2015-16 Second Extraordinary Session
Conference Committee on SBX2 2 and ABX2 1

Informational Hearing:
Managed Care Organization Tax Overview

Tuesday, December 1, 2015
9:30 a.m. to 11:30 a.m.
Ronald Reagan State Building, Auditorium
300 South Spring Street - Los Angeles

The purpose of this hearing is for the conference committee to receive an overview of California's managed care organization (MCO) tax issues and receive updates on the Governor's revised MCO tax proposal and the efforts of the California Association of Health Plans to develop consensus on possible alternative proposals.

Governor Brown issued a proclamation on June 19, 2015 convening the second extraordinary session to enact permanent and sustainable funding from a new MCO tax and/or alternative funding sources. According to the Governor, revenue solutions were needed to generate $1.1 billion annually to stabilize the General Fund's (GF) costs for the Medi-Cal program, sufficient funding to continue the 7% restoration of In-Home Supportive Services hours for recipients beyond fiscal year 2015-16 (estimated at $226 million in 2015-16), sufficient funding to provide increases in payments to Medi-Cal providers (estimated at potentially up to $6.5 billion depending upon which providers receive increases and the amount of those increases), and sufficient funding to increase payment rates for service providers who serve people with developmental disabilities. The Senate Public Health and Developmental Services Committee held hearings on July 2, 2015, and August 18, 2015, to explore the funding challenges before the Legislature as articulated in the Governor's proclamation and to examine the Governor's initial and revised MCO tax proposals. On October 10, 2015 the Governor vetoed six bills approved by the Legislature. [1] In his veto messages, the Governor indicated these bills, taken together, would require new spending at a time when there is considerable uncertainty in the funding of the Medi-Cal program.

The LAO's 2016-17 Fiscal Outlook

On November 24, 2015, the Legislative Analyst's Office (LAO) released its annual fiscal outlook. The LAO stated that California's state budget is better prepared for an economic downturn than it has been at any point in decades. The LAO projects that in 2015-16 the state's "Big Three" General Fund revenues—principally the personal income tax—will exceed June 2015 budget assumptions by $3.6 billion, with most of that gain to be deposited into the

[1] AB 50 (Mullin)
AB 858 (Wood)
AB 1162 (Holden)
AB 1231 (Wood)
AB 1261 (Burke)
SB 610 (Pan)

Proposition 2 rainy day fund. In 2016–17, the LAO projects that revenues will exceed spending under current policies, resulting in even further improvement in the state's fiscal situation. Assuming no new budget commitments are made, the LAO estimates 2016–17 would end with reserves of $11.5 billion. Of this total, the Legislature would have control over $4.3 billion in the Special Fund for Economic Uncertainties, the state's traditional budget reserve, with the rest of the reserves held for future budget emergencies by Proposition 2. The LAO fiscal outlook assumes the current MCO tax that generates $1.1 billion in GF offset expires as of its June 30, 2016 statutory deadline without replacement, leading to a $1.1 billion increase in Medi-Cal GF.

MCO Tax Background

California's current MCO tax imposes a 3.9% tax on the total revenue received by MCOs through their Medi-Cal managed care plans. This existing tax holds the MCOs harmless and generates funding to offset other GF costs. According to the Senate Budget Subcommittee on Health and Human Services, for 2015-16, the current MCO tax is projected to generate $1.13 billion in non-federal funding for the Medi-Cal program. The revenues are deposited into the Children's Health and Human Services Special Fund. Half of the MCO tax revenues are used to draw down federal Medi-Cal funds and then used to pay back Medi-Cal managed care plans in order to "make them whole". The other half of these funds is used to offset GF expenditures for Medi-Cal managed care rates for children, seniors and persons with disabilities, and dual eligibles. California's current MCO tax sunsets on July 1, 2016.

Federal Requirements

In a July 2014 letter to State Medicaid Directors, the federal Centers for Medicare and Medicaid Services (CMS) indicates that taxes structured like California's current MCO tax will likely be considered health care-related taxes that would have to meet Medicaid requirements. This means the tax:

- Must be applied to all providers in a class (meaning the tax must be applied to all MCOs and not just MCOs providing services to Medi-Cal beneficiaries, unless a waiver is obtained);
- Must be applied at the same rate for all payers of the tax (unless a federal waiver is obtained); and,
- Cannot directly or indirectly guarantee that providers receive their tax back.

The federal deadline for states to reform tax structures that are out of compliance is the end of their legislative session, which is August 31, 2016 for California.

The Governor's initial MCO tax proposal would have been levied on full-service health plans regulated by the Department of Managed Health Care (DMHC) and other Medi-Cal managed care plans not regulated by DMHC (county organized health systems) and created a tiered structure that assesses MCOs based on each MCO's quarterly member months of enrollment. The Administration estimated its proposed tax would raise $1.7 billion of gross revenue in 2015-16, with Medi-Cal MCO's receiving back $1.1 billion of their tax payment through Medi-Cal payment increases. This would leave a net liability to the MCOs of $669 million, mostly impacting MCOs with little or no Medi-Cal enrollment and mid-sized MCOs which would be subject to higher tax tiers, but not enough to reduce average tax rates through the lowest tax tiers. The LAO believes the Governor's proposal would likely meet federal approval. The LAO also

points out that some of the burden of a tax on commercial health coverage would likely be passed on to purchasers and enrollees through higher premiums.

The Administration revised its MCO proposal in early September 2015. This revised tax continues to use enrollment ranges with tax tiers for enrollment in each range, but it assesses the tax based on Medi-Cal enrollees at a higher amount than non-Medi-Cal enrollees. The revised proposal continues to generate roughly the same amount of revenue ($1.3 billion GF net to the state), but reduces the net impact to managed care plans from the Administration's prior proposal of $669 million, to $317 million. Another revision to the proposal further reduces the net impact to the plans to $114 million by selectively reducing corporate, gross premiums and corporate tax rates for plans paying the MCO tax, and by increasing some of the MCO taxing tier amounts and by exempting three plans from the MCO tax entirely. In addition, the revised proposal reduces the net impact to every plan, significantly reduces tax rates for non-Medi-Cal lives and reduces the differential between tiers for non-Medi-Cal enrollees from the previous proposal, particularly for those middle tiers that had the burden of the highest rates under the Administration's prior proposal.

MCO Structure Issues

The impact of a new MCO tax will vary depending upon the amount and structure of the levy, whether the MCO participates in Medi-Cal, the size of the MCO, and whether the MCO has "administrative services" lives that are subject to the MCO assessment ("administrative services" is generally where the MCO does not act as an insurer but pays claims on behalf of a purchaser using an established network of providers). For example, the current MCO tax is only levied on existing Medi-Cal MCOs, which are held harmless from the effect of the tax in the form of premium payments and federal Medicaid matching funds generated from the tax. The significance of the July 2016 CMS letter is that if California continues to assess a tax on all MCOs, those which do not participate in Medi-Cal (such as United, Aetna and Cigna) would have to pay the tax, but will not derive revenue from the tax in the form of Medi-Cal premiums or federal matching funds. The Governor's tiered tax structure is intended to place a greater share of the tax's burden on Medi-Cal MCOs, because much of their tax payment can draw down federal Medicaid matching funds and be restored through Medi-Cal payment increases. This helps minimize the net tax liability across the entire MCO industry. The Administration's proposal has been revised multiple times in an effort to minimize the impacts on these MCOs.

California Health Insurance Market

California has two insurance regulators. Enrollment data recently released by the California Department of Insurance (CDI) and DMHC reveal that as of the end of 2014, DMHC regulates the largest portion of enrollment in all three commercial markets, with 82% of the individual market, 77% of the small-group market, and 91% of the large-group market. In prior years, CDI was the predominant regulator of individual health coverage in the state. Most Medi-Cal managed care plans are regulated by DMHC, and none are regulated by CDI. Health insurance is a $123 billion dollar business in California with over 23 million Californians covered, another 5.5 million if "administrative services" enrollment for self-insured employers are included (approximately 1 million lives under DMHC and 4.6 million under CDI). Kaiser, Anthem Blue Cross, Blue Shield, Health Net and United Healthcare are the plans with the largest commercial enrollment and have the highest percentages of revenue. In terms of Medi-Cal managed care

enrollment, L.A. Care, Health Net and Inland Empire are the plans with the largest enrollment (3.3 million out of 11 million in 2014).

Between 2011 and 2014, the median rate increase for existing health insurance products in the individual market was 9.5%. For the small group market the median rate increase for existing health insurance was 8% during that same time period. However, during that same time period major transformation of the health insurance market was taking place because of the Affordable Care Act. In California, Covered California was established as the state-based market place (also known as an exchange). For the second year, Covered California has announced statewide weighted average premium rate increases around 4%. California's Public Employee Retirement system has approved HMO average premium rate increases of 7.2% and PPO average premium rate increases of 10.8% for 2016 according to a recent *Los Angeles Times* article.

Related Legislation

SBX 2 2(Hernandez) states it is the intent of the Legislature to enact statutory changes that would stabilize funding for the Medi-Cal program and provide rate increases for providers of Medi-Cal and developmental services. *This bill is pending in the Second Extraordinary Session Conference Committee.*

SBX2 14 (Hernandez) would impose increased taxes on cigarettes, tobacco products, and electronic cigarettes as well as a tiered MCO tax based on enrollment. Requires revenue from tobacco and electronic cigarette taxes to be used for various tobacco use prevention and research, law enforcement, medical school education, for improved payments for Medi-Cal funded services, and to backfill existing tobacco-tax funded services for any revenue decline resulting from the additional tax, transfers $230 million, to be used upon appropriation by the Legislature, to increase the funding provided to regional centers and to increase rates paid to providers of service to the developmentally disabled, and repeals the 7% reduction in hours of service to each In-Home Supportive Services recipient of services. *This bill is pending on the Senate Floor.*

AB X2 1 (Bonta) states it is the intent of the Legislature to enact statutory changes that would stabilize funding for the Medi-Cal program and provide rate increases for providers of Medi-Cal and developmental services. *This bill is pending in the Second Extraordinary Session Conference Committee.*

AB X2 4 (Levine) has been introduced to impose a "flat tax" of $7.88 per enrollee on the same MCOs identified in the Governor's proposal. *This bill is pending in the Second Extraordinary Session Assembly Public Health and Developmental Services Committee.*

AB X2 19 (Bonta) imposes a tiered MCO tax based on enrollment. *This bill is pending in the Second Extraordinary Session Assembly Public Health and Developmental Services Committee.*

AB 50 (Mullin, 2015) would require the Department of Health Care Services (DHCS) to develop a feasibility plan on or before January 1, 2017, that describes the costs, benefits, and any potential barriers related to offering evidence-based home visiting programs to Medi-Cal eligible pregnant and parenting women. *Vetoed.*

AB 858 (Wood, 2015) would add marriage and family therapists to the list of health care providers that qualify for a face-to-face encounter with a patient at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) for purposes of the per visit Medi-Cal payment billed by FQHCs and RHCs. *Vetoed.*

AB 1162 (Holden, 2015) would require tobacco cessation services to be a covered benefit under the Medi-Cal program, and requires tobacco cessation services to include all intervention recommendations, as periodically updated, assigned a grade A or B by the United States Preventive Services Task Force (USPSTF). *Vetoed.*

AB 1231 (Wood, 2015) would add nonmedical transportation as a Medi-Cal benefit, subject to utilization controls and federally permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services. *Vetoed.*

AB 1261 (Burke, 2015) would require Community-Based Adult Services (CBAS) to be a Medi-Cal benefit, and to be included as a covered service in contracts with all Medi-Cal managed health care plans, with standards, eligibility criteria, and provisions described in the Special Terms and Conditions of the state's "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver and any successor federal authorities. *Vetoed.*

SB 610 (Pan, 2015) would establish timeframes for the Department of Health Care Services (DHCS) to review and finalize federally qualified health center (FQHC) and rural health clinic (RHC) Medi-Cal-related scope-of-service changes and reconciliation changes, and requires DHCS to make payments within specified timeframes if reconciliation payments are owed. *Vetoed.*