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Funding the Medi-Cal Program

SUMMARY

California's uninsured rate has declined dramatically in the past few years. Much of the increase in health coverage has been the result of the state's decision to expand Medi-Cal, its Medicaid program, under the Affordable Care Act. While the federal government has funded a large share of program growth, state costs have also risen. This cost growth, combined with major policy shifts still conceivable at the federal level, has created additional uncertainty about the future of Medi-Cal financing. As state lawmakers and other stakeholders plan for the future of the program, it is important to understand how Medi-Cal is currently financed and how it fits into California's overall budget. This context is essential to any discussion of funding options.

- State spending on Medi-Cal has grown over the past decade, outpacing growth in state revenues. In recent years, the state has increasingly relied on sources beyond the General Fund to support the program.
- Still, Medi-Cal accounts for 15 percent of total General Fund expenditures (the second largest budget outlay after K–14 education), so the program is at the center of state budget discussions—particularly when revenues falter.
- There are many possible ways to generate additional funding that could support Medi-Cal. In exploring revenue options—including sin taxes, provider fees, and more general tax changes—it is important to assess how well they align with standard fiscal principles. The best funding sources are those that can provide consistent long-term funding that grows over time but also meet other important criteria, including progressivity, economic efficiency, and simplicity.
- If there are major policy changes at the federal level, the state will face difficult trade-offs related to expanding state funding for Medi-Cal, the scope of the current program or a successor program, and/or the repercussions of having many more uninsured Californians.

With the federal policy landscape still in flux, state discussions about the future of the Medi-Cal program will continue. Given the important role Medi-Cal plays in providing health coverage to such a large share of Californians—and some of our most vulnerable residents—it will be important to foster a wide-ranging discussion of options. Beyond the funding issues that are the focus of this report, the state and its residents need to decide what they want from the program and how these goals can best be achieved.

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Technical appendices to this paper are available on the PPIC website.

Introduction

California's Medicaid program, Medi-Cal, has long provided comprehensive health benefits to low-income children, seniors, and adults with dependent children and/or a qualifying disability. California chose to expand Medi-Cal under the Affordable Care Act (ACA), which provided states with enhanced federal funding to open the program to most low-income adults. In the three years since the coverage expansion was implemented in 2014, enrollment in Medi-Cal has increased nearly 60 percent. According to the state budget, Medi-Cal will cover more than 13 million Californians in the 2016–17 fiscal year—more than one-third of the state's population. Counting all sources of funds, Medi-Cal is the most costly program administered by the state.

To date, the federal government has provided the bulk of funds for the Medi-Cal expansion. Even so, General Fund spending for Medi-Cal has increased about 5 percent annually from 2012–13 through 2015–16 and now constitutes about 15 percent of total General Fund expenditures.

The outcome of the November 2016 election has resulted in a new level of uncertainty about Medi-Cal funding. Given that federal funds currently comprise about two-thirds of total program spending, potential changes to federal policies will dominate Medi-Cal finance discussions in the near future. While the possibility of a major policy shift at the federal level seems to have receded for now, Medi-Cal still faces other fiscal challenges. Higher costs as the result of demographic changes and the aging of the population, along with uncertainty about overall cost growth, loom large. Other longstanding challenges include increasing payment rates to providers and coordinating care for high-need, high-cost beneficiaries.

Medi-Cal's fiscal challenges are set within the broader context of California's revenue system. Given the state's reliance on personal income tax, in particular capital gains taxes and high-income earners, state revenues decline sharply when the economy takes a downward turn. The governor and legislature have set aside funds to help the state weather the next recession, but these funds will not eliminate the need to trim spending. Budgeting for Medi-Cal is especially challenging because program demand is counter-cyclical—it tends to rise during economic downturns.

As the policy discussion continues to evolve, this report provides an overview of the current financing structure of the Medi-Cal program and places Medi-Cal spending in the context of California's broader revenue system and expenditures in other large program areas. We then briefly discuss the future of Medi-Cal costs in California and sources of fiscal pressures. Finally, we evaluate various revenue sources that could support the Medi-Cal program in the context of basic fiscal principles—such as reliability, growth, and progressivity.[1]

How Is Medi-Cal Currently Financed?

Established in 1965, Medicaid is a joint federal-state program that provides comprehensive health benefits to low-income people. As an entitlement program, it currently has no caps on spending or enrollment so that anyone who meets eligibility criteria can receive benefits. The federal government covers at least half of the total financing for the program through matching funds for qualified expenditures; it also provides legal and regulatory frameworks and program oversight. States are responsible for a certain share of spending, for which they claim matching

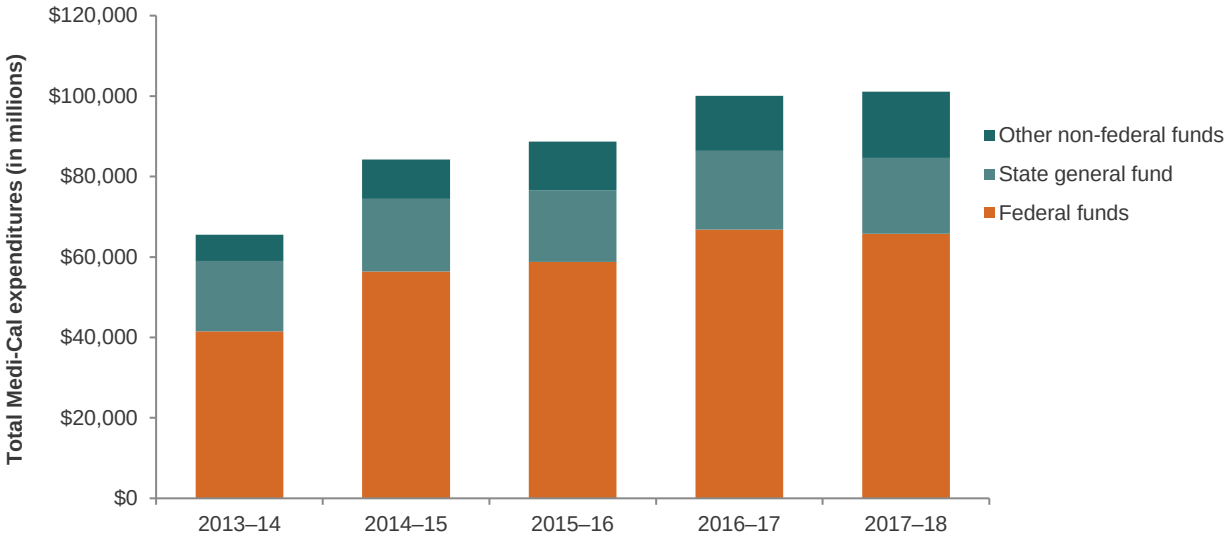
[1] The research for this report entailed collecting published revenue and expenditures data, reviewing the relevant literature, and interviewing state and national policy experts. Technical Appendix C discusses the data sources used for the budget analyses and lists the experts interviewed and provides the interview protocol.

federal funds. In addition, states ensure compliance with federal regulation, determine the scope of benefits offered under optional categories, set reimbursement rates for providers, and contract with managed care plans that provide services. Local governments, private hospitals, health plans, and other providers deliver health services to beneficiaries and contribute financing that can be matched by federal dollars.

In California, federal funding covered about two-thirds of total Medi-Cal spending in the current fiscal year and the governor's January budget projects a similar share for 2017–18 (Figure 1). General Fund expenditures for Medi-Cal totaled about $17.5 billion dollars in 2015–16 and, according to revised estimates, are slated to be $19.6 billion in the current fiscal year—about 20 percent of program expenditures. This represents an increase of more than 5 percent (nearly $1 billion) in state General Fund money going to the Medi-Cal program since 2013–14, the first year of ACA implementation. Non-federal funds from other sources—local governments, health plans, and provider fees—made up another 13.5 percent of total Medi-Cal funding in 2015–16 and are expected to comprise more than 16 percent in the current fiscal year.

FIGURE 1

The federal government has provided the bulk of new funds for Medi-Cal under the ACA



SOURCE: California Department of Health Care Services, Medi-Cal Local Assistance Estimates.

NOTES: Expenditures for 2016–17 and 2017–18 are from the November 2016 local assistance estimates and reflect revised estimates for 2016–17 and projected expenditures for 2017–18. All other expenditures are based on the estimate provided in the May estimate of the following fiscal year. All amounts have been inflation adjusted to 2016 dollars using CPI-U west.

Before the enactment of the ACA, California covered roughly half of the cost of the Medi-Cal program, and the General Fund provided the bulk of state program funds. The ACA offered a much higher rate of federal funding to state Medicaid programs to cover the cost of expanding coverage to low-income adults without disabilities or children. Thus, the state's current Medi-Cal funding responsibility reflects an average of the state shares for the pre-ACA population and the newly eligible group.

Over the past decade, total spending on the Medi-Cal program has grown substantially, from about $40 billion in 2005–06 fiscal year to about $100 billion in 2016–17. Over that same period, the share funded by the state's General Fund has declined from about 40 percent to about 20 percent (Mann et al. 2016). In part, this is caused by the higher federal match rate that helps states pay for newly eligible recipients. In addition, funding from other sources—including local governments and providers—has grown. In recent years all states have been increasingly

relying on sources of funding beyond state General Fund appropriations to support the Medicaid program (Snyder and Rubonitz 2015).

The share of Medi-Cal expenditures covered by the federal government is quite similar to the national average: in federal fiscal year 2015, the federal government covered 63 percent of Medicaid expenditures, which totaled over $532 billion dollars. Compared to other large states that expanded their Medicaid programs under the ACA, California relies more heavily on federal funding—federal funds accounted for about 55 percent of Medicaid expenditures in New York and Pennsylvania in 2015, compared to about 63 percent in California.[2] This is due in part to the large newly eligible population in California, but it also reflects California's use of other sources of funding to generate additional federal dollars.

Federal Funds

The federal government provides matching funds to states for all qualifying Medicaid expenditures. The federal share of expenditures for beneficiaries who were eligible for the program before the ACA is determined by the Federal Medicaid Assistance Percentage (FMAP), which is higher for states with per capita income that is lower than the national average. California and 14 other states have the lowest standard FMAP rate, which is 50 percent.[3] The federal government provides an enhanced FMAP for people who became newly eligible for Medi-Cal under the ACA coverage expansions—namely, low-income single adults without dependent children.[4] For the first three years of ACA implementation (2014–2016), the federal government paid 100 percent of the cost of Medi-Cal coverage for this newly eligible group; the federal contribution gradually decreases to 90 percent in 2020 where under current law it will remain.

The federal government matches at a higher rate for certain categories of Medicaid expenditures, including family planning services, certain administrative costs, and improvements to IT systems (Snyder and Rubonitz 2015). Enhanced FMAP rates have also been used to help states during recessionary periods—including the Great Recession—because states have more limited tools than the federal government for weathering economic downturns (GAO 2011).

In addition to matching qualified Medi-Cal expenditures, the federal government provides additional revenue to support the program, including Disproportionate Share Hospital (DSH) payments and 1115 Medicaid waiver funds.[5] DSH funds are directed to hospitals that serve a large number of Medi-Cal and uninsured patients; in 2015 DSH allotments provided about $1.2 billion to California hospitals.[6] Medicaid 1115 waivers are designed to give states flexibility to expand and improve their Medicaid programs. The state's waiver from 2010 to 2015 brought in more than $10 billion, while the current waiver, in effect through 2020, provides about $6 billion. In some cases, the waiver requires matching funds, usually from local governments or providers.

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[2] Based on Urban Institute estimates examining data from CMS (Form 64), as of September 2016 accessed from Kaiser Family Foundation state health facts. These estimates are based on national data rather than the state data from the Medi-Cal Local Assistance Estimates that are used in Figure 1. This is the cause of the slight discrepancy (64% vs. 66%) in the percentage of federal funds for California's Medi-Cal program.

[3] There have been calls to revisit the FMAP formula so that it better reflects differences in the need for Medicaid services across states and the ability of states to adequately fund the program. See Technical Appendix A for further discussion on revisiting the FMAP formula.

[4] The threshold for Medicaid eligibility under the ACA is 133 percent of the federal poverty line but there is a 5 percent income disregard (income that does not get counted towards the income on which program eligibility is based) which raises the effective threshold to 138 percent.

[5] Medicaid waivers allow states to waive certain federal Medicaid requirements. There are other types of federal waivers under the Medicaid program, including 1915(b) related to specialty mental health services and 1915(c)(i)(j) related to home and community-based services for populations needing long-term supports.

[6] According to information compiled by Kaiser Family Foundation, Kaiser State Health Facts, Federal Medicaid Disproportionate Share Hospital Allotments for fiscal year 2015.

State Funds

States must fund their share of Medi-Cal expenditures in order to access federal dollars, but they have some flexibility in the sources of funding. Federal law requires that at least 40 percent of the non-federal portion of Medicaid funds come from general state funds, but the Center for Medicaid and Medicare Services—the federal agency that oversees state Medicaid programs—recognizes several other funding sources: intergovernmental transfers (IGTs—transfers of funds from local agencies to Medicaid), certified public expenditures (CPEs—spending on Medicaid-covered services), and permissible taxes and provider donations.

Prior to the ACA expansions, state general funds accounted for about 63 percent, on average, of the nonfederal share of Medicaid expenditures nationwide, with local funds and provider fees covering the remaining share of state spending (GAO 2014). Current budget estimates for the Medi-Cal program indicate that the General Fund will cover about 58 percent of the nonfederal share of program costs in fiscal year 2016–17.[7]

As mentioned above, California must pay its standard FMAP rate—50 percent—for individuals who were eligible to receive Medi-Cal benefits under pre-ACA rules. Outreach that accompanied the roll-out of the ACA, along with streamlined eligibility systems and the requirement that most people have health insurance have increased enrollment among this population in California and other states. Often referred to as the "woodwork" or "welcome mat" effect, this surge of enrollment has added to state costs.

Local government funds

Local entities, including county and city governments along with hospital districts, contribute funding to support state Medicaid programs. In California, the bulk of local funding for Medi-Cal comes from designated public hospital systems, including those operated by counties and the University of California. Local funds typically take the form of either intergovernmental transfers (IGT)—a transfer of funds from another governmental entity to the state Medicaid agency—or Certified Public Expenditures (CPE)—an expenditure made by a governmental entity that funds Medicaid-covered services. Both are eligible for federal matching funds.

Nationwide, about 15 percent of the nonfederal share of Medicaid payments comes from local governments—about 5 percent from CPEs and the other 10 percent from IGTs (GAO 2014). In California, the local share is higher, with an estimated 20 percent of state Medi-Cal funds coming from local governments in the form of CPEs and IGTs. According to our best sources of information, these sources contribute more than $5 billion each year.[8] The substantial share of local government funds is due in large part to the public hospital systems that predominantly serve Medi-Cal patients and thus generate CPE funds.

In addition, state funds allocated to counties for indigent health care and specialty mental health services for Medi-Cal beneficiaries also support the program. These sources of local funds and the way they support the Medi-Cal program are relatively complicated—and recent policy changes have increased their complexity. We provide a more detailed account of the state-county fiscal relationship for Medi-Cal in Technical Appendix B.

Provider fees and taxes

Fees and taxes assessed on health care providers and health plans are allowable sources of funding for state Medicaid programs, though their use is limited by federal statute and regulations. Under current federal law, health care–related taxes must be "broad based" and "uniform"—they must be applied across all providers

[7] Based on revised expenditure estimates in the November 2016 Medi-Cal Local Assistance Estimates.

[8] This amount is based on authors estimates derived from DHCS Medi-Cal Local Assistance Estimates Program Change document for fiscal year 2015-16 and includes all fund categories labeled as either IGT or CPE. Some of the Medicaid funds derived from CPEs are "off-budget" meaning that they are not allocated through the budgetary process and thus are not reflected in these totals.

or entities, not just those that participate in the Medicaid program. In addition, providers cannot be "held harmless" through a direct or indirect guarantee that they will be repaid for the amount of taxes they contribute.

Like many other states, California makes use of provider fees from several sources—including hospitals, nursing care facilities, intermediate care facilities, and other providers. The hospital quality assurance fee (QAF), implemented in 2010, is the state's largest provider fee. In fiscal year 2015–16, the state collected $4.6 billion from the hospital QAF, and this generated $4.4 billion in federal funds for hospital payments. In addition, the hospital fee revenue generates state General Fund savings of about $850 million because it pays for children's health care services in Medi-Cal that would otherwise be covered by General Fund money (LAO 2016). Fees assessed on skilled nursing facilities and other long-term-care providers generate hundreds of millions of dollars annually.

California also taxes managed care organizations (MCOs). The MCO tax, while not considered a provider fee, is used to generate additional federal funds. In the current fiscal year, the MCO tax generated an estimated $1 billion in General Fund savings for the Medi-Cal program (LAO 2016). In 2016, the state needed to make changes to the structure of the MCO tax to meet federal requirements.[9] It is expected to generate about $1.4 billion in annual savings for the General Fund over the next three years but will sunset in 2019.

How Does Medi-Cal Fit into the State's Fiscal System?

California's revenue system is robust but volatile—which has implications for sustaining consistent funding particularly for large programs. An understanding of key current revenue sources that undergird the annual state budget is crucial to discussions about for the future of financing Medi-Cal—particularly in the face of looming federal changes. In this section, we provide a brief review of the state's revenue structure and place spending on Medi-Cal in the context of other state programs.

State Revenues: Robust but Volatile

Adjusting for inflation, California's General Fund grew 10 percent from 2000–01 to 2016–17. However, the major sources of General Fund revenues are volatile: year-to-year changes in the General Fund over the past two decades have ranged from a 15 percent decline to a 13 percent increase. The major sources of revenue that make up the General Fund grew by 17 percent over this period. General Fund spending has also been impacted by policy changes and by state lawmakers redirecting revenue into special funds.[10]

Like many other states, California has four main sources of state and local revenue: property taxes, personal income taxes, sales taxes, and corporation taxes (Auerbach 2010).[11] However, the mix in California is different. Due to Proposition 13 and to our progressive personal income tax system, the share of property tax revenues collected is lower and the share collected through income taxes is higher relative to other large states.[12] Proposition 13's

[9] Prior to these changes, the MCO tax applied only to Medi-Cal managed care plans and so did not seem to meet the federal rules that it be broad-based and uniform. The revised MCO tax now applies to all managed care plans in the state, although contains provisions that lower other state taxes assessed on managed care organizations to effectively reduce the net amount of taxes collected from plans.

[10] Changes to laws governing revenues have also contributed to volatility in the General Fund. For example, a 1 percentage point increase in the state sales tax was imposed from April 2009 through June 2011. Redirection to special funds occurred, for example, in 2011, when the state provided funding for corrections realignment by redirecting some state sales tax revenues to the counties.

[11] Some states do not levy income or sales tax.

[12] Property taxes are local revenues—not state General Fund revenues—although the state holds the authority to allocate property tax revenue, and higher property tax revenues tend to lower the state's K–12 education payments.

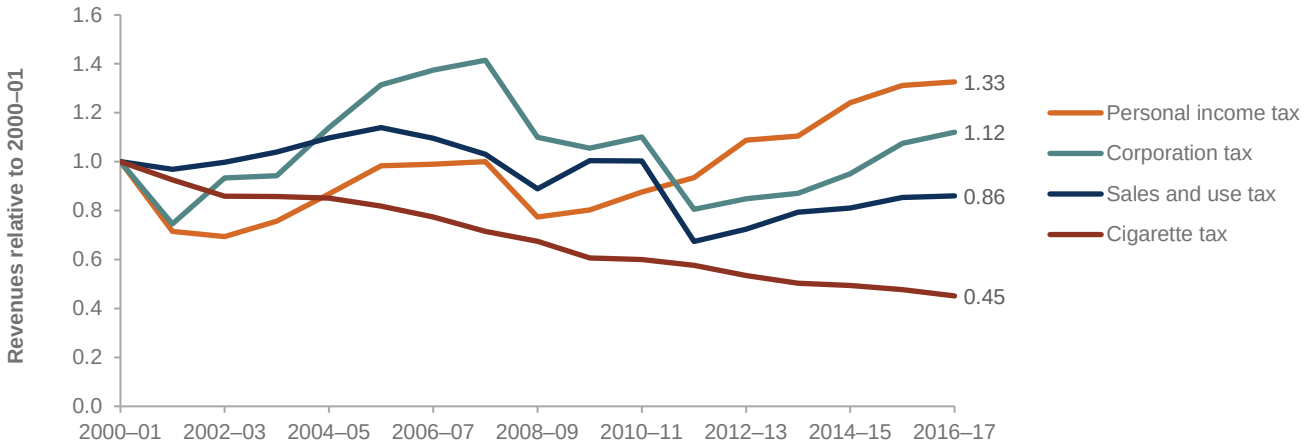
property tax limitations have caused California to raise a larger share of total revenue at the state level than at the local level, which is not the case in many other states. California also has a smaller sales tax base than some other states, leading to a declining share of revenue from sales taxes as consumers spend relatively more on untaxed goods and services over time. Corporation taxes make up a relatively small portion of overall revenues.[13]

Each revenue source has its own growth pattern. As Figure 2 illustrates, the three largest General Fund tax programs—personal income, sales and use, and corporate, which together account for about 95 percent of General Fund revenues—are volatile. That is, they change rapidly and dramatically along with changes in the economy and taxpayer behavior. In contrast, the state's GDP rose quite steadily between 2000 and 2015.[14] Personal income tax volatility is especially significant, because this tax accounts for two-thirds of all General Fund revenues.

A main source of income tax volatility is taxes on capital gains—income from the sale of assets, such as stocks and bonds. For example, during the Great Recession, state revenue generated from capital gains taxes declined more than 75 percent over a two-year period—from $10.9 billion in 2007 to $2.3 billion in 2009. All three of the state's major taxes proved to be volatile in the most recent downturn. But not all taxes follow the same trend. As Figure 2 illustrates, revenues from the tobacco taxes exhibit a quite different pattern of steady decline.

FIGURE 2

California's major tax revenues grow over time, but they are volatile



SOURCES: Legislative Analyst's Office, General and Special Funds Revenues (accessed at lao.ca.gov/ PolicyAreas/state-budget/historical-data) and Department of Finance May Revision Summary, 2015–16 and 2016–17.

NOTES: Figure shows the increase in each source of state revenues using fiscal year 1999–2000 as the base. Revenues are adjusted for inflation using the CPI-U west, but do not account for changes in tax rates or population growth.

Medi-Cal Spending Relative to Other State Programs

Medi-Cal is the state's second largest General Fund program, second only to state spending on K–12 education, which is constitutionally protected by Proposition 98.[15] Together, Medi-Cal and K–12 spending make up well over half of the General Fund budget (Figure 3). In 2016–17, the two programs accounted for 58 percent of all General Fund spending—and that share has slowly increased over the last decade. In 2016–17, K–12 accounted

[13] Overall, state and local revenues in California total about 11 percent of personal income, which is roughly on par with other large states, including Illinois, New Jersey, Ohio, and Massachusetts. New York taxes at a higher rate (15%) and Florida and Texas tax at a lower rate (about 8%–9%) (State Controller 2016)

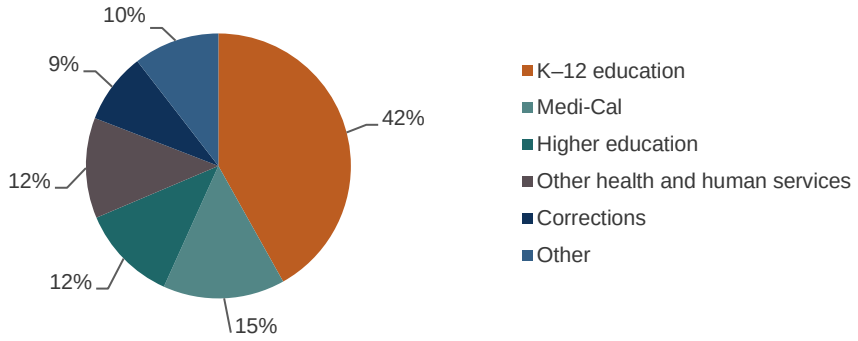
[14] The inflation-adjusted increase in GDP between 2000 and 2015 was 33 percent.

[15] Proposition 98, passed in 1988, constitutionally requires state General Fund spending on K–14 education to meet a "minimum guarantee" which is designed to grow over time. For an overview and more details, refer to the LAO report "A Historical Review of Proposition 98."

for 41.9 percent of the General Fund, 0.6 points more than in 2007–08, while Medi-Cal made up 14.8 percent of the budget, 1.2 points more.

FIGURE 3

Medi-Cal and K–12 education account for more than half of the General Fund budget



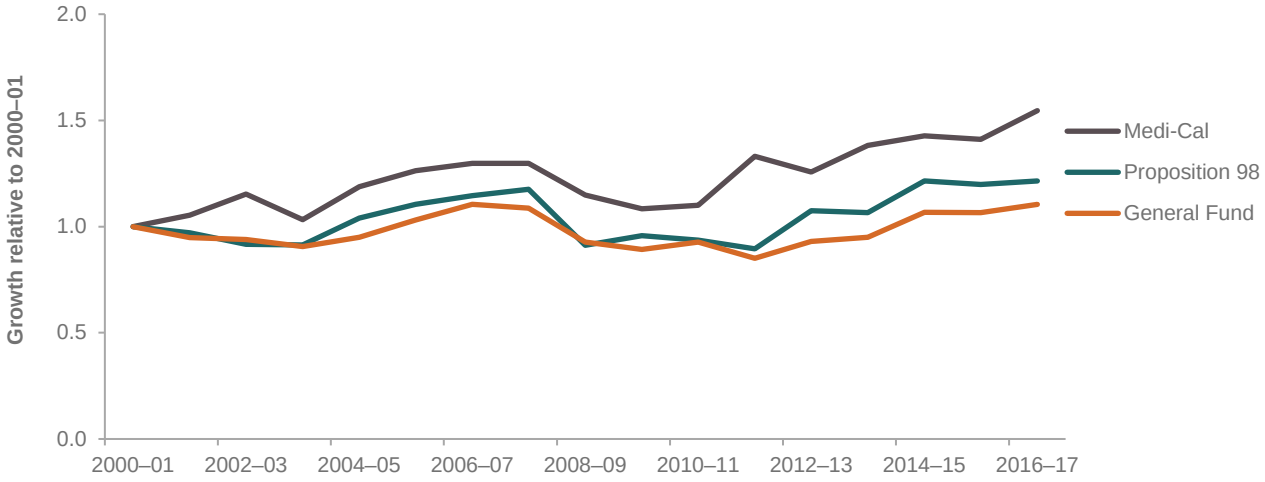
SOURCE: California Department of Finance, Enacted State Budget, 2016–17.

NOTE: Medi-Cal spending does not include Medi-Cal funds allocated through other programs; those are included in "other health and human services."

The large draw Medi-Cal makes on General Fund revenues puts the program at the center of state budget discussions—especially when revenues falter. Given the program's size, during economic downturns it is difficult to balance the state budget without cutting Medi-Cal (and other large programs). Figure 4 shows that outlays for Medi-Cal over the past 15 years generally mirror growth in the state's General Fund, although they have increased more quickly in recent years. Spending on K–12 education is even more closely tied to the fate of the General Fund, suggesting that even constitutional protection (by way of Proposition 98) may not offer stability when revenues fall.

FIGURE 4

Proposition 98 and Medi-Cal General Fund spending have moved in tandem with General Fund revenues



SOURCES: Legislative Analyst's Office, General and Special Funds Revenues (accessed at lao.ca.gov/ Policy Areas/state-budget/historical-data) and Legislative Analyst's Office, California Spending Plan annual reports, Department of Health Care Services, Medi-Cal Local Assistance Estimates, May 2006 through 2016 (accessed at www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/default.aspx).

NOTES: Years based on state fiscal year. Figure shows the relative increase in General Fund revenues and General fund expenditures for Medi-Cal and Prop 98 compared to fiscal year 2000–01. Medi-Cal expenditures prior to FY 2005–06 are from LAO Annual Spending Reports, all later years are from DHCS Medi-Cal Local Assistance Estimates. Underlying dollar amounts are adjusted for inflation using the CPI-U west.

Future recessions will be cushioned to some extent by the state's Budget Stabilization Account (also known as the Rainy Day Fund). The 2016–17 Budget Act estimates that the account balance will reach $6.7 billion by the end of the fiscal year. The account is not designed to completely replace General Fund revenue losses during all downturns. The fiscal experts we interviewed for this report expect that the Rainy Day Fund can reduce the size of program cuts but not prevent them entirely, even during relatively mild recessionary periods.

As we have seen, the General Fund is only part of the picture for Medi-Cal funding, particularly in recent years. Special fund revenues supporting Medi-Cal increased from about $700 million in 2008–09 to $9.2 billion in 2015–16. These funds represent a large and growing source of program funds that under current rules count towards the state portion of Medicaid spending that is eligible to be matched with federal funds.

The Future of Medi-Cal Costs

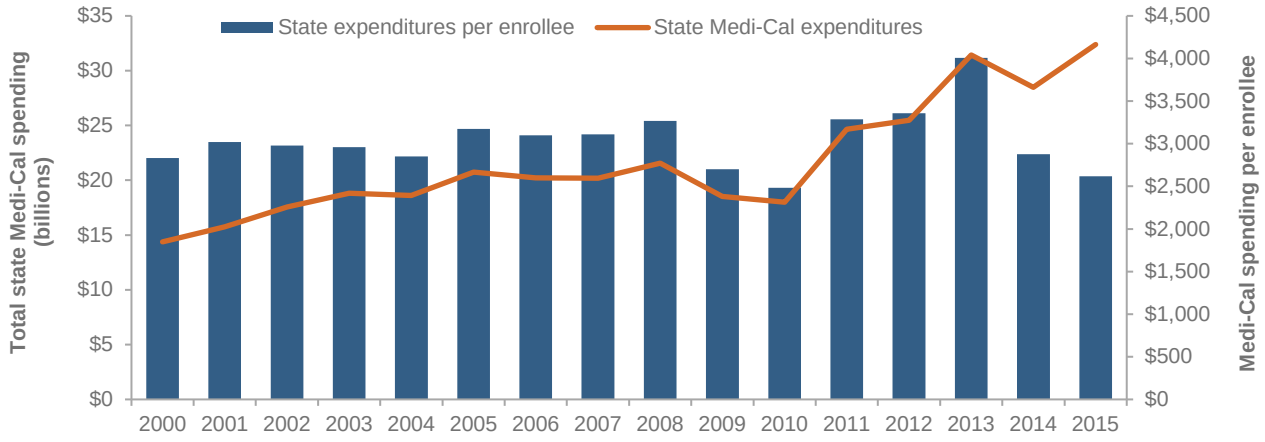
Across the country, rising health care expenditures have long been a concern, particularly for state and local governments. Over the past several decades, growth in health care costs has exceeded rates of inflation and revenue growth. According to the most recent simulations of long-term fiscal trends, state governments will face sizable future fiscal gaps, and expenditures on Medicaid are identified as one of the primary drivers of the financial unbalance between expenditures and revenues (GAO 2016).

In California, total costs of the Medi-Cal program have grown steadily over the past few decades, and that growth has accelerated in the past few years largely because of ACA coverage expansions. Generally speaking, this growth is being driven by increases in the number served by the program—due to policies that have expanded eligibility and population growth—and by the rising cost of medical services. Historically, about 70 percent of Medicaid spending growth is attributable to increases in enrollment, compared to about 30 percent related to growth in spending per enrollee. The other important factor is the composition of the caseload—the base cost of services differs across children, low-income adults, disabled adults, and seniors, as does the rate of growth (Medicaid and CHIP Payment and Access Commission 2016).

As a result, state Medi-Cal costs covered by both General Fund revenues and other non-federal revenue sources have increased considerably in recent years. Figure 4 illustrates the growth in state funds going toward the Medi-Cal program. Even after adjusting for inflation, total state costs more than doubled from 2000 to 2015. In contrast, state costs per enrollee have remained relatively flat.

FIGURE 5

State Medi-Cal costs per enrollee have remained relatively flat, but total costs have grown in recent years



SOURCES: Centers for Medicare and Medicaid Services, Medicaid Financial Management Reports. California Department of Health Care Services, Historical Trends and Most Recent 24 months.

NOTES: Based on federal fiscal years. Figure shows all non-federal costs of the program, which includes General Fund, local government funds, and provider fees and taxes. Dollar amounts are adjusted for inflation using the CPI-U west. Enrollment totals are based on the January estimate of certified eligibles. These enrollment totals include beneficiaries who are not eligible for full-scope services.

Fiscal Pressures under Current Policy

Beyond rising health care costs and state budget cuts when revenues falter, there are several other cost pressures facing the Medi-Cal program. Improving access to care and the quality of services have been longstanding goals. A recent report highlighted the need for improvement in these areas and pointed to a number of structural and fiscal issues—including low provider reimbursement levels and the complex relationship between the state and counties—that should be addressed. (Mann et al. 2016).[16]

A continued flow of federal funding has also been a long-standing concern. Even before the results of the presidential election, the federal Department of Health and Human Services expressed concerns about California's reliance on certain taxes as sources of state funds for the Medi-Cal program. Several of the experts we interviewed expressed concern about the long-term viability of some of these provider taxes and fees given federal concerns. In addition, federal regulatory changes set to take effect this year will affect the flow of funds through the program to providers.

While there is uncertainty about the impact of these changes on the fiscal situation of Medi-Cal, most of our experts agreed that they could result in increased spending pressure on the General Fund. Depending on the scope of future federal policy changes to Medi-Cal funding, these tax and fee issues may have fewer fiscal implications. Nonetheless, they are important to note.

MCO tax. As discussed in the previous section, California needed to make changes to its MCO tax in order to meet federal rules. Although the federal government approved these changes, the revised MCO tax expires in 2019 and, according to our expert interviews, the federal government has signaled it is unlikely to approve a similarly structured tax in the future. The MCO tax is estimated to generate about $1.4 billion to support the program; the loss of this funding would have fiscal implications for the state.

[16] Program participates are more likely to report difficulty finding doctors, for instance, and are much more likely to use emergency room care for chronic conditions. Quality of care in Medi-Cal also varies significantly across the state, with some care organizations falling below minimum benchmarks for care.

New Medicaid managed care regulations. In April 2016, the Center for Medicare and Medicaid Services finalized new rules governing how states operate their Medicaid managed care systems. The new regulations are being phased in starting in June 2017. They will necessitate changes to how California implements Medi-Cal managed care, which now serves more than 80 percent of all Medi-Cal beneficiaries. Some of the provisions—in particular, new rules for developing managed care payment rates and determining the actuarial soundness of rates, as well as limits placed on pass-through payments to hospitals—could have a significant impact on the way the state pays for Medi-Cal services. The fiscal impact of these new regulations is as yet unknown.

Reduced DSH funding. The ACA included provisions to reduce DSH funding over several years, although there have been delays in implementation of the reductions. While it is still unclear how much California could be affected by lower DSH allocations, in past years hospitals have received $1.1 billion through the Medicaid DSH program.

Reduced funds available through 1115 waivers. The most recently renewed 1115 waiver is less than half the amount requested by the state. In addition, during the negotiations of the most recent waiver the federal government indicated it would likely be the last major injection of funds for California through the 1115 waiver mechanism.

Passage of Proposition 52. While the passage of Proposition 52 in November 2016 makes the current hospital QAF permanent, it also reduces the ability of the legislature to make changes to the fee and prohibits the use of these funds to generate General Fund savings. As a result, the state may have less flexibility to deal with budgetary issues. In addition—and more importantly in the current policy context—the continuation of the hospital fee requires federal approval, as the revenues go toward the state share of Medi-Cal eligible for federal matching funds.

Future of CHIP. Enhanced federal payments under the Children's Health Insurance Program (CHIP) are scheduled through 2019, but the program must be reauthorized by Congress in 2017. The standard FMAP for state CHIP is 65 percent, and the enhanced rate is 88 percent. The General Fund may need to provide additional funding if there are changes to the formula. The governor's January budget assumes the enhanced rate will be eliminated resulting in about $535 million in additional state costs.

Uncertainty of Federal Policy

Although the future of Medi-Cal is difficult to assess until we know whether or how federal policy will shift, a rollback of the ACA would undoubtedly have a major impact on the program. In the 2016–17 state budget, Medi-Cal was expected to cover about 3 million newly eligible adults at a cost of about $16 billion, and almost all of that money was to come from the federal government. In the governor's budget for 2017–18, Medi-Cal expansion is projected to cover 4 million adults at a cost of nearly $19 billion.

There are also proposals to fundamentally alter the Medicaid program. Current proposals include distributing Medicaid funding to the states in the form of block grants, imposing per capita spending caps, and imposing certain conditions (i.e., work requirements or cost sharing) on Medicaid beneficiaries.

While recent federal policy actions suggest these changes are no longer imminent, the implications of these plans could mean that Medicaid ceases to be an open-ended entitlement program, with the federal government committed to providing at least half of program costs. At the same time, states could gain flexibility in administering their Medicaid programs—in areas such as program eligibility, services covered, and participation requirements for recipients. This could allow states to consider new ways of providing affordable insurance coverage to low-income residents.

If federal reforms reduce the level of federal funding for Medi-Cal, state lawmakers will need to have serious discussions about the scope of the program and state funding commitments.[17] There are ways to lower program costs—primarily through changes to eligibility, benefits, and/or provider rates. Obviously, rolling back ACA coverage expansions and restricting program eligibility would reduce costs, but this could prove politically difficult, and a larger uninsured population would create other fiscal demands. Certain program benefits could be cut (e.g., dental, medical supplies, acupuncture), but this would not generate large savings. Provider rates are already low, and while policy shifts toward alternative payment models could save money, the savings would probably take time to materialize and would need to be quite substantial in order to make up for potential federal funding reductions.

In sum, if state policymakers seek to maintain and improve the program, they will probably need to examine options for increasing state and/or other non-federal revenues to provide additional financial support. Given the complexity of the current funding structure for Medi-Cal, any future restructuring will probably involve a variety of sources. In the next section, we discuss and evaluate a range of revenue options.

Assessing Revenue Options to Support Medi-Cal

As we have seen, Medi-Cal's fiscal challenges predate the November 2016 election. The governor's special legislative session to address the MCO tax is one example of the growing policy focus on Medi-Cal financing issues. In addition, there were several propositions on the November ballot related to Medi-Cal funding. But with a major overhaul of the ACA and possibly the entire Medicaid program on the federal agenda, the future of Medi-Cal—at least in its current form—is uncertain, and the state may need to decide whether to increase state spending to maintain the current levels of health care coverage or deal with the ramifications of more uninsured residents.

In this section, we identify both options that increase state revenues overall – and thus provide additional funds that could go toward Medi-Cal or a successor program to support health coverage for low-income residents—as well as options that are specific to funding the Medi-Cal program. Options focused on growing state revenues broadly could be allocated to support health insurance for low-income Californians explicitly, although the example of Proposition 98 for K–12 education suggests that a guaranteed funding approach has limitations (LAO 2017). The advantages of securing funding dedicated for health care may or may not outweigh the costs of constraining future state fiscal decisions.

We discuss a range of options; some could generate relatively large revenue increases while others would have more modest effects. We pursued this strategy in order to provide a wide range of choices for supporting the Medi-Cal program in the future—particularly given the new challenges federal changes could bring. Moreover, it may make more sense from an economic and political perspective to piece together several changes that produce the needed revenues rather than relying on one very large increase.

Criteria for Evaluating Options

In identifying potential sources of funds, we followed a set of standard fiscal principles used to evaluate revenue systems and taxes (California State Controller's Office 2016; Sonstelie 2015). The five most critical principles are

[17] It is outside of the scope of this report to discuss coverage gained under Covered California— an additional 1.2 million people are supported by federal tax subsidies. Nonetheless, state lawmakers will likely want to consider how to continue coverage for the widest possible group who would otherwise lose their insurance under a federal overhaul of ACA.

reliability, growth, progressivity, economic efficiency, and transparency/simplicity. The best revenue sources are those that provide consistent long-term support for state programs. Revenues that do not change unexpectedly are preferred, although mechanisms such as rainy day funds can smooth volatility. Also, revenues should grow along with program demands.

Of course, predictability and growth are not the only criteria. It is also important to distribute the tax burden fairly. Progressive tax schemes balance payment among less- and more-affluent taxpayers. Economic efficiency, also referred to as neutrality, is another key principle—it is important to consider how tax changes might affect personal and business decisions. Tax options with relatively small effects on these decisions are preferable. Finally, taxes that are simple, inexpensive to administer, and easy for taxpayers to understand are preferred.

Criteria for Evaluating Revenue Options

Reliability. Revenues should be stable and predictable and not fluctuate wildly over time.

Growth. New revenues should grow consistent with future program costs.

Progressivity. New taxes should recognize the ability of individuals and entities to pay them.

Economic efficiency. New taxes should not distort economic decisions or undermine the health of the state's economy.

Transparency/simplicity. Taxes should be easy to understand and administer.

We do not include political viability in our evaluation criteria, although we return to it briefly at the end of the report. Taxes are always a sensitive issue. In the recent past, the state has relied on a relatively small set of revenue options, including raising taxes on higher incomes and increasing the state sales tax. Since California's income and sales tax rates are among the highest in the country, we focus on a wider range of options.

Personal Income Taxes

Personal income taxes (PIT) are the dominant revenue source in California. As a share of state revenue, income taxes have grown from about 25 percent of General Fund revenues in the 1950s to about 70 percent in 2016 (State Controller's Office 2016).

California's current income tax structure is more progressive than most other states, which means that high-income taxpayers pay a larger share of their incomes in taxes. For instance, in 2014, taxpayers with incomes between $20,000 and $50,000 paid an average 1.1 percent of their incomes in state taxes. At the upper end, the average state income tax rate for taxpayers earning more than $1 million was 11.7 percent (Franchise Tax Board 2016). As a result, California households with the top 1 percent of incomes account for about 25 percent of all income earned in the state but pay about half of all tax revenue (LAO 2015).

Increasing tax rates on high incomes has been a key state strategy for generating new revenue. Proposition 63, passed by voters in 2004, added an additional 1 percent tax on personal income in excess of $1 million, which generates about $1 billion annually dedicated to mental health services (Little Hoover Commission 2015). Proposition 55—passed in November 2016—extends a surcharge assessed on high incomes that passed in the

wake of the Great Recession to 2030.[18] Estimates suggest that Prop 55 will generate between $4 billion and $9 billion annually—depending on the economy and stock market—with roughly half going to K–14 education. A new state budget formula will determine the amount of revenue—up to $2 billion—that could support the Medi-Cal program (LAO 2016).

Proposition 55 as a revenue source for Medi-Cal

The passage of Proposition 55 created a potential new source of funds for Medi-Cal, although the amount of revenues allocated to the program—and how they are spent—is uncertain. Medi-Cal's share depends on both the amount of new revenue generated and also the funding demands of the state base budget. Even if the new tax generates additional resources, if base costs (such as caseload increases or loss of federal funds) are also increasing, there may be no new revenues available for Medi-Cal. And given the volatility of income tax revenues, the higher tax rate on high-income earners will likely not generate stable revenue growth over time.

While it remains to be seen how the governor and legislature decide to approach these provisions of Proposition 55, most experts we spoke with identified a need for stable, dependable, funding for Medi-Cal—and when probed, most could not think of a good option for using one-time funds in the program. That said, it is important to consider how this potential additional funding can be incorporated into the Medi-Cal program.

One option is to use the new funds cautiously. Because of the possibility that no new revenues may be available in any one year, this could mean letting revenues accumulate until there is a balance that could sustain a longer-term level of spending. This accumulated revenue also could be used as a reserve that provides base program support during recessions. Another option would be to use yearly revenue for one-time investments that could support Medi-Cal, such as health workforce training initiatives or targeted incentives to improve integration of data systems.

Modifying Tax Expenditures

Since tax rates on high incomes have increased recently and were already fairly high relative to other states, we looked at options for raising revenues through the personal income tax by reducing tax expenditures—popularly known as tax breaks or exemptions. Tax expenditures seek to promote societal goals by shaping the behavior of individuals and employers through the tax system. By lowering the amount of income on which an individual is required to pay taxes, these expenditures reduce state revenues.[19]

The largest tax expenditures—the exemption of employer contributions to employee health coverage, the home mortgage interest deduction, and the deduction for charitable contributions—are federal policies that the state follows. Like many states, California uses the federal Internal Revenue Code as the starting point for its income tax system. State tax forms start with the federal calculation of taxable personal income, requiring taxpayers to

[18] California has 10 marginal tax brackets that range from 1 percent to 13.3 percent. Proposition 63 increased the top tax bracket rate from 9.3 percent to 10.3 percent. Voters in 2012 passed Proposition 30 which increased personal income tax rates for Californians earning more than $250,000 with successively higher rates for taxpayers in this group. Under Prop 30, those earning $250,000 saw a 1 percent increase in rates and those earning over $1 million saw rates increase 3% bringing the top tax rate up to 13.3 percent. Proposition 55 has extended the increased rates for high-income earners created by Prop 30 for 12 years until 2030. In 2015–16, the higher PIT rates under Prop 30 generated about $6.7 billion in new revenues.

[19] See Technical Appendix D for a list of personal income tax expenditures that reduce revenues by more than $500 million annually.

make only a few adjustments to calculate their state tax liability. These three tax expenditures represent an estimated $14 billion in forgone state revenue.[20]

There have been recent bipartisan calls to revisit tax expenditures as a means of expanding revenues (AEI-Brookings Working Group on Poverty and Opportunity 2015). Additionally, proposals at both the state and federal levels have focused on a reconsideration of each of these tax expenditures. In 2007, the California Legislative Analyst's Office (LAO) recommended that the state eliminate the mortgage interest deduction and replace it with a program designed to assist first-time homebuyers.[21] Several changes to the exemption for charitable donations have been proposed at the federal level (CBO 2011). And both the ACA and some of the ACA replacement plans that have been proposed include provisions that effectively cap the amount of tax-exempt employer contributions for health coverage.

Reducing tax expenditures in these areas would generate fairly stable, predictable revenues that grow along with the economy. Because tax expenditures forgive the first dollar earned, the amount of revenue lost does not change much when income goes up and down. All three of these large tax expenditures are "upside-down" subsidies that mostly benefit high-income taxpayers. This suggests that reducing them would mostly affect taxpayers who are more likely to be able to afford higher taxes. The calls to reexamine these tax expenditures have been driven not only by a search for state revenue but also by concerns about inequity and effectiveness. There is evidence that these deductions do not always promote the goals they seek to encourage and that modification could actually reduce existing distortions created by the tax system. The tax exemption for employer-based health coverage may have an undesirable impact on how people consume health care.[22] Research on the home mortgage interest deduction has found that it has little effect on home ownership rates, and the relationship between the amount of charitable giving and the size of the tax deduction is not well understood (Glaeser and Shapiro 2003; Gale et al. 2007; Hilber and Turner 2014; Colinvaux et al. 2012).

Implications of Federal Tax Reforms

Like health care, tax reform is high on the federal agenda. Federal tax changes could provide an opportunity for California to reassess its tax programs, opening the door for revenue enhancements.[23] California does not automatically conform its tax system to the federal system. The state passes legislation in order to conform whenever possible for taxpayer convenience and administrative simplicity. Basing state taxes on the federal formula means taxpayers follow one set of rules. Conformity also permits the Franchise Tax Board to rely on the Internal Revenue Service for a variety of administrative tasks. However, when California conforms to federal tax law changes, it does not always adopt all federal changes.

Thus, any major restructuring of federal taxes would necessitate a state-level policy debate about how to react. Tax expenditures related to personal income taxes reduce state revenues by more than $40 billion each year, and many are based on federal tax policies (California Department of Finance 2016). If federal tax reform eliminated all or some tax expenditures—including those highlighted here—and California conformed to the new federal system, state revenues could increase by billions of dollars.[24]

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[20] The impact of each tax expenditure is estimated separately. Since some taxpayers have excess deductions, the revenues that would be generated by eliminating all tax expenditures would be less than the sum of the individual estimates.

[21] For a discussion of the LAO proposal as well as an analysis of how the home mortgage interest deduction impacts home ownership in the state, see LAO 2007.

[22] For a discussion of the issues surrounding tax exemption of employer-based health coverage, see Budget Options: Reduce Tax Preferences for Employment-Based Health Insurance, on the Congressional Budget Office website.

[23] Both the Trump administration and House Republicans propose major reductions in federal personal and corporate income tax rates and would make a number of other changes in these federal tax programs. The House proposal would streamline the personal tax calculation by eliminating many deductions, exclusions, and credits.

[24] Tax expenditure estimates are done individually. If all tax expenditures were eliminated, however, there would be significant interaction effects—that is, the cumulative revenue increase would likely be much less than the sum of the individual estimates.

Federal tax reform could also have other longer-term impacts. To the extent that changing federal tax policies changes behavior, federal reform could result in long-term increases in state tax revenues. For example, if health benefits were taxed under federal law, employees might take more income in the form of cash (by purchasing health plans with lower costs and higher deductibles, for instance). If people were to spend less on health insurance, the amount of income exempted from state income taxes would decline.

Corporate Taxes

In contrast to the personal income tax, revenues from corporate taxes have grown slowly. In 1960, the state collected more income tax revenue from corporations than from individuals.[25] In 2016–17, corporate income taxes are expected to deliver about $11 billion to the state budget—about 10 percent of total revenues.

For many years, California's corporate and personal tax rates were similar. The top corporate rate is 8.85 percent and, until 2004, the top personal rate was 9.3 percent. However, two increases over the past decade have raised the top personal income tax rate to 13.3 percent. Aligning corporate tax rates with the personal tax rate could generate additional revenues, possibly in the low billions.[26]

State revenues generated by corporate income taxes are also affected by tax expenditures. Like personal income taxes, corporate taxes also conform largely to the federal system, though there are more state-only tax exemptions for corporations. One of the largest corporate tax expenditures is a credit for research and development, which is intended to spur innovation.[27] In 2016–17, this credit cost the state an estimated $1.7 billion in forgone revenue—more than triple the amount of state revenue lost in the early 2000s.

Some have raised questions about whether California's research and development credit is too generous. The Franchise Tax Board reports that more than $19 billion in unused credits are being held by companies—apparently, these firms did not have enough tax liability to use their credits (Chen 2016). There are also questions about the efficacy of the state's tax credit in boosting private investment in these activities; some of this research would probably have occurred without any tax incentive (LAO 2003). Other research suggests state R&D credits shift research to states with tax credits rather than increasing the total amount of research (Weiner 2009).

Assessing adjustment to corporate taxes against our criteria yields a mixed picture. Compared to personal income taxes, corporate tax revenues are more stable, though they also exhibit a fair amount of volatility. They are relatively progressive, since most of the corporate tax burden falls to shareholders although some is borne by labor (Nunns 2012.)They fall short, however, in two areas. First, the growth potential for corporate tax revenues is modest. As noted above, revenues from this source grow slowly. Second, raising corporate taxes could discourage companies from locating or expanding in the state. Many businesses already believe that the cost of doing business in California is high, although research suggests that factors outside the state's control, such as climate and geography, are more strongly linked with economic growth than business costs (Kolko et al. 2011).

Sales Taxes

Sales taxes—the second-largest source of state General Fund revenue—are bringing in $25 billion in 2016–17. The statewide sales tax rate is currently 7.5 percent. Of this amount, the state receives 5.25 percent and local

[25] Based on authors examination of historical data of state revenues from the Legislative Analyst's Office, State of California Revenues, 1950− 51 to 2014− 15.
[26] Author's rough calculation using 2013 corporate tax data from the Franchise Tax Board.
[27] Applied research (generally part of a product-development process) qualifies for a 15 percent credit, and basic research (intended to advance scientific knowledge or improve existing products) earns a 24 percent credit. The amount of the credit is based on specific research-related employee and support costs. The state credit supplements a similar federal tax credit.

governments receive the remaining 2.25 percent. (LAO 2015).[28] However, about 1.1 percentage points of the state share is redirected to county governments to support the 2011 realignment of program responsibilities between the state and county governments for public safety, mental health, and social service programs. In addition, local government can raise sales tax rates for specific purposes with the approval of local voters. Prior to the November 2016 election, the effective average statewide sales tax rate in California was 8.5 percent (LAO 2015).

Extending the Sales Tax to Services

In California, sales tax revenue has not grown rapidly because individual consumption has shifted toward untaxed services (Auerbach 2010). In 1960–61, sales tax revenue was almost three times higher than revenue from personal income taxes. As shown in Figure 2, personal income taxes have grown by 33 percent, while sales tax revenues have dropped by 14 percent since 2000 (after adjusting for inflation).

Fewer services are taxed in California than in other states (LAO 2015). Expanding sales taxes to more services has been the focus of some recent proposals aimed at increasing state revenues. For instance, in 2008, at the beginning of the Great Recession, Governor Schwarzenegger proposed applying the sales tax to a relatively small set of services—including car and appliance repair, golfing, veterinarian services, and tickets for sporting events—to raise an estimated $1.2 billion annually (LAO 2009). More recently, Senate Bill 8 sought to extend sales tax to a wide range of services, which was projected to raise $10 billion in the first year (State Controller's Report). Neither of these proposals moved forward, but they are evidence of policymaker interest in broadening the sales tax base.

Sales taxes on services meet several of our criteria. They are less volatile than personal income taxes, and—depending on the services included—could provide a growing source of revenues.[29] Increasing the cost of services might not be neutral—it could reduce their use by some amount. On the other hand, taxing both services and tangible goods would reduce an implicit subsidy on services. All sales taxes are regressive because they are the same regardless of income—but taxing services could be more or less progressive, as low-income households tend to spend less on services and could be provided with tax relief to help offset the higher tax rates (State Controller's Office 2016). The best argument against this idea is that the administrative burden in implementing taxes on services could be substantial. The California Board of Equalization—which administers and collects various sales and use taxes —has highlighted several issues that would need to be addressed in extending the sales tax to services.[30]

Revisiting a Snack Tax

California's constitution currently prohibits sales tax from applying to food items, including candy and savory snacks. Forgone sales tax revenue on candy, snacks, and bottled water amounts to approximately $1 billion annually accounting for both state and local revenues (Department of Finance 2016). The state legislature approved a "snack tax" in the early 1990s, but the measure was struck down by voters with a constitutional amendment.[31] In the past few years, voters at the local level in the bay area cities of San Francisco, Oakland, and Berkeley have passed excise taxes on sugar-sweetened beverages. In addition, legislation has been introduced

[28] Local governments can also raise revenue through add-ons to the statewide sales tax. See the LAO report "Understanding California's Sales Tax" for more information.
[29] The California Board of Equalization produced a comprehensive listing of all untaxed services and an estimate of the revenue that would be derived from extending sales and use tax to these services.
[30] See California Board of Equalization, Sales Tax on Services Fact Sheet.
[31] In 1991, the California legislature passed legislation that would impose sales tax on certain types of food including candy and other snack items. The passage of Proposition 163 in 1992 struck down the legislation and added a constitutional amendment categorizing these items as food that was not subject to a sales tax.

in the current session (AB 274) that seeks to revisit the constitutional amendment prohibiting sales tax from being assessed on certain snack items, including candy.

Expanding Sin Taxes

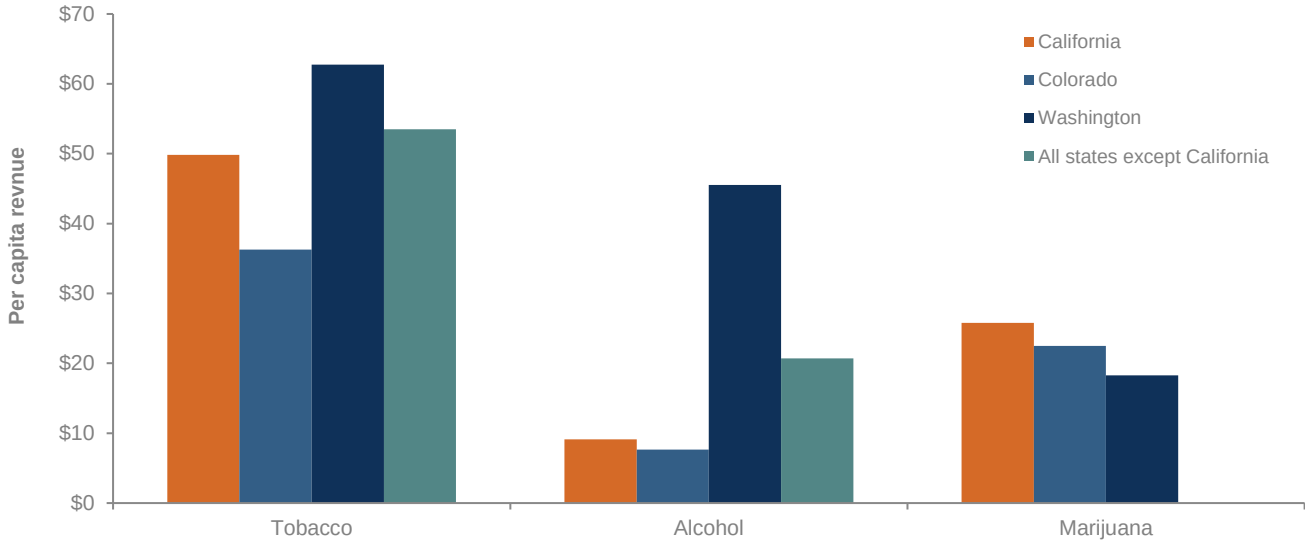
Another source of revenue could be taxes on products such as tobacco, alcohol, and marijuana. Some of these products are already subject to sales tax, but an excise tax can also be applied. Often referred to as "sin taxes," excise taxes target habits that are deemed undesirable and/or harmful. States use sin taxes not only to raise revenue, but also to affect personal behavior—to discourage the use of products that are considered unhealthy. As the price of a good goes up, consumption will drop, and negative societal consequences—the rate of lung cancer, for instance—will decrease. Thus, from the point of view of aligning collected revenue with programmatic purposes, it makes sense to link sin taxes to health-related programs.

With the passage of Proposition 56, California's tobacco taxes are comparable to those in other states (Figure 6). Most of the additional revenues generated by the increase in taxes on tobacco products are designated to support the Medi-Cal program (82% after funds are disbursed for enforcement and other required allocations). According to the governor's 2017–18 budget proposal, $1.2 billion in revenues from Prop 56 will go to Medi-Cal.

With the legalization of recreational marijuana in November 2016, the state has a new source of tax revenue—it could total as much as $1 billion a year (LAO 2016). Revenue generated by the new tax on marijuana sales, however, must be spent on specific activities including youth programs, environmental protection, and law enforcement and it is not clear if (or how much) could be used to support other state programs such as Medi-Cal. In addition, there is still considerable uncertainty about how legalization will be implemented and how the market will work. Still, taxes assessed on marijuana represent a new source of state revenue and to the extent that money is fungible could provide additional funding for health programs.

FIGURE 6

Proposition 56 has brought California's per capita revenue from tobacco closer to the that of other states



SOURCES: Centers for Disease Control and Prevention (CDC), US Census, Office of Attorney General (OAG), California Legislative Analyst's Office (LAO).

NOTES: All data is based on 2015 figures. Per capita alcohol consumption is taken from the NIAAA, which calculates consumption based on sales and a conversion of gallons in terms of pure alcohol (ethanol). Population data are from the US Census.

California's alcohol tax is lower than that of most other states—on a per capita basis, California ranks 40th of the 50 states in revenue collected. Taxes on alcohol have not generated large revenues in the past. In 2014, California collected only $9 per resident in alcohol taxes, while the average amount raised in the rest of the country was $21 per resident. The governor's 2016–17 budget estimated that the excise tax would generate $377 million for the state.

In recent years there have been two proposals to increase the excise tax on alcoholic beverages. In 2008, Governor Schwarzenegger proposed a substantial increase in alcohol taxes, dubbed the "nickel a drink" tax, which would have generated about $600 million annually (LAO 2009). In the 2016 special legislative session on the MCO tax, one proposal focused on taxing alcoholic beverages as a means to generate additional funds for the Medi-Cal program.[32]

Alcohol taxes fare relatively well on stability and predictability. However, the growth potential for the tax is low—sin taxes generally represent a declining revenue source because as the cost of the items increases, demand will decrease. They also fare poorly when assessed through the lens of progressivity—that is, they have a disproportionate effect on less-affluent people. That said, seeking sources of revenues that discourage unhealthy behavior is a sensible proposition. To the extent that increased taxation reduces consumption, these revenue options not only raise funds but result in lower health care costs.

Enacting ACA Revenue Provisions at the State Level

The ACA includes several new revenue provisions. If federal efforts to dismantle elements of the law continue and are successful in the future, these federal revenue streams could be altered or eliminated. This could create the possibility for California to capture some portion of those funds since they are already being collected at the federal level to fund public health insurance programs. Enacting these revenue options at the state level would either require legislation and a super-majority vote (two-thirds of both the state senate and assembly) or be passed through the initiative process with a majority of the popular vote.

The major revenue sources in the ACA include:[33]

- Tax penalties for individuals without health insurance coverage
- Tax penalties for employers that do not provide affordable options
- Hospital insurance fund (Medicare) surcharge on high-income taxpayers
- Net investment tax on high-income taxpayers
- Limitations on contributions to flexible spending accounts
- Tax on prescription medications
- Health insurance providers fee

Individual and employer mandates—which require individuals to have health insurance and employers to offer coverage or face financial penalties—were included in California's attempt at state-level health reform in 2008.[34] In 2015, approximately 7.9 million taxpayers nationwide reported a total of $1.6 billion in tax penalty payments for not having a minimum level of health insurance coverage. Payments were generally relatively small, with the average payment around $210. A year later, fewer taxpayers paid penalties but the penalties were higher;

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[32] California Legislative Information, "AB-18 Taxation: Cocktails for Healthy Outcomes Act,"

[33] For specifics on each revenue source and how it could be impacted by ACA repeal proposals, see Congressional Research Service, "The Affordable Care Act's Employer Shared Responsibility Determination and the Potential Employer Penalty."

[34] California attempted major health reform prior to the passage of the Affordable Care Act. Governor Schwarzenegger developed a plan along with state legislators to provide affordable insurance coverage options to Californians. The plan would have enacted new revenue sources to support coverage costs including an individual and employer mandate, along with fees on hospitals and other providers.

approximately 6.5 million taxpayers nationwide reported a total of $3.0 billion in penalty payments, with an average payment of $470.[35]

Several of the other revenue sources in the ACA are similar in concept to many of those we have discussed. The Medicare surcharge and investment tax rely on high-income earners paying higher payroll taxes on income above a certain threshold and paying taxes on income generated from investments including capital gains, dividends, and royalties, respectively. Limiting flex spending accounts and assessing sales tax on prescription medications are examples of tax expenditures. And the health insurance provider fee is akin to other taxes assessed on health plans and insurance companies in the state. In its analysis of the implications of a repeal of the ACA, the Congressional Budget Office provides national estimates of revenue generated from each of these sources, which could serve as a rough base to assess the revenue potential of these sources (CBO 2015).

Provider Fees and Taxes

As previously discussed, California makes use of provider fees and taxes on health plans to support the Medi-Cal program. According to a recent survey of state Medicaid programs, in 2016 California along with 33 other states had three or more provider fees in place. Some states have added new provider taxes in recent years—such as taxes on ambulatory surgery centers and ambulance providers—although many more states reported they had increased or plan to increase existing provider fees (Smith et al. 2016). Given California already relies on several provider taxes, while there may be some additional health facilities that could be taxed, it is not likely they would produce sizable new revenues.

The larger issue, of course, is the extent to which these provider fees and taxes remain eligible for federal financial participation. In the past, these fees were typically supported by the provider classes that pay them—in large part because they generated additional federal funds, which were then used to increase rates and supplemental payments to the providers who were being taxed. Proposition 52, the hospital quality assurance fee passed in November 2016, is a prime example. The initiative was sponsored by hospitals and represents the single largest source of Medi-Cal funds derived from health care provider taxes. It includes a provision that allows the fee to be revisited if the revenues are not eligible to be matched by the federal government.

It is unclear how the use of provider fees and taxes fits into current federal plans to alter the program. However, if federal funding for Medi-Cal is capped in the future it is hard to see how providers could be assured they would receive monetary benefit. In this case, provider fees would look more like a traditional tax on medical care, although it is not clear how this would affect costs of care or who would bear any increased costs associated with the tax; that would likely depend on the type of provider and their ability to pass costs along through increased rates.

Revisiting the State-Local Fiscal Relationship

The financing and provision of Medi-Cal benefits (and other health and social services to low-income state residents) involves a complex collaboration between state and local governments. This state-local relationship has been shaped by a series of historical decisions, often made in response to short-term budgetary crises rather than long-term needs (for more on this history, see Technical Appendix B). Simplifying Medi-Cal financing could improve the program's transparency and help make the case for providing enough funding to maintain services.

Unwinding these historical decisions, however, would be difficult. Some of the funds allocated to counties to support health programs—for example, the vehicle license fee (VLF)—are constitutionally protected local funds.

[35]See letters from the IRS to Congress on the impact of the ACA on taxpayers, posted on the IRS website.

Constitutional protections were also created for county specialty mental health funds as the result of 2011 realignment.

Still the current complexity of financing for Medi-Cal is made that much more complicated as the result of these historical, largely budget-driven decisions. The current focus on Medi-Cal financing and the possibility of major federal policy changes could offer the opportunity for some simplification that could align with programmatic goals. For example, the carve-out of specialty mental health services for Medi-Cal beneficiaries with severe mental health needs to county mental health plans complicates attempts to better integrate physical and behavioral health services.

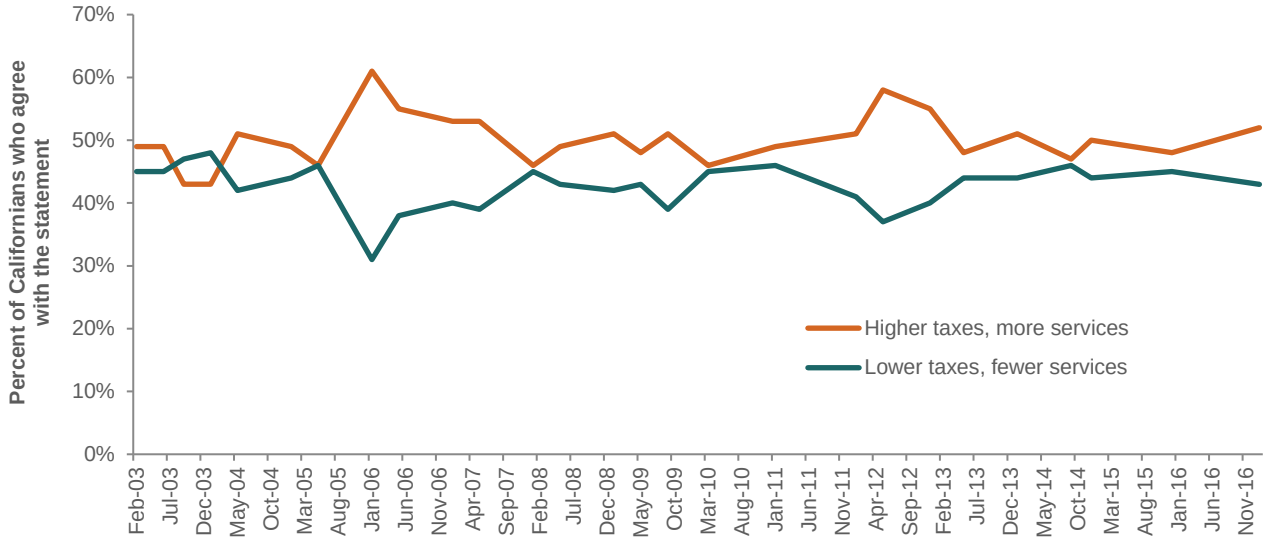
Assessing the Political Landscape

Many of the revenue options we have discussed would involve major changes to the state's tax system. In general, the state has broad authority to levy taxes and fees, but the California state constitution requires a supermajority (two-thirds voting in favor) in both houses of the state legislature, along with the signature of the governor.

Any of these changes would also necessitate a serious policy discussion about how to use additional revenues. Some might argue that any changes to the tax system should result in lower overall tax rates for state residents, while others would advocate for expanding program spending and services. While it is impossible to predict the outcome of these debates, over the past decade more often than not a majority of Californians report that they favor higher taxes and more services over lower taxes and fewer services (Figure 7). Obviously, as more information becomes available and specific proposals move forward, it will be important to gauge how policymakers and Californians respond.

FIGURE 7

Californians' support for higher taxes to provide more services fluctuates but more often than not stays over 50%



SOURCE: *PPIC Statewide Survey: Californians and Their Government*, 2003–2016.

NOTE: The survey question was as follows: "In general, which of the following statements do you agree with more— (1) I'd rather pay higher taxes and have a state government that provides more services, [or] (2) I'd rather pay lower taxes and have a state government that provides fewer services?"

We should note that none of the experts we spoke with suggested major changes to the tax code as a key strategy for supporting Medi-Cal. Still as we have emphasized throughout this discussion, governors in recent years have shown interest in tax reform of one kind or another and discussions about tax reform continue in the state legislature. Of course, the history and outcome of recent proposals suggest that tax reform is a heavy lift.

Indeed, despite reporting abstract support for taxes to support more services as shown above, surveys find the majority of Californians wary of tax reforms that would increase the amount of taxes they pay. In 2014, a PPIC Statewide Survey found that 59 percent of state residents opposed applying the sales tax to services, while a majority of those surveyed would support increasing corporate income taxes (51%) and taxes on high incomes (63%) (Baldassare et al. 2014). This suggests that Californians are supportive of taxing others but not necessarily themselves.

There are additional political considerations beyond what California residents and voters may signal about their support and preferences. Industry groups also wield political influence and to the extent that some of the revenue options we have discussed target particular goods—for example, alcoholic beverages or certain food items—or particular services—for example, recreational activities or professional services—there will likely be opposition from these groups. Likewise, concerns that changes to corporate taxes would drive businesses out of the state would also come to the fore, particularly from the many business interests engaged in the political process, and would give pause to policymakers concerned with negatively impacting the state's economy.[36]

With respect to options involving fees and taxes on health plans and providers specifically, it is unclear whether these entities are willing to be taxed to support the Medi-Cal program in the absence of assurances that doing so would increase their payments. California's attempt at major health reform in 2008—prior to the ACA—included fees levied on hospitals and other providers to support major coverage expansions. But the reform proposal also presumed federal matching funds to be used for increased payment rates—in many ways laying the groundwork for the current hospital QAF. To the extent that private hospitals throughout the state have experienced declines in their bad debt and charity care expenditures since the ACA coverage expansions, their willingness to contribute in order to maintain the state's large gains in insurance coverage could be greater (Dranove et al. 2016; Blavin 2016).

Californians across the political spectrum largely supported the health reform proposals attempted under the Schwarzenegger administration in 2008—just a few years before the passage of the ACA. In fact, the PPIC Statewide Survey found that more than 70 percent of Californians favored a plan that required all Californians to have health insurance with costs shared between employers, health care providers, and individuals (Baldassare et al. 2007). And while state residents in recent polls report more mixed feelings on the ACA, mirroring national polling data, California's attempt at major health reform in 2008 contained many of the same elements as the ACA—including individual and employer mandates, fees on providers, and expansions of public coverage sources—suggesting that there could be opportunities for further state-based reform efforts.

Finally, any attempts at revisiting the state-local relationship would also be politically sensitive. There is a long history of difficulties and litigation over county program responsibilities and adequate state funding (Belshé and McConville 2013; Kelch 2005). In addition, public health systems—including county hospitals, county clinics, and county mental health departments—are key partners with the state providing care to millions of Medi-Cal beneficiaries as well as the uninsured. California's public hospital system, in the counties where it exists, is also a critical component of the state's emergency medical system, provision of trauma care, and capacity to train physicians.

[36] However, there is sound evidence to suggest that there have not been large migrations of businesses or employment out of California over the last few decades (Kolko and Neumark 2007; Kolko et al. 2010).

Despite these challenges, the importance of the Medi-Cal program in providing health benefits to such a large share of Californians makes it likely that a wide range of options will be considered. And while it is not clear how Californians would feel about tax increases that could affect a large share of state residents, Medi-Cal's dramatic growth has almost certainly increased its visibility—a majority of Californians probably receive Medi-Cal benefits themselves or have a relative or friend who does. This new reality could open the door to a new perspective on what the program means to California and the possibility of developing a broader financial base for the program.

Looking Forward

Medi-Cal is a core state program that provides comprehensive health coverage to more than one-third of the population. Along with state support for K–14 education, Medi-Cal shapes state budget discussions each year. The state's decision to expand Medi-Cal under the ACA even when financially challenged by a severe recession underscores the commitment of state lawmakers to provide health insurance to Californians. The passage of several state initiatives in the November 2016 election that provide funding for Medi-Cal provides evidence that voters also see the value of the program.

Despite this support, Medi-Cal faces an uncertain future. Since the federal government currently provides nearly two-thirds of program funding, federal changes to the ACA and/or Medicaid more broadly may have a large impact on Medi-Cal. But the Medi-Cal program faced fiscal challenges even before the recent election. Medical costs have moderated in recent years, but they will continue to rise, probably at a rate that outpaces revenue growth. In addition, demographic changes and the aging of the population—factors that lie outside of state control—will add cost pressures.

While the extent of future federal funding changes is still unclear, the state may soon face a difficult fiscal decision: whether to increase state funds for the Medi-Cal program or once again live with a large uninsured population. Increasing state revenues—whether through the General Fund or special funds that provide targeted support for Medi-Cal—may be needed to maintain current coverage rates.

While we have laid out several revenue options for supporting Medi-Cal, the state's policy response should not revolve exclusively around funding. The discussions and program changes that will occur if major federal reforms are enacted could offer an important opportunity for the state to think carefully about how the financing system relates to programmatic goals as several of the experts we interviewed emphasized. The complexity of program financing along with the effects of changes in the allocation of state revenues for health care over the past several decades—some of which were accompanied by constitutional guarantees—make rethinking Medi-Cal financing a daunting task. Nonetheless, a thoughtful discussion about what the state and its residents want from the program would be a good place to start.

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