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July 2, 2015

Overview of MCO Tax, Selected Other Tax Increase Options, and IHSS Issues

LEGISLATIVE ANALYST'S OFFICE

Presented to:
Senate Committee on Public Health and Developmental Services
Second Extraordinary Session
Hon. Ed Hernandez, Chair

July 2, 2015

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Managed Care Organization (MCO) Tax Background: Health Care-Related Taxes

☑ ***What Are Health Care-Related Taxes?*** Federal Medicaid law defines a *health care-related tax* as a licensing fee, assessment, or other mandatory payment that is related to the provision of or payment for health care services or items. In many cases, states collect these payments from health care providers to help finance the nonfederal share of their Medicaid expenditures.

☑ ***Federal Requirements for Health-Care Related Taxes.*** Health care-related taxes must meet three major requirements to be permissible under federal law. (Two of these requirements may be waived under certain conditions, as we describe later.)

Three Requirements for Health Care-Related Taxes

Broad-Based. The tax is broad-based if it is imposed on all providers within a specified class of providers.

Uniform. The tax is uniform if it is applied at the same rate for all payers of the tax.

No Hold Harmless. The state may not provide a direct or indirect guarantee that providers receive their tax payment back (or be "held harmless" from the tax).

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MCO Tax Background: Some Federal Requirements May Be Waived

☑ ***States Can Receive Waivers of Broad-Based and Uniform Requirements . . .*** Federal Medicaid rules permit some health care-related taxes that do not meet the strict definitions of *broad-based* and *uniform*. That is, some permissible taxes may be applied neither to all providers within a class, nor at the same rate across all taxed providers. To ensure such a tax is treated as permissible, a state must formally request the federal government to waive the broad-based and uniform requirements.

☑ ***. . . But Not the No-Hold-Harmless Requirement . . .*** Federal law does not allow for any waivers of the no-hold-harmless requirement.

☑ ***. . . And Only if Tax Remains Redistributive.*** Within its waiver request, the state must demonstrate that its proposed tax structure—like a strictly broad-based and uniform tax—would tend to redistribute revenue from non-Medicaid to Medicaid providers. Therefore, if the state attempted to exempt *all* non-Medicaid providers from the tax, the tax would likely fail to be redistributive and be denied federal approval.

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California's Current MCO Tax

- ***Tax on MCOs' Revenues From Medi-Cal Managed Care.*** Chapter 33, Statutes of 2013 (SB 78, Committee on Budget and Fiscal Review), imposes a 3.9 percent tax on the total operating revenue received by MCOs *through their Medi-Cal managed care plans*.

- ***Does Not Create Net Benefit or Cost to MCOs.*** The current MCO tax is economically neutral to the MCOs paying the tax. At a high level, the tax can be thought of as financing the nonfederal share of Medi-Cal payments to MCOs, which are matched with enough federal funds to (1) hold MCOs harmless and (2) offset other General Fund costs.

- ***Is Likely Impermissible.*** Over half of the state's MCOs do not operate Medi-Cal managed care plans and therefore do not pay any MCO tax. Therefore, the tax is neither broad-based nor redistributive, and likely impermissible under federal Medicaid requirements.

- ***May Jeopardize Federal Medicaid Funding if Continued in Current Form . . .*** In a July 2014 letter, the federal government clarified that health care-related taxes structured like California's current MCO tax are likely impermissible. If the MCO tax were extended in its current form past the federal government's deadline for states to reform their tax structures, California would risk the entire amount of federal Medicaid funds attached to the tax.

- ***. . . Though Not in 2015-16.*** The federal deadline to states to reform their tax structures is the end of states' legislative sessions—August 31, 2016 for California. The current MCO tax sunsets on July 1, 2016. Therefore, we believe the federal funds leveraged by the tax in 2015-16 are *not* at risk, even if the state took no further action to extend or modify the tax.

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Governor's Proposal for a Restructured MCO Tax

☑ ***Goals.*** In his January 2015 budget, the Governor proposed to restructure the MCO tax to conform to federal Medicaid requirements. The Governor proposed that the new structure, in addition to being federally permissible, be designed to raise enough revenue to fund two objectives.

- ***Fund 7 Percent Service-Hour Restoration in In-Home Supportive Services (IHSS).*** The first objective is to fund the nonfederal share of payments needed to restore IHSS hours that were eliminated as a result of the current 7 percent reduction. The nonfederal cost for restoring the hours is currently estimated to be $226 million in 2015-16.
- ***Maintain Current General Fund Offset in Medi-Cal.*** The second objective is to maintain the General Fund offset from the current tax. This offset is estimated to be $1.1 billion in 2015-16.

☑ ***Timing.*** The administration sought to permanently authorize the proposed tax, effective July 1, 2015, and render the current MCO tax inoperative a year earlier than the existing sunset.

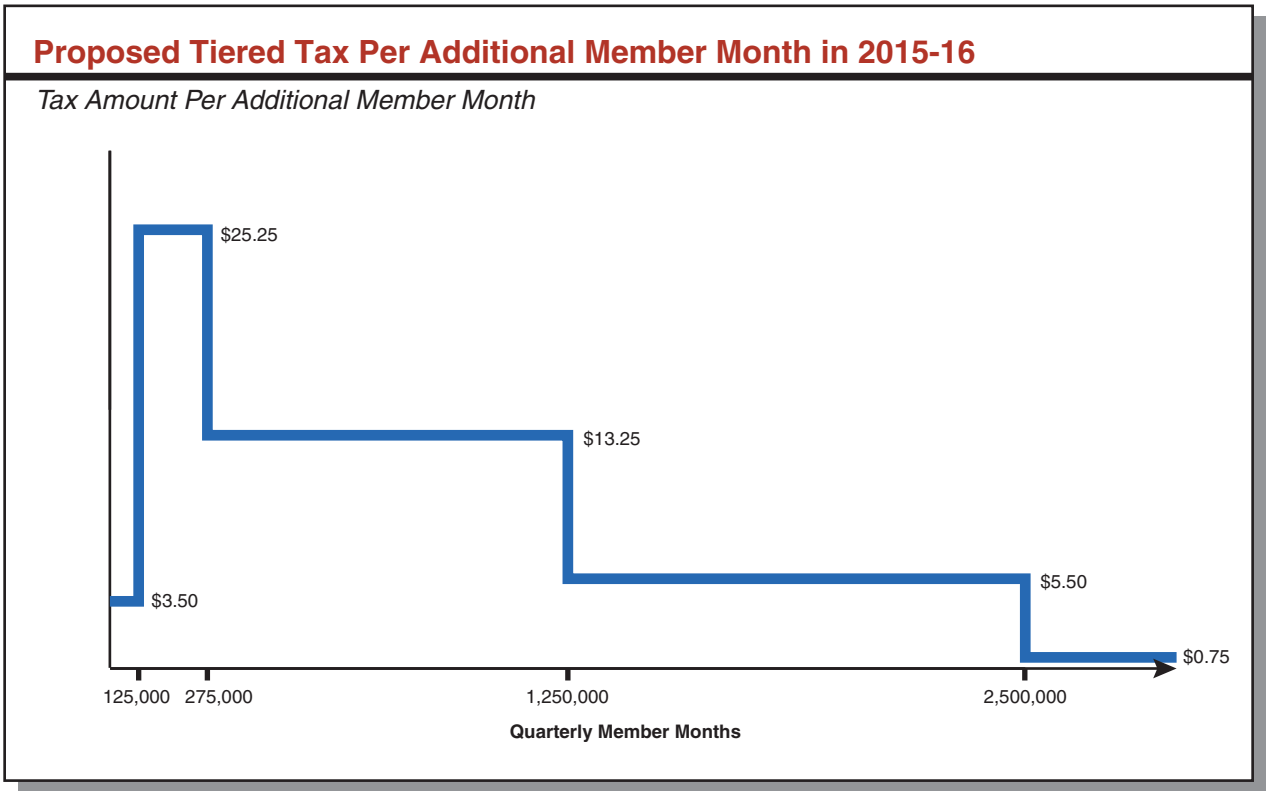
☑ ***Structure.*** The Governor proposed to impose the new tax *on most MCOs* that are licensed and regulated by the Department of Managed Health Care. (That is, in contrast to the current MCO tax, the Governor's proposal would also apply to MCOs that do not participate in Medi-Cal managed care.) This would expand the set of taxpayers to around 40 MCOs, compared to 25 MCOs that pay the current tax.

- ***Unit Tax on Non-Medicare Enrollment.*** The proposed tax is a unit tax based on each MCO's enrollment, excluding enrollment in Medicare managed care plans. (This exclusion is allowed under federal rules.)

Governor's Proposal for a Restructured MCO Tax *(Continued)*

- ***Tiered Structure Based on Enrollment Size.*** The proposed unit tax rises, then falls with increasing MCO enrollment. For example, an MCO with 1 million taxable member months would pay $3.50 per unit for the first 125,000 member months, $25.25 per unit for the next 150,000 member months, and $13.75 per unit for the remaining 725,000 member months, resulting in a total payment of $14.2 million.

Proposed Tiered Tax Per Additional Member Month in 2015-16



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Governor's Proposal for a Restructured MCO Tax *(Continued)*

- ***Continue Holding MCOs Harmless for Tax Paid on Medi-Cal Managed Care . . .*** Although states normally cannot hold providers harmless for health care-related taxes, federal rules also require that Medicaid managed care rates reflect MCOs' reasonable costs of doing business—including state-mandated taxes and assessments. Under these rules, the state can continue building the cost of the tax into Medi-Cal managed care payments. This would effectively hold MCOs harmless for the Medi-Cal portion of the tax.
- ***. . . But Not Commercial Managed Care.*** Federal rules still bar the state from holding MCOs harmless for enrollment *outside* of Medi-Cal managed care, such as commercial coverage.

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LAO Assessment of Governor's MCO Tax Proposal

☑ ***Proposal Likely to Meet Federal Approval …*** We believe the Governor's tax proposal is redistributive and meets the conditions for a waiver of the broad-based and uniform requirements.

☑ ***. . . And in Doing So Necessarily Creates Losers . . .*** The administration estimates the proposed tax would raise $1.7 billion of gross revenue in 201516, with MCOs receiving back $1.1 billion of their tax payment through Medi-Cal payment increases. Thus, under the proposal, the net financial liability across all MCOs paying the tax would be $660 million.

☑ ***. . . Especially Among Some Mid-Sized MCOs.*** Many MCOs that participate extensively in Medi-Cal managed care are mid-sized. Therefore, the Governor's tiered tax structure is intended to place a greater share of the tax's burden on these MCOs, since much of their tax payment can (1) leverage federal funds and (2) be restored through Medi-Cal payment increases. This helps minimize the net tax liability across the *entire* MCO industry. However, some individual MCOs would face disproportionate net liability for the following reasons:

- They have little or no Medi-Cal enrollment to offset their tax liability through increased Medi-Cal payments.
- They are mid-sized, meaning they have enough enrollment to be subject to the highest tax tiers, but not enough to reduce their average tax rates through the lowest tax tiers.

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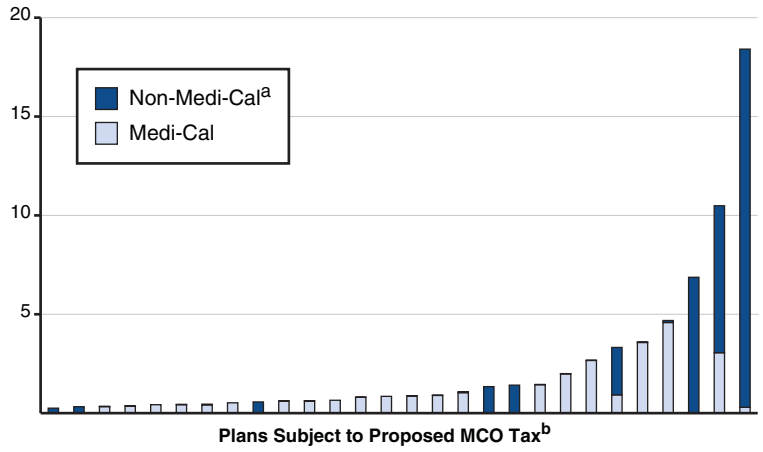
LAO Assessment of Governor's MCO Tax Proposal *(Continued)*

Distribution of MCOs by Size and Medi-Cal Share of Enrollment

Quarterly Member Months (In Millions)



[a] Excludes Medicare and plan-to-plan enrollment, which are exempt under proposed tax.

[b] Each column represents a different MCO's enrollment, as reported to the Department of Managed Health Care in the third quarter of 2014.

Note: Figure excludes 11 MCOs with fewer than 250,000 quarterly member months of enrollment.

MCO = managed care organization.

☑ ***Tax Would Likely Be Passed Onto Consumers.*** In economic terms, the proposal resembles an actual tax on commercial health coverage. In the long term, purchasers and enrollees of commercial coverage would likely bear some of the burden of the proposed tax through higher premiums.

☑ ***On Balance, Governor's Overall Concept Worthy of Consideration.***

- ***Funding Goals Are Important.*** For 2015-16, the current MCO tax offsets General Fund spending in Medi-Cal by 5 percent of what it otherwise would have been. Absent

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LAO Assessment of Governor's MCO Tax Proposal *(Continued)*

the tax, the state would have to find alternative revenue sources or consider General Fund program reductions of a comparable amount. In addition, the Governor's proposed restructured MCO tax provides a dedicated non-General Fund funding source for the restoration of IHSS service hours.

- ***Approach Has Advantages Over Other Revenue Sources.*** Because MCOs can be partially restored through Medi-Cal managed care, the proposal only requires imposing $660 million in net tax liability on taxpayers to generate $1.3 billion for the state's use. The remainder is subsidized by the federal government.

☑ ***Enrollment-Based Tax Would Need to Be Periodically Adjusted.*** The proposed tax base of MCO enrollment would grow modestly with the general population. To fully fund the 7 percent IHSS service-hour restoration on an ongoing basis, the tax would have to keep pace with caseload and wage growth in the IHSS program. Health care inflation in Medi-Cal may also outpace the growth of the proposed tax base. Under this scenario, the state would likely have to recalibrate the tax tiers and amounts every year (assuming the goal is to maintain the amount of General Fund offset that the current MCO tax would have achieved). To address these issues, the Legislature could explore options for a federally permissible tax based on managed care premiums or revenues, rather than enrollment.

☑ ***Mitigating Impact on Mid-Sized MCOs Would Present Trade-Offs.*** A flatter tax structure than the Governor's proposal would reduce the net tax liability for mid-sized MCOs with little or no Medi-Cal enrollment. However, it would leverage less federal funds and raise the net liability for the industry as a whole, including the MCOs that serve the most enrollees.

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Selected Other Tax Increase Options

The LAO has been asked by the committee to discuss possible revenue increases if certain taxes (other than the MCO tax) are raised. Possible tax options include, but are not limited to, the following:

- ***Tobacco Taxes.*** Including an equivalent increase for other tobacco products, a $1 per pack cigarette tax increase likely would raise $600 million to $700 million per year, net of backfilling for losses to special funds that rely on cigarette and other tobacco taxes. If the tax increase were $2 instead, the net revenue increase would be $1 billion to $1.3 billion.

- ***Alcoholic Beverage Tax.*** Updating alcohol excise tax rates to reflect inflation since 1991, when they were last changed, could raise around $200 million of annual revenue. The precise tax rate increase would depend on the inflation measure used in this scenario, but generally would involve an over 50 percent increase in current per-gallon tax rates. Currently, beer and most wine is taxed at 20 cents per gallon, distilled spirits of 100 proof or less are taxed at $3.30 per gallon, and distilled spirits over 100 proof are taxed at $6.60 per gallon.

- ***Taxes on Sweetened Beverages.*** In recent years, proposals have emerged to tax certain sweetened beverages, including higher-calorie carbonated beverages known as “soda” or “soft drinks.” A 2013 state legislative proposal to impose a 1-cent tax per fluid ounce of specified sweetened beverages would have generated about $1.7 billion of revenue annually (including $1.2 billion from carbonated soft drinks alone), according to a State Board of Equalization estimate.

- ***These Taxes Would Affect Consumption.*** These revenue estimates could prove to be too high or too low as they reflect assumptions about decreases in consumption of the taxed products with varying tax increases. Changes in consumption due to higher tobacco taxes are fairly well understood based in part on our state’s experience in raising these taxes. California, however, has less experience concerning changes in consumption due to increased beverage taxes.

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Overview of IHSS

- ***Services.*** The IHSS program provides various services to eligible aged, blind, and disabled persons who are unable to remain safely in their own homes without such assistance. The IHSS workers assist recipients with tasks such as bathing, housework, feeding, and dressing. Recipients are eligible to receive up to 283 hours of IHSS per month.

- ***Eligibility.*** When a potential IHSS recipient applies for the program at a county office, the determination of his/her eligibility takes into account the applicant's income and his/her need for IHSS services.

- ***IHSS Is a Medicaid Benefit.*** About 99 percent of IHSS recipients receive IHSS as a Medicaid benefit.

- ***Multiple Funding Sources.*** The IHSS program is funded by a combination of state, county, and federal funds.

- ***The Estimated Caseload for 2015-16.*** It is estimated that the 2015-16 caseload for IHSS will be 467,000 recipients—about 4.6 percent above the estimated caseload for 2014-15. The average hours per case per month are estimated to be 99.

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Past Strategies to Control Costs in IHSS

☑ ***Four Categories of Budget Solutions.*** In the past, the methods to decrease costs in the IHSS program generally fall into the following four categories:

- Service Reductions—Reducing the number of hours IHSS recipients receive.
- Tightening Eligibility—Reducing the number of people actually receiving IHSS.
- Provider Payment Reductions—Reducing the amount the state pays for each hour of IHSS services.
- Increasing Federal Cost Share—Increasing the federal share (thereby reducing the state General Fund share) of IHSS expenditures.

Some approaches incorporated a combination of these strategies, and not all attempts at decreasing costs were ultimately implemented, as discussed on the next page.

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Implementation Status of Major Changes to the IHSS Program Since 2009-10

General Fund (In Millions)

Policy Change (Budget Solution)	Estimated Solution Value[a]	Implemented?		
		Yes	No	
			Due to Litigation	No Longer Being Pursued
2009-10				
Implementation of antifraud activities	$162	X		
Functional index service reductions and eliminations	102		X	
Reduction in state participation in provider wages	98		X	
Elimination of Share of Cost Buy-Out program	42	X		
Public Authority reduction	13	X		
2010-11				
Provider tax and supplemental payment	190			X
3.6 percent across-the-board reduction in hours[b]	35	X		
2011-12				
Medication dispensing pilot project	140			X
Implementation of additional federal funding available under Affordable Care Act	128	X		
Triggered 20 percent across–the–board reduction in hours	100		X	
Elimination of IHSS for recipients without a health certificate	67	X		

[a] We note that these values reflect the estimated savings from the policy at the time it was enacted. Once implemented, these values could change to account for a full year of savings, interactions with other program changes, and actual data.

[b] Implemented from February 1, 2011 to June 30, 2013.

IHSS = In-Home Supportive Services.

☑ ***Some Major Budget Solutions Not Implemented Due to Litigation.*** As shown in the figure, three of the budget solutions were not implemented because they were legally challenged and enjoined by the federal courts. These are: (1) functional index service reductions and eliminations, (2) reduction in state participation in provider wages, and (3) 20 percent across-the-board reduction in hours.

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The IHSS Settlement Agreement

- ***Repeals Three Enacted IHSS Reductions.*** A March 2013 settlement agreement reached between the state and plaintiffs provides for the repeal of three previously enacted IHSS program reductions that had been legally challenged and enjoined by court orders. These previously enjoined reductions were replaced with reductions that resulted in less total savings for the state, but provided some certainty in achieving some level of General Fund savings while lessening the magnitude of the reductions for recipients.

- ***Implements a One-Time 8 Percent Across-the-Board Reduction in Hours.*** In place of the reductions that had been previously enjoined, the settlement agreement included an 8 percent across-the-board reduction in authorized service hours for one year. In 2013-14, this was estimated to save $195 million General Fund.

- ***Implements an Ongoing 7 Percent Across-the-Board Reduction in Authorized Hours Beginning in 2014-15.*** In accordance with the terms of the settlement agreement, the 2014-15 budget included a 7 percent across-the-board reduction in service hours. (In effect, IHSS recipients experienced a 1 percentage point increase in service hours relative to the previous year's 8 percent reduction.) This reduction was estimated to save about $200 million in 2014-15.

- ***Establishes Intent to Rescind the Across-the-Board Reduction if an Alternative Revenue Source Is Found.*** Reflecting the terms of the settlement agreement, the 2013-14 budget package included legislation that specified that the ongoing 7 percent reduction would be fully or partially rescinded if the costs are offset by General Fund savings resulting from an assessment on home care services, including, but not limited to, home health care and IHSS.

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The IHSS Settlement Agreement *(Continued)*

☑ ***How the Across-the-Board Reductions Impact IHSS Service Hours.***

- ***What the Reduction Means for a Recipient's Monthly Hours.*** A recipient receiving the average number of IHSS hours monthly (estimated to be 99 hours in 2015-16) would lose 6.9 hours per month as a result of the 7 percent reduction. A recipient receiving the monthly maximum of 283 hours per month would lose 19.8 hours per month as a result of the reduction.
- ***Operationalizing the Reduction.*** For both the 7 percent and 8 percent across-the-board reductions, recipients were authorized to determine the manner in which the reduction would be applied to their previously authorized hours.

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The 2015-16 IHSS Budget

☑ ***The Governor's MCO Tax Budget Proposal.*** The Governor's budget included a proposal to restore the 7 percent across-the-board reduction in IHSS service hours with the revenue generated from a restructured managed care tax.

☑ ***The Enacted Budget Includes One-Time Funding From the General Fund to Restore Service Hours.*** The enacted 2015-16 budget includes $226 million from the General Fund on a one-time basis to restore the service hours associated with the 7 percent reduction. The Governor called a special session to consider and act upon legislation to identify permanent and sustainable funding to continue the 7 percent restoration of IHSS service hours beyond 2015-16.