Proposition 35:
Permanent Funding for Medi-Cal Health Care Service

Initiative Statute

By

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I. EXECUTIVE SUMMARY

Proposition 35 establishes a permanent and fixed tax on managed healthcare insurance plans ("MCO"). It would permanently apportion the funds to increase the rates at which Medi-Cal reimburses doctors, focusing on primary care, mental health, emergency care, specialty care, and prescriptions. If this measure passes, it will increase the state budget obligation by about $5 billion yearly.[1] The spending obligations put in place by Proposition 35 would continue as long as the Federal Affordable Care Act provides for State Medicaid matching funds, as long as the federal approvals are granted for the MCO tax, and regardless of the health of the California budget in any given year.

In 2023, Governor Gavin Newsom's administration, healthcare proponents, and legislators entered into negotiations to help alleviate some of the structural issues with Medi-Cal, particularly regarding the difficulty some patients faced scheduling appointments. In particular, there was concern that not enough doctors were accepting Medi-Cal patients and this deficit was negatively impacting patient care. To attract more providers and have current providers accept more Medi-Cal patients, the group prioritized increasing the provider pay reimbursement rates, and in late 2023, the working group struck a deal. In light of the new budget realities projected in 2024, many structural changes were made to this deal, particularly regarding provider rates. Proposition 35 would reverse any changes made in 2024 to reduce Medi-Cal reimbursement rates to doctors and permanently affix the rate increases that had been negotiated in 2023 to incentivize more doctors to see more Medi-Cal patients.

A "YES" vote would permanently affix the MCO tax in California law, dependent on continued federal approval. It would also establish permanent spending limits for certain health programs, particularly focusing on increasing provider rates in primary, specialty, and emergency care.

A "NO" vote would maintain the current spending limits that extend through 2027. The MCO tax in California law would need to be reauthorized every few years and the Legislature would continue to have great flexibility to adjust all budgetary needs when considering Medi-Cal funding. The current 2024 negotiated adjustments to the rate increases for Medi-Cal doctors would take effect resulting in smaller and more delayed provider rate increases than were planned for in 2023.

[1] Legislative Analyst's Office, *Proposition 35: Provides Permanent Funding for Medi-Cal Health Care Services. Initiative Statute*., LEGISLATIVE ANALYST'S OFFICE (August 13, 2024), https://lao.ca.gov/BallotAnalysis/Proposition?number=35&year=2024 (last visited Oct. 15, 2024).

II. THE LAW

A. California Healthcare Background

1. *The Medicare and Medicaid Act (1965) and the Affordable Care Act (2010).*

On July 30, 1965, President Lyndon B. Johnson signed the Medicare and Medicaid Act,[2] which established two different federal healthcare programs. The first was Medicare, a health insurance program for the elderly paid for through payroll deduction taxes, a significant allocation of the national budget, premiums, copays, and deductibles.[3] The second was Medicaid, a comprehensive health insurance program paid jointly through large grants to states by the federal government and states taxes, and local taxes.[4] Medicaid is administered by states and financed by federal, state, and local governments to insure children and those with low income.[5] However, decades after adopting Medicaid, the program faced many notable shortfalls. First, the program faced funding shortages, and many states instituted stringent income requirements that severely limited eligibility for the program.[6] To remedy this issue, Congress passed the Affordable Care Act in 2010. With this act, state Medicaid programs received a federally funded expansion that sought to enroll all Americans of limited income. [7] Since the enactment of the Affordable Care Act, California's Medicaid system, "Medi-Cal," has received about 50% of its funding from the Federal Government.[8] The remaining half has been funded by the state, and financed through California's General Fund. [8]

2. *Medi-Cal and the California Budget*

Currently, over one-third of California's population, including about one-half of California's children, are covered through Medi-Cal.[9] California has enacted a fairly generous form of Medi-Cal that requires substantial funding. In 2023-2024, the total Medi-Cal budget was $157 billion.[10] About 13%-17% of the General Fund spending has financed Medi-Cal over the last

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[2] Pub. L. 89-97, 79 Stat. 286 (1965).
[3] Kimberly Lankford, *What is the Difference Between Medicare and Medicaid?* AARP MEDICARE QUESTION AND ANSWER TOOL What Is the Difference Between Medicare and Medicaid? (aarp.org) (last visited Sept. 24, 2024).
[4] *Id.*
[5] Liz Weston, *Medicare vs. Medicaid: What's the Difference? NERDWALLET* Medicare vs. Medicaid: What's the Difference? - NerdWallet (last visited Sept. 23, 2024).
[6] Lyon, Douglass, Cooke, *Medicaid Expansion under the Affordable Care Act. Implications for Insurance-related Disparities in Pulmonary, Critical Care, and Sleep,* ANNALS OF THE AMERICAN THORACIC SOCIETY (March 17, 2024).
[7] *Understanding the Affordable Care Act | What is the ACA?* AMERICAN MEDICAL ASSOCIATION Understanding the Affordable Care Act | What is the ACA| AMA (ama-assn.org) (last visited Oct. 7, 2024)
[8] Athena Champan, Samantha Pelon, *Medi-Cal Explained,* FACTSHEET, CALIFORNIA HEALTH CARE FOUNDATION. (July 2023), Medi-Cal Explained - California Health Care Foundation (chcf.org) (last visited Oct. 15, 2024).

[9] Medi-Cal Eligibility Statistics last visited Oct 6, 2024). (last visited Oct. 6, 2024).
[10] California Legislative Analyst's Office, *Medi-Cal Analysis*, THE 2024-25 BUDGET, The 2024-25 Budget: Medi-Cal Analysis (last visited Oct. 8, 2024).

10 years.[11] This is the second-largest line item in the California Budget after K-12 spending, which was set by Proposition 98 (1988).[12]

The Medi-Cal budget has reached an all-time high in recent years for two primary reasons. The first is that California has made a gradual effort since 2014 to increase eligibility to all low-income adults and children, regardless of immigration status.[13] The second reason is the expansion of covered services. Medi-Cal recipients can receive medical, dental, Doula (childbirth), vision, podiatry, substance abuse, preventative, auditory, in-home, and long-term care, depending on their age and location.[14]

This policy serves important humanitarian purposes. However, budget analysts acknowledge that this expansion will also increase the strain on the existing Medi-Cal system in several ways. First, there are fewer doctors than the demand requires.[15] Doctors' associations claim this is due to Medi-Cal's pay structure, which is historically low relative to inflation.[16] Medi-Cal pays 30% less than Medicare., and [17]Medicare pays 30% less than traditional insurance.[18] Given the number of Medi-Cal recipients, which increased by 3.5 million from 2020 to 2023, [19] and the number of physicians who accept Medi-Cal: 40% of Californians' doctors provide services to 80% of Medi-Cal patients. [20] With insufficient physicians taking Medi-Cal and increasing enrollment, Medi-Cal faces major structural problems.[21]

3. *What is the MCO Tax?*

In 2005, California enacted the original tax on Managed Care Organizations (MCOs), [22] like Kaiser or Blue Cross; the current tax is estimated to raise between $7 billion and $8 billion for the state's General Fund. [23] California's MCO tax charges health plans based on the number of members these plans served the prior year. In addition to the funds raised through the tax, federal

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[11] *Id.*
[12] *Id.*
[13] Miranda Dietz, *California's Biggest Coverage Expansion Since the ACA: Extending Medi-Cal to All Low-Income Adults,* UCLA CENTER FOR HEALTH POLICY RESEARCH (last visited Oct. 6, 2024).
[14] Full-Scope Medi-Cal for Adults 50+ (chcf.org) (last visited Oct 5, 2024)
[15] Margaret Tater, *Medi-Cal Managed Care: An Overview and Key Issues*, KAISER COMMISSION OF MEDICAID AND THE UNINSURED Medi-Cal Managed Care: An Overview and Key Issues – Issue Brief - 8844 | KFF (last visited Oct. 8, 2024).
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] Hannah Hough, *Fewer California Doctors Accept Medi-Cal, despite the Surge in Number of Patients*, CALIFORNIA HEALTH REPORT, (Oct. 21, 2016).
[21] Margaret Tater, *Medi-Cal Managed Care: An Overview and Key Issues*, KAISER COMMISSION OF MEDICAID AND THE UNINSURED Medi-Cal Managed Care: An Overview and Key Issues – Issue Brief - 8844 | KFF (last visited October 8, 2024).
[22] Legislative Analyst's Office, *Proposition 35: Provides Permanent Funding for Medi-Cal Health Care Services. Initiative Statute*., LEGISLATIVE ANALYST'S OFFICE (August 13, 2024), Proposition 35 [Ballot] (ca.gov) (last visited Oct. 15, 2024).
[23] Kristen Hwang, *California Voters Will Decide Who Wins on Health Care Tax: Gavin Newsome or Doctors*, CALMATTERS (Jul. 1, 2024) Billions for Medi-Cal at stake with health tax in CA 2024 election - CalMatters (last visited Oct. 15, 2024).

regulations allow states to receive a federal match in Medicaid funds for every dollar raised through these taxes, provided that the state's tax meets federal regulations.[24] Because of the revenue raised through these levies, Republican and Democratic legislatures in California have renewed the tax in the past two decades.[25] To meet federal regulations and receive a federal match, the tax must be broad and uniformly applied to medical providers across the state.[26] To meet this requirement, California must receive pre-approval to ensure that each successive version of the tax the state enacts will receive this federal match.[27]

California's legislatures have imposed a higher tax rate on Medi-Cal MCO plans than on private insurance plans to maximize revenues through the federal matching provisions and protect commercial interests.[28] Federal subsidies are naturally required to be built into Medi-Cal per enrollee rates based on how it is funded.[29] There is no equivalent federal funding for commercial plans.[30] So when a tax is placed on Medi-Cal plans, a large portion of the revenue generated by the tax is the federal subsidy. If a similar tax were placed on commercial, market-based health plans, they would have no choice but to raise rates.[31] So, the legislature, with the support of proponents like the California Hospital Association, has placed an over 10 to 1 higher tax rate differential on Medi-Cal than on private commercial plans, hoping that it will raise a significant amount of revenue without the negative impact of higher commercial premiums on individual Californians. [32] Due partly to the funds gained through the federal matching provisions, the MCO tax has raised considerable amounts of money for California since 2005. California's Department of Health Care Services estimates the most recent version of the tax, effective from April 2023 through December 2026, will raise over $19.6 billion in revenue through its duration.[33] Currently, there is no requirement for these specific funds to be used for Medi-Cal expenses[34]. However, these funds have historically been used to cover General Fund shortfalls in Medi-Cal spending.[35]

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[24] 42 U.S.C 139b § 1903 (w)(3)(B) and (C) (2023).
[21] *Managed Care Organization Provider Tax*, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (May 2023).
[26] *Id.*
[27] *Managed Care Organization Provider Tax*, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (May 2023).
[28] Interview with California Hospital Association (notes on file with the *California Initiative Review*).
[29] Kayla Kitson, *Understanding Proposition 35*, CALIFORNIA BUDGET & POLICY CENTER, (August 2024) Understanding Proposition 35 - California Budget and Policy Center (calbudgetcenter.org) (last visited Oct. 15, 2024).
[30] *Id.*
[31] CHA Issues FAQs on MCO Tax Budget Agreement - California Hospital Association (calhospital.org) (last visited Sept. 20, 2024).
[32] *Id.*
[33] Legislative Analyst's Office, *Proposition 35: Provides Permanent Funding for Medi-Cal Health Care Services. Initiative Statute*., LEGISLATIVE ANALYST'S OFFICE (August 13, 2024), Proposition 35 [Ballot] (ca.gov) (last visited Oct. 15, 2024).
[34] *Id.*
[35] *Id.*

B. Existing Law

1. *MCO and Medi-Cal Negotiations in 2023*

The most recent version of the MCO tax was scheduled to sunset at the beginning of 2023. While now reauthorized, this brief sunset led healthcare advocates like the California Medical Association, the California Hospital Association, and provider groups like the California Dental Association and Primary Care Association to meet with legislators and the Newsom administration to work out an agreement.[36] This 2023 agreement primarily included a commitment to use MCO tax revenues to address the longstanding shortfalls in Medi-Cal provider payments.[37] The agreement led to AB 118, which in sections 139-141 reflected the allocation of the spending that the negotiators had contemplated.[38] AB 118 also established a new Medi-Cal Provider Payment Reservice Fund account, partially funded by the MCO tax.[39] The negotiated plan was supposed to support augmentations in Medi-Cal and other health programs.[40]

2. *Medi-Cal Bargains between 2023 and 2024.*

The budget deficit of 2024 created a new reality for many in the state, including the legislators and the administration that had worked out the 2023 Medi-Cal deal. That year, the California Legislature approved, and Governor Newsom signed, the Budget Act, which was authorized by the previous year's MCO extension but changed the allocation of funds, lowering the negotiated reimbursement rate expansions. Rather than doing away with rate increases altogether, the Budget Act established new baselines for rate increases, effective January 1, 2025, and January 1, 2026.[41] The 2024 spending plan did not make across-the-board cuts; many rates were increased, and services for long-term support were added.[42] Another change is how spending increases are defined. Rather than giving providers a specific amount of money for a service, augmentations are defined as a percentage, such as "an increase of 80%."[43][44]

The current MCO tax, authorized in 2024, expires in 2026. In 2024, the monthly tax on commercial plans will be $1.75 per enrollee on private commercial plans, whereas the monthly rate for Medi-Cal plans is $182.50 per enrollee through 2025.[45][46] Notably, both the current legislative plan and the Proposition have built-in increases to the tax on Medi-Cal enrollees to

[36] *AB- 119 2024 Leg.,* 2023-2024 Reg. Sess. (Cal. 2024).
[37] *CHA Issues FAQs on MCO Tax Budget Agreement* CALIFORNIA HOSPITAL ASSOCIATION (July 13, 2024).
[38] *AB-118. 2024 Leg.,* 2023-2024 Reg. Sess. (Cal. 2024).
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] CAL. WEL. & INST.CODE Art. 7.1 § 14199.80.
[46] California Legislative Analyst's Office, *The MCO Tax Package at May Revision*, THE 2024-25 BUDGET (May 2024) The 2024-25 Budget: The MCO Tax Package at May Revision (ca.gov) (last visited Oct. 15, 2024).

confront budget issues, and both plans assume that the federal government will continue to approve of these increases.[47]

Currently, Medi-Cal programs traditionally do not need to spend all their annual budget to retain it for the following year; it is not a "use it or lose it" system [48] like you see in federal agencies like the Department of Defense or the State Department[49] In those systems, programs must use all their budgets to justify their budget size. If they do not spend the money, it is assumed they do not need it. For the Medi-Cal program, because of the uncertainty about federal approval and/or the Legislature passing the necessary legislation, Medi-Cal programs created funds that acted like rainy-day funds in case their funding was ever unavailable.[50]

Under current law, in 2026, the MCO tax money will still offset General Fund spending and be allocated toward provider rate increases. This will include raised rates for non-physician professionals, such as nurses, physician assistants, and nurse practitioners. In addition, there will be a one-time $40 million investment in supporting, developing, and retaining the Medi-Cal workforce.[51] Some are critical that this is less supported than past California legislatures have provided, arguing that Medi-Cal's long-term viability relies on more robust and sustained funding.[52]

The first table below represents the difference between the 2023 negotiated agreement and the 2024-2025 legislation regarding many areas. Physician and professional services represent increases in payment reimbursements for providers, most specifically doctors.[53] Both plans offer increases but differ in the amount and timing of these increases. The second category is facilities, like hospitals and rural health centers; the 2023 plan provides significantly more funding directly for facilities, and those in the negotiation felt like this would facilitate patient care and help in obtaining appointments.[54] Next is transportation—the 2024 package funds all forms of medical transportation at a significantly higher amount than the 2023 plan. California is ranked the highest in the nation for ambulance services, with an average ride cost of around $1200.[55] Furthermore,

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[47] California Legislative Analyst's Office, *Health,* 2024-25 CALIFORNIA SPENDING PLAN (Sept. 17, 2024) The 2024-25 California Spending Plan: Health (last visited Oct. 15, 2024).
[48] Kayla Kitson, *Understanding Proposition 35*, CALIFORNIA BUDGET & POLICY CENTER, (August 2024) Understanding Proposition 35 - California Budget and Policy Center (calbudgetcenter.org) (last visited Oct. 15, 2024).
[49] Jacob Plott, *reckless End of Year Spending Illustrates Agency Irresponsibility: "Use It or Lose It"* NATIONAL TAXPAYERS UNION FOUNDATION, Sept. 18, 2019 Reckless End-Of-Year Spending Illustrates Agency Irresponsibility: "Use it or Lose It" – Foundation - National Taxpayers Union (ntu.org) (last visited: Oct. 14, 2024).
[57] Kayla Kitson, *Understanding Proposition 35*, CALIFORNIA BUDGET & POLICY CENTER, (August 2024) Understanding Proposition 35 - California Budget and Policy Center (calbudgetcenter.org) (last visited Oct. 15, 2024).
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] Bernard Wolfson, *New California Law Offers Fresh Protections From Steep Ambulance Bills,* CALIFORNIA HEALTHLINE, (Nov. 202) New California Law Offers Fresh Protection From Steep Ambulance Bills - California Healthline (last visited Oct. 15, 2024).

California is reporting shortages of paramedics.[56] The next category is long-term support. Whether it is daycare or adult services, the impact of caretaking can cause emotional and financial bankruptcy, especially when there are no safety nets to help people.[57]

Augmentation Differences between the 2023 Negotiated Framework and 2024 Budget Plan		
Budget Area	2023-2024 Framework	2024-2025 Budget Plan
Physician & Professional Services		
Primary Care[1]	X	X[2]
Maternity Care[1]	X	X[2]
Mental Health[1]	X	X[2]
Specialty Care	X	X[2]
Emergency Care	X	X
Facilities		
Outpatient Procedures and Services	X	
Designated Public Hospitals	X	
Emergency Rooms	X	
Behavioral Health Facilities	X	
Federally Qualified & Rural Health Ctrs	X	X[2]
Medical Transport		
Ground Emergency	X	X
Emergency Air		X
Nonemergency		X[2]
Long-Term Supports		
Community-Based Adult Services		X
Congregate Living Health Facilities		X
Pediatric Day Health Centers		X
Other Services		
Community Health Workers		X
Reproductive Health & Family Planning	X	X
Continuous Medi-Cal Coverage for Kids up to 5		X
Private Duty Nursing		X[2]
Medi-Cal Workforce Pool	X	X[3]
Graduate Medical Education	X[4]	
1- Services also receive an increase in 2024 that remain in effect in the 2024-25 budget package, 2- Begins in 2026, 3- One time in 2026-2027, 4- was to begin in 2023-2024. AUGMENTATIONS BEGIN IN 2025 UNLESS OTHERWISE NOTED		

[56] Jamie Kennedy, CDC Health Care Systems at Breaking Point due to staffing and mental Health Issues, SPECTRUM NEWS 1, Nov. 1, 2023 Staffing and mental health issues plague health care systems (spectrumnews1.com) (last visited Oct. 7, 2024).

[57] Amy Goyer, *How Years of Caregiving Led to Bankruptcy,* AARP, (Feb. 26, 2021) How My Family Caregiving Expenses Led to Bankruptcy (aarp.org) (last visited Oct. 6, 2024).

The next two tables show the specific funding allocations for 2025 and 2026 according to the current law, the 2024 Budget Bill.

Provider and Rate Increases from the 2024 Budget Act for the Medi-Cal Spending Plan taking effect on Jan. 1, 2025	
Emergency Dept. Physicians	$100,000,000
Abortion Care & Family Planning	$90,000,000
Ground Emergency Medical Transport	$50,000,000
Air Emergencu Medical Transport	$8,000,000
Community-Based Adult Service	$8,000,000
Congragte Living Health Facilities	$8,000,000
Pediatric Day Health Centers	$3,000,000

As mentioned above, under the 2024 plan, funding allocation will be different as of January 1, 2026. More money is planned to be allocated to increasing provider reimbursement rates. The chart below reflects this priority shift.

Provider and Rate Increases from the 2024 Budget Act for the Medi-Cal Spending Plan taking effect on Jan. 1, 2026	
Physician & Non-Physician Professional Health Services	$753,000,000
Private-Duty Nursing	$62,000,000
Federally Qualified Health Centers & Rural Health Centers	$50,000,000
Continous Coverage for Kids (1-5)	$33,000,000
Non-Emergency Medical Transport	$25,000,000
Non-physician professionals include physician assistants, nurse practitioners, & certified midwives	

C. Proposed Law

1. *MCO Tax*

One of the most important changes that Proposition 35 states is that the MCO tax is permanent.[58] Proposition 35 is contingent on the federal government's approval to match the tax and continue the Affordable Care Act's Medicaid expansion. Procedurally, this "permanence" is achieved by tasking the Centers for Medicare and Medicaid Services with seeking renewed federal approval for the written MCO tax as required.[59] As per the language of the initiative and federal legislation, the procedure regarding the MCO tax and the federal government would be unchanged; periodic renewals will be needed. The mechanism for obtaining federal approval would change in that the MCO tax will not have a sunset provision and not further legislative action would be needed to trigger the request to the federal government for its approval.[60]

2. *Changes to Spending*

Proposition 35 also changes funding between (2025 and 2026), and long-term (2027 and beyond).[61] Currently, money raised through the tax offsets General Fund spending and is allocated according to budget needs.[62] The initiative earmarks more funding than current legislation provides for. In essence, it would permanently enact the 2023 compromised terms.

In the short term, in 2025 and 2026, about 40% of the MCO tax will offset General Fund spending, nearly identical to the 2024 law. [63] However, the money will be dedicated to different and specific funding sources in the following years.[64] Another change is that beginning in 2027, program money allocated for each fiscal year must be spent that year and cannot be rolled over to the next year.[65] Programs will no longer have access to a rainy-day fund.[66] Proponents argue that the passage of Proposition 35 will stabilize funding sources, reducing the need for rollover funds.[67]

Beginning in 2027 and going forward, the allocation of the MCO tax changes significantly. Rather than offsetting General Fund spending, approximately the same amount of money used for this purpose, slightly more than 40%, will provide funding to primary and specialty care. This

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[58] Kayla Kitson, *Understanding Proposition 35*, CALIFORNIA BUDGET & POLICY CENTER, (August 2024) Understanding Proposition 35 - California Budget and Policy Center (calbudgetcenter.org) (last visited Oct. 15, 2024).
[59] *Id.*
[60] *Id.*
[61] Kayla Kitson, *Understanding Proposition 35*, CALIFORNIA BUDGET & POLICY CENTER, (August 2024) https://calbudgetcenter.org/resources/understanding-proposition-35/ (last visited Oct. 15, 2024).
[62] *Id.*
[63] Legislative Analyst's Office, *Proposition 35: Provides Permanent Funding for Medi-Cal Health Care Services. Initiative Statute*., LEGISLATIVE ANALYST'S OFFICE (August 13, 2024), Proposition 35 [Ballot] (ca.gov) (last visited Oct. 15, 2024).
[64] *Id.*
[65] Kayla Kitson, *Understanding Proposition 35*, CALIFORNIA BUDGET & POLICY CENTER, (August 2024) Understanding Proposition 35 - California Budget and Policy Center (calbudgetcenter.org) (last visited Oct. 15, 2024).
[66] *Id.*
[67] *Id.*

includes the reimbursement rates for these providers. In addition, the MCO tax money will go to services and providers in emergency departments and family planning. About 8% of the remaining funds would go towards administrative costs and general support of the Medi-Cal system. The detailed proposal also explains how any remaining funds are to be spent. These instructions include a grant that expands the number of community healthcare workers, a reduction in the cost of prescriptions, and additional funding for various healthcare initiatives.

The chart below shows the short-term difference between the current law and that proposed by Prop. 35. It is important to remember that in the short term, a consequential amount of money will still offset General Fund spending under Prop. 35. Providers will see the weighty increases in reimbursement rates in 2027.

Proposition 35 Changes Which Services Get Funding Increases

Funding Increases in the Short Term (in 2025 and 2026)

	Current Law	Proposition 35[a]
Doctors and other related providers[b]	✓	✓
Specified hospital services		✓
Outpatient facilities		✓
Safety net clinics	✓	✓
Behavioral health facilities		✓
Reproductive health and family planning	✓	✓
Emergency medical transportation	✓	✓
Nonemergency medical transportation	✓	
Private duty nursing	✓	
Certain long-term supports	✓	
Community health workers	✓	c
Continuous Medi-Cal coverage for children up to five-years old	✓	
Medi-Cal workforce programs	✓	✓
Doctor postgraduate training programs		✓

[a] More services are eligible for funding increases in the long term (beginning in 2027).
[b] Current law and Proposition 35 include some differences over which related providers get funding increases.
[c] Eligible for funding increases in the long term (beginning in 2027), depending on how much money is raised by the health plan tax.

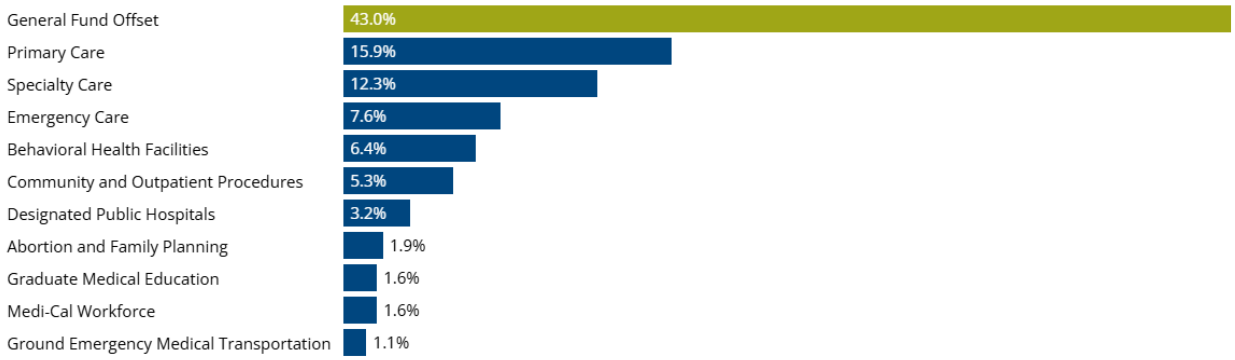
[68]

The next two charts show, as a percentage of the total Medi-Cal budget, how the resources will be allocated in the short term (2025-2026) and the long term (2027 and beyond).

[68] Legislative Analyst's Office, *Proposition 35: Provides Permanent Funding for Medi-Cal Health Care Services. Initiative Statute*., LEGISLATIVE ANALYST'S OFFICE (August 13, 2024), Proposition 35 [Ballot] (ca.gov) (last visited Oct. 15, 2024).

Prop. 35 Would Direct Large Share of MCO Tax Dollars to Offset General Fund Spending in 2025 and 2026

Percent Allocation of $4,656,000,000



Note: This does not reflect all MCO tax expenditures. A portion of the revenue would first pay MCOs back and also cover administrative costs.

Source: Welfare and Institutions Code 14199.108.3, as proposed by Prop. 35 • Download image

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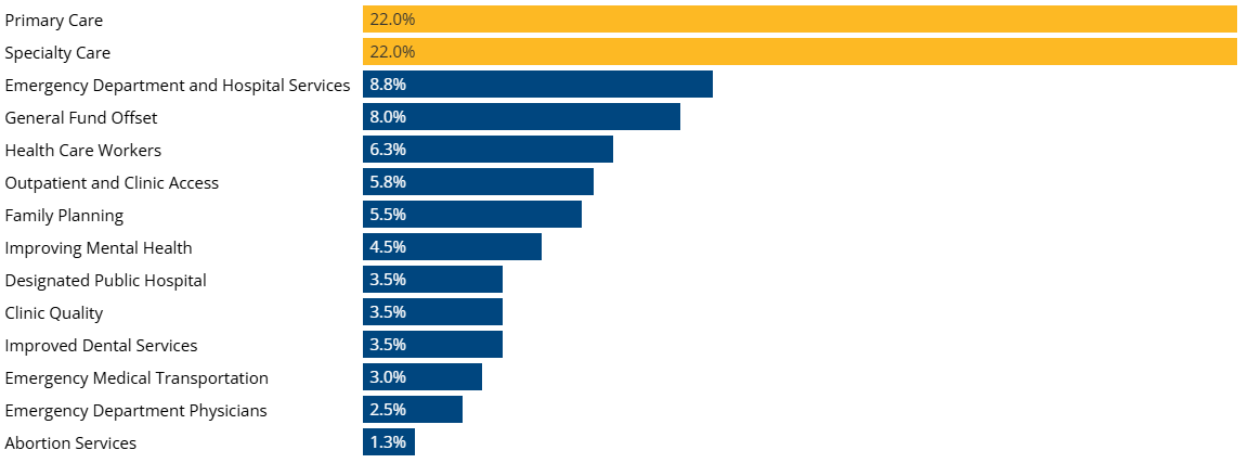
Prop. 35 Would Direct More MCO Tax Dollars for Primary Care and Specialty Care Starting in 2027

Percent Allocation of $4.3 Billion



Note: This does not reflect all MCO tax expenditures. A portion of the revenue would first pay MCOs back and also cover administrative costs.

Source: Welfare and Institutions Code 14199.108, as proposed by Prop. 35 • Download image

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III. CONSTITUTIONAL AND DRAFTING ISSUES

A. Binding the Hands of the Legislature

Proposition 35 is very specific about allocating money to different health programs. This may excessively bind the hands of the Legislature in a manner so transformative it would be more appropriately contained in a constitutional amendment rather than legislation. As the Legislature has seen over the years, the needs of each of the vast areas Medi-Cal covers cannot always be properly forecast years in advance. Proposition 35, especially after 2027, will permanently affix the same funding structure for Medi-Cal. Proponents argue that the Proposition's $2 billion buffer, raised by the MCO tax and not already allocated, can be used for General Fund expenses. However, this may not be enough with an expansive and expensive program.[69]

Regarding predicting future expenses, Medi-Cal demand may continue to grow due to population growth, increased services added, or increased healthcare costs overall.[70] California's Medicaid services are some of the most expansive in the nation.[71] Californians pay about 10% more than the average American for healthcare, and Medi-Cal has outpaced private insurance and Medicare in aggregate per capita spending.[72] If costs rise, policymakers may need to make substantive changes to the allocation of Medi-Cal dollars. While it is unconstitutional for one Legislature to bind another Legislature's decision-making ability,[73] courts may give significantly more deference to citizens who enact these same legislative changes through the ballot initiative process out of deference to the people's will expressed through the election process.[74]

B. High Legislative Vote Threshold Established by Initiative

The initiative requires a three-fourths vote margin in each house of the legislature to pass amendments to Proposition.[75] This is not as difficult as some Propositions, which require a seven-eighths vote margin[76] or require any changes or repeals to pass through the initiative process. However, this is still a significant hurdle, especially in an area as contentious as healthcare. Importantly and potentially restrictively, any amendments would need to further the initiative's purpose regarding the performance of the MCO tax and augmentations in Medi-Cal funding, meaning that a legislative repeal would be unlikely.

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[69] Interview with California Hospital Association (2024, Notes on file with the *California Initiative Review*).
[70] California Population 1900-2023 | MacroTrends MACROTRENDS.NET (last visited Oct. 8, 2024).
[71] *California | MedicaId.gov* MEDICA*ID*.GOV (last visited Oct 8, 2024).
[72] Katherine Wilson, *2023 Edition- California Health Care Spending*, CALIFORNIA HEALTH CARE FOUNDATION (March 14, 2023) 2023 Edition — California Health Care Spending - California Health Care Foundation (chcf.org) (last visited Oct. 15, 2024).
[73] *In re Collie*, 38 Cal.2d 396 (1952).
[74] Chris Micheli, *Binding a Future Legislature*, CALIFORNIA GLOBE, (Aug. 20, 2023) *Binding a Future Legislature – California Globe* (last visited Oct. 15, 2024).
[75] Cal. Proposition 35 (2024).
[76] Cal. Proposition 22 (2020).

C. MCO Tax and Reliance on Federal Approval

Proposition 35 depends on the continued existence of California's MCO tax and federal funding.[77] Rather than relying on the Legislature to renew the MCO tax every couple of years, Proposition 35 would allow the Department of Healthcare Services to request that the federal government reauthorize the existing tax as needed.[78] In the past, California has not faced pushback from the federal government in MCO tax renewals, but as opponents note, there have been recent indications that this might change.[79] The disparate rates at which Medi-Cal and commercial accounts are taxed have recently been scrutinized. One reason is that if the MCO tax is greater than 6% of a company's total revenue, the tax will be more than what is federally allowed to be collected. To collect more revenue, the California government has implemented creative accounting techniques to manipulate this tax figure to meet the federal definition.[80] Whether the federal government will continue to approve the tax as it is currently structured is questionable.[81] This will directly impact the proposition since it will determine how much money will be generated, and the initiative is so precise in how it directs money to each line item expenditure. Proposition 35 will fail to be implemented if the tax is not approved.

IV. PUBLIC POLICY CONCERNS

A. Fiscal Concerns

Proposition 35 will structurally change how Medi-Cal is funded and may require more money to be allocated from the Legislature and the budget in the long term. Proposition 35 focuses on the MCO tax as a funding source at the expense of finding and cementing multiple funding streams for Medi-Cal. The Legislative Analyst's Office (LAO) has estimated the short-term cost of the initiative to be around $1-$2 billion because they only fund what has already been approved in the Medi-Cal budget, and this should not impact state funding.[82] The long-term implications are uncertain, given the budget's health and the uncertainty surrounding whether the tax will be federally approved.

Increased obligations from the General Fund would necessarily have implications in other budget areas. The largest line item in California's General Fund spending is for health and human services, which accounts for approximately 37% of the state budget.[83] Medi-Cal makes

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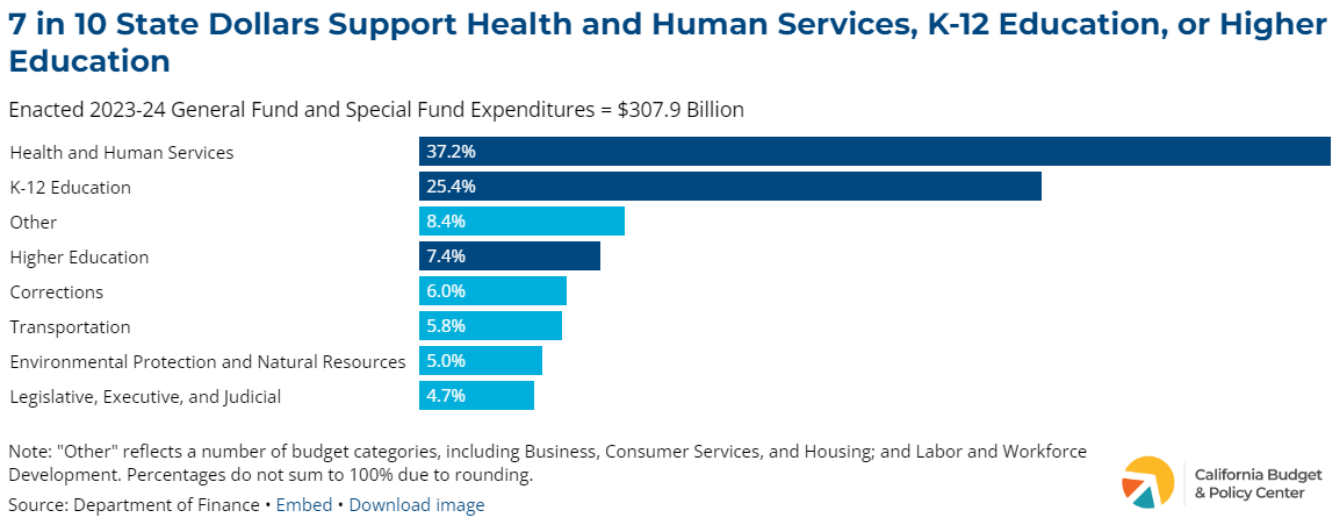
[77] Kayla Kitson, *Understanding Proposition 35*, CALIFORNIA BUDGET & POLICY CENTER, (August 2024) Understanding Proposition 35 - California Budget and Policy Center (calbudgetcenter.org) (last visited Oct. 15, 2024).
[78] Bill Text- *AB- 119, Medi-Cal: managed care organization provider tax,* 2023-2024 LEGISLATIVE SESSION (last visited Oct. 6, 2024).
[79] California Legislative Analyst's Office, *The MCO Tax Package at May Revision*, THE 2024-25 BUDGET (May 2024) The 2024-25 Budget: The MCO Tax Package at May Revision (ca.gov) (last visited Oct. 15, 2024).
[80] Kayla Kitson, *Understanding Proposition 35*, CALIFORNIA BUDGET & POLICY CENTER, (August 2024) Understanding Proposition 35 - California Budget and Policy Center (calbudgetcenter.org) (last visited Oct. 15, 2024).
[81] *Id.*
[82] Cal. Proposition 35 (2024).
[83] Scott Graves, *Guide to the California State Budget Process*, CALIFORNIA BUDGET & POLICY

up a major portion of this spending, but not all of its programs, such as Cal-Fresh and California Child Support Services.[84]



Legislative leaders could also look to other, more creative solutions like those used in this year's budget to cover shortfalls. These included spending cuts and delays, budget reserve withdrawals, and revenue increases. Financing tricks like these have led the Department of Finance to raise estimates on the economic impact of Proposition 35 from LAO's estimate of $1-$2 billion to between $2.6 and $4.9 billion from 2025-2027.[85]

Proponents for Proposition 35 include Planned Parenthood Affiliates of California, the California Medical Association, the California Hospital Association, and the California Dental Association, along with the state Democratic and Republican parties. Most of these groups would see significant investments from Proposition 35's various healthcare funds and increases in provider reimbursement rates, so it is not surprising that they would offer their endorsement for the measure. Proponents such as Susan McEntire, Vice President of the California Medical Association, however, assert that the Proposition mitigates several issues plaguing California's Medi-Cal system and harming patients.[86]

CENTER (May 2024) Guide to the California State Budget Process - California Budget and Policy Center (calbudgetcenter.org) (last visited Oct. 15, 2024).

[84] *Id.*

[85] Kayla Kitson, *Understanding Proposition 35*, CALIFORNIA BUDGET & POLICY CENTER, (August 2024) Understanding Proposition 35 - California Budget and Policy Center (calbudgetcenter.org) (last visited Oct. 15, 2024).

[86] Interview, Susan McEntire. (Sept. 19, 2024, notes on file with *The California Initiative Review*).

B. Proponents' Main Arguments

1. *Protecting Healthcare Funding for Outreach*

Proponents maintain that the initiative prevents legislators from redirecting funds obtained from the MCO tax for nonhealthcare purposes.[87] Proponents maintain that this problem of fund redirection has cost the Medi-Cal system over thirty billion dollars since the enactment of the original MCO tax in 2005.[88] Proponents further claim that multiple and repeated increases in the population of individuals eligible for Medi-Cal and offered services have increased the issues surrounding the need for more funding. Susan McEntire also stressed that the provisions within Proposition 35 aimed at increasing enrollment would help the state to engage in outreach to newly eligible residents who may not be aware of their eligibility. Since eligible residents speak various languages and live in various areas, protecting investment for outreach will continue to be essential.

2. *Increasing Reimbursement Rates and Securing Supply of Providers*

Proponents point to low reimbursement rates as the driving force behind barriers to care and doctor and hospital shortages. Proponents, such as Susan McEntire, note that the last broad increase in reimbursement rates for Medi-Cal occurred in 2000 and that piecemeal increases have not kept pace with inflation.[89] This lack of investment, McEntire claims, is not enough to attract care providers to accept Medi-Cal patients.[90] Proponents argue that Proposition 35 would ameliorate this problem by creating dedicated funding streams for various doctors, nurses, and specialists.[91] Additionally, proponents note that the investments in education for doctors and nurses would aid in replacing retiring healthcare workers.[92]

C. Opponent's Main Arguments

Opponents of the measure include the League of Women Voters of America, the California Pan-Ethnic Health Network, The Children's Partnership, the California Alliance for Retired Americans, and Courage California. Maya Meinert, Director of Communications for the Children's Partnership, states that, while the Children's Partnership agrees with proponents regarding the need to increase provider reimbursement rates, the measure ultimately does more harm than good.[93] The organization's opposition revolves around three key issues with the proposed legislation. First, they assert that the specificity of the bill's provider increases shifts money away from other Medi-Cal initiatives aimed at expanding eligibility and optional benefits. Second, they assert that the plan's tax cap of $2.75 per enrollee for commercial plans could threaten future revenues. Finally, they assert that the proposition does not include enough input from community members and Medi-Cal recipients. While she does not purport to speak for other

[87] *Id.*
[88] *FactSheet* Get the Facts | Vote Yes on 35 (voteyes35.com), (Accessed October 9, 2024).
[89] Interview, Susan McEntire. (Sept. 19, 2024, notes on file with *The California Initiative Review*).
[90] *Id.*
[91] *Id.*
[92] *Id.*
[93] Interview with Maya Meinert, Director of Communications at the Children's Partnership, (Sept. 12, 2024, notes on file with *The California Initiative Review*).

groups, Meinert suggests that other advocacy groups have started to make similar observations regarding the needs of their constituents. On September 5, 2024, several organizations issued a joint opposition paper on many of these issues.[94]

1. *Specific Provider Increases underfunding other initiatives.*

The Children's Partnership asserts that because of the shift in funds towards provider rate increases, Proposition 35 would shift resources away from the state's childhood enrollment program. Currently, California guarantees continuous enrollment for children under the age of five, meaning these children do not have to reapply for enrollment on an annual basis.[95] Proponents argue that this would protect thousands of children. About 80% of California children dropped from coverage yearly are removed because of missing paperwork, an incorrect address, or other red tape.[96] With automatic enrollment, these children would not lose their coverage. . However, Meinert suggests that the funding shift from Proposition 35 would threaten efforts to keep and hopefully extend this program and could ultimately increase lapses in coverage for children during a period of crucial development. Ramon Castellbach, the Vice President of the California Alliance of Retired Americans, echoes a similar sentiment, stating that these shifts in funding would cut funding to living facilities that provide essential services to severely disabled seniors.[97]

2. *The Plan's Cap on Commercial Plans Would Threaten Future Healthcare Funding.*

Furthermore, opponents state that the plan's proposed cap on individual commercial plans would threaten future healthcare funding and reduce future revenues. They point to recent signaling from the federal government of its intent to change the rules around the MCO tax, requiring states to make their taxes on individual plans and Medi-Cal plans more equal.[98] Proponents argue that since the initiative proposes a cap of $2.50 per person for commercial providers, if the federal government were to require the rates to be equal, the measure would result in an artificially low ceiling for taxes on Medi-Cal providers.[99] Such a move would threaten the revenue from the MCO tax and the Medi-Cal funds from the Federal government's matching provisions.

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[94] *LEADING HEALTH CARE CONSUMER, COMMUNITY ADVOCATES ANNOUNCE OPPOSITION TO PROPOSITION* THE CHILDREN'S PARTNERSHIP (Sept. 5, 2024).
[95] Kristen Hwang, *California Voters Will Decide Who Wins on Health Care Tax: Gavin Newsome or Doctors*, CALMATTERS (July. 1, 2024) Billions for Medi-Cal at stake with health tax in CA 2024 election - CalMatters (last visited Oct. 15, 2024).
[96] Kayla Kitson, *Understanding Proposition 35*, CALIFORNIA BUDGET & POLICY CENTER, (August 2024) Understanding Proposition 35 - California Budget and Policy Center (calbudgetcenter.org) (last visited Oct. 15, 2024).
[97] "*Leading Health Care Consumer, Community Advocates Announce Opposition To Proposition 35"* THE CHILDREN PARTNERSHIP, (Sept. 5, 2024).
[98] California Legislative Analyst's Office, *The 2024-2024 Budget,* (May 2024). The 2024-25 Budget (ca.gov) (last visited Oct. 15, 2024).
[99] *Leading Health Care Consumer, Community Advocates Announce Opposition To Proposition 35"* THE CHILDREN PARTNERSHIP, (Sept. 5, 2024).

3. *The Plan Does Not Include Input from Community Members and Medi-Cal Enrollees.*

Opponents argue that the plan does not include enough input from community members and Medi-Cal recipients, who would be most affected by the proposed changes.[100] In a joint statement with advocacy groups, Senator Caroline Menjivar, a State Senator and the chairperson of the Senate's Budget #3 Subcommittee on Health and Human Services, argued that Proposition 35 undid years of legislators' effort to include community providers in the budget process.[101] Senator Menjivar added that "Prop. 35 excludes community priorities and only prioritizes larger providers."[102] This concern echoes a sentiment shared by other opposition groups. Maya Meinert of the Children's Partnership phrased this as a notable shift in "decision makers" from community members to larger, better-funded healthcare coalitions. With this policy no longer being implemented, there are questions about children's access to sustained healthy development, preventative care, and primary care.[103] Childcare advocates hope investments in other programs will offset any deleterious effects from the initiative but remain skeptical. The California Pan-Ethnic Health Network asserts that the new scheme will have harmful effects on lower-income communities of color.[104] A recent federal study from a Medicaid access commission lent some evidence to this assertion, finding that the proposed changes may have the most harmful effects in lower-income, Black, and Latinx communities.[105]

D. Funding of The Proposition

A significant amount of resources have been raised and spent on the passage of Prop. 35. The primary campaign, Yes on 35—Protect our Healthcare, has raised about $48.5 million.[106] Interestingly, since the measure has registered no opposition, the Secretary of State's Office or others do not track the amount raised to combat it.[107] The largest single contributor to the support committees has been the lobbying and fundraising arm of the California Association of Hospitals and Health Systems, with approximately $15 million.[108] The next largest donor at $10 million is Global Medical Response, Inc. (GMR).[109] GMR is one of the largest private transportation companies in California. Interestingly, due to low transport value, severe inflation, and low Medi-Cal reimbursements, one of its largest affiliates, American Medical Response, had to close its

[100] *Id.*
[101] *Leading Health Care Consumer, Community Advocates Announce Opposition To Proposition 35"* THE CHILDREN PARTNERSHIP, (Sept. 5, 2024).
[102] *Id.*
[103] Interview with Maya Meinert, Director of Communications at the Children's Partnership, (Sept. 12, 2024, notes on file With *The California Initiative Review*).
[104] *Leading Health Care Consumer, Community Advocates Announce Opposition To Proposition 35"* THE CHILDREN PARTNERSHIP, (Sept. 5, 2024).
[105] *An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP*, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (October 2021).
[106] Legislative Analyst's Office, *Proposition 35: Provides Permanent Funding for Medi-Cal Health Care Services. Initiative Statute*., LEGISLATIVE ANALYST'S OFFICE (August 13, 2024), Proposition 35 [Ballot] (ca.gov) (last visited Oct. 15, 2024).
[107] *Id.*
[108] California Proposition 35, Managed Care Organization Tax Authorization Initiative (2024) - Ballotpedia (last visited Oct. 9, 2024).
[109] *Id.*

office doors and begin mass layoffs in San Leandro.[110] The next largest donors are the California Medical Association and the California Primary Care Association, respectively, with about $9 million and $1.9 million.[111] The final large-scale donor is Family Health Centers of San Diego, which donated $ 1 million.[112] This group is the largest provider of primary care and wrap-around services to the homeless in San Diego County.[113] Their 62 sites throughout the county also focus on providing affordable, high-quality healthcare, especially to the uninsured, low-income, and medically underserved.[114] They serve their patients, 91% of which are low-income, with primary care clinics, behavioral health facilities, dental, vision, mobile units, and more.[115]

V. CONCLUSION

Proposition 35 seeks to resolve several structural issues in California's Medi-Cal system, such as inconsistent funding and historically low provider reimbursement rates. Proponents argue this is necessary to secure the Medi-Cal system. Opponents criticize the lack of community input in funding, and the significant constraints the measure puts on the legislature's budgeting process are enough to defeat the measure. The measure also relies heavily on uncertain federal funds and approval that could threaten it in the future.

A **YES** vote would change the federal approval process for the MCO tax by eliminating the sunset provision and permanently establishing Medi-Cal's spending preferences and categories. The law's continuation would depend on continued federal approval of the MCO tax rates and the Affordable Care Act. Spending preference would attempt to ensure that Medi-Cal patients could make appointments and obtain primary, specialty, and emergency care treatment. The goal would be achieved by ensuring demand was managed by a sufficient doctor and provider supply by increasing reimbursement rates for doctors, nurse practitioners, midwives, and other providers.

A **NO** vote would maintain the current spending limits for providers and services through 2027. Due to the sunset provision, the MCO tax would need to be reauthorized every couple of years and then resubmitted to the federal government for approval. The legislature would look at the global budgetary picture to determine funding decisions regarding Medi-Cal. The negotiated adjustments that were made to the rate increases for Medi-Cal providers would take effect later and result in smaller and more delayed provider rate increases than were planned for in 2023.

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[110] Alex Barreira, *Private Ambulance Company Lays Off 84, Permanently Closes in San Leandro*, SAN FRANCISCO BUSINESS TIMES, Jan. 23, 2024 Global Medical Response lays off 84, shutters in East Bay - San Francisco Business Times (bizjournals.com) (last visited Oct. 9, 2024).
[111] California Proposition 35, Managed Care Organization Tax Authorization Initiative (2024) - Ballotpedia (last visited Oct. 9, 2024).
[112] *Id.*
[113] Family Health Centers of San Diego: Overview | LinkedIn (last visited Oct. 9, 2024).
[114] *Id.*
[115] *Id.*