California State Senate

PUBLIC HEALTH AND DEVELOPMENTAL SERVICES

ED HERNANDEZ
CHAIR

Informational Hearing:
Managed Care Organization Tax Options and Issues

Tuesday, August 18, 2015
9:30 a.m. to 12 p.m. -- John L. Burton Hearing Room (4203)

The purpose of this hearing is for the committee to explore in more detail the Governor's managed care organization (MCO) tax proposal, discuss pros and cons of other potential MCO tax structures and receive an update from the California Association of Health Plans on its efforts to model alternative proposals. The hearing will also provide an overview of more health insurance market data and trends.

Background

The first hearing of this committee was held on July 2, 2015 to explore the funding challenges before the Legislature as articulated in the Governor's proclamation. As indicated in the proclamation, the Governor convened this extraordinary session to enact permanent and sustainable funding from a new MCO tax and/or alternative funding sources. The revenue solutions are 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 (at least another $63 million. This amount is based on the proposed legislative budget compromise which was not included in the final budget).

California's existing 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

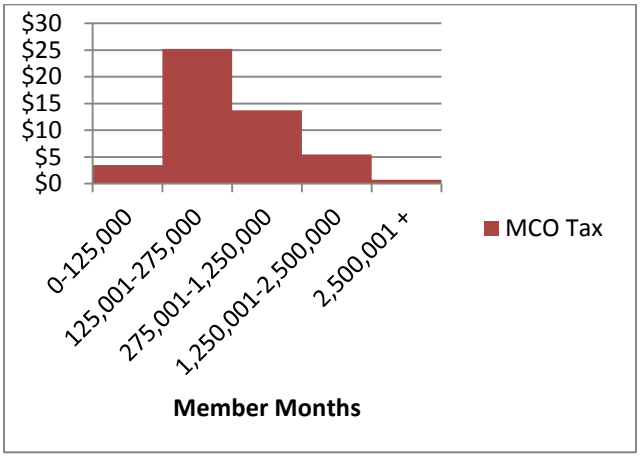
In a July 2014 letter to State Medicaid Directors, the federal Centers for Medicare and Medicaid Services (CMS) indicates that taxes structured like California's current MCO tax will likely be considered health care-related taxes that would have to meet Medicaid requirements. This means the tax must:

- 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,
- 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 the states' legislative session which is August 31, 2016 for California.

The Governor has proposed an MCO tax 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). The Governor's proposal excludes Medicare managed care plans, specialized health plans (generally vision and dental plans), insurance products regulated by the Department of Insurance, and some border plans. The Governor's proposal creates a tiered structure that assesses MCOs based on each MCO's quarterly member months of enrollment.

Governor's Tiered MCO Tax Structure



An assessment of $3.50 for each member month for the first 125,000 member months, $25.25 for each member month for the next 150,000 member months, and $13.75 for each member month for the next 975,000 member months, $5.50 for each member month for the next 1.25 million member months and $.75 for each member month over 2.5 million. The Administration estimates 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 leaves a net liability to the MCOs of $660 million. This would mostly impact 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 Legislative Analyst's Office (LAO) believes the Governor's proposal will 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.

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.

California Health Insurance Market Information

California has two insurance regulators. Enrollment data recently released by the Department of Insurance 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, the Department of Insurance 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 service enrollment for self-insured employers are included (.9 million lives under DMHC and 4.6 million at the Department of Insurance). 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. 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 or 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.

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. 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 July 2016 CMS letter means that MCOs which do not participate in Medi-Cal, such as United, Blue Shield, 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. However, under the Governor's proposal, some individual MCOs would face a higher net liability because they have little or no Medi-Cal enrollment to offset their tax liability through increased Medi-Cal payments, and they have enough enrollments to be subject to the highest tax tiers, but not enough to reduce their average tax rates through the lowest tax tiers. By contrast, the flat tax of $7.88 per enrollee in AB X2 4 (Levine), as noted by the LAO in its review, would cost the MCO industry more and would draw down less in federal Medicaid funds.