state controls over medical practice, and supplemental Medicaid payments to certain hospitals have been met. A listing of the funding uses, and the Medicaid expansions, follows.

The estimated costs are the annual costs for FY 2011-12 in the bill's Fiscal Note.

A. **Give hospitals more money for treating Medicaid patients**, people covered under the Colorado Indigent Care Program, and for increasing the number of persons "covered by public medical assistance." The aim here is to increase the amount paid for various qualifying services so that the state can increase the amount of federal matching funds it collects under the Medicaid and SCHIP programs.

B. **Increase payments to hospitals to 100 percent of hospital costs.**

(1) There is no definition of hospital costs or any discussion of how they will be determined in the bill. In practice, hospital costs will likely be whatever hospitals say they are. This has been a particular problem in heavily unionized states like New York. New York hospitals have little incentive to resist unreasonable union demands because they know that they can simply pass costs to taxpayers via Medicaid reimbursement. At $7,733 per person, New York per capita Medicaid costs are the highest in the country.

(2) Few other government suppliers enjoy cost plus reimbursement.

(3) Hospitals historically have received substantial disproportionate share payments to cover the cost of treating indigent and nonpaying patients. There has been no demonstration that these funds fail to compensate hospitals for these costs. Contrary to the claims in the Legislative Declaration of the bill, there is no evidence that the uninsured use emergency facilities at a higher rate than the privately insured.

(4) Hospitals historically have not shared their disproportionate share funds with on-call physicians who use hospital facilities to treat those who do not pay. The bill does nothing to rectify this problem. In areas with high fractions of patients who do not pay, physicians can no longer afford to provide on-call services. This has left some hospitals unable to cope with medical emergencies.

(5) This bill does not ensure that all providers are protected from undue uncompensated care costs.

C. **Increase supplemental Medicaid payments to certain hospitals as the State sees fit.** This

type of arrangement invites corruption and the improper use of government influence on hospital operations.

D. **Pay for all of the costs related to establishing "outcomes-based practices and intensive care coordination" and related matters.**

(1) Neither outcomes-based practices nor intensive care coordination have been shown to definitively improve outcomes. In many cases they have been shown to increase costs without improving patient health.

(2) If the state finds it worthwhile to use tax money to fund academic research on outcomes or to support the implementation of medical fads, good policy would dictate that the effort be funded from general revenues based on taxes spread across the whole population. Instead, this bill taxes the sick.

(3) The related matters referred to here, specifically the adoption of evidence-based clinical guidelines that control how physicians must treat patients if they wish to be paid, perform exceptionally poorly for people with comorbidities. Because outcomes-based practices also include denying care when a guidelines committee declares that it is not cost-effective, this bill has the potential to seriously harm the sickest, frailest, and most vulnerable people in the population.

(4) This bill would institute far-reaching controls on patient treatment with no transparency about how they are determined or whether they work to a sick individual's advantage. The clinical controls that would be funded by this bill deserve substantial public debate, as the potential for harm is large.

E. **Pay the administrative costs to the Department of Health Care Policy and Financing for administering the program**, including extra staff, consulting costs, and information technology services. There are no limits on these administrative costs and elected officials do not control how the Department uses the funds. [FN cost $12,987,926]

(1) Hospital patients will be paying a tax for administrative activities that likely give them no benefits.

(2) The information technology services beyond those used voluntarily have so far been ineffective; very, very, expensive; and filled with bugs. The system in development for the NHS is billions of dollars over budget and still not operational. Its patient privacy limits are questionable, and multiple hospitals have been shut down by common viruses.

(3) It is not fair to tax sick people to fund government operations unlikely to immediately improve their welfare.

D. **Earmark for a group facilitator.** On page 18, line 27

(1) (d) THE ADVISORY BOARD MAY DIRECT THE STATE DEPARTMENT TO CONTRACT FOR A GROUP FACILITATOR TO ASSIST THE MEMBERS OF THE ADVISORY BOARD IN PERFORMING THEIR REQUIRED DUTIES

(2) Normally, spending on a group facilitator would this would be included in administrative costs, assuming that the Advisory Board isn't functional enough to organize itself. The fact that it is explicitly in the bill suggests that there is a specific group facilitator in mind.

G. **Expand Medicaid and CHP if there is money left over.** The expansions in the bill are mostly for adults. They are listed below.

The ability of the state to manage an expansion is in doubt. In 2008 the State Auditor estimated that 10 percent of CHP enrollees were improper. The Auditor noted that the Colorado Children's Basic Health Plan program suffers from "an overall lack of effective management and oversight." The state did not monitor the program to ensure that the plans it contracted with offered inadequate service, and the Auditor's Office found that at least 885 people remained enrolled after their eligibility expired under the current system of re-enrollment.

a) **Add parents, parents without a dependent child, and childless adults** if a household *earns* less than 100 percent of the federal poverty level, currently $14,570 for a family of two. Later in the bill, this provision is changed to a household *income* of less than 100 percent of the federal poverty level. It is not clear which standard holds.

i. Households that earn less than 100 percent of the federal poverty level are a much larger group. The bill needs to be clear about the income versus earnings standard before it is passed. [FN states that this will cost an additional $197,366,991 a year.]

ii. The standard child health plan application document requires that applicants state all sources of income, not just earnings.

b) **Add pregnant women and children up to 250 percent of the federal poverty level.** This means households with current incomes of $55,125 for a family of four, or $36,425 for a family of two. [Fiscal Note estimated cost is $82,009,995 a year.]

i. Median household income in Colorado in 2007 dollars is $54,262.

ii. Without detailed information on household size and income there is no way of knowing how many additional people this will add to the Medicaid rolls. The state estimates that the number will be 21,000.

iii. Nationally, an estimated 60 percent of SCHIP enrollees previously had private insurance but dropped it to take advantage of health coverage. In Colorado, CHP charges at most $35 a year to cover all the children in a family.

c) **Make children eligible for medical assistance for an entire year at a time.** [Estimated fiscal note cost is $75,861,294.] At present, families are required to report changes to their income and other eligibility factors. This changes those reporting requirements to an annual reapplication.

d) **Creates a medical assistance buy-in program for disabled adults and children if their *earnings* are less than 400 percent of the federal poverty level**, currently $88,200 for a family of four. Later in the bill this is changed to income. It is not clear whether earnings or income is the standard.

i. Using earnings rather than income as an enrollment eligibility test means that disabled people with substantial personal assets would be free to enroll in subsidized programs that are supported by people who have far less personal wealth.

ii. The fairness of taxing someone who is ill and has minimal personal wealth to support someone who is disabled with much larger personal wealth is questionable. All income should be considered.

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