



January 3, 2018

Hon. Xavier Becerra  
Attorney General  
1300 I Street, 17<sup>th</sup> Floor  
Sacramento, California 95814

Attention: Ms. Ashley Johansson  
Initiative Coordinator

Dear Attorney General Becerra:

Pursuant to Elections Code Section 9005, we have reviewed the proposed constitutional initiative related to funding for California's health care safety net (A.G. File No. 17-0047, Amendment #1).

## **BACKGROUND**

### **Safety Net Hospitals**

**Definition.** Safety net hospitals are defined broadly as hospitals that, compared to other hospitals, serve a higher share of patients covered by Medicaid and the uninsured. (Medicaid—in California, Medi-Cal—is a federal-state program that provides health care services to low-income individuals.) Most safety net hospitals are operated either by a public entity—such as a local health care district—or by a private, nonprofit corporation. (A local health care district is a local government entity authorized to build and operate hospitals in underserved areas.)

**Financing.** A majority of annual hospital revenues statewide come from public government sources, such as Medi-Cal and Medicare. (Medicare is a federally funded program that provides coverage to most individuals 65 and older and certain younger persons with disabilities.) Other sources of annual hospital revenues include commercial health insurance and private pay from individuals. Safety net hospitals, however, receive a much greater portion of their annual revenues from Medi-Cal as compared to other hospitals. Safety net hospitals are also generally eligible for the federal disproportionate share hospital (DSH) program, which reimburses hospitals for some of their uncompensated costs associated with serving Medi-Cal beneficiaries and the uninsured. Of around 375 hospitals statewide, roughly 150 hospitals (or 40 percent) are eligible for the federal DSH program.

## Community Health Clinics

**Definition.** Community health clinics are generally state-licensed primary care clinics. Primary care clinics (eligible for licensure in the state) are defined as outpatient health facilities that provide direct health care services to patients for less than 24 hours, based either on the patient's ability to pay (a community clinic) or with no charges directly to the patient (a free clinic). In 2016, there were around 1,300 licensed primary care clinics in the state. In addition, there are other community health clinics that provide similar services to licensed primary care clinics that are not eligible for state licensure.

**Financing.** A majority of community health clinics are also federally qualified health centers (FQHCs). FQHCs are facilities that qualify for specific reimbursement systems under Medicare and Medicaid by, among other requirements, providing comprehensive primary care services in a medically underserved area (MUA) or to a medically underserved population (MUP) regardless of their ability to pay. (MUAs and MUPs are defined in federal regulation as geographic areas or populations with a shortage of primary health care services.) FQHCs are paid a single bundled rate for each patient visit that is intended to pay for all covered services provided and supplies used during the visit. The Department of Health Care Services (DHCS) is required by the federal government to reimburse FQHCs up to the federal bundled rate, and has developed a process to do so in Medi-Cal managed care. Other sources of annual clinic revenues include commercial health insurance and private pay from individuals.

## State Health Care Workforce Development and Training Programs

**Office of Statewide Health Planning and Development (OSHPD) Administers Several Health Care Workforce Programs.** OSHPD administers several health care workforce development and training programs including, but not limited to, the Song-Brown Healthcare Workforce Training Programs (for primary care education and training), the Workforce Education and Training Program (for mental health professionals), and the State Loan Repayment Program (for primary care service commitments in California Health Professional Shortage Areas). A 15-member advisory board within OSHPD—the California Healthcare Workforce Policy Commission—provides health care workforce policy guidance to the department, reviews program applications, and recommends grant awards to the Director of OSHPD.

**Other State Entities Administer Health Care Workforce Programs.** The University of California system, the California State University system, and the California Community Colleges, among other state entities, also administer several health care workforce development and training programs. These include—but are not limited to—associate, undergraduate, and graduate degree programs; apprenticeships; and physician residency programs.

**Financing.** Funding for the state's health care workforce programs comes from a mix of federal, state, and local sources.

## **State Personal Income Tax**

*California Taxes Personal Income.* California levies a personal income tax (PIT) on the income of state residents and on income of nonresidents that is derived from California sources. The portion of the PIT that flows to the state's General Fund imposes rates ranging from 1 percent to up to 12.3 percent on different portions of a filer's income. For example, in 2017, the first \$8,223 of a single filer's income is taxed at 1 percent, while the amount over \$551,473 is taxed at 12.3 percent. The amounts of these brackets are doubled for couples filing jointly (1 percent on the first \$16,446, et cetera) and are adjusted for inflation every year.

*Proposition 63 (2004) Levies 1 Percent Tax on Income Over \$1 Million.* In addition to the rates discussed above, Proposition 63 imposes a 1 percent rate on the portion of a filer's income over \$1 million. The proceeds from this portion of the PIT are deposited into the state's Mental Health Services Fund. Unlike the General Fund portion, the \$1 million threshold applies to all filers regardless of filing status (single, joint, et cetera) and is not adjusted for inflation. Since its inception in 2005, Proposition 63's 1 percent income tax on high-income earners has been a volatile source of revenue to the state.

## **PROPOSAL**

### **New Additional 1 Percent Rate on Income Over \$1 Million**

The initiative would amend the State Constitution to impose an additional 1 percent rate on the portion of a filer's income over \$1 million starting in tax year 2019. In other words, in addition to the rates up to 12.3 percent described earlier, income over \$1 million would be taxed at a 2 percent rate (the 1 percent tax imposed by Proposition 63 and the 1 percent tax imposed by this initiative). As with the existing Proposition 63 tax, the \$1 million threshold would be the same regardless of filing status and would not be adjusted for inflation each year.

### **Allocates New Tax Revenues Annually to a New Special Fund for Health Care-Related Purposes**

The new revenue raised by this initiative would be deposited in a new special fund, the California Care Fund, to be administered by the California Health and Human Services Agency (HHSA). After deducting up to 1 percent of total revenues to pay for state administrative costs to implement the initiative, the remaining revenues are allocated to three accounts—the Safety Net Hospital Account (70 percent of the remaining revenues), the Community Health Clinic Account (25 percent of the remaining revenues), and the Health Care Workforce Training Account (5 percent of the remaining revenues). Revenues allocated to these three accounts are distributed to eligible health facilities and projects as specified in the initiative and discussed further below. Revenue placed in the California Care Fund would not be subject to certain constitutional requirements relating to state budgeting and spending, including minimum funding requirements for schools and community colleges.

## **Allocates Funding to Eligible Health Facilities and Projects**

***Allocation to Eligible Safety Net Hospitals.*** To receive funding from the Safety Net Hospital Account, hospitals must (1) be licensed as a general acute care hospital, (2) meet the definition of a DSH and be eligible for federal DSH funding, (3) be located in a MUA or serve a MUP, and (4) be licensed to either a nonprofit corporation or a local health care district. An estimated 27 hospitals in the state meet these criteria, 19 of which are licensed to a nonprofit corporation and 8 of which are licensed to a local health care district. The initiative would distribute 90 percent of funding to eligible hospitals licensed to nonprofit corporations and 10 percent of funding to eligible hospitals licensed to local health care districts. Each individual hospital's allocation would be calculated based on how many Medi-Cal patient days the hospital provided relative to other eligible hospitals. Under the initiative, HHSA would be required to develop a formula to calculate and distribute funding to eligible hospitals. This funding could be used for a wide variety of purposes—as stated in the initiative, to improve the health care and well-being of communities and community members.

***Allocation to Eligible Community Health Clinics.*** To receive funding from the Community Health Clinic Account, clinics must either be licensed by the state as primary care clinics or be a “qualified primary care provider.” The initiative defines a qualified primary care provider as an entity not licensed by the state as a primary care clinic, but providing substantially similar services. Under the initiative, HHSA would be required to develop a formula to calculate and distribute funding to eligible clinics. This funding could be used for a wide variety of purposes—as stated in the initiative, to improve the health care and well-being of communities and community members—except for those activities not permitted to be carried out by a nonprofit corporation.

***Allocation to Eligible Health Care Industry Workforce Development and Training Projects.*** To receive funding from the Health Care Workforce Training Account, organizations sponsoring health care industry workforce development and training projects must apply for grants from a new Health Care Workforce Training Panel created by the initiative and to be set up by HHSA. To be eligible for funding, these projects must be intended to increase the number of “frontline health care workers,” which include, for example, practical and vocational nurses, nursing aides, and medical assistants. The initiative prohibits grants to any workforce development and training projects for physicians and surgeons.

***Prohibits Offsetting Any Other Public Funding.*** Under the initiative, the revenue would be prohibited from offsetting any other public funding, including but not limited to, (1) serving as reimbursement by any payer for services rendered, (2) being factored into any formula providing distribution of funds to health care providers, and (3) being considered as a factor in the award of any discretionary grants or other funding sources. As a result, this new revenue may be ineligible for federal Medicaid matching funds.

***Audit Requirements.*** The initiative requires the State Controller to at least annually conduct a compliance and financial audit to determine whether special fund revenues were properly disbursed and expended.

## FISCAL EFFECTS

***Amount of New Revenues Raised by the Initiative Annually Would Depend on Economy and Asset Markets.*** The amount of revenue raised annually by the initiative over time would depend on factors that are difficult to predict. A large share of high-income filers' income is derived from capital gains on asset sales. Future amounts of these gains—and thus revenue raised by the initiative—would depend on the future values of stocks and other real and financial assets, which are volatile and difficult to predict. In addition, high-income filers' wage, salary, business, and other income fluctuate with the economy. Given these uncertainties, we estimate that revenues raised by the initiative generally would range between \$1.5 billion in weaker years for the economy and asset markets to \$2.5 billion in stronger years. In very strong or very weak years, revenues could be outside of this range. (These amounts are in today's dollars and would tend to grow over time.)

***Allocation of New Revenues for Various Health Care-Related Purposes.*** As previously mentioned, after deducting up to 1 percent of revenues for state administrative costs, 70 percent of the remaining new revenue raised by the initiative would be deposited into the Safety Net Hospital Account, 25 percent into the Community Health Clinic Account, and 5 percent into the Health Care Workforce Training Fund. However, as with Proposition 63, this would likely be a volatile source of revenue to the state. In weaker years for the economy and asset markets, \$1.5 billion in new revenue, for example, would translate into roughly \$1.05 billion allocated to safety net hospitals, roughly \$375 million allocated to community health clinics, and roughly \$75 million allocated to health care workforce programs. In stronger years for the economy and asset markets, \$2.5 billion in new revenue, for example, would translate into roughly \$1.75 billion allocated to safety net hospitals, roughly \$625 million allocated to community health clinics, and roughly \$125 million allocated to health care workforce programs.

***Annual State Administrative Costs.*** We anticipate some annual state administrative costs to implement the initiative. These include annual operations costs of the new Health Care Workforce Training Panel created by the initiative, annual costs for HHS to allocate funding to individual eligible safety net hospitals and community health clinics, and minor costs associated with the State Controller conducting an annual compliance and financial audit of special fund revenues and spending. DHCS currently administers programs that provide funding for safety net hospitals, community health clinics, and providers. The initiative requires HHS to administer funding for these three programs. To the extent Agency delegates workload, it may result in state administration costs to another state entity. The measure allows up to 1 percent of the total revenue to be used for administrative purposes, which is projected to be between \$15 million and \$25 million, dependent on annual revenue.

***Summary of Major Fiscal Effects.*** The initiative would have the following major effect on state government finances:

- Additional state revenues typically between \$1.5 billion and \$2.5 billion annually, depending on the economy and asset markets. This funding is allocated to safety net hospitals (70 percent), community health clinics (25 percent), and health care

workforce development and training projects (5 percent) eligible for funding under the initiative.

Sincerely,

---

Mac Taylor  
Legislative Analyst

---

Michael Cohen  
Director of Finance