Introduction
The California legislature is working with the Department of Health Care Services (DHCS) to find a solution for a $1.1 billion dollar gap in funding needed for various expenditures under the Medi-Cal program (California’s Medicaid program), most pertinently In-Home Supportive Services (IHSS) hours restoration, and Medi-Cal provider and developmental disability service rate increases. The taxes collected from managed care organizations (MCO) are used as the State’s portion of funds, that the federal government then matches, bringing in additional federal money to fund Medi-Cal. A solution to restructuring the MCO tax, a robust revenue stream for the Medi-Cal program, is a top priority for Governor Brown as he called for a special legislative session to address this issue. Failure to make up this $1.1 billion dollars would result in program cuts equal to this amount.

Change in the current MCO tax structure is required due to violations of the health-care related tax rules in some states, California included. Federal legislation and Centers for Medicare and Medicaid (CMS) rules require the MCO tax, defined as a health care-related provider tax, to meet three criteria, as depicted in table 1. States may seek waivers to adjust the “broad-based” and “uniform” tax rules, but there are no modifications to the “no hold harmless” rule. The clarification of the rules was issued by CMS in July 2014.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Explanation</th>
<th>CMS’ position on whether current CA MCO tax meets criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad-based</td>
<td>All providers in a category are levied the tax</td>
<td>No</td>
</tr>
<tr>
<td>Uniform</td>
<td>The tax is the same for all providers</td>
<td>Yes</td>
</tr>
<tr>
<td>No hold harmless</td>
<td>The state cannot guarantee that the tax will be returned to the provider</td>
<td>No</td>
</tr>
</tbody>
</table>

Source: Social Security Act § 1903(w)

CMS has found that California is in violation of the “broad-based” and “no hold harmless” criteria. California currently only taxes Medi-Cal MCOs, and not all MCOs as specified by federal regulation, thus violating the broad-based criterion. MCOs, including both Medi-Cal and commercial health plans, would need to be taxed to meet this requirement. Additionally, in its current form, the tax has no negative impact on the MCOs being taxed because providers receive the tax back in the match amount from the federal government. It is these two criteria that CMS contends must be addressed for California’s MCO tax to be permissible under federal regulation.

The legislature must agree on a modified tax by the end of the fiscal year or the State is at risk of losing revenues from the tax and the federal match amount, which in total would be about $2.2 billion.

The existence of the MCO tax is not new and has been in place in different forms for a decade. California first issued the MCO tax in 2005 as a Quality Improvement Fee. Currently, the tax on Medi-Cal MCOs is a sales tax at a rate of 3.9%. The rate is assessed on the revenues of the MCOs’, Medi-Cal line of business. The Board of Equalization collects this tax as it does other sales taxes. The funds from the MCO tax are then put in a special fund.

Governor’s Proposal for MCO Tax in Compliance
In order to generate $1.1 billion needed by the State, the Governor has proposed an updated MCO tax to meet federal regulations. To meet the broad-based rule, the tax will apply to all full-service MCOs,
including private, commercial managed care health plans and not just Medi-Cal MCOs.\textsuperscript{4,5} Commercial health plans will disproportionately feel the effects of the tax because Medi-Cal MCOs are allowed to build this tax into their reimbursement rates, which will then be recovered from a mix of state and federal funds, also known as federal financial participation (FFP).\textsuperscript{4} Commercial organizations will not recoup this tax from the government. According to the Legislative Analyst’s Office (LAO), the revenues from the tax will be approximately $1.4 billion.\textsuperscript{7} However, there will be an overall cost to the health plan industry with a net loss of $658 million or 0.5% of all the revenue earned by the health plan industry.\textsuperscript{8}

As mentioned, the tax will result in some MCOs that will be more financially impacted than others, yet the proposed MCO tax is strategically structured in a way that has the smallest impact on the health plan industry as a whole. This will be accomplished by introducing a stratified tax (see figure 1).\textsuperscript{9}

The proposed stratified tax will be based on health plans’ quarterly member months of enrollment (MME). The stratified structure applies the highest tax amounts to mid-MME MCOs, which are mainly the Medi-Cal MCOs, that average 1 million MME.\textsuperscript{10} The structure less heavily taxes MCOs with low enrollment (125,000 MME or below) or very high enrollment (over 2.5 million MME).\textsuperscript{11}

Figure 1
Proposed Tiered Tax Structure based on Month of Member Enrollment

\begin{center}
\includegraphics[width=\textwidth]{figure1.png}
\end{center}


\textsuperscript{4} MCOs that are not full service, for example plans that just offer dental or vision, are excluded. Additionally, as allowed under federal rule, Medicare MCOs may also be excluded.

\textsuperscript{5} The 2005 federal Deficit Reduction Act made a strategic change in the class of MCOs taxes that could be collected from as it changed the scope from just Medicaid MCOs to include commercial MCOs, as well.

\textsuperscript{6} Federal financial participation is the federal government’s contribution to Medicaid programs. It is based off of specific state and federal formulas, which includes criteria such as per capita income. California’s FFP is at the lowest possible match of 50%.

\textsuperscript{7} Ibid.

\textsuperscript{8} Ibid.

\textsuperscript{9} Although federal regulations taxes must be uniform, a waiver will be sought to employ the stratified tax structure. The stratified structure is not new and is used in other health care-related taxes and should not be an issue.

\textsuperscript{10} Ibid.

\textsuperscript{11} Ibid.
Impact of the Tax

Although the tax will be half a percent of all MCOs’ combined gross operating revenues some health plans will be impacted more. The effective tax rate that will be absorbed by the pool of 39 MCOs will range between zero and four percent. As stated previously, MCOs with high Medi-Cal enrollment will be less impacted because even though they will likely pay the highest tax due to the stratified structure, their taxes will be recouped through increased reimbursements from the State. Figure 2 shows 28 unnamed MCOs that will be responsible for paying the MCO tax. Thus, it is likely, MCOs that serve primarily commercial populations will be impacted the most by the tax, as they have little to no share of Medi-Cal beneficiaries. As is the general practice when taxes are incurred by organizations, the additional costs will likely be passed onto consumers. The increase of commercial consumer premiums by the plans should vary based on the plans’ tax liability. The expectation is a one-to-one correlation of tax increase from the health plan to the consumer (i.e. if the effective tax on the plan is 1%, consumers will see an premium increase of 1%). However, this increase will likely be negligible for the largest plans as recent commercial plan rate increases are usually much higher.

Issues with the Proposed Tax

There are elements of the proposal that may need to be addressed. First, the tax may not grow with healthcare inflation. This is because the tax is based on member enrollment. Although enrollment in managed care has increased at a rapid rate in the past few years, it may not grow as quickly with inflation to generate the funds required to cover all health care expenses, thus creating a possible need for additional General Funds in the future.

Assembly Bill Proposed Tax

Recently in the State Assembly, a flat tax on health plans was introduced as an alternative to the Governor’s proposed. Proposed bill ABX2-4 would institute a $7.88 monthly flat tax for each plan enrollee and include 45 health plans. Medi-Cal plans would still be able to recoup their tax losses from federal matching funds.

Figure 2
Distribution of MCOs by Size and Medi-Cal Share of Enrollment


Comparison of Current vs. Proposed MCO Tax

The proposed tax will look very different from the current tax structure. In table 2, an overview of the current MCO tax to the proposed MCO tax is described. Both branches of the legislature have heard presentations about the proposed tax. The special session date to discuss the tax has yet to be set. A follow-up on the details of the tax will be provided in the future. It is important to note that neither the current or proposed MCO taxes apply to health insurance products under the Department of Insurance.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Overview of Comparison of Current MCO Tax vs. Proposed MCO Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of tax</td>
<td>Current MCO Tax</td>
</tr>
<tr>
<td></td>
<td>Flat sales tax based on revenues from premiums</td>
</tr>
<tr>
<td>Tax rate on MCOs</td>
<td>3.9375% 13</td>
</tr>
<tr>
<td>Number, type of MCOs</td>
<td>27, Medi-Cal MCOs</td>
</tr>
<tr>
<td>Administration of tax</td>
<td>Board of Equalization</td>
</tr>
</tbody>
</table>

13 The rate of the tax is 3.9375% and is a sales tax. Retrieved from https://www.boe.ca.gov/sutax/medi-cal_managed_care.htm