Date of Hearing: February 10, 2016

ASSEMBLY COMMITTEE ON PUBLIC HEALTH AND DEVELOPMENTAL SERVICES
Rob Bonta, Chair
ABX2 20 (Bonta) – As Introduced February 8, 2016

SUBJECT: Medi-Cal: managed care organization tax.

SUMMARY: Reforms the existing managed care organization (MCO) provider tax that is only paid by Medi-Cal managed care plans (MCPs) and replaces it with a tax that would be assessed on health care service plans licensed by the Department of Managed Health Care (DMHC), and/or managed care plans contracted with the Department of Health Care Services (DHCS) to provide services to Medi-Cal beneficiaries, unless exempted, from July 1, 2016 to July 1, 2019. Specifically, **this bill**:

1) Specifies it is the intent of the Legislature that DHCS implement an MCO provider tax, effective July 1, 2016, to provide ongoing funding for health care and prevention, and minimize any need for new reductions to the program, and meet all of the following goals: a) generate an amount of nonfederal funds for the Medi-Cal program, equivalent to the sales tax currently imposed on MCPs; and, b) comply with federal Medicaid requirements, as specified.

2) Defines various terms, including the following:

   a) Alternate Health Care Service Plan (AHCSP) is a nonprofit health care service plan with at least 4 million enrollees statewide, that owns or operates pharmacies, and provides professional medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each geographic region in which it is licensed;

   b) AHCSP enrollee is an individual enrolled in an AHCSP, who is not a Medi-Cal beneficiary;

   c) Base year means the 12-month period of October 1, 2014 through September 30, 2015;

   d) Base data source means the quarterly financial statement filings submitted by health plans to DMHC retrieved by DHCS as of January 1, 2016, and supplemented by, as necessary, Medi-Cal enrollment data for the base year as maintained by DHCS and retrieved as of January 1, 2016:

   e) Countable enrollee means an individual enrolled in a health plan, during a month of the base year according to the base data source. Excludes from this definition an individual enrolled in a Medicare plan, a plan-to plan enrollee, or an individual enrolled in a health plan pursuant to the Federal Employees Health Benefits Act of 1959;

   f) Excluded plan means a prepaid health plan operating under the laws of Mexico or a health plan owned and operated by a 501(c)(3) hospitals or health systems if that health plan has both a substantial amount of its enrollment in and is headquartered in either the County of Sacramento or San Diego;

g) Health care service plan or health plan is a health care service plan, other than a plan that provides only specialized or discount services, that is licensed by DMHC under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) or a managed care plan contracted with DHCS to provide Medi-Cal services;

h) Medi-Cal enrollee is an individual enrolled in a health plan who is a Medi-Cal beneficiary for whom DHCS directly pays the health plan in a capitated payment;

i) Other enrollee means an individual enrolled in a health plan who is not a Medi-Cal beneficiary or an AHCSP enrollee; and,

j) Plan to plan enrollee means an individual who receives his or her health care services through a health plan pursuant to a subcontract from another health plan.

3) Imposes a MCO provider tax on each health plan, unless excluded, for the following fiscal years (FY):

a) 2016-17;
b) 2017-18; and,
c) 2018-19.

4) Specifies the following Medi-Cal taxing tiers:

Enrollees	**2016-17**	**2017-18**	**2018-19**
0 – 2,000,000	$40.00	$42.50	$45.00
2,000,001 to 4,000,000	$19.00	$20.25	$21.00
Over 4,000,000	$1.00	$1.00	$1.00

5) Specifies the following other taxing tiers:

Enrollees	**2016-17**	**2017-18**	**2018-19**
0 -4,000,000	$7.50	$8.00	$8.50
4,000,001 – 8,000,000	$2.50	$3.00	$3.50
Over 8,000,000	$1.00	$1.00	$1.00

6) Establishes the following taxing tier for AHCSP (Kaiser):

Enrollees	**2016-17**	**2017-18**	**2018-19**
0 – 8,000,000	$2.00	$2.25	$2.50

7) Establishes the Health and Human Services Special Fund (HHSS Fund) where all revenues, less refunds derived from the taxes specified in this bill, would be deposited to the credit of the HHSS Fund. Requires that any interest and dividends earned on moneys to be retained in the HHSS Fund for funding the nonfederal share of Medi-Cal managed care rates for health care services furnished to children, adults, seniors and persons with disabilities, and persons dually eligible for Medi-Cal and Medicare.

8) Requires DHCS to provide an annual report to all health plans accounting for the funds deposited in and expended from the HHSS Fund, as determined by the DHCS Director. Requires the report to identify the taxes imposed on each health plan and provide an itemized accounting of expenditures from the HHSS Fund.

9) Requires DHCS to determine for each health plan using the base data source all of the following: a) total cumulative enrollment for the base year; b) total Medicare cumulative enrollment for the base year; c) total Medi-Cal cumulative enrollment for the base year; d) total plan-to-plan cumulative enrollment for the base year; e) total cumulative enrollment through the Federal Employees Health Benefits Act of 1959; and, f) total cumulative enrollment for the base year that is not otherwise counted in b) to e). Authorizes the DHCS Director to correct any identified material or significant errors in the data. Specifies that the DHCS Director's determination on whether to exercise discretion and any determination made by the DHCS Director is not subject to judicial review, as specified. Authorizes a health plan to bring a writ of mandate to rectify an abuse of discretion relating to the data specified above.

10) Requires DHCS to compute the annual tax for each health plan subject to the tax, as specified.

11) Requires DHCS to collect the annual tax in four installments and to determine the amount due for each installment in the state FY by dividing the annual tax for that state FY by four.

12) Prohibits DHCS from collecting the tax until it has received approval from the federal Centers for Medicare and Medicaid Services (CMS) that the tax is a permissible health care-related tax and is eligible for federal financial participation (FFP).

13) Requires, on October 1, 2016, or the date DHCS receives the federal approval, whichever is later, the following to commence:

    a) The DHCS Director to certify in writing that the federal approval was received and within five business days, the DHCS to post the certification on its Internet Website and send a copy of the certification to the Legislature and Legislative Counsel;

    b) By October 14, 2016 or within 10 business days following receipt of the notice of federal approval, whichever is later, DHCS to send a notice to each health plan subject to the tax, to contain: i) the annual tax due for each FY; and, ii) the dates on which the four installment tax payments are due;

    c) Requires a health plan to pay the annual tax in installments, based on a schedule developed by DHCS. Requires DHCS to establish the date that each tax payment is due, provided that the first tax payment is due no earlier than 20 days following the date the department sends the notice specified in b) above, and the tax payments to be paid at least one month apart, but no more than one quarter apart;

    d) A health plan to pay the taxes that are due, in the amounts and at times set forth in the notice, as specified. The taxes assessed to be deposited in the HHSS Fund; and,

    e) Interest accrues the day after the date the tax payment is due. Interest will be assessed for any amount that is not paid on the due date at a rate of 10% per annum. Provides that if a

tax payment is more than 60 days overdue, a penalty shall be assessed for each month for which tax payment is not received after 60 days. Authorizes the DHCS Director to waive a portion or all of the interest or penalties or both, if the DHCS Director determines that the imposition of the full amount of the tax pursuant to the timelines has a high likelihood of creating an undue financial hardship for the health plan or creates a significant financial difficulty in providing needed services to Medi-Cal beneficiaries. Conditions a waiver of the interest or penalties on the health plan's agreement to make tax payments on an alternative schedule that takes into account the financial situation of the health plan and the potential impact on the delivery of services to Medi-Cal beneficiaries.

14) Provides that in the event of a merger, acquisition, establishment, or any other similar transaction that results in the transfer of health plan responsibility for all countable enrollees from a health plan to another health plan or similar entity, the resultant health plan shall be responsible for paying the full tax amount upon the effective date of such transaction. If a merger or acquisition results in the transfer of health plan responsibility for only some of a health plan's countable enrollees, the full tax amount shall remain the responsibility of the health plan to which that full tax amount was assessed.

15) Authorizes DHCS to modify or adjust the methodology, tax amount, taxing tier or other similar provision to the extent necessary to meet the requirements of federal law or regulations, obtain federal approval, or to ensure FFP is available, as specified. Specifies that any modification or adjustment that would be higher than the following aggregate amounts for the other enrollees and AHCSP enrollees, combined, would be in conflict with this measure:

    a) $266,000,000 in the 2016-17 FY;
    b) $287,000,000 in the 2017-18 FY; and,
    c) $309,000,000 in the 2018-19 FY.

16) Authorizes DHCS to make an adjustment that would result in lowering the amounts in 15) above. States that nothing would limit the authority of DHCS to make an adjustment that does not impact the amounts in 15) above.

17) Requires, if DHCS identifies that a modification or adjustment may be necessary under 15) above, to consult with affected health plans, to the extent practicable, to implement that modification or adjustment. Requires DHCS to notify affected health plans, and the Legislature within 10 business days of the modification or adjustment.

18) Requires DHCS to request approval from CMS to implement this bill. Authorizes DHCS to request a waiver of the broad-based and uniformity requirements, as specified.

19) Authorizes DHCS to implement the provisions of this bill outside of the administrative rulemaking process and to implement this measure pursuant to provider bulletins, all plan letters, or other similar instructions. Requires DHCS to notify specified committees of the Legislature within 10 business days of such action.

20) Establishes a the gross premiums tax (GPT) rate of 0% for premiums received for the provision of health insurance on or after July 1, 2016, and on or before June 30, 2019. Limits the application of this GPT rate to premiums received by an insurer that provides health

insurance and has a corporate affiliate, which is either a "health care service plan" or "health plan" that meets the following requirements:

a) Is licensed by DMHC or is a MCP;

b) Has had at least one enrollee enrolled in the health plan in the base year, as defined, not including individuals who are enrolled in a Medicare plan, who receive health care services through a health plan pursuant to a subcontract from another health plan or who are enrollees through the Federal Employees Health Benefits Act of 1959, as specified; and,

c) Is subject to the MCO provider tax imposed by this bill.

21) Defines an insurer that has a corporate affiliate as a health care service plan or health plan as an "insurer that is, directly or indirectly, controlled by, under common control with, or controls a health care service plan".

22) Prohibits the Insurance Commissioner from considering the reduction of the GPT rate authorized by this bill in any determination to impose or enforce a tax under the relevant retaliatory tax provisions of the Insurance Code and the Revenue and Taxation Code.

23) Excludes from the definition of "gross income," under the Corporation Tax (CT) Law, the qualified health care service plan income of a health plan that is subject to the MCO provider tax. Specifies that the income must properly accrue with respect to enrollment or services that occur on or after July 1, 2016, and on or before June 30, 2019. Defines a "qualified health care service plan" as a health care service plan that: a) is licensed by DMHC or is a MCP, and, b) subject to the MCO provider tax imposed by this bill.

24) Defines "qualified health care service plan income" as any of the following revenue associated with the operation of a qualified health care service plan and required to be reported to the DMHC, including the following:

a) Premiums (commercial);
b) Copayments, coordination of benefits, and subrogation;
c) Title XIX Medicaid;
d) Point-of-Service Premiums;
e) Risk pool revenue;
f) Capitation payments;
g) Title XVIII Medicare;
h) Fee-for-service (FFS);
i) Interest; and,
j) Aggregate write-ins for other revenues, including capital gains and other investment income.

25) Requires DHCS to submit to the Franchise Tax Board (FTB), no later than December 1, 2016, information regarding every health care service plan that is subject to the tax, as specified. Requires the information to include the corporate name, address, and calendar period for which each health care service plan is subject to the MCO provider tax.

26) Exempts from the minimum franchise tax, a qualified health care service plan with no income other than the excluded qualified health care service plan income.

27) Authorizes the FTB to prescribe rules, guidelines, or procedures necessary or appropriate to carry out the purposes of the provisions relating to the gross income exclusion for health care service plans. Exempts the FTB from the administrative rulemaking process.

28) Provides Legislative intent that the FTB Legal Ruling 2006-01 of April 28, 2006 regarding the treatment of apportionment factors attributable to income exempt from taxation shall apply to the apportionment factors attributable to the income of qualified health care service plans excluded by this bill.

29) Sunsets this measure on July 1, 2019, and as of June 30, 2020, is repealed. States that any tax and applicable interest and penalties imposed under this bill continues to be due and payable until the tax and any applicable interest and penalties are fully paid.

30) Provides that this bill's reduction in the GPT rate and gross income exclusion shall become operative on the later of July 1, 2016, or the effective date of the federal approval necessary for receipt of federal financial participation in conjunction with the new MCO provider tax.

31) Provides that this bill's tax law modifications shall cease to operate on the first day of the first FY beginning on or after:

    a) The date the Director of DHCS, in consultation with the Director of the Department of Finance, determines that the taxes have not met their goal of providing funding for health care and prevention, or the state does not have the federal approval necessary for receipt of FFP; or,

    b) The effective date of a final judicial determination made by a court of appellate jurisdiction that any of the tax law modifications cannot be implemented.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by DHCS, under which qualified low-income patients receive health care benefits. Medi-Cal is California's version of the federal Medicaid program in which funding is provided by both the state and federal government.

2) Establishes the Knox-Keene Act, the body of law governing health care service plans and enforced by DMHC.

3) Provides for the regulation of insurers and health insurance agents and brokers by the California Department of Insurance.

4) Establishes sales and use tax laws which impose sales tax on retailers for the privilege of selling tangible personal property at retail.

5) Establishes a sales tax in the amount of 3.9% on MCPs, beginning July 1, 2013 through July 1, 2016, and specifies that these funds be directed to DHCS for purposes of funding managed care rates for health care services for children, seniors, persons with disabilities, and

individuals dually eligible for Medicare and Medi-Cal that reflect the cost of services and acuity of the population served.

6) Imposes, under the California Constitution, a 2.35% tax on insurers doing business in California, commonly referred to as the "gross premiums tax," and specifies that the GPT is in lieu of all other taxes and licenses, with specified exceptions.

7) Imposes, under the CT Law, an annual tax on corporations measured by income sourced to California, unless otherwise exempted. Generally, for corporations operating both in and outside of the state, income sourced to California is determined on a worldwide basis applying the unitary method of taxation. The unitary method combines the income of affiliated corporations that are members of a unitary business and apportions the combined income to California based upon either a single sales factor or the average of three factors (the property factor, the payroll factor, and sales factor), whichever is applicable.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the sponsor, "This proposed legislation would implement a tax reform proposal to restructure the taxes paid by managed care plans. This includes a replacement MCO tax for the tax expiring at the end of June 2016 and replaces other taxes currently paid by the health plan industry. This tax reform proposal provides three years of critical funding for the Medi-Cal program, allowing for the continued expanded health care coverage for millions of Californians and protecting programs from cuts during future budget deficits."

2) **BACKGROUND**. Federal Medicaid law authorizes states to impose health care-related taxes on MCO's without affecting federal matching funding under Medi-Cal. Health care-related taxes are defined 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 states, including California, states collect these payments from health care providers to help finance the nonfederal share of their Medicaid expenditures. To be deemed permissible under federal law, health-care related taxes must be:

   a) Broad based: imposed on all providers within a specified class of providers;

   b) Uniform: applied at the same rate for all payers of the tax; and,

   c) 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.

   Federal rules permit some health care-related taxes that do not meet the definition of being "broad-based" and "uniform." To obtain permission for such a tax, states must formally request a waiver of the broad-based and uniform requirements from CMS, and within the waiver request, demonstrate that the tax structure is generally redistributive. However, federal law does not allow for any waiver of the no-hold-harmless requirement.

3) **CALIFORNIA'S PREVIOUS AND CURRENT MCO TAXES**. Background information provided by the Administration indicates that since 2005, California has used various forms of MCO fees and taxes. Below are descriptions of these fees/taxes:

   a) ***Quality Improvement Fee (2005-2009/10)***. Based on federal rules, the quality improvement fee (QIF) was assessed on all premiums paid to legal entities providing health coverage to Medi-Cal enrollees. When the fee was established, 75% of the revenue generated was matched with federal funds and used for payments to MCO's and the remaining 25% was retained by the state GF. Effective October 1, 2007, as part of the implementation of the State's new managed care rate methodology, this arrangement changed and 50% of the revenue generated by the QIF was matched with federal funds and used for payments to MCOs and the remaining 50% was retained by the state GF. Changes in federal law resulted in this fee to sunset on October 1, 2009, as it no longer complied with federal requirements. New federal law required that provider fees be broad based and uniformly imposed throughout a jurisdiction, meaning that they cannot be levied on a subgroup of providers, such as only those enrolled in Medicaid programs.

   b) ***Gross Premium Tax level MCO tax (2010-13)***. AB 1422 (Bass), Chapter 157, Statutes of 2009, imposed a 2.35% GPT on the total operating revenue of MCPs until July 1, 2011. The proceeds from the tax were be continuously appropriated to: i) DHCS for purposes of the Medi-Cal program in an amount equal to 38.41% of the proceeds from the tax; and, ii) to the Managed Risk Medical Insurance Board (MRMIB) for purposes of the Healthy Families Program in an amount equal to 61.59% of the proceeds from the tax. The tax was extended by ABX1 21 (Blumenfield), Chapter 11, Statutes of 2011, until July 1, 2012 and updated the sharing percentages for DHCS and MRMIB. Finally, SB 78 (Budget and Fiscal Review), Chapter 33, Statutes of 2013, extended the sunset date to June 30, 2013. After the Healthy Families transition to Medi-Cal in 2013, the MRMIB portion was used to offset the GF cost for the Medi-Cal program.

   c) ***Current MCO Tax (2013-June 2016)***. SB 78 imposed a 3.9375% tax based on the state sales tax rate on sellers of Medi-Cal health services. The tax was imposed from July 1, 2013 through July 1, 2016. The revenue derived from this sales tax was continuously appropriated to DHCS to be used solely for the purpose of funding managed care rates for health care services for children, seniors and persons with disabilities, and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served. In July 2014, CMS issued a guidance indicating that MCO taxes similar to California's were likely no longer permissible for the purposes of funding the Medi-Cal program, and in turn, required states with such taxes to make appropriate modifications.

   d) ***Proposed MCO Tax Reform (July 2016-June 2019)***. Under the Administration's proposal as codified in this bill, all full-service health plans licensed by the DMHC and/or plans contracted with DHCS to provide services to Medi-Cal beneficiaries, except plans licensed to provide care across international borders and locally operated non-profit health plans in Sacramento and San Diego, would be subject to the proposed tax. Effective July 1, 2016, a new MCO provider tax would replace the expiring tax, provide an ongoing source of funding for the Medi-Cal program, encourage California's continued successful implementation of the Affordable Care Act, and minimize the need for reductions to the program.

4) **TIERED TAX STRUCTURE.** In light of CMS' guidance regarding MCO taxes, the Administration proposes to replace the existing MCO tax on MCPs with a broad-based MCO tax that should satisfy federal requirements. Specifically, the proposal would apply broadly to all managed care plans regulated by DMHC and/or DHCS. It is projected to raise over $1 billion each year, generating enough revenue to maintain the current funding for Medi-Cal. Additionally, the tax structure in this bill would require a waiver of the uniformity requirement since there are difference tax tiers for MCPs, commercial plans and AHCSPs.

5) **MODIFICATION OR ADJUSTMENT OF TAX**. The Administration's proposal contains language that authorizes DHCS to modify or adjust the tax amount or tax tiers as necessary to meet federal requirements. However, this modification or adjustment cannot be higher than the following aggregate tax amounts for the other enrollees and AHCSP enrollees, combined, for each of the FYs: $266 Million (2016-17), $287 Million (2017-18); and, $309 million (2018-19). If there is any modification or adjustment, DHCS must consult with the affected health plans to implement the modification. Within 10 business days of any adjustment, DHCS must also notify the affected health plans and the Legislature.

6) **CALIFORNIA'S GROSS PREMIUM TAX**. Insurance companies in California are subject to a GPT equal to 2.35% of all premiums written. The GPT is imposed by Article XIII, Section 28, of the California Constitution. Section 28(a), in turn, defines an "insurer" to include "insurance companies or associations and reciprocal or inter-insurance exchanges together with their corporate or other attorneys in fact considered as a single unit, and the State Compensation Insurance Fund."

   For most types of insurers, this tax is in lieu of all other taxes except property taxes and vehicle license fees. Thus, insurers do not pay tax on other forms of income, such as investment income or income earned from other trades or businesses. Most other states also have a state-level GPT.

   The special tax treatment of insurance companies is primarily grounded in the economics of the insurance industry. Most businesses calculate their income by subtracting costs incurred in the production of a good or service from the revenues received from sales. Insurance companies, by contrast, collect their revenues "up front," and subsequently make payments to policyholders based on contingent events that may occur months or years later. Thus, it can be challenging to match up revenues to related expenses. For this reason, a gross premiums tax was adopted. As the Legislative Analyst's Office (LAO) has noted:

   > In an income tax framework, insurers ideally would be allowed to deduct the current value of all future obligations (claims) covered by the insurance policies they have written when calculating their taxable income for a given year. Because the actual amount of these obligations is uncertain, as are the amount of investment earnings on accumulated premiums received during the intervening period, an accurate determination of the theoretically appropriate amount of taxable income proves very difficult to achieve in practice.

   The LAO also notes that the GPT appears, in most years, to raise more revenue than would be raised by applying the CT Law to insurers' net income.

7) **GPT PROVISIONS OF THIS BILL**. This bill provides that, notwithstanding existing law, the GPT rate for specified insurers shall be 0% for premiums received on or after July 1, 2016, and on or before June 30, 2019. The 0% rate shall specifically apply only to health insurers with a corporate affiliate operating as a "health care service plan" meeting all the following requirements:

   a) The plan must be licensed by the DMHC or be a managed care plan contracted with DHCS to provide Medi-Cal services;

   b) The plan must have had at least one enrollee in the health plan in the base year, as specified; and,

   c) The plan must be subject to the new MCO provider tax enacted by this bill.

   Thus, under this bill, health insurers currently subject to the GPT will receive the functional equivalent of a GPT exemption for FYs 2016-17 through 2018-19, provided the insurer has a corporate affiliate operating as a health care service plan subject to the new MCO provider tax.

8) **TEMPORARY "GROSS INCOME" EXCLUSION**. Under California's CT Law, all corporations doing business in California are subject to the income tax or the franchise tax equal to the greater of the minimum franchise tax of $800 or an amount measured by net income attributable to California multiplied by the current tax rate, which is 8.84%. Multistate or multinational businesses must apportion their income among the jurisdictions in which they do business. California may only tax a portion of the income earned by businesses that operate in other states (or nations), in addition to California. That amount is calculated based on an apportionment formula.

   Health care plans (including all HMOs and some PPOs) determined not to be subject to the GPT are subject to the CT Law. As such, a health care provider may be subject to the franchise or income tax as a general "C" corporation. A health care provider may, however, qualify as an exempt (i.e. charitable) organization and thus be subject to franchise or income tax only on the organization's unrelated business income. In the case of a "for-profit" health care plan, its "gross income" generally includes all income, from whatever source derived. This bill would exclude from the CT Law the "qualified health care plan income" of a health care plan subject to the MCO provider tax proposed by this bill. Only the revenue associated with the operation of a qualified health care service plan and required to be reported to the DMHC would qualify for the exclusion. Examples of qualified revenue include premiums, copayments, capitation payments, FFS and investment income, among others.

9) **THE FRANCHISE MINIMUM TAX**. A minimum franchise tax of $800 is imposed on all corporations that are incorporated under the laws of California, qualified to transact intrastate business in California, or are doing business in California. Taxpayers must pay the minimum franchise tax only if it is more than their regular franchise tax liability.

   Existing law provides certain exceptions with respect to imposition of the minimum franchise tax. For instance, credit unions and nonprofit organizations are not subject to the minimum franchise tax and a corporation is not subject to the minimum franchise tax for its first taxable year. However, even though a corporation is not subject to the minimum tax in its

first taxable year, it will be subject to franchise tax in its first taxable year based on its taxable income.

This bill would create an additional exception from the minimum franchise tax for health care service plans with only qualified income, namely income that is excluded from the CT Law under this bill.

10) **UNCODIFIED PROVISIONS**. This bill contains a number of uncodified provisions chiefly pertaining to the operative dates of this bill's tax law modifications. For example, this bill contains uncodified language providing that the GPT rate reduction and gross income exclusion shall become operative either on July 1, 2016, or the effective date of federal approval of the new MCO provider tax, whichever is later.

This bill also contains uncodified language providing that the tax law modifications will automatically sunset on the first day of the FY immediately following: a) a final appellate court decision finding that the provisions cannot be implemented; or, b) a determination that the tax law modifications have not met their stated goal or have not received federal approval.

11) **RELATED LEGISLATION**. SBX2 15 (Ed Hernandez) is substantially similar to this bill and is currently pending in the Senate Public Health and Developmental Services Committee.

12) **SUPPORT**. Health Net states that it supports a stable funding stream for Medi-Cal to ensure high-quality care to all beneficiaries. It is confident that the proposal represents a balanced approach that will not negatively affect its purchasers, while generating significant revenue to support the Medi-Cal program. Additionally, Health Net points out that this tax reform proposal will have a positive overall aggregate impact on the marketplace and will have, at most, a negligible negative impact on its purchasers.

The Local Health Plans of California (LHPC) believes DHCS has devised a new MCO tax model that is fair and meets federal requirements. Under this proposed MCO model, local health plans will continue to pay the tax on their Medi-Cal enrollment, as well as begin paying a tax on their commercial lines of business. LHPC states that while the local health plans will not benefit from policy reforms because of their non-profit status, they believe that the tax applied to their commercial lines of business is absorbable and supportable – particularly because they recognize it is a critical component to ensuring the continuation of the MCO tax altogether. Finally, LHPC states that if this MCO tax package fails, the Medi-Cal program will lose an estimated $1.1 billion in critical funding and that this loss can neither be absorbed without crisis nor replaced with a source of predictable funding.

Health Access California, also in support, writes that the MCO tax is an existing tax and this bill proposes to reconfigure the state match, which allows California to draw down $1 billion in federal funds that the state would otherwise lose. Another benefit is that the MCO tax is less volatile than the GF because it is based on health plan enrollment. With the enactment of the Patient Protection and Affordable Care Act and its full implementation in California, health plan enrollment is less subject to economic downturns that the portion of GF revenue derived from capital gains.

13) **NEUTRAL**. Kaiser Permanente states that it has adopted a neutral position on the proposed MCO tax and that after review of this bill, Kaiser is confident that the proposal is a balanced approach that will not negatively affect its purchasers, while generating important revenue to support the Medi-Cal program. Kaiser also believes that the proposed MCO tax will have a positive impact on the health care marketplace.

14) **OPPOSE**. The National Federation of Independent Business (NFIB) states that it opposes the MCO tax proposal and raises concerns regarding impact on California's small businesses. These concerns include cost impact to small business and consumers. NFIB also states that there is no unity in the industry due to the measure treating healthcare plan providers differently and thereby driving up costs for consumers. In addition, NFIB identifies the lack of public analysis for the tax proposals and the long term effects for consumers. NFIB also points out that the proposal will net more tax revenues than necessary to obtain federal matching dollars. Finally, NFIB raises concerns with future tax implications since DHCS has authority to make adjustments to tax levels without legislative approval.

REGISTERED SUPPORT / OPPOSITION:

Support

Blue Shield of California
Health Access California
Health Net
Local Health Plans of California

Opposition

National Federation of Independent Business

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