City of Palo Alto
City Council Staff Report

13

(ID # 9342)

Report Type: Action Items **Meeting Date: 6/11/2018**

Summary Title: Health Care Costs Initiative Measure

Title: Accept the City Clerk's Report Certifying the Sufficiency of an Initiative Petition to Limit Health Care Costs that Hospitals and Medical Clinics May Charge; and Adopt a Resolution Placing the Initiative Petition on the November 2018 Ballot, or Adopt the Petition as an Ordinance Without Alteration, or Provide Other Direction to Staff

From: City Manager

Lead Department: City Clerk

Recommendation

Staff recommends that Council:

1. Accept the City Clerk's Certificate of Sufficiency (Attachment A) of the Initiative Petition to Impose Limits on Costs that Hospitals and Clinics May Charge in Palo Alto ("Initiative Measure") (Attachment B); and
2. Approve an ordinance (on first reading) amending Title 5 of the Palo Alto Municipal Code to establish regulations related to health care costs, as proposed by the Initiative Measure, and direct staff to place the ordinance on a future Council agenda for final adoption (second reading) by August 10, 2018; or
3. Direct staff to return at a later meeting with a resolution calling for an election to submit the Initiative Measure to the voters at the next General Municipal Election to be held on November 6, 2018; or
4. Provide other direction to Staff with respect to the Initiative Measure.

Background

Around the beginning of this year, nearly identical initiative measures were submitted in five Bay Area cities – Palo Alto, Redwood City, Pleasanton, Livermore and Emeryville – where Stanford Hospital and affiliated clinics are located. The initiative measures are

spearheaded by the Service Employees International Union ("SEIU"), and seek to cap the amount that hospitals and medical clinics (not limited to Stanford) in the city may charge payers of patient services (e.g., patients, insurers, and other private entities). In Palo Alto, as provided for in the City Charter, the initiative sponsors published a notice of intent to circulate the initiative petition in a newspaper of general circulation, and submitted the notice of intent and the text of the proposed ordinance to the City Clerk on January 9, 2018. These are the only procedural requirements prior to circulating the petition for signatures under the City Charter. (Charter, Art. VI, Sec. 2.) On May 22, 2018, the initiative sponsors submitted the petition with signatures to the City Clerk. On June 3, 2018, the Santa Clara County Registrar of Voters completed examination and verification of the signatures and determined that sufficient signatures were submitted to qualify the initiative for the ballot.

Once an initiative measure is determined to qualify through the City's Clerk's issuance of a Certificate of Sufficiency, the Council has two options under the City Charter – either adopt the measure as written, without change, or place the measure on the ballot for the next general municipal election (that is no sooner than 88 days from the date of the Clerk's Certificate of Sufficiency). Because the Clerk's Certificate of Sufficiency is dated June 7, 2018, the next general municipal election more than 88 days from the date of certification is the election on November 6, 2018. The last day to place a matter on the ballot is August 10, 2018. The Council may request further information related to the initiative's impacts, including fiscal impacts, but there would be no extension of time to determine whether to adopt or place the measure on the November 2018 ballot.

Initiative Measure

- ***Pricing Limits***: The Initiative Measure would cap the amount that hospitals and medical clinics in Palo Alto can charge private payers, including individual patients, insurers, and other entities. The amount (referred to as the "acceptable payment amount") would be capped at 115 percent of the sum of the "reasonable cost of direct patient care for a particular patient" and the "pro rata health care quality improvement cost". These terms are defined in the Initiative Measure. The "reasonable cost of direct patient care" would include estimated salaries and benefits of identified personnel categories, excluding managerial and administrative positions. "Health care quality improvement costs" would be limited to those costs paid by a hospital or clinic to "maintain, access or exchange electronic health information; support health information technologies; train non-managerial personnel engaged in direct patient care; and provide patient-centered education and counseling." Health care providers could petition the City to include other costs as allowable recoverable costs by demonstrating that the cost was spent on patient services and activities "designed to improve health quality and increase the

likelihood of desired health outcomes in ways that are capable of being objectively measured and producing verifiable results and achievements."

- ***Annual Rebates***: The Initiative Measure would require each hospital and medical clinic to calculate for each patient the "reasonable cost of direct patient care for a particular patient" and the "pro rata health care quality improvement cost" no later than 150 days from the end of each fiscal year for the prior fiscal year, and if the amount actually billed or paid for the patient's services exceeds the "acceptable payment amount", reduce the billing or issue a rebate with interest, no later than 180 days from the end of the fiscal year. Failure to meet this timeframe would result in fines.

- ***City Responsibility to Implement, Administer and Enforce***: The Initiative Measure would require the City's Administrative Services Department ("ASD") to implement, administer and enforce the regulatory program, and require the City to appropriate sufficient funds for ASD to execute these responsibilities. These new responsibilities include the following:

    - ***Fines***. ASD would need to issue notices of violation and receive payment of fines.

    - ***Recordkeeping***. ASD would need to receive and maintain records from hospitals and medical clinics (a) identifying the reasonable cost of direct patient care for each patient each fiscal year, and (b) describing each instance a required rebate or reduction was not timely issued. Records would be submitted at least annually. ASD would be required to annually publish information on rebates, reductions and fines.

    - ***Petitions to include additional "health care quality improvement costs"***: As described above, ASD would evaluate and make determinations on petitions by hospitals and clinics to include a cost not specified in the Initiative Measure as an eligible "health care quality improvement cost". The hospital or clinic would need to demonstrate to ASD's satisfaction, that the cost was actually paid and spent on certain activities to improve health quality and outcomes.

Impacts on Palo Alto

The Initiative Measure would impose limits on the amount that hospitals and medical clinics in Palo Alto could charge, and require the City of Palo Alto to assume and fund a number of new responsibilities related to health care pricing regulation.

At this time, the City does not have expertise or experience in the regulation of health care costs or health care generally. If the measure were to pass and become effective, the City would need to establish and identify funding for an administrative structure to implement and enforce the new law. The City does not currently have on staff personnel who would be able to implement this program. The Administrative Services Department that the Initiative Measure tasks with implementation, administration and enforcement currently performs functions related to the budget, investments, purchasing and contract administration, real estate and property management, warehouse, print shop and revenue collections. Because this type of program has not been adopted at the local level, it is unclear how much it would cost and the feasibility of implementation by the effective date of the ordinance. The City has been reducing staffing levels since 2010 and currently has 33 full time equivalent (FTE) positions fewer than before the great recession in FY 2009 (nearly 65 less in the General Fund). In addition, the Finance Committee recommended to the City Council that it direct staff to reduce the General Fund Operating Budget by an additional $4 million dollars by the end of this calendar year; this will most likely lead to further reductions in staff. Beyond the fiscal impacts to the City organization, which costs would ultimately be borne by City taxpayers, there could well be impacts associated with the potential loss of health care providers that may relocate out of Palo Alto due to the unique requirements and limitations that would not apply in adjoining cities like Menlo Park and Mountain View. Staff is not at this time able to fully account for and analyze the potential for this kind of exodus. In the letter from Stanford Health Care, attached to this report as Attachment C, they state that based on preliminary estimates the implementation of the initiative would result in a 20-24% reduction in revenue, which is much greater than its margin. To the extent that this type of result would apply to other providers, and the uncertainty inherent in navigating this new system, it is possible, if not likely, that a fair number of providers would elect to relocate their practices. The City has not performed an economic impact study, but direct and indirect revenue impacts are very likely if these providers were to relocate. The type of revenues potentially impacted would be unsecured property tax, sales and use tax and transient occupancy tax (hotel tax).

The medical sector, along with the high technology sector, is a significant part of Palo Alto's vibrant economy. Stanford University Medical Center (SUMC), which includes the Stanford University School of Medicine, the Stanford University Clinic, Stanford University Hospital and Lucile Salter Packard Children's Hospital, currently employs approximately 10,000 people and is one of the largest concentrations of health care services in the Bay Area. SUMC is one of three Business Employment Districts identified in the Comprehensive Plan's Land Use and Community Design Element (the others are Stanford Research Park and East Bayshore and San Antonio Road/Bayshore Corridor).

As described in the Comprehensive Plan, "These districts provide thousands of local jobs, establish a customer base for many other Palo Alto businesses and generate tax revenues for the city. Because each plays a central role in maintaining the fiscal health of the City, it is important to support their long-term viability and ability to respond to changing global economic conditions." (Comprehensive Plan 2030, p. 194.)

If the Initiative Measure passes and becomes effective, there would likely be a number of direct impacts on Palo Alto residents, which staff cannot fully quantify at this time. Residents who use affected medical providers could experience a decrease in their health care costs. If these service providers left Palo Alto, however, those cost reductions would not occur andcity residents would need to travel further to obtain medical services.

Status of Initiative in Other Cities

As of the date of this report, the initiative measure has only qualified for the ballot in Palo Alto. City staff understands that the initiative petition and signatures were submitted to the City of Livermore last week and are in the process of being evaluated to determine if the initiative has qualified, and signature gathering efforts are underway in Redwood City.

The City of Emeryville filed a pre-election challenge to the initiative there based on the alleged invalidity of the initiative on preemption and due process grounds. In that litigation, Emeryville also filed a motion for a temporary stay seeking a declaration from the court that its City Attorney is not required to prepare a ballot title and summary prior to signature gathering (a ministerial duty under the general state law that does not apply in Palo Alto) pending a court determination on the legality of the initiative. The hearing on the City of Emeryville's motion for a stay is scheduled for June 21, 2018 in the Alameda County Superior Court.

In contrast to Emeryville and the other affected cities, Palo Alto's initiative process is guided by its Charter, not the California Elections Code. The Elections Code requires the City Attorney to provide a ballot title and summary prior to the circulation of the petition for signatures. The Palo Alto Charter does not include this process. As noted above, after submittal of the notice of intent to circulate an initiative petition, Palo Alto initiative sponsors may begin gathering signatures, which they have done.

Legal Concerns

The Initiative Measure raises significant issues as to its legal validity based on federal and state law preemption. Health care pricing and reimbursement are complex areas of regulation that are addressed by several federal and state laws. Cities cannot regulate by local ordinance in those areas that the state has fully occupied either expressly or impliedly, or where the local ordinance would conflict with state law.

These legal concerns are described in greater detail in the Stanford Health Care and Stanford University letters dated June 1, 2018 (Attachment C) and June 6, 2018 (Attachment D), which reflect the arguments also presented in the legal briefs filed by the City of Emeryville and *Amici Curiae* in the pending litigation in Alameda County on the similar Emeryville initiative measure. In addition to preemption, those documents also raise legal concerns about the initiatives' violating due process as unconstitutionally vague and by preventing providers from realizing a fair and just return on their investment.

The legality of an initiative measure can be challenged at multiple points in the process, both pre-election and post-election if the measure passes.

Conclusion

Sponsors of the Initiative Measure have obtained sufficient voter signatures to qualify the measure for placement on the ballot at the next general municipal election on November 6, 2018. The Council's choices are to adopt the measure or to place it on the ballot, which it must do by August 10, 2018.

Stanford Health Center has stated its intent to file a pre-election challenge to the Palo Alto measure. Stanford, together with other hospitals, has already filed an *amici curiae* brief in the Emeryville litigation in support of that City.

Environmental Review

The potential actions in response to a voter-sponsored initiative are not a project under the California Environmental Quality Act (CEQA).

Attachments:

- Attachment A: Healthcare Cert
- Health Care Initiative
- Attachment C - Letter to Molly Stump from Sarah DiBoise re Palo Alto Accountable and Affordable Health Care Initiative - 06-01-2018
- Attachment D - Letter to Molly Stump re Legal Challenge - 06-06-2018

County of Santa Clara
Registrar of Voters

1555 Berger Drive, Bldg. 2
San Jose, CA 95112
Mailing Address: P.O. Box 611360, San Jose, CA 95161-1360
(408) 299-VOTE (8683) 866-430-VOTE (8683) FAX: (408) 998-7314
www.sccvote.org

June 3, 2018

Ms. Beth Minor, City Clerk
City of Palo Alto
250 Hamilton Ave.
Palo Alto, CA 94301

RE: Limit Overpricing Healthcare

Dear City Clerk Minor:

The petition submitted to our office on May 23, 2018 contained a raw count of 3,541 signatures. Pursuant to your request and based on six percentum of the number of regsiered voters at the last general municipal election for the City of Palo Alto, the petition needs petition needs 2,407 valid signatures to pass.

Your jurisdiction requested that the Registrar of Voters' Office conduct a full count of signature verification in an attempt to reach 2,407 valid signatures.The Registrar of Voters' Office verified the necessary number of signatures filed in accordance with Elections Code Section 9115.

The signature verification resulted in the verification of 2,825 signatures of the 3,541 signatures submitted, with 2,430 signatures found valid.

Please contact us to make arrangemensts to pickup your petition. If you have any questions concerning this matter, please feel free to contact our office at (408) 282-3009.

Sincerely,

Julia Saenz, Elections Process Supervisor II
Voter Registration Division
County of Santa Clara

Attachments: Clerk's Certificate to Initiative Petition
Petition Result Breakdown Report
Statistics Summary Report
Statistics Detail Report

Santa Clara County
Registrar of Voters

CLERK'S CERTIFICATE TO INITIATIVE PETITION

I, SHANNON BUSHEY, Registrar of Voters of the **County of Santa Clara**, State of California, hereby certify:

That the "**City of Palo Alto Accountable and Affordable Health Care**" Initiative measure has been filed with this office on May 23, 2018.

That said petition consists of 534 sections;

That each section contains signatures purporting to be the signatures of qualified electors of this county;

That attached to this petition at the time it was filed was an affidavit purporting to be the affidavit of the person who solicited the signatures, and containing the dates between which the purported qualified electors signed this petition;

That the affiant stated his or her own qualification, that he or she had solicited the signatures upon that section, that all of the signatures were made in his or her presence, and that to the best of his or her knowledge and belief each signature to that section was the genuine signature of the person whose name it purports to be;

That after the proponent filed this petition I verified the required number of signatures by examining the records of registration in this county, current and in effect at the respective purportive dates of such of signing, to determine what number of qualified electors signed the petition, and from that examination I have determined the following facts regarding this petition:

1.	Number of unverified signatures filed by proponent	3,541
2.	Number of signatures verified	2,825
a.	Number of signatures found SUFFICIENT	2,430
b.	Number of signatures found NOT SUFFICIENT	395
1.	NOT SUFFICIENT because DUPLICATE	32

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal this 3rd day of June, 2018.

Shannon Bushey
Registrar of Voters
By: _____
Deputy

JOBD84

Petition Result Breakdown

JobD84 City of Palo Alto Health Care
JobD84 City of Palo Alto Accountable and Affordable Health Care Initiative

		Percent of Sigs Checked	Percent of Sample Size
Signatures Required	**2407**		
Raw Count	**3,541**		
Sample Size	**3,541**		20.2 %
Sigs Checked	**2,825**		
Sigs Not Checked	**716**		
Sigs Valid	**2,430**	86.0 %	68.6 %
Sigs Invalid	**395**	14.0 %	11.2 %
Duplicated	32	1.0 %	0.9 %
Non-duplicate Invalids	363	13.0 %	10.3 %

RESULT ABBR	RESULT DESCRIPTION		
Approved	Approved	2,430	86.0 %
NotReg	Not Registered	216	7.6 %
OutOfDist	Out of District	20	0.7 %
Duplicate	Signed more than once	32	1.1 %
RegLate	Registered Late	14	0.5 %
RegDiffAdd	Registered at a Different Address	70	2.5 %
NoResAdd	No Residence Address Given	2	0.1 %
NoSig	No Signature	1	0.0 %
PrintedSig	Printed Signature	2	0.1 %
SigNoMatch	Signatures Don't Match	38	1.3 %

STATISTICS SUMMARY	Value	% Raw	% Req
Pages Processed	534	100.0 %	
Total Checked	2825	79.8 %	117.4 %
Uncorrected Valid	2430	68.6 %	100.9 %
Duplicate Adjustment	0		
Estimated Valid	2430	68.6 %	100.9 %

Min Required (95%): 2286.7
Min Required to pass Based on Sample (110%): 2647.7

Petition Abbr: JobD84 City of Palo Alto Health Care

Petition Name: JobD84 City of Palo Alto Accountable and Affordable Health Care Initiative

Status: In Process

District: City of Palo Alto

Details | Statistics Summary | **Statistics Detail** | Survey Questions | Time Mgmt

Values

Raw	3541	Sigs Found Valid in Sample:	2430
Sample	3541	Sigs Withdrawn:	0
Num of Sigs	2825	Dup Sigs Found:	32
Num Not Checked:	716	Other Invalid:	363
		Sigs Found Not Valid in Sample:	395

Calculations

Percent Of Valid = Number Found Valid/Number in Sample	68.6%
Uncorrected Total Valid = Raw Count * Percent of Valid	2430
Duplicate Signature Factor = Raw Count/Sample Size	1
Dup Sig Weight = Dup Sig Factor * (Dup Sig Factor - 1)	0
Dup Sig Adjustment = Dup Sig Weight * Number of Dup Sigs	0
Total Valid Based on the Sample = Uncorrected Total Valid - Dup Sig Adjustment	2430

Results

Total Valid Based on the Sample	2429
Required Valid	2407
Minimum Required (95%)	2286.65
Minimum Valid Required to Pass based on Sample (110%)	2647.7

Petition Abbr: JobD84 City of Palo Alto Health Care

Petition Name: JobD84 City of Palo Alto Accountable and Affordable Health Care Initiative

Status: In Process

District: City of Palo Alto

Details | Statistics Summary | Statistics Detail | Survey Questions | Time Mgmt

	Value	% of Raw	% of Req
Pages Processed	534	100.0%	
Total Checked	2825	79.8%	117.4%
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Estimated Valid	2430	68.6%	100.9%

Refresh Statistics

Minimum Required (95%) 2286.65

Minimum Required to Pass Based on Sample (110%) 2647.7

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AFFIDAVIT OF PUBLICATION

IN THE

DAILY POST

385 Forest Avenue, Palo Alto, California 94301
(650)328-7700

IN THE
SUPERIOR COURT
OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF SANTA CLARA

No. AD #66677

Notice of Intent to Circulate Petition

STATE OF CALIFORNIA }
COUNTY OF SANTA CLARA } SS

I, the undersigned, state that I am, and at all times herein mentioned was, a citizen of the United States of America, over the age of eighteen years, and not a party to or interested in the above entitled matter, that I was at and during all said times and still am the principle clerk of the publisher of the Daily Post in said County of Santa Clara, State of California; that said is and was at all times herein mentioned a newspaper of general circulation as that term is defined by Section 6000 and 6020 of the Government Code of the State of California; that said was adjudged as such by Superior Court of the County of Santa Clara, State of California, under date of February 27, 2017, Case Number 17CV305056; that the notice of which the annexed is a true printed copy, was set not smaller than nonpareil and was preceded with words printed in black-face type not smaller than nonpareil, describing and expressing in general terms, the purport and character of the notice intended to be given; that said notice was published and printed in said newspaper on the following dates, to wit:

January 5, 2018

January 5, 2018

DATE OF FIRST PUBLICATION IN THE DAILY POST

I declare under penalty of perjury that the foregoing is true and correct.

Executed on

January 5, 2018

at Palo Alto, California

Signed

NOTICE OF INTENT TO CIRCULATE PETITION
(Palo Alto City Charter Article VI. § 2)

NOTICE OF INTENT TO CIRCULATE PETITION

Notice is hereby given of the intention of the persons whose names appear hereon to circulate an initiative petition within the city of Palo Alto for the purpose of imposing reasonable limits on prices that healthcare providers may charge and encouraging further investment in healthcare quality improvements.

A statement of the reasons of the proposed action as contemplated in the petition is as follows:

The People of Palo Alto wish to limit overpricing in health care while incentivizing real quality improvement. Too often, health systems leverage their market power and prestigious reputations to charge consumers prices that are many times higher than the cost of treatment. And, too often, these very same providers preform poorly on quality metrics like Hospital Acquired Conditions (HACs). This initiative will ensure providers use consumer dollars on direct patient care instead of ancillary expenses, like executive salaries, landscaping, and facility expansion.

Currently, some healthcare providers charge as much as 600% above cost for patient care. These overcharges are passed on to consumers in the form of higher premiums, co-pays, and other out-of-pocket expenses. By limiting healthcare charges to 115% of the cost of treatment and quality improvement, this initiative will reduce patients' overall healthcare spending -- and ensure that a significant portion of revenues are used to improve the quality of care through measures such as better staffing ratios, equipment, and patient care protocols.

ELI AKERIB
NAME OF PROPONENT

ELI AKERIB
PROPONENT'S SIGNATURE

1/3/2018
DATE

CITY OF PALO ALTO, CA
CITY CLERK'S OFFICE
18 JAN -9 PM 12:19

ENTERTAINMENT

Live music tonight

ANGELICA'S BELL THEATER & BISTRO — Vocalist Juls and friends: "Latin Rhythms and originals," 8:30 p.m. $17-$29. 863 Main St., Redwood City. (650) 365-3226, www.angelicasllc.com.

CLUB FOX — Gamma featuring Davey Pattison, The Butlers, 8 p.m. $25. 2223 Broadway, Redwood City. (877) 435-9849, www.clubfoxrwc.com.

SAVANNA JAZZ — Pascal Bokar Band and special guest, 8 p.m. 1189 Laurel St., San Carlos. (415) 624-4549, www.savannajazz.com.

BISCUITS AND BLUES — JJ Thames, 7:30 p.m. and 10 p.m. $24. 401 Mason St., San Francisco. (415) 292-2583, www.biscuitsandblues.com.

BRICK AND MORTAR MUSIC HALL — Direct Collapse, Wander, The Culling, Supplement, 8 p.m. $8. 1710 Mission St., San Francisco. (415) 800-8782, brickandmortarmusic.com.

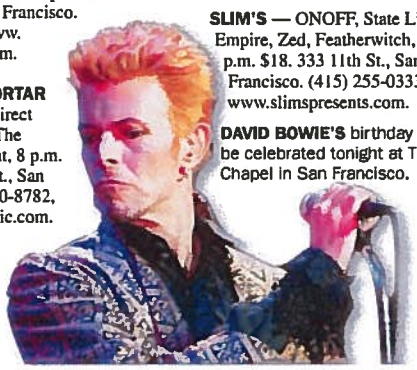
THE CHAPEL — David Bowie birthday bash with The First Church of the Sacred Silversexual, 9 p.m. $25-$40. 777 Valencia St., San Francisco. (415) 551-5157, www.thechapelsf.com.

GREAT AMERICAN MUSIC HALL — Reid Genauer and Folks, Colonel and The Mermaids, 9 p.m. $21. 859 O'Farrell St., San Francisco. www.slimspresents.com.

THE INDEPENDENT — Long Beach Dub Allstars, Burnt, DJ Sep, 9 p.m. $25. 628 Divisadero St., San Francisco. (415) 771-1421.

SFJAZZ — Savion Glover and Marcus Gilmore, 7:30 p.m. $35-$95. 201 Franklin St., San Francisco. (866) 920-5299, www.sfjazz.org.

SLIM'S — ONOFF, State Line Empire, Zed, Featherwitch, 9 p.m. $18. 333 11th St., San Francisco. (415) 255-0333, www.slimspresents.com.



DAVID BOWIE'S birthday will be celebrated tonight at The Chapel in San Francisco.

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ELI AKERIB
NAME OF PROPONENT

ELI AKERIB
PROPONENT'S SIGNATURE

1/3/2018
DATE

18 JAN -9 PM 12:19
CITY OF PALO ALTO, CA
CITY CLERK'S OFFICE

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(Palo Alto City Charter Article VI. § 2)

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ELI AKERIB

NAME OF PROPONENT

PROPONENT'S SIGNATURE

1/3/2018

DATE

CITY OF PALO ALTO,CA
CITY CLERK'S OFFICE
18 JAN -9 PM 12:19

PALO ALTO ACCOUNTABLE AND AFFORDABLE HEALTH CARE INITIATIVE

SECTION 1. Chapter 5.40 is added to Title 5 of the Palo Alto Municipal Code, governing Health and Sanitation, to read:

Sec. 5.40.010 Purpose and intent.

It is the purpose and intent of this Chapter to provide for the orderly regulation of hospitals and other health facilities, as defined in this Chapter, in the interests of the public health, safety and welfare, by providing certain minimum standards and regulations regarding their operation. The prices charged to patients and other payers have far-reaching effects on consumers purchasing health care services and insurance, as well as taxpayers supporting public health and welfare programs. Investments in quality of care improvements can benefit patients and caregivers, and ultimately result in lower overall health care costs. For these reasons, and because neither the State nor federal governments have yet done so, this Chapter seeks to impose reasonable limits on prices that hospitals and other health facilities may charge and encourages further investment in health care quality improvements.

Sec. 5.40.020 Definitions.

For purposes of this Chapter the following terms have the following meanings:

(a) "Acceptable payment amount" means an amount equal to 115 percent of the sum of the reasonable cost of direct patient care for a particular patient and the pro rata health care quality improvement cost, or such amount determined by the Administrative Services Department pursuant to Section 5.40.030(d).

(b) "Amount reasonably estimated to be paid" means the payment amount specified by agreement between the hospital, medical clinic, or other provider, and the payer, or, in the absence of such an agreement, the amount of the bill or invoice for services.

(c) "Health care quality improvement costs" means costs a hospital, medical clinic, or other provider pays that are necessary to: maintain, access or exchange electronic health information; support health information technologies; train non-managerial personnel engaged in direct patient care; and provide patient-centered education and counseling. Additional costs may qualify as health care quality improvement costs, as authorized pursuant to Section 5.40.030(c).

(d) "Hospital" means a hospital within the meaning of subdivision (a) of Section 1250 of the California Health and Safety Code, but does not include: (1) any children's hospital identified in Section 10727 of the California Welfare and Institutions Code; (2) public hospitals, as defined in paragraph (25) of subdivision (a) of Section 14105.98 of the California Welfare and Institutions Code; or (3) hospitals operated by or licensed to the United States Department of Veterans Affairs.

(e) "Medical clinic" means a clinic within the definition of Section 1200 of the California Health and Safety Code, but does not include: (1) a chronic dialysis clinic, as defined by Section 1204(b)(2) of the California Health and Safety Code; (2) a clinic that provides services exclusively to children or operates under the license of a children's hospital identified in Section 10727 of the California Welfare and Institutions Code; (3) community clinics or free clinics, as defined by Sections 1204(a)(1)(A) and (B) of the California Health and Safety Code; (4) clinics that primarily provide reproductive health care services, as defined in Section 6215.1 of the California Government Code, or family planning services, as defined by Section 14503 of the California Welfare and Institutions Code; (5) a clinic that is licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state; or (6) a clinic operated by or licensed to the United States Department of Veterans Affairs.

(f) "Other provider" means any provider organization within the meaning of subdivision (f) of Section 1375.4 of the California Health and Safety Code, any risk-bearing organization within the meaning of subdivision (g) of Section 1375.4 of the California Health and Safety Code, and any outpatient setting within the meaning of Section 1248 of the California Health and Safety Code. Provided, however, that "other provider" shall not include: (1) a chronic dialysis clinic, as defined by Section 1204(b)(2) of the California Health and Safety Code; (2) an organization that provides services exclusively to children or operates under the license of a children's hospital identified in Section 10727 of the California Welfare and Institutions Code; (3) community clinics or free clinics, as defined by Sections 1204(a)(1)(A) and (B) of the California Health and Safety Code; (4) clinics that primarily provide reproductive health care services, as defined in Section 6215.1 of the California Government Code, or family planning services, as defined by Section 14503 of the California Welfare and Institutions Code; (5) an organization owned by, operated by, or licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state; or (6) an organization owned by, operated by or licensed to the United States Department of Veterans Affairs.

(g) "Payer" means the person or persons who paid or are financially responsible for payments for services provided to a particular patient, and may include the patient or other individuals, primary insurers, secondary insurers, and other entities, provided that the term does not include Medicare or any other federal, state, county, city, or other local government payer.

(h) "Pro rata health care quality improvement cost" means the total health care quality improvement costs paid by a hospital, medical clinic, or other provider in a fiscal year, divided by the total number of patients treated by that hospital, medical clinic, or other provider in the same fiscal year.

(i) "Reasonable cost of direct patient care" means the cost of providing care to a patient in a fiscal year, as provided for in Section 5.40.030(b)(1).

Sec. 5.40.030 Pricing limitations and rebates.

All hospitals, medical clinics, and other providers shall comply with the following requirements:

(a) Commencing January 1, 2019, a hospital, medical clinic, or other provider shall annually issue a rebate and a reduction in billed amount to a payer for all money paid or billed for services provided to a patient in excess of the acceptable payment amount for those services, as follows:

(1) No later than 150 days after the end of its fiscal year, a hospital, medical clinic, or other provider shall calculate its health care quality improvement costs and pro rata health care quality improvement cost for the most recently completed fiscal year.

(2) No later than 150 days after the end of its fiscal year, a hospital, medical clinic, or other provider shall compile the following information for each patient to whom it provided care in the most recently completed fiscal year:

(i) patient;

(ii) total amount received from each payer or payers for health care services provided in the fiscal year, or, if payment has not been made in full, the amount reasonably estimated to be paid by that payer or those payers for health care services provided in the fiscal year;

(iii) reasonable cost of direct patient care provided in the fiscal year;

(iv) acceptable payment amount for the fiscal year; and

(v) the amount, if any, by which the total amount identified pursuant to subparagraph (ii) exceeds the acceptable payment amount.

(3) No later than 180 days after the end of its fiscal year, a hospital, medical clinic, or other provider shall (i) issue a rebate of any amount paid, as described by subdivision (a)(2)(ii), in excess of the acceptable payment amount, and (ii) for any amount that has not been paid and for which the amount reasonably estimated to be paid exceeds the acceptable payment amount, as described by subdivision (a)(2)(ii), reduce the invoice to the acceptable payment amount and reissue the invoice to the payer.

(4) Where a rebate must be paid or an amount billed but not yet paid must be reduced pursuant to this section, and more than one payer is responsible, the hospital, medical clinic, or other provider shall divide and distribute the total required rebate or reduction in billed amounts among the payers consistent with the payers' relative obligations to pay for the services. The hospital, medical clinic, or other provider shall issue the rebate together with interest thereon at the rate of interest specified in subdivision (b) of Section 3289 of the California Civil

Code, which shall accrue from the date the hospital, medical clinic, or other provider received payment.

(5) Where, in any fiscal year, the rebate the hospital, medical clinic, or other provider must issue to a single payer is less than twenty dollars ($20), the hospital, medical clinic, or other provider need not issue that rebate.

(6) In the event a hospital, medical clinic, or other provider is required to issue a rebate or reduction in amount billed under this section, no later than 180 days after the end of its fiscal year the hospital, medical clinic, or other provider shall pay a fine to the Administrative Services Department for each patient for whom a rebate or reduction is required in the following amounts:

> (i) If rebates or reductions are owed by a hospital, medical clinic, or other provider for services provided to 50 patients or fewer in the fiscal year, an amount equal to five percent of the required rebate or reduction, provided that the fine for each rebate or reduction shall be at least one hundred dollars ($100), but shall not exceed one thousand dollars ($1,000) per rebate or reduction.
>
> (ii) If rebates or reductions are owed by a hospital, medical clinic, or other provider for services provided to more than 50 patients in the fiscal year, an amount equal to 10 percent of the required rebate or reduction, provided that the fine for each rebate or reduction shall be at least one hundred dollars ($100), but shall not exceed one thousand dollars ($1,000) per rebate or reduction.

(7) In the event a hospital, medical clinic, or other provider fails to issue a rebate or reduction within the time required by paragraph (3), consistent with Municipal Code Section 1.08.010(d) each subsequent day that the required rebate or reduction is not issued constitutes a separate violation for which a fine is to be imposed pursuant to paragraph (6).

(8) Fines collected pursuant to paragraphs (6) and (7) shall be used by the Administrative Services Department to implement and enforce laws governing hospitals, medical clinics, and other providers.

(9) Where reimbursement for health care services is subject to the requirements of Section 1371.31(a) of the California Health and Safety Code, nothing in this Chapter shall affect the reimbursements required by that Section. Further, (i) the payments received for health care services that are subject to the reimbursement requirements of Section 1371.31(a) of the California Health and Safety Code shall not be included in the total amount received, or the total amount reasonably estimated to be paid, for the fiscal year pursuant to subdivision (a)(2)(ii), and (ii) the costs associated with providing health care services that are subject to the reimbursement requirements of Section 1371.31(a) of the California Health and

Safety Code shall not be included in the reasonable cost of direct patient care for the fiscal year pursuant to subdivision (a)(2)(iii).

(b) (1) No later than 150 days after the end of its fiscal year, every hospital, medical clinic, or other provider shall provide to the Administrative Services Department information identifying the reasonable cost of direct patient care for each patient to whom services were provided in the fiscal year. The reasonable cost of direct patient care shall be the reasonable costs directly associated with operating a hospital, medical clinic, or other provider in Palo Alto and providing care to patients in Palo Alto. The reasonable cost of direct patient care shall include only (i) salaries, wages, and benefits of non-managerial hospital, medical clinic, or other provider staff, including all personnel who furnish direct care to patients, regardless of whether the salaries, wages, or benefits are paid directly by the hospital, medical clinic, or other provider, or indirectly through an arrangement with an affiliated or unaffiliated third party, including but not limited to a governing entity, an independent staffing agency, a physician group, or a joint venture between a hospital, medical clinic, or other provider, and a physician group; (ii) staff training and development; (iii) pharmaceuticals and supplies; (iv) facility costs, including rent, maintenance, and utilities; (v) laboratory testing; and (vi) depreciation and amortization of buildings, leasehold improvements, patient supplies, equipment, and information systems. For purposes of this paragraph, "non-managerial hospital, medical clinic, or other provider staff" includes all personnel who furnish direct care to patients, including doctors, nurses, technicians and trainees, social workers, registered dietitians, environmental service workers, and non-managerial administrative staff, but excludes managerial staff such as facility administrators. Categories of costs of direct patient care may be further prescribed by the department through regulation.

(2) Each hospital, medical clinic, or other provider shall maintain and report to the Administrative Services Department the information described in paragraph (1) of this subdivision, the information described in paragraph (1) of subdivision (a), and information describing every instance during the period covered by the submission when the rebate or reduction required under subdivision (a) was not timely issued in full, and the reasons and circumstances therefor. The information required to be maintained and the report required to be submitted by this paragraph shall each be independently audited by a certified public accountant in accordance with the standards of the Accounting Standards Board of the American Institute of Certified Public Accountants, and shall include the opinion of that certified public accountant as to whether the information contained in the report fully and accurately describes, in accordance with generally accepted accounting principles in the United States, the information required to be reported.

(3) Each hospital, medical clinic, or other provider shall annually submit the report required by paragraph (2) of this subdivision on a schedule, in a format, and on a form prescribed by the Administrative Services Department, provided

that the hospital, medical clinic, or other provider shall submit the report no later than 150 days after the end of its fiscal year.

(4) The chief executive officer or administrator of the hospital, medical clinic, or other provider shall personally certify under penalty of perjury that he or she is satisfied, after review, that all information submitted to the department pursuant to paragraph (2) of this subdivision is accurate and complete.

(5) The Administrative Services Department shall annually publish information showing the number and aggregate amount of rebates provided, as well as the number and aggregate amount of fines paid, by each hospital, medical clinic, or other provider. Any information that must be reported to or by the Department pursuant to this Chapter shall be made available to the public upon request, consistent with the requirements of the California Public Records Act and any other applicable law, including limitations on public disclosure in the interest of personal privacy.

(c) (1) A hospital, medical clinic, or other provider may petition the Administrative Services Department at any time for a determination that a cost not specified in Section 5.40.020(c) is a health care quality improvement cost or for a determination that a cost not specified in Section 5.40.030(b)(1) is a reasonable cost of direct patient care.

(2) The Administrative Services Department may grant a petition concerning health care quality improvement costs only upon finding that the hospital, medical clinic, or other provider has demonstrated:

(i) The cost was spent on activities designed to improve health quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;

(ii) The hospital, medical clinic, or other provider actually paid the cost; and

(iii) The cost was spent on services offered at the hospital, medical clinic, or other provider to patients.

(3) The Administrative Services Department may grant a petition concerning reasonable costs of direct patient care only upon finding that the hospital, medical clinic, or other provider has demonstrated:

(i) The cost was directly associated with operating a hospital, medical clinic, or other provider in Palo Alto and providing care to patients in Palo Alto and is reasonable in light of market rates for similar goods or services;

(ii) The hospital, medical clinic, or other provider actually paid the cost; and

(iii) The cost was spent on services offered at the hospital, medical clinic, or other provider to patients.

(4) The Administrative Services Department may permit the hospital, medical clinic, or other provider to apply a cost incurred in one year equally over a period not to exceed five years upon finding that the hospital, medical clinic, or other provider has demonstrated that the cost is reasonably expected to provide health care quality improvements or support direct patient care during that period.

(d) (1) A hospital, medical clinic, or other provider may petition the Administrative Services Department at any time for a determination that the acceptable payment amount defined in Section 5.40.020(a) should be increased with respect that hospital, medical clinic, or other provider.

(2) The Administrative Services Department may grant such a petition only upon finding that an acceptable payment amount of 115 percent of the sum of the reasonable cost of direct patient care and the pro rata health care quality improvement cost would be confiscatory or otherwise unlawful as applied to that hospital, medical clinic, or other provider.

(3) If the Administrative Services Department grants a petition pursuant to subdivision (d)(2), it may adjust the number "115" in Section 5.40.020(a) to the lowest whole number such that the resultant acceptable payment amount would not be unlawful. The Administrative Services Department shall not increase the acceptable payment amount to any amount greater than that minimally necessary under California and federal law. Any variance granted pursuant to subdivision (d) shall be for a period of one fiscal year, unless the petitioner demonstrates that a variance is likely to be required for subsequent fiscal years, in which case the Department may grant a variance for up to five years.

(4) In a petition pursuant to subdivision (d), the burden shall be on the hospital, medical clinic, or other provider to (i) prove that an acceptable payment amount of 115 percent of the sum of the reasonable cost of direct patient care for a particular patient and the pro rata health care quality improvement cost would be unlawful, and (ii) provide the Administrative Services Department with all information necessary to determine the lowest acceptable payment amount required by law.

Sec. 5.40.040 Implementation and Enforcement.

(a) The Administrative Services Department shall be authorized to coordinate implementation and enforcement of this Chapter and shall promulgate appropriate guidelines, regulations or rules for such purposes consistent with this Chapter. Such guidelines, regulations or rules shall ensure that implementation of this Chapter is consistent with the requirement of due process imposed by the California and United States Constitutions and, as necessary, shall provide guidance concerning the process for bringing a petition under this Chapter with the goals of minimizing the burden to the petitioner and increasing the efficiency of the petition review process. Any guidelines,

regulations or rules promulgated by the department shall have the force and effect of law. The City shall appropriate to the Administrative Services Department sufficient funds to enable the department to implement and enforce this Chapter.

(b) If a determination of a violation has been made, consistent with the requirements of due process, and except where prohibited by state or federal law, the department may request that City agencies or departments revoke or suspend any registration certificates, permits or licenses held or requested by the violator until such time as the violation is remedied. All City agencies and departments shall cooperate with revocation or suspension requests from the department. A violation of this Chapter may also be grounds for denying a hospital, medical clinic, or other provider a business license under Municipal Code Section 4.04.140(a)(5).

(c) Violation of this Chapter shall be a misdemeanor. The department, the City Attorney, any person aggrieved by a violation of this Chapter, any entity a member of which is aggrieved by a violation of this Chapter, or any other person or entity acting on behalf of the public as provided for under applicable state law, may bring a civil action in a court of competent jurisdiction against a hospital, medical clinic, or other provider violating this Chapter, or against the City for *de novo* review of a determination pursuant to Section 5.40.030(c) or (d), and, upon prevailing, shall be entitled to such legal or equitable relief as may be appropriate including, without limitation, twice the amount of the required rebate or reduction up to the maximum amount allowable by law and injunctive relief, and shall be awarded reasonable attorneys' fees and expenses. Provided, however, that any person or entity enforcing this Chapter on behalf of the public as provided for under applicable state law shall, upon prevailing, be entitled only to equitable, injunctive or restitutionary relief, and reasonable attorneys' fees and expenses. Nothing in this Chapter shall be interpreted as restricting, precluding, or otherwise limiting a separate or concurrent criminal prosecution under the Municipal Code or state law. Jeopardy shall not attach as a result of any administrative or civil enforcement action taken pursuant to this Chapter.

Sec. 5.40.050 Severability.

The provisions of this Chapter are severable. If any provision of this Chapter or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

STANFORD
UNIVERSITY

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June 1, 2018

Molly Stump
City Attorney
Office of the City Attorney
City Hall, 8th Floor
250 Hamilton Avenue
Palo Alto, CA 94301

Re: **"Palo Alto Accountable and Affordable Health Care Initiative"**

Dear Ms. Stump:

I write on behalf of Stanford Health Care ("Stanford") to express concerns regarding the "Palo Alto Accountable and Affordable Health Care Initiative" (the "Initiative") that was recently submitted for certification by individuals affiliated with the Service Employees International Union – United Healthcare Workers West ("SEIU-UHW"). Stanford believes that the Initiative is facially invalid and an improper exercise of the initiative power. In fact, the city attorney in Emeryville, where SEIU-UHW is funding a nearly identical initiative, has filed suit to prevent that initiative from proceeding for those very reasons. If the Palo Alto city clerk certifies the sufficiency of the signatures submitted in connection with the Initiative and the city council votes to place the initiative on the ballot, Stanford intends to challenge the validity of the measure. We hope that, rather than place the Initiative on the ballot, the City of Palo Alto would join us in that effort to stop this unconstitutional and otherwise unlawful measure from appearing on the ballot. However, I write today for a different reason—to request that the City (a) set the Initiative as a separate agenda item if the clerk certifies the signatures for presentation to the city council, and (b) order a report addressing the fiscal impact and the impact on the community's ability to attract and retain business and employment.

The stated purpose of the Initiative is "to impose reasonable limits on prices that hospitals and other health facilities may charge." Sec. 5.40.010. To do so, the Initiative would require Palo Alto hospitals, medical clinics, and certain "other providers" to calculate the "reasonable cost of direct patient care" and the pro-rata "health care quality improvement costs" for each patient, and caps the amount a provider can recover in reimbursement for care provided to that patient at 115% of the sum of those amounts, which the Initiative defines as the "acceptable payment amount." Secs. 5.40.020, 5.40.030(a). If a provider collects from or bills the "person or persons who paid or are financially responsible for payments for services provided to a particular patient"

an amount greater than the acceptable payment amount over the course of a fiscal year, the provider must issue that "payer" a rebate (plus interest) or reduction in the amount collected or billed "in excess of the acceptable payment amount" and pay fines of up to $1,000 per rebate or reduction, with those fines continuing to accrue if they are not timely paid. Secs. 5.40.030(a)(2)-(4), (6)-(7). While the Initiative allows providers to petition the City to obtain relief from the 115% cap, such a variance may be granted only when the City's Administrative Services Department (the "Department")—a city agency that has no experience or expertise as a health care payer or with health care costs or reimbursement—decides that the Initiative's application would be "confiscatory or otherwise unlawful." Sec. 5.40.030(d)(2). And, even if it grants a petition, the Department must evaluate the increase to ensure that it does "not increase the acceptable payment amount to any amount greater than that minimally necessary under California and federal law." Sec. 5.40.030(d)(3)

Setting aside for the moment the fact that the Initiative would be, if enacted, unconstitutional, the billing, rebate, and penalty process set out in the Initiative would place extraordinary burdens on the City. While the Department must wade into legal determinations when a provider petitions for relief from the 115% cap as discussed above, the Department must analyze the economics behind other petitions. Before granting a provider's petition to include in its cost calculations any health care quality improvement costs not specified by the Initiative, the Department must evaluate and find that each cost was "spent on activities designed to improve health quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements." Sec. 5.40.030(c)(2). Similarly, before granting a provider's petition to include in its cost calculations any reasonable costs of care not specified by the Initiative, the Department must evaluate and find that each cost was "directly associated with operating a hospital, medical clinic, or other provider in Palo Alto and providing care to patients in Palo Alto and is reasonable in light of market rates for similar goods or services." Sec. 5.40.030(c)(3). And, if a provider seeks to apply a cost incurred in one year over a longer period (up to five years), the Department must evaluate and find that "the cost is reasonably expected to provide health care quality improvements or support direct patient care during that period." Sec. 5.40.030(c)(4).

The Initiative would require the Department not only to hear and assess provider petitions for relief from the 115% cap and the restrictions on allowable costs, but also to take on many other new administrative responsibilities. For example:

- The Department must obtain from every covered provider "information identifying the reasonable cost of direct patient care for each patient to whom services were provided in the fiscal year." Sec. 5.40.030(b)(1). Those costs must be calculated according to the Initiative's determination of which costs are reasonable, on a category-by-category basis. *Id.*

- The Department must obtain from every covered provider (i) the information used to calculate the reasonable cost of direct patient care per patient discussed above; (ii) the information used to determine whether a rebate or reduction is required after calculating health care quality improvement costs, amounts received from each payer for a patient, the reasonable cost of direct patient care, the acceptable payment amount per patient, and the amount any payments exceed the acceptable payment amount; (iii) "information

describing every instance during the period covered by the submission when the rebate or reduction required … was not timely issued in full, and the reasons and circumstances therefor"; and (iv) an opinion by a "certified public accountant as to whether the information contained in the report fully and accurately describes … the information required to be reported." Sec. 5.40.030(b)(2).

- The Department must establish a schedule, format, and form for accepting the reports containing the information discussed above. Sec. 5.40.030(b)(3).

- The Department must "annually publish information showing the number and aggregate amount of rebates provided, as well as the number and aggregate amount of fines paid, by each hospital, medical clinic, or other provider," and make that information available to the public upon request after evaluating and taking into account "limitations on the public disclosure in the interest of personal privacy." Sec. 5.40.030(b)(5). Thus, the City will also have to assume the significant compliance costs and potential liability under the Health Insurance Portability and Accountability Act (HIPAA).

Implicit in these provisions is a further responsibility for the City to maintain this vast quantity of information so that it can evaluate compliance and enforce the Initiative.

The Initiative also requires the City to engage in extensive implementation and enforcement activities. The Department must "promulgate appropriate guidelines, regulations or rules" for implementation and enforcement "consistent with" the Initiative, while ensuring that the implementation is also "consistent with the requirement of due process imposed by the California and United States Constitutions." Sec. 5.40.040(a). The Department must also "provide guidance concerning the process for bringing a petition … with the goals of minimizing the burden to the petitioner and increasing the efficiency of the petition review process." *Id.* Where the Initiative has been violated, the City must revoke or suspend registration certificates, permits, and licenses held by the violator at the Department's request. Sec. 5.40.040(b). And while the City may bring a civil action against a provider for violating this chapter, the City may also be named as a defendant in an action for review of any determinations it makes on a provider's petition for a variance from the Initiative's terms. Sec. 5.40.040(c).

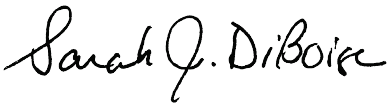
The Initiative does not identify any source of funding for the City's new responsibilities, which the City will have to discharge regardless of whether any provider violates the Initiative. Instead, the Initiative simply directs the City to "appropriate to the Administrative Services Department sufficient funds to enable the department to implement and enforce" the new law. Sec. 5.40.040(a). And while the Department is charged with collecting any fines that may be paid under the Initiative, those hypothetical funds are not even ear-marked for the Initiative's enforcement, but instead are to be used generally "to implement and enforce laws governing hospitals, medical clinics, and other providers." Sec. 5.40.030(a)(8).

Given the significant administrative burdens the Initiative would place on the City, we request that the City set the Initiative as a separate item on it is agenda if the city clerk certifies the signatures submitted in support of the Initiative and order a staff report to address the Initiative's impact on the City's administrative function. Further, we request that the City refer the Initiative to the appropriate city agency or agencies for a report addressing the Initiative's fiscal impact

and its impact on the community's ability to attract and retain business and employment. *See, e.g.*, Cal. Elec. Code § 9212(a)(1) & (6); *id.* § 9215. In that regard, Stanford's preliminary calculations indicate that implementation of the initiative would result in a 20-25% drop in its revenues, which is many times greater than Stanford's margin. As a consequence, Stanford would have to implement cuts to its staffing and benefit levels, facilities, and/or programs to avoid violating the statute and incurring still greater expenses in the form of fines and interest on rebates required by the Initiative. Given the dramatic impact on the City and its health care providers—and, as a necessary consequence, the community and the employers that rely on Palo Alto's world-class health care providers—we urge the City to refrain from considering whether the Initiative should be placed on the ballot until the City has received and evaluated the reports requested here.

Thank you for the opportunity to express Stanford's concerns, and for your attention to this important matter. Please let me know if you believe that any further information would be of assistance.

Sincerely,



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June 6, 2018

Molly Stump
City Attorney
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City Hall, 8th Floor
250 Hamilton Avenue
Palo Alto, CA 94301

Re: **"Palo Alto Accountable and Affordable Health Care Initiative"**

Dear Ms. Stump:

I write on behalf of Stanford Health Care ("Stanford") to express concerns regarding the "Palo Alto Accountable and Affordable Health Care Initiative" (the "Initiative") recently submitted to the city clerk for certification by individuals affiliated with the Service Employees International Union – United Healthcare Workers West ("SEIU-UHW"). We believe that the Initiative is facially invalid and unconstitutional. Moreover, because the proposed measure "exceed[s] the initiative power," pre-election review is "eminently appropriate." *City & County of San Francisco v. Patterson*, 202 Cal. App. 3d 95, 100 (1988). In fact, the city attorney in Emeryville, where SEIU-UHW is funding a substantively identical initiative, already filed suit to prevent the initiative from proceeding in that city. The electorate has no more power than the City Council to enact laws that are preempted by state and federal law. Here, the Initiative would place Stanford and other Palo Alto health care providers in the impossible situation of having to choose between complying with either a local ordinance or state and federal laws that govern the charging and payment of health care. It also intrudes in numerous phases of the health care field that are fully occupied by state and federal law. On its face, the Initiative would also violate due process by impairing Stanford's ability to provide technologically-advanced, high-quality care to all patient populations, including charity care to uninsured patients, and undermine the policy determinations that California and the federal government have already made in this area. And, it would create an impermissible burden on the City of Palo Alto by requiring the Administrative Services Department (the "Department") to act as a *de facto* court while attempting to enforce an ordinance that would be unconstitutionally vague. For these reasons, set forth in more detail below, we respectfully request that the City refrain from placing the Initiative on the ballot if the city clerk certifies that sufficient signatures have been collected.

The stated purpose of the Initiative is "to impose reasonable limits on prices that hospitals and other health facilities may charge." Sec. 5.40.010. To do so, the Initiative would require Palo Alto hospitals, medical clinics, and certain "other providers" to calculate the "reasonable cost of direct patient care" and the pro-rata "health care quality improvement costs"

for each patient, and would cap the amount a provider can recover in reimbursement for care provided to that patient at 115% of the sum of those amounts, which the Initiative defines as the "acceptable payment amount." Secs. 5.40.020, 5.40.030(a). If a provider collects from or bills the "person or persons who paid or are financially responsible for payments for services provided to a particular patient" an amount greater than the acceptable payment amount over the course of a fiscal year, the provider must issue that "payer" a rebate (plus interest) or reduction in the amount collected or billed "in excess of the acceptable payment amount" and pay fines of up to $1,000 per rebate or reduction, with those fines continuing to accrue if they are not timely paid. Secs. 5.40.030(a)(2)-(4), (6)-(7). While the Initiative allows providers to petition the City to obtain relief from the 115% cap, such a variance may be granted only when the Department—a city agency that has no experience or expertise as a health care payer or with health care costs or reimbursement—decides that the Initiative's application would be "confiscatory or otherwise unlawful." Sec. 5.40.030(d)(2).

The Initiative defines "health care quality improvement costs" and the "reasonable cost of direct patient care" narrowly, and excludes categories of costs that are critical to the care Stanford provides to the public, including but not limited to administrative, management, and technology costs, and salary and benefit costs for positions associated with those functions. Secs. 5.40.020(c), 5.40.030(b)(1). The Initiative even excludes costs that Stanford is required by state law to incur, including for various managerial staff critical to the provision of care. *See, e.g.*, Cal. Code of Regs., tit. 22, §§ 70211(b) (nursing service administrator), 70225(c) (surgical service manager), 70425(e) (burn center manager), 70465(b) (coronary care service manager), 70485(b) (intensive care newborn nursery service oversight), 70243(f) (director of clinical laboratory service). Nor do the permissible costs account for the emergency care that providers are legally required to provide uninsured patients regardless of their ability to pay. The Initiative allows providers to petition for costs "not specified" in section 5.40.030(b)(1) to be designated as health care quality improvement costs or reasonable costs of direct patient care, but the costs eligible for such a variance are limited to costs "spent on services offered at the hospital, medical clinic, or other provider," which is impermissibly narrow, particularly when read in light of the express restrictions in section 5.40.030(b)(1). *See* Sec. 5.40.030(c)(2)(iii), (3)(iii). And the procedures for petitioning for relief from the 115% cap are poorly defined and would impose significant costs on both providers and the city government. *See* Sec. 5.40.030(d).

Under preemption principles, a city's authority to enact and enforce local laws like the Initiative is limited by state and federal law. A city can neither invade an area already occupied by state or federal laws nor pass legislation that conflicts with state or federal law. Cal. Const. Art. XI, § 7 ("A county or city may make and enforce within its limits all local, police, sanitary, and other ordinances and regulations not in conflict with general laws."); U.S. Const. Art. VI, cl. 2 (Supremacy Clause); *Hillsborough County, Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 713 (1985) ("[F]or the purposes of the Supremacy Clause, the constitutionality of local ordinances is analyzed in the same way as that of statewide laws."). The Initiative raises both state and federal preemption concerns.

First, contrary to the proposed initiative's assertion that "neither the State nor federal governments have" imposed limits on the prices charged by hospitals and health facilities, Sec. 5.40.010, extensive federal and state regulations aimed at protecting insurance beneficiaries and patient access to low-cost and high-quality care are already in place, including pricing and payment regulations that determine the reasonable costs for particular health care services. *See, e.g., Cal. Med. Ass'n, Inc. v. Aetna U.S. Healthcare of Cal., Inc.*, 94 Cal. App. 4th 151, 167 (2001) (describing California's "highly-regulated health care finance and delivery schemes"); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 729 (1985) (recognizing "extensive" regulation of group health insurance contracts). Together, these regulations leave no room for individual municipalities to insert their own regulatory schemes restricting health care pricing and payment.

Second, by setting artificial pricing limitations without regard to pre-existing contracts between providers and insurers or the applicable "reasonable cost" determinations set forth in state and federal regulations, the Initiative would make it impossible for providers and insurers to comply with state and federal regulations while also complying with the initiative's proposed pricing cap. More broadly, the pricing limitations would also interfere with state and federal policy determinations that have already been made about how best to balance concerns about excessive prices against the costs of providing high-quality medical care to insured and uninsured patients alike.

The body of state and federal health care and insurance laws is vast, but we include several illustrative examples here:

At the state level, California enacted the Knox-Keene Act to "promote the delivery and the quality of health and medical care" for people enrolled or subscribed in health care plans by "[h]elping to ensure the best possible health care for the public at the lowest possible cost." Cal. Health & Safety Code § 1342. In implementing this legislation, the State determined that the best way to pursue the legislature's goals was to define the compensation paid by a health plan to a provider as either the "agreed upon contract rate," the "amount set forth in [a PPO or POS] enrollee's Evidence of Coverage," or, for non-contracted emergency services, the "reasonable and customary value for health care services." Cal. Code Regs. tit. 28, § 1300.71(a)(3). These reimbursement levels are necessary to "'ensure[] the continued financial viability of California's health care delivery system.'" *Bell v. Blue Cross of Cal.*, 131 Cal. App. 4th 211, 218 (2005) (citation omitted). For example, "[g]iven that the law elsewhere requires that emergency services and care be provided without regard to a patient's insurance or ability to pay, the Knox-Keene Act imposes a requirement that health care service plans must reimburse a provider who has provided emergency services or care to a health care service plan's enrollee" based on "reasonable and customary" rates. *YDM Mgmt. Co. v. Sharp Cmty. Med. Group, Inc.*, 16 Cal. App. 5th 613, 624-25 (2017). And providers are "entitled to reimbursement from a health care service plan" at those same rates. *Id.* at 627. Moreover, by requiring reimbursement at "reasonable and customary" rates by reference to specific factors, one of which includes the prices usually charged for such services, the State "established the minimum criteria for reimbursement." *Children's Hosp. Cent. Cal. v. Blue Cross of Cal.*, 226 Cal. App. 4th 1260,

1273 (2014); *see also Bell*, 131 Cal. App. 4th at 217-18.[1] In contrast, the Initiative would disregard contracted rates entirely, and impose its own rate calculation based on a distinct determination of what costs are reasonable and what criteria should be considered.

Local efforts such as these that deviate from statewide law are preempted. *See Am. Fin. Servs. Ass'n v. City of Oakland*, 34 Cal. 4th 1239, 1254-56 (2005) (holding city could not pass more restrictive measure that would ban practice allowed under state law); *N. Cal. Psychiatric Soc'y v. City of Berkeley*, 178 Cal. App. 3d 90, 105-06 (1986) (holding that where state placed detailed regulations on when and how controversial psychiatric treatment could be offered, city could not ban such treatment entirely). In fact, because "regulation of statewide commercial activities" like health care "command statewide uniformity," courts are particularly wary of individual cities setting their own standards in "matters of health and medicine," which "are of statewide concern." *N. Cal. Psychiatric Soc'y*, 178 Cal. App. 3d at 101, 108. Moreover, to the extent the proposed initiative prevents health plans and insurers from paying contracted rates and reasonable and customary value for non-contracted emergency care, it forbids what state law permits and even requires, and thus would be subject to conflict preemption. *See Coyne v. City & County of S.F.*, 9 Cal. App. 5th 1215, 1229-30 (2017) (local ordinance requiring relocation subsidies when a landlord chooses to go out of the rental business subject to conflict preemption because it prohibited landlords from "exercis[ing] their rights under [California's] Ellis Act").

At the federal level, the ACA retains a role for "State law"—not local law—in the oversight of the provider-plan relationship, while preempting all laws that "prevent application of the" ACA's provisions. 42 U.S.C. § 18041(d). On that front, regulations implemented as part of the Affordable Care Act have set forth detailed methods to determine appropriate prices for certain categories of medical care, which are similarly reliant on regularly charged and negotiated prices as well as the federal government's own determination of what costs and other considerations should be taken into account. For example, Public Welfare regulations require group and individual health plans to provide benefits for out-of-network emergency services in an amount "at least equal to the greatest of three amounts," which in turn are based on contracted prices for such services when they are provided in-network, the "usual, customary and reasonable" amount paid for such services, or the amount that would be paid under Medicare. 45 C.F.R. § 147.138(b); *see also* 42 U.S.C. § 300gg-19a(b)(1)(C)(ii)(I).

Courts have also recognized that ERISA preempts all state or local laws that "govern[] the payment of benefits" by an ERISA plan, including laws that "directly conflict[] with ERISA's requirement that plans be administered, and benefits be paid, in accordance with plan documents." *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001). Here, by limiting the prices that hospitals can charge and that health plans and insurers can pay, the proposed initiative would conflict with employee benefit plans' ability to pay benefits as required by plan documents. Notably, ERISA preemption is so broad with respect to the plans

[1] Similarly, California Insurance Code section 10112.82 applies minimum reimbursement criteria to an insurer's payment for provision of non-contracted care to a beneficiary of a plan not regulated by the Knox-Keene Act. See also Cal. Ins. Code § 10133.65(c) (setting forth provider rights including limitations on the circumstances in which rates of payment may be changed from those set forth in contracts between plans and providers).

within its scope, such as self-funded payer plans, that it has been found to displace some of the same California statutes and regulations that would preempt the Initiative in its application to others, such as Knox-Keene health plans, were it enacted. *See, e.g.*, *Lodi Mem'l Hosp. Ass'n v. Tiger Lines, LLC*, No. 2:15-CV-00319-MCE, 2015 WL 5009093, at *7 (E.D. Cal. Aug. 20, 2015) (concluding that Knox-Keene Act reimbursement requirement did "not extend to a self-funded ERISA plan"). Thus, to the extent that state law does not preempt the Initiative in some applications, that is only because federal law preempts those applications of the Initiative. *See Atay v. County of Maui*, 842 F.3d 688, 705 (9th Cir. 2016) (finding local regulations preempted by a mix of state and federal law).

Apart from preemption concerns, we believe the Initiative and its pricing restrictions would violate due process in at least two respects. First, the Initiative's narrow definition of costs that can be factored into hospital prices—which excludes, among other things, the cost of free emergency care hospitals are legally required to provide—would leave hospitals and other providers unable to subsidize the services they are required to provide without payment. *See Kavanau v. Santa Monica Rent Control Bd.*, 16 Cal. 4th 761, 771 (1997) (a statute imposing pricing controls violates due process where it would "deprive investors of a 'fair return' and thereby become 'confiscatory'"). Second, due process requires that a regulated party must be able to petition for variances from pricing restrictions, and that the procedural mechanism to obtain such variances "must not be prohibitively burdensome." *Id.* at 772. Here, however, to obtain relief from the 115% limit, providers must demonstrate that application of the limit would be "unlawful" and provide sufficient information to demonstrate what a "lowest acceptable payment" for a particular patient would be, without regard to the fluctuating costs incurred by a provider for the entirety of its patient base over the fiscal year. These procedures are too burdensome to allow for meaningful relief. *See Birkenfeld v. City of Berkeley*, 17 Cal. 3d 129, 172-73 (1976) (striking down rent control law because its procedures were so cumbersome and time-consuming that landlords could not in reality obtain relief from confiscatory rates).

Finally, the Initiative's variance procedures also raise concerns beyond due process limits on price controls. First, the Initiative would require the Department to sit as a *de facto* court, evaluating the strength of a provider's legal and factual showing for a variance and determining whether application of the 115% cap would be "confiscatory or otherwise unlawful." Sec. 85.40.030(d)(2), (3), (4). Asking City officials to make these determinations would violate bedrock principles of separation of powers by usurping the courts' proper role and shifting controversial decisions onto an executive body. *See Kasler v. Lockyer*, 23 Cal. 4th 472, 493 (2000) (cautioning that the "separation of powers doctrine prevents any delegation of power that would result in the 'aggrandizement' or 'encroachment' of one branch of power" and that an "unconstitutional delegation of authority" occurs when the executive or judicial branch is called on to resolve "fundamental policy issues"). In fact, "a local administrative agency has *no* authority under the California Constitution to exercise judicial power." *Lockyer v. City & County of San Francisco*, 33 Cal. 4th 1055, 1094 (2004). Second, the Initiative's variance procedures and definitions lack essential details, rendering them unconstitutionally vague. For example, it fails to identify the market to be used for comparison in determining whether additional costs are "reasonable in light of market rates for similar goods or services." It also fails to identify what burden of proof health care providers would bear in "prov[ing]" application

of the cap would be unlawful, or how "necessary information" provided to the Department would be presented. Moreover, the Initiative lacks sufficient specificity in its definition of "other providers" to put Palo Alto health care providers on notice of whether they are covered by the Initiative. *See, e.g.*, Sec. 5.40.020(f) (incorporating Health & Safety Code § 1375.4(f), which extends to any entity that "delivers, furnishes, or otherwise arranges for or provides health care services," without accounting for the essential limitations of that definition within that statutory scheme). Together, these flaws and the burdens imposed on the City will have the effect of interfering with essential government functions already allocated to the Department.

For all these reasons, the Initiative is facially invalid. Because it is preempted by state and federal law, the Initiative "exceed[s] the initiative power," making pre-election review "eminently appropriate." *Patterson*, 202 Cal. App. 3d at 102 (affirming removal of initiative from San Francisco ballot where proposed ordinance was preempted and thus "unmistakably beyond the power of the people to enact"); *see also Wiltshire v. Superior Court*, 172 Cal. App. 3d 296, 305 (1985) (affirming order precluding initiative from proceeding where it was "beyond the power of the voters to adopt" because, in part, it ran "aground on the shoals of preemption"). And, because pre-election review on preemption grounds is appropriate, a court would be authorized to address all of the Initiative's defects. *See Citizens for Responsible Behavior v. Superior Court*, 1 Cal. App. 4th 1013, 1024 n.5 (1991) (explaining that if a court is "permitted" to conduct a pre-election review of one issue, "there is no logical reason why [it] should be prohibited from reaching all the challenges raised to the measure"). As Emeryville recognized in filing suit to prevent a substantively identical initiative from proceeding in that city, placing the Initiative on the ballot notwithstanding the these clear legal deficiencies would only waste public resources, create divisions in the community, and mislead the public. *See also id.* at 1023.

Thank you for the opportunity to express Stanford's concerns, and for your attention to this important matter. Please let me know if you believe that any further information would be of assistance.

Very truly yours,

Debra L Zumwalt /KM

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