July 22, 2024

To: CSAC Health and Human Services Policy Committee

From: Jolie Onodera, Senior Legislative Advocate
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Re: Action Item: Proposition 35: Initiative 23-0024A1
Title: "Provides Permanent Funding for Medi-Cal Health Care Services"

Recommendation
CSAC staff recommend the committee forward a recommendation to the CSAC Executive Committee to take "NO POSITION" regarding Proposition 35, the "Provides Permanent Funding for Medi-Cal Health Care Services" initiative, for the reasons outlined by staff in this memo.

CSAC Ballot Measure Review and Position Process
CSAC policy committees may recommend a position of support, oppose, or neutral on a measure, or it may take no position. The recommendation will be considered by the CSAC Executive Committee, and the Executive Committee's recommendation will be considered by the CSAC Board of Directors. More information regarding CSAC's policy for consideration of and positioning on statewide initiatives is available in the Policies and Procedures Manual, beginning on page 11.

Measure Status and Title – A Note for Clarity
Filed with the Office of the Attorney General in October 2023 and qualified by the Secretary of State's Office in June 2024, Proposition 35 (full text) is sponsored by the Coalition to Protect Access to Care and will appear on the November 5 statewide ballot. Initiatives are known by many titles or other labels throughout the often long and intricate process from the time a measure is filed with the Office of the Attorney General and qualification of the measure by the Secretary of State's Office 131 days prior to the next statewide general election. Although this memo will refer to the measure as Proposition 35, the following titles and labels will appear in the media or elsewhere:

- *As assigned by the Secretary of State's Office:* Proposition 35
- *Secretary of State's Title:* Provides Permanent Funding for Medi-Cal Health Care Services.
- *As assigned by the Office of the Attorney General:* Initiative 23-0024A1
- *Sponsor's Title*: Protect Access to Healthcare Act of 2024

Measure Summary
The Managed Care Organization (MCO) tax is a tax on managed care organizations based on health insurance enrollment in the Medi-Cal program and in the commercial sector. The 2023 Budget Act, with federal approval, authorized the MCO tax from April 2023 to December 2026. The MCO tax revenues offset General Fund spending in the existing Medi-Cal program and support program augmentations. This initiative would make the MCO tax permanent, subject to federal approval, and would limit the structure of the tax, and would establish specific uses for the tax revenue.

BACKGROUND

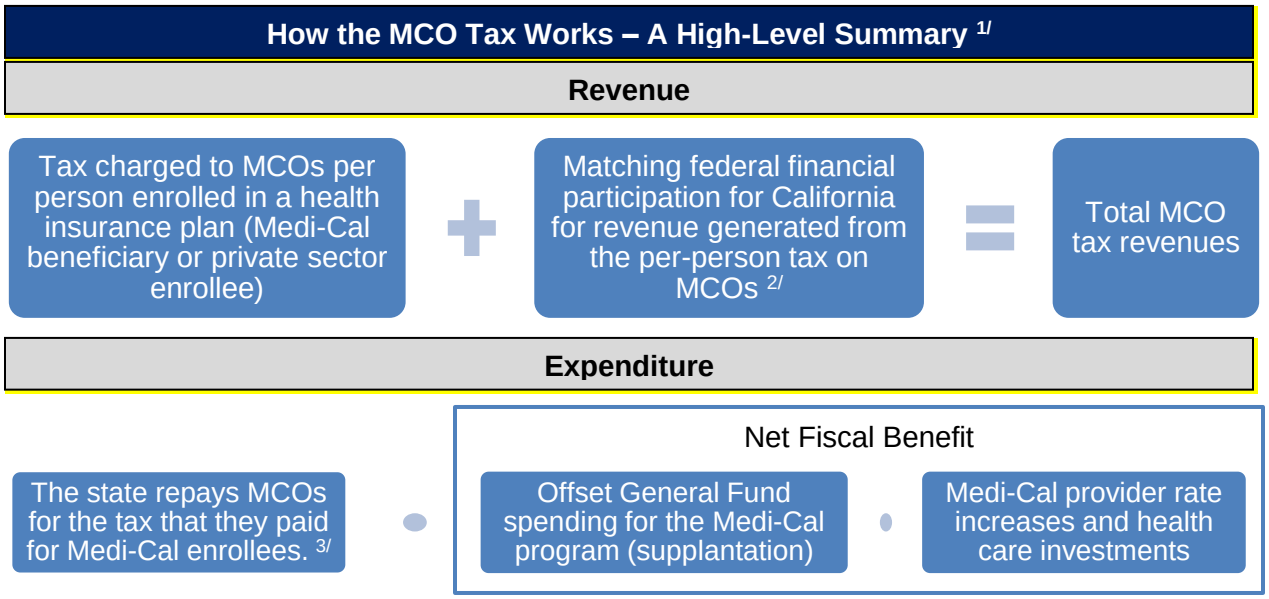
California's Medi-Cal Program

Medi-Cal is California's Medicaid program. Medicaid is a federal public health insurance program which provides health care services for low-income individuals and families. Medicaid is administered by states (then delegated to counties in California), and funded jointly between the federal government and states. In 2024, there are an estimated 14.5 million Californians enrolled in Medi-Cal. A majority of Medi-Cal beneficiaries are enrolled in managed care plans. "Managed care" is a health care delivery system in which state Medicaid agencies (for California, this is the Department of Health Care Services) contract with managed care organizations (e.g., Kaiser Permanente, Anthem Blue Cross). Managed care organizations accept capitation payments (per person, per month payments) for delivering health benefits to individuals enrolled in Medi-Cal.

In total, the 2024 Budget Act includes $161 billion ($35 billion state General Fund) for the Medi-Cal program in 2024-25. The 2024 Budget Act also includes nearly $7 billion of MCO tax revenues in 2024-25 to support the Medi-Cal program (i.e., offsetting state General Fund expenditures by $6.9 billion). The balance of the MCO tax revenues are allocated for Medi-Cal provider rate increases (increased reimbursement for, amongst other things, primary care physicians, women's health services, and ground emergency transport services) and other health care investments. The state and stakeholders are consistently engaged regarding the appropriate use of the MCO tax revenues (level of offsetting existing General Fund cost pressures vs. augmentations for the Medi-Cal program).

History and Structure of the MCO Tax

According to the Department of Health Care Services (DHCS), "the MCO tax is used as a mechanism to generate new state funds that can be used to match with federal funds to bring additional federal Medicaid dollars to California." California's MCO tax has existed in various forms for limited durations beginning in 2005. Today, the MCO tax is a tax on managed care organizations based on health insurance enrollment in the Medi-Cal program and in the commercial sector.



1/ This is a high-level summary for illustrative purposes. For more information, see the LAO's May 2023 issue brief.
2/ Subject to approval from the federal Centers for Medicare and Medicaid Services.
3/ The state may not hold MCOs harmless for all taxes paid. The state does not repay the portion of the tax on commercial enrollment.

The 2023 Budget Act
The 2023 Budget Act, with federal approval, reauthorized the MCO tax with a new structure from April 2023 through December 2026. Over the lifetime of the tax, it was estimated to yield a net benefit to the state's General Fund of $19.4 billion. The 2023 Budget Act agreement included $8.3 billion in MCO tax revenue to backfill budget shortfalls across several fiscal years, and appropriated $11.1 billion for investments in the Medi-Cal program, including provider reimbursement rate increases. Although the federal Centers for Medicare and Medicaid Services (CMS) approved California's 2023 - 2026 MCO tax model in December 2023, in late 2023 the state acknowledged that the federal government has indicated it may not approve such a large MCO tax again. Negotiations to address the state's budget shortfall throughout Spring 2024 resulted in significant adjustments to the MCO tax spending package included in the 2023 Budget Act.

The 2024 Budget Act
The 2024 Budget Act includes an estimated $23.1 billion in General Fund offsets for the Medi-Cal program across the lifetime of the tax. The 2024 Budget Act significantly reduces the planned funding for provider rate increases included in the 2023 Budget Act. As enacted, the 2024 Budget Act includes $133 million in 2024-25, $728 million in 2025-26, and $1.2 billion in 2026-27 for new, targeted Medi-Cal provider rate increases and investments funded by MCO tax revenue. The provider rate increases that were preserved in the 2024 Budget Act were fiscally sustainable because the budget also includes another proposed modification to the 2023 Budget Act MCO tax model to increase forecasted revenues (AB 160, Chapter 39, Statutes of 2024).

How did we get here? One year in the life of the MCO tax		
Point-In-Time	**Vehicle**	**Timeline: Recent changes to the 2023-2026 MCO tax**
June 2023	2023 Budget Act - Budget Trailer Bills AB 118/119	Effective January 1, 2024, would have increased rates for primary care, maternity care, and non-specialty mental health services to at least 87.5% of Medicare rates. Effective January 1, 2025, would have planned for a second phase of rate increases for a broad array of services.
December 2023	~	CMS approves California's MCO tax model for 2023 - 2026.
March 2024	Early Action Budget Agreement (SB 136)	• The Legislature and Administration agreed to a package of early budget actions to shrink the shortfall. • DHCS submitted a request to CMS to modify the MCO tax model to increase the amount of the tax; estimated to generate $1.5 billion in additional net funding to the state over the remaining life of the tax. CMS approval is pending.
May 2024	Governor's 2024-25 May Revision	To further address the state's budget deficit, the Administration proposed to eliminate the $6.7 billion in MCO tax-funded provider rate increases initially planned over multiple fiscal years as of the 2023 Budget Act.
June 2024	2024 Budget Act - Budget Trailer Bills SB 159/AB 160	Authorized new Medi-Cal provider rate increases and modified the MCO tax model (in addition to changes enacted by SB 136 in March 2024). Increases the MCO tax rate, thereby increasing the revenue forecast over the lifetime of the tax, subject to federal approval.

PROVISIONS OF PROPOSITION 35

Composed of 43 pages, Proposition 35 considerably diverts from the state's status quo and makes significant changes to the allowable expenditures of MCO tax revenue, while mostly maintaining the 2023 Budget Act structure of the levied tax. The bulleted information below captures the most significant components and requirements of Proposition 35.

Structure and Implementation of the MCO Tax

- Makes the MCO tax permanent.
- Requires DHCS to employ the models and methodologies used to structure the MCO tax as included in the 2023 Budget Act in perpetuity, to the extent permitted by federal law.

Federal Considerations

- Requires DHCS to seek federal approval necessary to implement Proposition 35.
- Requires DHCS to attempt to maximize the amount of federal matching funds available to California.
- Specifies that Proposition 35 is only operative during periods of federal approval.
- Allows DHCS to modify provisions of Proposition 35 if necessary to obtain federal approval of the MCO tax, within specified limitations.

Appropriation of MCO Tax Revenues

During Calendar Years 2025 and 2026:

- Appropriates $4.7 billion MCO tax revenues each year for 12 specified purposes, including but not limited to: Medi-Cal managed care rates for primary care services, women's health services, ground emergency transport services, and designated public hospitals.

Beginning January 1, 2027:

- Assumes at least $4.3 billion in MCO tax revenues annually.
- Creates a layered formula for allocation of MCO tax revenues, including creating more than 18 new state subfunds, accounts, or subaccounts.
- Each account and subaccount includes specific, distinct requirements for revenue expenditure.

Oversight and Accountability

- Requires the State Controller's Office to audit DHCS and programs receiving MCO tax revenues every four years.
- Prohibits borrowing or loan of the MCO tax revenues to the state's General Fund or any other state account, with limited exceptions.
- Prohibits using MCO tax revenue to supplant any other state revenues.
- Requires DHCS to make every reasonable effort to obligate or expend all MCO tax revenues annually, beginning January 1, 2027.
- Requires DHCS to publish an annual compliance report for use of the MCO tax revenues, which will be independently reviewed by the State Controller's Office. The State Controller's Office will publish a separate report evaluating DHCS' compliance.
- Establishes the Protect Access to Healthcare Act Stakeholder Advisor Committee within DHCS to research and analyze best practices for the development and implementation of Proposition 35 by DHCS.
- Requires DHCS to consult with the Stakeholder Advisory Committee to implement the components of Proposition 35, including the design of payment methodologies.

Administrative and Legislative Considerations

- Excludes MCO tax revenue expenditures from the state's calculations pursuant to the State Appropriations Limit (also known as the "Gann Limit").
- Provides that if the Legislature introduces a bill to amend Proposition 35 it must receive a 3/4 majority vote.

ESTIMATED IMPACTS AND OUTCOMES

Legislative Analyst's Office

According to the Legislative Analyst's Office (LAO) this measure will have uncertain overall impact on state revenues and spending, including reduced legislative flexibility over the use of MCO tax funds. The extent of this impact depends on whether the measure would result in different state decisions around imposing, structuring, and spending proceeds from the MCO tax than in the absence of the measure.

The Administration

According to the provisions of the recently enacted Health budget trailer bill (SB 159), if Proposition 35 is approved by voters, the MCO tax spending package included in the 2024 Budget Act would largely become inoperable, as both expenditure plans are not sustainable. Although Governor Newsom has not taken a formal, public position on Proposition 35, the Governor has been quoted as follows, "This initiative hamstrings our ability to have the kind of flexibility that's required at the moment we're living in. I haven't come out publicly against it. But I'm implying a point of view. Perhaps you can read between those many, many lines." It is widely understood that the Administration is uncomfortable with the inflexibility of the measure and its potential to disrupt longstanding state policy on use of the MCO tax revenues.

Public Hospitals

California's 21 public health care systems (PHS) include county-owned or affiliated systems and the five University of California academic medical centers. Together, these systems operate in 15 counties and play an important role in supporting the state's health care safety net. It should be noted the vast majority of PHS funding is self-financed across a wide array of Medi-Cal subprograms, and their governmental status enables PHS to contribute the non-federal share of costs in place of the state. Public hospitals have been experiencing financing challenges due to low Medi-Cal base payments, which most public hospitals cannot make up through commercial insurance payors, and supplemental payments have not kept up with the growth in the Medi-Cal program. As indicated below, Proposition 35 includes dedicated funding for these designated public hospitals.

STAFF COMMENTS

As described above, the engagement between the Administration and healthcare providers over the state of Medi-Cal reimbursement rates is longstanding. This was described and affirmed by the Public Policy Institute of California in 2023 in a literary review on health insurance in California, as follows: "'…there are longstanding concerns about whether Medi-Cal coverage offers adequate access to health care providers and services. Researchers and advocates often cite lower payment rates and provider reimbursements as the main reason that fewer health care providers are willing to treat Medi-Cal enrollees. In a recent study, Medi-Cal enrollees did report more problems finding doctors who would accept their insurance compared to people with employer-based insurance or Covered California plans, even after adjusting for socio-economic factors and health status.' Moreover, against this backdrop, the introduction of Proposition 35 was not entirely unexpected and was not created in a vacuum. However, the PPIC ultimately concluded that

'Without more detailed information on health care costs and usage patterns, it is difficult to pinpoint a Medi-Cal payment rate that would ensure adequate access.'"

Further, it is worth noting that Proposition 35 is not the first citizen-led tax initiative with the goal of increasing quality of and access to health care delivered via the Medi-Cal program. Proposition 56 (2016) shared some of the same proponents as Proposition 35, and raised the tax rate on tobacco products by $2 with the intent that the revenue be used for targeted Medi-Cal provider rate increases and other investments in the Medi-Cal program. Although the Proposition 56 tobacco tax is now a declining revenue source, Proposition 56 currently provides more than $1 billion annually for a variety of investments in the Medi-Cal program, the largest of which is supplemental payments for physicians' services.

In the aggregate, both the Administration and the proponents of Proposition 35 have presented fiscal strategies to expend the MCO tax revenue in the best interest of the fiscal health of the Medi-Cal program and the literal health of low-income Californians. The true choice before voters is whether to preserve or restrict the state's flexibility, and which providers and services to prioritize. The following table displays a comparison between the MCO tax expenditure plans in the 2024 Budget Act and in Proposition 35:

Services/Providers *In alphabetical order with no regard to fiscal year.*	**2024 Budget Act**	**Prop 35** [1/]
Affordable Drugs [2/]		Tier 3
Allied Health Loan Repayment [2/]		Tier 3
CalHealthCares Loan Repayment [2/]		Tier 3
Clinic Quality Incentive Pool		Tier 1
Community-based adult services	X	
Community health workers [2/]	X	Tier 3
Congregate living health facilities	X	
Continuous coverage Ages 0-5	X	
Designated public hospitals [3/]		Tier 1
Emergency Department Services		Tier 1
Emergency medical transportation (ground and air)	X	Tier 1
Emergency Department Physician Services	X	Tier 1
Family Planning and Reproductive Health	X	Tier 1
Federally qualified and rural health center services	X	
Graduate medical education		Tier 1
Improved Dental Services		Tier 1
Improved Access to Mental Health [4/]		Tier 1
Medi-Cal Access and Support [1/]		Tier 1 & 2
Non-emergency medical transportation	X	
Outpatient and clinic access		Tier 1
Pediatric day health centers	X	
Primary Care [5/]	X	Tier 1
Private duty nursing	X	
Specialty Care [5/]	X	Tier 1
Workforce Capacity [1/, 2/]	X	Tier 1 & 3

Sources: DHCS MCO Tax-Funded Investments Sheet and Proposition 35 text

[1/] Proposition 35 includes an initial appropriation of $4.3 billion to a first tier of 15 specified purposes. $400 million in revenues received past $4.3 billion are appropriated to a second tier, Medi-Cal Access and Support (also included in the first-tier allocations). Any additional funding is available to a third tier of allocations.

[2/] Third tier: Receives funding only after the designated appropriations for the first tier and second tier are satisfied.

[3/] Funding for Public Hospitals is capped at $150 million, with any additional funding rolled over to the Emergency Department allocation.

[4/] Funding for Improved Access to Mental Health is capped at $200 million, with any additional funding rolled over to the Emergency Department allocation.

[5/] The designation Physician and Non-Physician Health Professional Services as defined by the Administration and included in their investment sheet includes Primary Care and Specialty Care.

If Proposition 35 passes, the MCO tax-funded portions of the budget-balancing solutions package included in the 2024 Budget Act would be disrupted by an unknown, but potentially significant amount. Any decreases to the enacted and future budgeted General Fund offsets for the Medi-Cal program in current and future years will require more budget-balancing solutions to fill the gap. Notwithstanding the benefits to the Medi-Cal program that the specified provider rate increases could yield (e.g., increased access to health care and increased quality of care), the potential impacts of Proposition 35 should be considered against the fiscal risks to the state and, by extension, local governments. The passage of Proposition 35 would result in renewed budget-balancing negotiations for 2024-25 and subsequent fiscal years, and potentially put at risk all the wins that counties secured in the 2024 Budget Act, such as the $1 billion in 2024-25 for the Homeless Housing, Assistance and Prevention (HHAP) Program.

For these reasons, CSAC staff recommends that the Association take **no position** on Proposition 35.

Policy Considerations

While the CSAC Policy Platform does not include specific statements regarding the MCO tax, there is some broad guidance regarding Medi-Cal reimbursement rates for providers:

- "Counties support Medi-Cal payment reforms that result in increased payments and state General Fund" (page 63).
- "The state needs to recognize county experience with geographic managed care and make strong efforts to ensure the sustainability of county organized health systems. The Medi-Cal program must offer a reasonable reimbursement and rate mechanism for local managed care systems which should help ensure sufficient health plan participation and expand the number of providers serving Medi-Cal participants" (page 63).

Recorded Support

Coalition to Protect Access to Care (Sponsor) which includes but is not limited to the California Medical Association, California Association of Hospitals and Health Systems, Global Medical Response, California Hospital Association, and Planned Parenthood.

Recorded Opposition

None known at this time.

Resources Referenced and Materials for Further Reading

- Full text of Proposition 35
- Legislative Analyst's Office Fiscal estimate and review of Proposition 35 (October 2023)
- Legislative Analyst's Office May 2023 MCO Tax Issue Brief

- DHCS 2024 Budget Act MCO Tax-Funded Investments
- DHCS MCO Tax Primer (May 2023)
- DHCS News Release - CMS Approves MCO Tax (January 2024)
- CMS Approval Letter (December 2023)
- Department of Finance 2024 Budget Act Summary
- Public Policy Institute of California: The Impact of Health Insurance on Poverty in California (March 2023)
- DHCS: Proposition 56 Expenditures
- Full text of Proposition 56 (2016)
- CSAC Policy Platform
- CSAC Policies and Procedures Manual

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