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Managed Care Organization Tax: Background and Issues for Consideration on Administration's Proposal

PRESENTED TO:

Assembly Committee on Health
Hon. Jim Wood, Chair

Assembly Budget Subcommittee No. 1 on Health and Human Services
Hon. Joaquin Arambula, Chair

LEGISLATIVE ANALYST'S OFFICE

Part I: Background and Context for the Managed Care Organization (MCO) Tax

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- **How Medi-Cal Pays Providers**
- **Recent Key Developments in Medi-Cal Provider Payments**
- **How the MCO Tax Works**
- **Federal Approval of the MCO Tax**

Medi-Cal Basics

Medi-Cal Is California's Medicaid Program. Adopted by Congress in 1965, Medicaid is a joint state-federal program that provides health care coverage for low-income individuals. Medi-Cal, California's Medicaid program, provides coverage to about 15 million residents (nearly 40 percent of California's population).

Medi-Cal Delivers Services in Several Ways. Medi-Cal has a few key ways it delivers services to beneficiaries, described below:

- ***Managed Care.*** The primary way Medi-Cal delivers health services to beneficiaries is by contracting with health insurance plans—also known as "managed care organizations" (MCOs). Most Medi-Cal beneficiaries enroll in an MCO, which is responsible for arranging for their care. Medi-Cal makes monthly payments to each participating MCO to support the cost of health care for each Medi-Cal enrollee.
- ***Fee-for-Service.*** Traditionally, the other major delivery system in Medi-Cal is "fee-for-service," in which the state pays providers directly for services to beneficiaries. Over the years, the state has shifted more beneficiaries out of the fee-for-service system and into managed care. In 2023-24, the Department of Health Care Services (DHCS) projects that around 6 percent of beneficiaries will be fee-for-service only.
- ***Other Delivery Systems.*** Even though virtually all beneficiaries are enrolled in the managed care system, beneficiaries receive some services outside of managed care. For example, counties are responsible for providing many behavioral health services to Medi-Cal beneficiaries, and the state continues to pay for some services (such as pharmacy) on a fee-for-service basis.

Medi-Cal Basics

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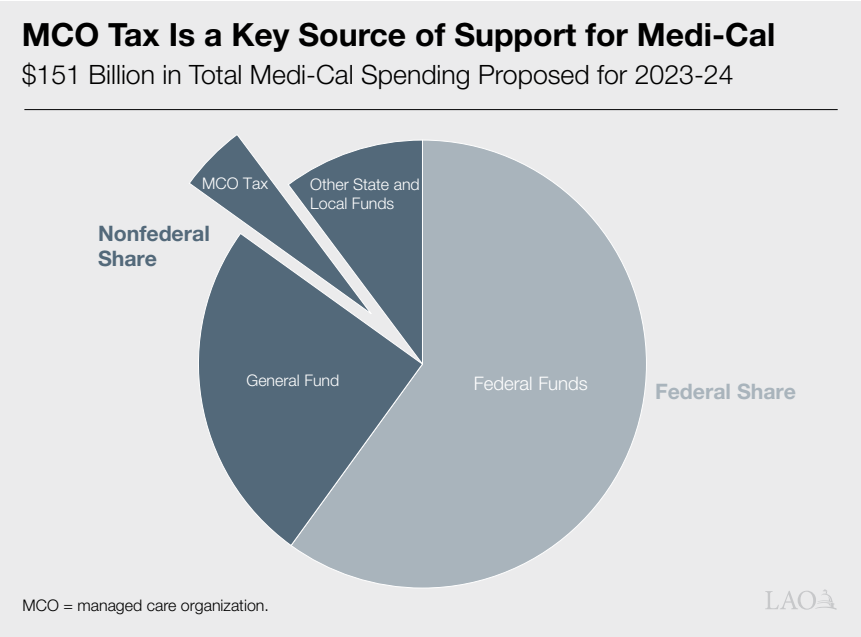
Medi-Cal Is Supported by Federal, State, and Local Funding. As a joint federal-state program, Medi-Cal, like Medicaid programs in other states, is supported from a mix of funding provided by the federal government and the state. The federal government's share of Medi-Cal costs is 50 percent for most beneficiaries and services, but is higher or lower for certain populations and services. California uses a variety of sources to cover its nonfederal share of Medi-Cal costs, including state General Fund support, state special funds, and funding from local governments. As the below figure shows, the MCO tax also is a key source of support for Medi-Cal's nonfederal share of costs.



How Medi-Cal Pays Providers

State Sets Fee-for-Service Payments to Providers. In the case of the fee-for-service delivery system, the state sets payment levels to providers. Generally, the state sets rates for services initially at 80 percent of comparable payments in Medicare, the federal government's health insurance program for the elderly and disabled. Some fee-for-service payments are adjusted for inflation, whereas others are not and have lagged behind Medicare over time. For example, according to the Kaiser Family Foundation, in 2019, Medi-Cal's payments for physician services (which generally have not been adjusted for inflation) were 73 percent of Medicare. For certain types of services the ratio was even lower—61 percent, for example, for obstetric care.

MCOs Negotiate Payments to Providers. In the case of Medi-Cal managed care, MCOs, rather than the state, are responsible for setting payments to their providers. MCOs make these payments using the monthly payments they receive from the Medi-Cal program. We understand that MCOs tend to use Medi-Cal fee-for-service payments as a starting point to negotiate payments to providers in their networks. That said, payment levels for providers in the managed care system likely vary across the state, reflecting different negotiations and arrangements made between MCOs and their providers.

State Also Provides Supplemental Payments. For some services in Medi-Cal (such as for physician and hospital services), the state provides supplemental payments above the base payments made in the fee-for-service and managed care systems. These supplemental payments generally are supported from special funds, such as tobacco tax revenues and fees on hospitals.

Recent Key Developments in Medi-Cal Provider Payments

State Reduced Base Payments During Great Recession but Has Since Restored Pre-Recession Levels for Many Providers. As part of a budget solution during the Great Recession, the state in the 2011-12 budget enacted a 10 percent reduction to base payments for most services in Medi-Cal. These reductions, which affected provider payments both in the managed care and fee-for-service delivery systems, are known as "AB 97 reductions." Over the years, most recently in the 2022-23 budget, the state restored funding for some but not all of these reductions.

State Provides Supplemental Payments to Providers Using Funds From Proposition 56 (2016). Proposition 56 increased state taxes on tobacco products. Most of the funding from the increase in taxes must be spent on the Medi-Cal program. The state has used most of this funding to provide supplemental payments to providers in both the managed care and fee-for-service delivery systems. The state also has begun using General Fund support to help sustain these supplemental payments, backfilling gradual declines in Proposition 56 funds resulting from declining statewide tobacco product consumption.

State Recently Increased Certain Base Payments to Draw Down Additional Federal Funding. In late January 2023, the federal government approved the state's plan to use existing state spending on non-Medi-Cal health programs to draw down additional federal Medicaid funds. As a condition of receiving this approval, the state must adopt increases to certain provider payments to close the gap between their existing levels and the 80 percent of Medicare threshold. The *2023-24 Governor's Budget*, as well as the May Revision, correspondingly assume both the increase in federal funding and the increase in payments for primary care services (in fee-for-service only) and obstetric services (both in fee-for-service and managed care).

How the MCO Tax Works

State Has Levied MCO Tax For Over a Decade. Since 2005, the state has charged a tax on MCOs—both those that participate in Medi-Cal and those that do not—to support the nonfederal share of Medi-Cal spending. The MCO tax provides two key fiscal benefits:

- It reduces General Fund costs to maintain the existing Medi-Cal program.
- It leverages additional federal funding.

Recent Versions of the Tax Have Been Enrollment-Based. The structure of the tax has changed over the years, but more recent versions have taxed monthly Medi-Cal and commercial (that is, private sector) enrollment. Tax rates have been much higher on Medi-Cal enrollment than on commercial enrollment. Recent versions also have been "tiered," meaning that they have applied different rates to different enrollment thresholds. For example, the last MCO tax charged rates on enrollment levels between 675,001 and 4,000,000 member months. The rates were $0 for enrollment levels below and above these thresholds. Revenues from past versions of the MCO tax have been placed into special funds—most recently, the Health Care Services Special Fund.

MCO Tax Has Imposed a Relatively Small Cost to MCOs… Most state taxes provide funding to the state budget by imposing a cost on taxpayers. In this regard, the MCO tax is very different from most taxes, in that the federal government—rather than the MCOs that pay the tax—bears most of the burden of the tax. This is because the Medi-Cal program, through the monthly payments it makes to MCOs, pays MCOs back for the tax that they paid on their Medi-Cal enrollment. Less than half of this Medi-Cal payment to MCOs (historically around 35 percent) has been covered by the state using a portion of MCO tax revenues. The remaining portion (historically around 65 percent) is covered by the federal government. While Medi-Cal does not cover the portion of the tax on commercial enrollment, this cost has been relatively small (low tens of millions of dollars annually) because the tax rates on commercial enrollment have been substantially lower than the tax rates on Medi-Cal enrollment.

How the MCO Tax Works

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…And Provided a Relatively Large Net Fiscal Benefit to the State. Even after subtracting out the portion revenue used by the state to help cover MCOs' associated cost of tax on Medi-Cal enrollment, the MCO tax has provided a substantial fiscal benefit to California. For example, the most recent version of the MCO tax generated over $2 billion in annual revenue. After accounting for the cost to the state to help cover the tax on Medi-Cal enrollment, the tax yielded an annual net fiscal benefit ranging from $1.5 billion to $1.7 billion.

State Has Used Net Fiscal Benefit to Pay for Services in Existing Medi-Cal Program, Thereby Reducing General Fund Spending. After helping to cover the cost of the tax to Medi-Cal MCOs, the remaining portion of MCO tax revenues have been used to pay for services in Medi-Cal. To date, the funds have been used to maintain, rather than augment, Medi-Cal's budget. In years when there was no MCO tax, the state used General Fund support to backfill the lost funding. Using the MCO tax's net benefit entirely to "free up" General Fund spending has been a policy decision of the state. Under the administration's proposal, described in Part II, revenues from the tax would reduce existing General Fund costs and augment Medi-Cal.

Most Recent Version of MCO Tax Provided Sizable Fiscal Benefit

(In Millions)

	2019-20[a]	2020-21	2021-22	2022-23[a]
Net State Fiscal Benefit				
Total MCO tax revenue	$1,031	$2,318	$2,584	$1,420
Portion of cost of tax covered by state	-316	-792	-893	-491
Totals	**$715**	**$1,526**	**$1,691**	**$929**
Portion from additional federal funding	$704	$1,503	$1,657	$912
Portion paid by health insurance industry	11	23	34	17
Use of Net State Fiscal Benefit				
Replacement of General Fund spending in Medi-Cal	$715	$1,526	$1,691	$929

[a] Tax began in January 2020 and extended through December 2022. Reflects Legislative Analyst's Office's estimates. Estimates reflect timing of when MCOs incurred the cost of the MCO tax (accrual basis). The state, however, budgets for Medi-Cal based on when cash payments are made, which delayed the year-to-year timing of these fiscal impacts.

MCO = managed care organization.

Federal Approval of the MCO Tax

State Must Receive Federal Approval to Use MCO Tax to Support Medi-Cal and Draw Down Federal Funding. The state must receive approval from the federal government to use the MCO tax to draw down federal Medicaid funds. Federal authorizations are limited term, typically spanning a few years. In some years, the federal government rejected the state's proposed MCO tax, necessitating changes to the structure and resubmission to the federal government before it could go into effect.

Federal Approval Is Conditioned on Meeting Certain Rules. To receive approval, federal regulations require the state to prove that the burden of paying the tax does not fall too disproportionately on Medicaid as opposed to non-Medicaid services. In addition, the state may not hold MCOs harmless by providing them direct or indirect payments that do so, as determined by the federal government.

Federal Government Has Contemplated Changes That Would Limit State Use of the MCO Tax. Virtually all states use taxes and fees on health care providers like the MCO tax to help support their Medicaid programs, and most (including California) have more than one provider tax or fee. While federal policymakers have allowed states to use these kinds of arrangements within certain limits, over the years Congress and the federal government have changed these rules and continue to contemplate policies to further limit how much fiscal benefit states can leverage. For this reason, future federal policy decisions have been a continued source of uncertainty in this area.

Part II: Issues for Consideration on Administration's MCO Tax Proposal

Order of Presentation

- **How the Governor Proposes to Structure the New Tax**
- **How the Governor Proposes to Spend the Net State Fiscal Benefit**
- **Issues Around Renewing the Tax**
- **Issues Around Spending the Net State Fiscal Benefit of the Tax**

How the Governor Proposes to Structure the New Tax

Governor Proposes Renewed Tax Extending From April 2023 Through 2026. The Governor proposes renewing the MCO tax, with the tax beginning in April 2023 and extending through the end of the 2026 calendar year. The same rates would apply in 2023 and 2024, and then would increase at the start of the 2025 and 2026 calendar years. To receive this retroactive start date in April 2023, the state would need to submit the tax to the federal government for approval by the end of this coming June.

Proposed MCO Tax Would Share Many Features to the Most Recent Version… The common features of the proposed MCO tax to the most recent version include: (1) the tax would be enrollment based, (2) rates on Medi-Cal enrollment would be much higher than the rates on commercial enrollment, and (3) the tax would apply a nonzero rate to a specific tier of enrollment.

…With Two Key Differences. As the below figure shows, the proposed tax would enact a much larger rate on Medi-Cal enrollment relative to the most recent version of the tax. Also, the proposed tax narrows the tier of enrollment that is taxed.

Proposed MCO Tax Medi-Cal Rates Much Higher Than Most Recent Version

Annual Rate Per Member Month

	Expired 2020 Tax[a]				Proposed 2023 Tax[b]			
	2019-20[c]	2020-21	2021-22	2022-23[c]	2023[d]	2024	2025	2026
Medi-Cal tax rate	$40.00	$45.00	$50.00	$55.00	$182.50	$182.50	$187.50	$192.50
Commercial tax rate	1.00	1.00	1.50	1.50	1.75	1.75	2.00	2.25

[a] Rates applied to each plan's aggregate monthly enrollment level between 675,001 and 4,000,000 member months during calendar year 2018.

[b] Rates would apply to each plan's aggregate monthly enrollment level between 1,250,001 and 4,000,000 member months during calendar year 2022 (with certain adjustments).

[c] Tax began January 2020 and expired at the end of December 2022.

[d] Tax would begin April 2023 and would expire at the end of December 2026.

MCO = managed care organization.

How the Governor Proposes to Spend the Net State Fiscal Benefit

Proposed Tax Would Yield Substantial Fiscal Benefit to State. Because the Governor proposes enacting much higher tax rates on Medi-Cal enrollment relative to the most recent version, the resulting net fiscal benefit also would be higher. Specifically, the proposed MCO tax would generate $8.2 billion in revenue in 2023-24 ($32.1 billion through 2026-27) and, after covering the state share of the cost of the MCO tax to MCOs on Medi-Cal enrollment, a net state fiscal benefit of $4.4 billion in 2023-24 ($19.4 billion through 2026-27). As in past versions of the MCO tax, the bulk of this net benefit would come from drawing down more federal funding, with a very small portion also coming from taxing commercial enrollment.

Governor Proposes Three Uses for Net State Fiscal Benefit. According to DHCS, the next MCO tax after this proposed one likely will raise significantly less revenue. This is because, according to DHCS, the federal government has signaled interest in tightening the existing rules around using health care-related taxes (like the MCO tax) to draw down federal Medicaid funds. At the same time, the administration proposes to take advantage of the large increase in MCO tax proceeds to augment Medi-Cal's budget. Recognizing these competing factors, the administration proposes three specific uses, as described below and shown in the figure on the next page.

- ***General Fund Offset.*** A still sizable portion of the MCO tax's net state fiscal benefit—$3.4 billion in 2023-24 ($8.3 billion through 2026-27)—would be used to offset General Fund spending in Medi-Cal and help address the state's budget problem.
- ***Targeted Provider Payment Increases.*** The Governor proposes increasing managed care and fee-for-service base payments for primary care, obstetric care, and non-specialty mental health services to 87.5 percent of Medicare, costing $98 million in 2023-24 ($820 million through 2026-27). This action would restore funding from AB 97 reductions to those services, as well as count existing Proposition 56 supplemental payments for these services as part of the 87.5 percent threshold. The payment increases would begin in January 2024.

How the Governor Proposes to Spend the Net State Fiscal Benefit

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- ***Future Augmentations.*** The remaining fiscal benefit—$923 million in 2023-24 ($10.3 billion through 2026-27)—would be set aside in reserve for future augmentations in Medi-Cal, either for additional payment increases or other activities that improve Medi-Cal services and promote provider participation. Proposed trailer bill legislation would direct DHCS to submit a proposal to the Legislature as part of the 2024-25 budget process to spend the funds. The administration also indicates that it intends to spend these funds over an eight-to-ten-year period, thereby lessening the potential fiscal cliff from having smaller versions of the MCO tax in the future.

Two New Special Funds Created. As with past versions, funds from the proposed MCO tax would be placed in a new special fund (the "Managed Care Enrollment Fund") to help cover the nonfederal share of Medi-Cal spending. The trailer bill legislation also creates a second reserve account (the "Medi-Cal Provider Payment Reserve Fund") for the future Medi-Cal augmentations.

Governor Plans Three Key Uses of Net State Fiscal Benefit

(In Millions)

	2023-24[a]	2024-25	2025-26	2026-27[a]	Totals
Net State Fiscal Benefit					
Total MCO tax revenue	$8,269	$8,527	$8,762	$6,704	$32,261
Portion of cost of tax covered by state	-3,860	-3,415	-3,507	-2,077	-12,860
Totals	**$4,410**	**$5,112**	**$5,254**	**$4,626**	**$19,402**
Portion from additional federal funding	$4,383	$5,084	$5,223	$4,600	$19,289
Portion paid by health insurance industry	27	28	32	26	112
Uses of Net State Fiscal Benefit					
Replacement of General Fund spending in Medi-Cal	$3,389	$1,858	$2,019	$1,050	$8,316
Certain provider rate increases[b]	98	240	241	241	820
Reserve for future augmentations in Medi-Cal[c]	923	3,014	2,994	3,335	10,266
Totals	**$4,410**	**$5,112**	**$5,254**	**$4,626**	**$19,402**

[a] Tax would begin April 2023 and extend through calendar year 2026. Tax rates would be adjusted at the start of each calendar year. This table converts amounts to a state fiscal year (extending from July though June) and cash budgeting basis, reflecting state budget practice.

[b] Increases base Medi-Cal fee-for-service and managed care payments for primary care, obstetrics, and non-specialty mental health services to 87.5 percent of comparable Medicare payments beginning in January 2024.

[c] Funds would support additional targeted increases to Medi-Cal payments, as well as other activities that advance access, quality, and equity for Medi-Cal beneficiaries and promote provider participation in Medi-Cal. Proposed trailer bill legislation would direct Department of Health Care Services to submit proposal to Legislature as part of the 2024-25 budget process to spend the funds.

Issues Around Renewing the Tax

Should the Legislature Renew and Increase the MCO Tax? The MCO tax has been a key source of support for the Medi-Cal program, providing a substantial fiscal benefit at a relatively small cost to the health insurance industry. Given these factors, as well as the state's existing budget constraints, renewing and increasing the tax warrants serious legislative consideration. Importantly, the MCO tax revenues and corresponding General Fund offset are assumed in the overall budget structure of the Governor's May Revision budget. Accordingly, without the MCO tax, the Governor's budget would be out of balance by $3.4 billion in 2023-24, necessitating additional budget solutions of a like amount.

How Should the Legislature Structure the Renewed MCO Tax? The structure of the proposed MCO tax, which carries forward many elements from the previous version, is a reasonable starting point for the Legislature to consider. To the extent the Legislature is interested in exploring other ways to structure the tax, we recommend it keep three goals in mind: (1) the new tax provides a sizable fiscal benefit to the state, (2) the new tax stands a reasonable chance of receiving federal approval, and (3) the new tax provides a stable and predictable source of support.

Issues Around Spending the Tax's Net State Fiscal Benefit

How Much of the Tax Should Reduce General Fund Costs Versus Augment Medi-Cal's Budget? The much larger MCO tax proposed by the Governor presents an unprecedented fiscal opportunity to the state. Deciding how to allocate this fiscal opportunity between addressing the state's budget problem versus augmenting Medi-Cal (or both, as proposed by the administration) comes with trade-offs. Our office's fiscal outlook suggests that the state faces annual budget deficits ranging from around $5 billion to around $20 billion over the duration of the MCO tax. The more MCO tax funding the Legislature commits for augmentations, the less it has to address this deficit, necessitating corresponding reductions elsewhere in the state budget.

What Medi-Cal Augmentations Should the Legislature Consider? The administration's focus on increasing base payments to providers has some programmatic advantages. Increases in payments to providers have the potential to result improved access to services for beneficiaries. The Governor's proposal also could allow for a more streamlined approach to pay providers by incorporating existing supplemental payments into the base. On the other hand, to the extent the administration intends to propose ongoing augmentations and the increased MCO tax structure is not a permanent arrangement, the proposed augmentations create ongoing budget pressure in future years. Limited-term uses, such as enacting limited-term supplemental payments or setting aside funds in a Medi-Cal-specific reserve for economic uncertainty, could help mitigate this future budget pressure.

Issues Around Spending the Tax's Net State Fiscal Benefit

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Over What Period of Time Should the State Spend MCO Tax Funds for Medi-Cal Augmentations? The administration's proposal to spend the funds over an eight-to-ten-year period is intended to help manage a potential fiscal cliff. This fiscal cliff would arise were the federal government to tighten its rules around approving the MCO tax, limiting how much fiscal benefit the state could leverage from future versions of the tax. Given this risk, as well as the state's constrained overall fiscal situation, spreading out ongoing augmentations over the proposed time period warrants consideration. That said, the administration's approach also reduces the annual augmentation to Medi-Cal relative to if the state were to spend all of the funding over the nearly four-year life of the tax, lessening the potential impact of the augmentations on expanding access to Medi-Cal services. We also emphasize that the timing, nature, and scope of any future federal regulatory changes is uncertain, making it impossible to project with precision the fiscal cliff facing the state.

How Can the Legislature Ensure It Is an Active Participant in How the Funds Are Spent? To the extent the Legislature is interested in pursuing provider payment increases (beyond the increases proposed to begin January 2024), allowing the administration to return during next year's budget cycle with a more detailed analysis and proposal would be reasonable. We also recommend the Legislature modify the proposed trailer bill legislation to set forth key parameters for the administration's analysis of provider rate adequacy (such as, for example, assessing existing access and quality shortfalls in Medi-Cal and documenting how combined base and supplemental payments compare to Medicare for each provider type). We also recommend the Legislature explore other actions to ensure funding allocations align with legislative priority. For example, the Legislature could enact stricter rules around when the administration can transfer and spend funds in the proposed MCO tax and provider payment reserve accounts. Under the Governor's proposal, both accounts would be continuously appropriated, granting the administration flexibility to make these decisions without turning to the Legislature.

Appendix

Annual Cost to Eliminate Remaining AB 97 Provider Payment Reductions After MCO Tax Proposal Is Implemented

Estimates From Department of Health Care Services and Legislative Analyst's Office (In Millions)

Provider or Service	General Fund	Federal Funds
Physician services[a]	$33	$98
Pharmacy medical supplies	8	12
Clinical laboratories	7	22
Ground medical transportation[b]	5	15
Other[c]	1	3
Totals	**$54**	**$150**

[a] Reflects estimate of remaining cost after eliminating reductions for primary care, obstetrics, and non-specialty mental health services..

[b] Excludes non-emergency medical transportation.

[c] Includes chiropractors; long-term care facilities; physical therapists; and early and periodic screening, diagnostic, and treatment supplemental services providers, among others.