Senate Bill No. 2

CHAPTER 2

An act to add Section 685.5 to the Insurance Code, to add and repeal Sections 12202.2 and 24330 of the Revenue and Taxation Code, and to add and repeal Article 6.7 (commencing with Section 14199.50) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal, and making an appropriation therefor.

[Approved by Governor March 1, 2016. Filed with Secretary of State March 1, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 2, Hernandez. Medi-Cal: managed care organization tax.

(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing law, until July 1, 2016, imposes a sales tax on sellers of Medi-Cal managed care plans.

This bill, on July 1, 2016, and until July 1, 2019, would establish a new managed care organization provider tax, to be administered by the State Department of Health Care Services. The tax would be assessed by the department on licensed health care service plans, managed care plans contracted with the department to provide Medi-Cal services, and alternate health care service plans (AHCSP), as defined, except as excluded by the bill. The bill would require the department to determine for each health plan using the base data source, as defined, specified enrollment information for the base year. By October 14, 2016, or within 10 business days following the date upon which the department receives approval for federal financial participation, whichever is later, the bill would require the department to commence notification to the health plans of the assessed tax amount due for each fiscal year and the dates on which the installment tax payments are due for each fiscal year.

This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–17, 2017–18, and 2018–19 fiscal years, respectively, for Medi-Cal enrollees, AHCSP enrollees, and all other enrollees, as defined. The bill would require the department to request approval from the federal Centers for Medicare and Medicaid Services as necessary to implement this bill. The bill would authorize the department to implement its provisions by means of provider bulletins, all-plan letters, or similar instructions, and to notify the Legislature of this action.

This bill would establish the Health and Human Services Special Fund in the State Treasury, into which all revenues, less refunds, derived from the taxes imposed by the bill would be deposited into the State Treasury to the credit of the fund. Interest and dividends earned on moneys in the fund would be retained in the fund, as specified. The bill would continuously appropriate the moneys in the fund to the State Department of Health Care Services for purposes of funding the nonfederal share of Medi-Cal managed care rates for health care services furnished to specified persons, thereby making an appropriation.

(2) Existing law imposes a gross premiums tax of 2.35% on all insurers, as defined, doing business in this state, as set forth in the California Constitution. For purposes of the Corporation Tax Law, existing law sets forth items specifically excluded from gross income.

This bill would provide that the qualified health care service plan income, as defined, of health plans that are subject to the managed care organization provider tax would be excluded from the definition of gross income for purposes of taxation under the above provisions, as specified. The bill would reduce the gross premiums tax rate from 2.35% to 0% for those premiums received on or after July 1, 2016, and on or before June 30, 2019, for the provision of health insurance paid by health insurers providing health insurance that has a corporate affiliate, as defined, that is a health care service plan or health plan that is subject to the managed care organization provider tax imposed under the bill, as specified. The bill would require the State Department of Health Care Services to annually report specified information to the Franchise Tax Board with regard to these provisions. The bill would authorize the board to implement these provisions and would exempt the board from the administrative rulemaking process.

Existing law provides that when the laws of another state or foreign county impose certain taxes or other amounts on California insurers, or their agents or representatives, the same taxes or other amounts are imposed in this state upon the insurers, or their agents or representatives, of the other state or country doing business in this state.

The bill would prohibit the Insurance Commissioner from considering the reduction of the gross premiums tax rate under this bill in any determination to impose or enforce a tax under those retaliatory tax provisions.

The bill would provide that these provisions become operative on the later of July 1, 2016, or on the date the Director of Health Care Services certifies in writing that federal approval necessary for receipt of federal financial participation has been obtained.

(3) This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of ⅔ of the membership of each house of the Legislature.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. It is the intent of the Legislature that Franchise Tax Board Legal Ruling 2006-01 (April 28, 2006) regarding the treatment of apportionment factors attributable to income exempt from income tax shall apply to apportionment factors attributable to the income of qualified health care service plans excluded by Section 24330 of the Revenue and Taxation Code, as added by Section 4 of this act.

SEC. 2. Section 685.5 is added to the Insurance Code, to read:

685.5. The reduction in the gross premiums tax rate made by Section 12202.2 of the Revenue and Taxation Code shall not be considered in any determination by the Insurance Commissioner to impose or enforce a tax under the retaliatory tax provisions of Sections 685 to 685.4, inclusive, and reported pursuant to Sections 12281, 12287, 12288, and 12289 of the Revenue and Taxation Code.

SEC. 3. Section 12202.2 is added to the Revenue and Taxation Code, to read:

12202.2. (a) Notwithstanding the rate specified by Section 12202, the gross premiums tax rate for premiums received for the provision of health insurance, as defined in subdivision (b) of Section 106 of the Insurance Code, paid by an insurer described in this subdivision shall be 0 percent for any of those premiums received on or after July 1, 2016, and on or before June 30, 2019. Only an insurer that provides health insurance that has a corporate affiliate that is a "health care service plan" or "health plan," defined as a health care service plan that meets all of the following requirements, shall be subject to the rate change provided in this section:

(1) Is licensed by the Department of Managed Health Care or is a managed care plan contracted with the State Department of Health Care Services to provide Medi-Cal services.

(2) Had at least one enrollee enrolled in the health plan in the base year, as defined in subdivision (e) of Section 14199.51 of the Welfare and Institutions Code, not including individuals who are enrolled in a Medicare plan, who receive health care services through a health plan pursuant to a subcontract from another health plan, or who are enrollees through the Federal Employees Health Benefits Act of 1959 (Public Law 86-382).

(3) Is subject to the tax imposed by Section 14199.54 of the Welfare and Institutions Code.

(b) For purposes of this section, an "insurer that has a corporate affiliate that is a health care service plan or health plan" means an insurer that is, directly or indirectly, controlled by, under common control with, or controls a health care service plan.

(c) This section shall remain in effect only until June 30, 2019, and as of June 30, 2020, is repealed.

SEC. 4. Section 24330 is added to the Revenue and Taxation Code, to read:

24330. (a) Gross income shall not include the qualified health care service plan income of a qualified health care service plan properly accrued

with respect to enrollment or services that occur on or after July 1, 2016, and on or before June 30, 2019.

(b) For purposes of this section, the following definitions shall apply:

(1) "Qualified health care service plan" means a health care service plan, as defined in subdivision (k) of Section 14199.51 of the Welfare and Institutions Code, that is subject to the tax imposed under Section 14199.54 of the Welfare and Institutions Code.

(2) "Qualified health care service plan income" means the revenue listed in subparagraphs (A) to (J), inclusive, that is associated with the operation of a qualified health care service plan and that is required to be reported to the Department of Managed Health Care pursuant to the instructions for filing financial statements and Section 1384 of the Health and Safety Code and the regulations adopted thereunder.

(A) Premiums (commercial).

(B) Copayments, COB, subrogation.

(C) Title XIX Medicaid.

(D) Point-of-service premiums.

(E) Risk pool revenue.

(F) Capitation payments.

(G) Title XVIII Medicare.

(H) Fee-for-service.

(I) Interest.

(J) Aggregate write-ins for other revenues, including capital gains and other investment income.

(c) (1) No later than December 1, 2016, and annually thereafter, the State Department of Health Care Services shall provide to the Franchise Tax Board information regarding every health care service plan that is subject to the tax imposed under Section 14199.54 of the Welfare and Institutions Code. The information shall include the corporate name, address, and calendar period for which each health care service plan is subject to the tax imposed under Section 14199.54 of the Welfare and Institutions Code, and, if applicable, the owner or owners of those health care service plans.

(2) A qualified health care service plan with no income other than qualified health care service plan income that is excluded from gross income pursuant to this section for a taxable year shall be exempt from the minimum franchise tax imposed under Chapter 2 (commencing with Section 23101) for that taxable year.

(d) The Franchise Tax Board may prescribe rules, guidelines, or procedures necessary or appropriate to carry out the purposes of this section. Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code does not apply to any rule, guideline, or procedure prescribed by the Franchise Tax Board pursuant to this section.

(e) This section shall remain in effect only until December 1, 2019, and as of June 30, 2020, is repealed.

SEC. 5. Article 6.7 (commencing with Section 14199.50) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 6.7. Managed Care Organization Provider Tax

14199.50. It is the intent of the Legislature that the department implement a managed care organization provider tax effective July 1, 2016, to provide ongoing funding for health care and prevention, minimize to the extent possible any need for new reductions to the program, and meet all of the following goals:

(a) Generate an amount of nonfederal funds for the Medi-Cal program equivalent to the funds generated by the tax imposed pursuant to Article 5 (commencing with Section 6174) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code.

(b) Comply with federal Medicaid requirements applicable to permissible health care-related taxes, including, but not limited to, Section 433.68 of Title 42 of the Code of Federal Regulations.

14199.51. The following definitions shall apply for the purposes of this article:

(a) "Alternate Health Care Service Plan" or "AHCSP" means a nonprofit health care service plan with at least four million enrollees statewide, that owns or operates pharmacies, and provides professional medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it is licensed.

(b) "AHCSP enrollee" means an individual enrolled in an AHCSP, as defined in subdivision (a), who is not a Medi-Cal beneficiary.

(c) "AHCSP enrollee tax amount" means the amount of tax assessed per countable enrollee within an AHCSP taxing tier.

(d) "AHCSP taxing tier" means a range of cumulative enrollment of countable AHCSP enrollees for the base year.

(e) "Base year" means the 12-month period of October 1, 2014, through September 30, 2015.

(f) "Base data source" means the quarterly financial statement filings submitted by health plans to the Department of Managed Health Care retrieved by the department as of January 1, 2016, and supplemented by, as necessary, Medi-Cal enrollment data for the base year as maintained by the department and retrieved as of January 1, 2016.

(g) "Countable enrollee" means an individual enrolled in a health plan, as defined in subdivision (k), during a month of the base year according to the base data source. "Countable enrollee" does not include an individual enrolled in a Medicare plan, a plan-to-plan enrollee, as defined in subdivision (r), or an individual enrolled in a health plan pursuant to the Federal Employees Health Benefits Act of 1959 (Public Law 86-382) to the extent the imposition of the tax under this article is preempted pursuant to Section 8909(f) of Title 5 of the United States Code.

(h) "Department" means the State Department of Health Care Services.

(i) "Director" means the Director of Health Care Services.

(j) "Excluded plan" means any of the following:

(1) A health plan licensed pursuant to Section 1351.2 of the Health and Safety Code.

(2) A health plan that is owned and operated by a 501(c)(3) hospital or health system or multiple 501(c)(3) hospitals or health systems if that health plan has both a substantial amount of its enrollment in and is headquartered in either the County of Sacramento or San Diego.

(k) "Health care service plan" or "health plan" means a health care service plan, other than a plan that provides only specialized or discount services, that is licensed by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or a managed care plan contracted with the State Department of Health Care Services to provide Medi-Cal services.

(*l*) "Medi-Cal enrollee" means an individual enrolled in a health plan, as defined in subdivision (k), who is a Medi-Cal beneficiary for whom the department directly pays the health plan a capitated payment.

(m) "Medi-Cal per enrollee tax amount" means the amount of tax assessed per countable Medi-Cal enrollee within a Medi-Cal taxing tier.

(n) "Medi-Cal taxing tier" means a range of cumulative enrollment of countable Medi-Cal enrollees for the base year.

(o) "Other enrollee" means an individual enrolled in a health plan, as defined in subdivision (k), who is not a Medi-Cal beneficiary or an AHCSP enrollee.

(p) "Other per enrollee tax amount" means the amount of tax assessed per countable other enrollee within another taxing tier.

(q) "Other taxing tier" means a range of cumulative enrollment of countable other enrollees for the base year.

(r) "Plan-to-plan enrollee" means an individual who receives his or her health care services through a health plan pursuant to a subcontract from another health plan.

14199.52. (a) The Health and Human Services Special Fund is hereby created in the State Treasury.

(b) All revenues, less refunds, derived from the taxes provided for in this article shall be deposited in the State Treasury to the credit of the Health and Human Services Special Fund.

(c) Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the Health and Human Services Special Fund shall be retained in the fund and used solely for the purpose specified in subdivision (d).

(d) Notwithstanding Section 13340 of the Government Code, the funds deposited in the Health and Human Services Special Fund pursuant to this article shall be continuously appropriated, without regard to fiscal year, to the department for purposes of funding the nonfederal share of Medi-Cal managed care rates for health care services furnished to children, adults, seniors and persons with disabilities, and persons dually eligible for Medi-Cal and Medicare.

(e) The department shall provide an annual report to all health plans accounting for the funds deposited in and expended from the Health and Human Services Special Fund, in a time and manner as deemed appropriate by the director. The report shall identify the taxes imposed on each health plan pursuant to this article, and shall provide an itemized accounting of expenditures from the fund.

14199.53. (a) The department shall determine for each health plan using the base data source all of the following:

(1) Total cumulative enrollment for the base year.

(2) Total Medicare cumulative enrollment for the base year.

(3) Total Medi-Cal cumulative enrollment for the base year.

(4) Total plan-to-plan cumulative enrollment for the base year.

(5) Total cumulative enrollment through the Federal Employees Health Benefits Act of 1959 (Public Law 86-382) for the base year.

(6) Total other cumulative enrollment for the base year that is not otherwise counted in paragraphs (2) to (5), inclusive.

(b) Notwithstanding any provision in this article, the director may correct any identified material or significant errors in the data, including, but not limited to, the overall cumulative enrollment, Medicare cumulative enrollment, Medi-Cal cumulative enrollment, cumulative enrollment through the Federal Employees Health Benefits Act of 1959 (Public Law 86-382), and other cumulative enrollment. The director's determination whether to exercise his or her discretion under this section and any determination made by the director under this section shall not be subject to judicial review, except that a health plan may bring a writ of mandate under Section 1085 of the Code of Civil Procedure to rectify an abuse of discretion by the department in correcting that health plan's data when that correction results in a greater tax amount for that health plan pursuant to Section 14199.55.

14199.54. (a) A managed care organization provider tax shall be imposed on each health plan that is not an excluded plan. The tax shall be imposed for the following fiscal years:

(1) 2016–17 fiscal year.

(2) 2017–18 fiscal year.

(3) 2018–19 fiscal year.

(b) The department shall compute the annual tax for each health plan subject to the tax during each applicable state fiscal year pursuant to Section 14199.55.

(c) The department shall collect the annual tax for each health plan in four installments and shall determine the amount due for each installment in the state fiscal year by dividing the annual tax for that state fiscal year by four.

(d) The department shall not collect the tax imposed pursuant to this article until the department receives approval from the federal Centers for Medicare and Medicaid Services that this tax is a permissible health care-related tax in accordance with Section 433.68 of Title 42 of the Code of Federal Regulations and is eligible for federal financial participation. On October 1, 2016, or the date the department receives that federal approval

from the federal Centers for Medicare and Medicaid Services, whichever is later, the following activities shall commence:

(1) The director shall certify in writing that federal approval has been received, and within five business days, the department shall post the certification on its Internet Web site and send a copy of the certification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(2) By October 14, 2016, or within 10 business days following receipt of the notice of federal approval, whichever is later, the department shall send a notice to each health plan subject to the tax, which shall contain the following information:

(A) The annual tax due for each fiscal year.

(B) The dates on which the four installment tax payments are due for each fiscal year.

(3) A health plan shall pay the annual tax in installments as calculated pursuant to Section 14199.55, based on a schedule developed by the department. The department shall establish the date that each tax payment is due, provided that the first tax payment shall be due no earlier than 20 days following the date the department sends the notice pursuant to paragraph (2), and the tax payments shall be paid at least one month apart, but no more than one-quarter apart.

(4) A health plan shall pay the taxes that are due, if any, in the amounts and at the times set forth in the notice unless superseded by a subsequent notice issued by the department.

(e) The tax assessed pursuant to this article shall be paid by each health plan subject to the tax to the department for deposit in the Health and Human Services Special Fund created pursuant to Section 14199.52.

(f) (1) Interest shall be assessed on an applicable health plan for any amount of the managed care organization provider taxes that are not paid on the date due at a rate of 10 percent per annum. Interest shall begin to accrue the day after the date the tax payment was due and shall be deposited in the Health and Human Services Special Fund created pursuant to Section 14199.52.

(2) If a tax payment is more than 60 days overdue, a penalty equal to the total accrued interest charge described in paragraph (1) shall also be assessed on the applicable health plan and due for each month for which the tax payment is not received after 60 days.

(g) (1) Subject to paragraph (2), the director may waive a portion or all of either the interest or penalties, or both, assessed under this article in the event that the director determines, in his or her sole discretion, that the health plan has demonstrated that imposition of the full amount of the tax pursuant to the timelines applicable under this article has a high likelihood of creating an undue financial hardship for the health plan or creates a significant financial difficulty in providing needed services to Medi-Cal beneficiaries.

(2) Waiver of some or all of the interest or penalties pursuant to this subdivision shall be conditioned on the health plan's agreement to make tax payments on an alternative schedule developed by the department that

takes into account the financial situation of the health plan and the potential impact on the delivery of services to Medi-Cal beneficiaries.

(h) In the event of a merger, acquisition, establishment, or any other similar transaction that results in the transfer of health plan responsibility for all countable enrollees under this article from a health plan to another health plan or similar entity, and that occurs at any time during which this article is operative, the resultant health plan or similar entity shall be responsible for paying the full tax amount as provided in this article that would have been the responsibility of the health plan to which that full tax amount was assessed, upon the effective date of any such transaction. If a merger, acquisition, establishment, or any other similar transaction results in the transfer of health plan responsibility for only some of a health plan's countable enrollees under this article but not all countable enrollees, the full tax amount as provided in this article shall remain the responsibility of that health plan to which that full tax amount was assessed.

14199.55. (a) For each fiscal year, the Medi-Cal taxing tiers shall be as follows:

(1) Medi-Cal taxing tier I shall consist of all countable Medi-Cal enrollees in a health plan from zero to 2,000,000, inclusive.

(2) Medi-Cal taxing tier II shall consist of all countable Medi-Cal enrollees in a health plan from 2,000,001 to 4,000,000, inclusive.

(3) Medi-Cal taxing tier III shall consist of all countable Medi-Cal enrollees in a health plan greater than 4,000,000.

(b) For each fiscal year, the other taxing tiers shall be as follows:

(1) Other taxing tier I shall consist of all countable other enrollees in a health plan from zero to 4,000,000, inclusive.

(2) Other taxing tier II shall consist of all countable other enrollees in a health plan from 4,000,001 to 8,000,000, inclusive.

(3) Other taxing tier III shall consist of all countable other enrollees in a health plan greater than 8,000,000.

(c) For each fiscal year, the AHCSP taxing tier shall consist of all countable AHCSP enrollees in a health plan from zero to 8,000,000, inclusive.

(d) For the 2016–17 fiscal year, the Medi-Cal per enrollee tax amount for each Medi-Cal taxing tier shall be as follows:

(1) The Medi-Cal per enrollee tax for Medi-Cal taxing tier I shall be forty dollars ($40).

(2) The Medi-Cal per enrollee tax for Medi-Cal taxing tier II shall be nineteen dollars ($19).

(3) The Medi-Cal per enrollee tax for Medi-Cal taxing tier III shall be one dollar ($1).

(e) For the 2016–17 fiscal year, the other per enrollee tax amount for each other taxing tier shall be as follows:

(1) The other per enrollee tax for the other taxing tier I shall be seven dollars and fifty cents ($7.50).

(2) The other per enrollee tax for the other taxing tier II shall be two dollars and fifty cents ($2.50).

(3) The other per enrollee tax for the other taxing tier III shall be one dollar ($1).

(f) For the 2016–17 fiscal year, the AHCSP per enrollee tax for the AHCSP taxing tier shall be two dollars ($2).

(g) For the 2017–18 fiscal year, the Medi-Cal per enrollee tax amount for each Medi-Cal taxing tier shall be as follows:

(1) The Medi-Cal per enrollee tax for Medi-Cal taxing tier I shall be forty-two dollars and fifty cents ($42.50).

(2) The Medi-Cal per enrollee tax for Medi-Cal taxing tier II shall be twenty dollars and twenty-five cents ($20.25).

(3) The Medi-Cal per enrollee tax for Medi-Cal taxing tier III shall be one dollar ($1).

(h) For the 2017–18 fiscal year, the other per enrollee tax amount for each other taxing tier shall be as follows:

(1) The other per enrollee tax for the other taxing tier I shall be eight dollars ($8).

(2) The other per enrollee tax for the other taxing tier II shall be three dollars ($3).

(3) The other per enrollee tax for the other taxing tier III shall be one dollar ($1).

(i) For the 2017–18 fiscal year, the AHCSP per enrollee tax for the AHCSP taxing tier shall be two dollars and twenty-five cents ($2.25).

(j) For the 2018–19 fiscal year, the Medi-Cal per enrollee tax amount for each Medi-Cal taxing tier shall be as follows:

(1) The Medi-Cal per enrollee tax for Medi-Cal taxing tier I shall be forty-five dollars ($45).

(2) The Medi-Cal per enrollee tax for Medi-Cal taxing tier II shall be twenty-one dollars ($21).

(3) The Medi-Cal per enrollee tax for Medi-Cal taxing tier III shall be one dollar ($1).

(k) For the 2018–19 fiscal year, the other per enrollee tax amount for each other taxing tier shall be as follows:

(1) The other per enrollee tax for the other taxing tier I shall be eight dollars and fifty cents ($8.50).

(2) The other per enrollee tax for the other taxing tier II shall be three dollars and fifty cents ($3.50).

(3) The other per enrollee tax for the other taxing tier III shall be one dollar ($1).

(*l*) For the 2018–19 fiscal year, the AHCSP per enrollee tax for the AHCSP taxing tier shall be two dollars and fifty cents ($2.50).

(m) (1) The department may modify or make adjustments to any methodology, tax amount, taxing tier, or other similar provision specified in this article to the extent necessary to meet the requirements of federal law or regulations, obtain federal approval, or to ensure federal financial participation is available provided the modification or adjustment does not otherwise conflict with the purposes of this article. Any modification or adjustment that would result in more than the following aggregate tax

amounts for the other enrollees and AHCSP enrollees, combined, shall be considered to conflict with the purposes of this article:

(A) Two hundred sixty-six million dollars ($266,000,000) in the 2016–17 fiscal year.

(B) Two hundred eighty-seven million dollars ($287,000,000) in the 2017–18 fiscal year.

(C) Three hundred nine million dollars ($309,000,000) in the 2018–19 fiscal year.

(2) In implementing any modification or adjustment, the department may only make an adjustment that would result in lowering the amounts in subparagraph (A), (B), or (C) of paragraph (1). Nothing in this subdivision shall limit the authority of the department to make an adjustment that does not impact the amounts in subparagraph (A), (B), or (C) of paragraph (1).

(3) If the department identifies that a modification or adjustment may be necessary in accordance with paragraph (1), the department shall consult with affected health plans, to the extent practicable, to implement that modification or adjustment.

(4) In the event of a modification or adjustment made pursuant to this subdivision, the department shall notify affected health plans, the Joint Legislative Budget Committee, the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health within 10 business days of that modification or adjustment.

(n) The department shall request approval from the federal Centers for Medicare and Medicaid Services as is necessary to implement this article. In making that request, the department may seek, as it deems necessary, a request for waiver of the broad-based requirement, waiver of the uniformity requirement, or both, pursuant to Section 433.68(e)(1) and (2) of Title 42 of the Code of Federal Regulations, or a request for waiver of any other provision of federal law or regulation necessary to implement this article.

(o) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this article by means of provider bulletins, all-plan letters, or other similar instructions, without taking regulatory action. The department shall provide notification to the Joint Legislative Budget Committee and to the Senate Committees on Appropriations, Budget and Fiscal Review, and Health, and the Assembly Committees on Appropriations, Budget, and Health within 10 business days after the above-described action is taken.

14199.56. This article shall become operative on July 1, 2016, and shall become inoperative on July 1, 2019. As of June 30, 2020, this article is repealed. Notwithstanding this section, a tax and any applicable interest and penalties imposed under this article shall continue to be due and payable until the tax and any applicable interest and penalties are fully paid.

SEC. 6. Section 685.5 of the Insurance Code, and Sections 12202.2 and 24330 of the Revenue and Taxation Code shall become effective and operative on the later of July 1, 2016, or the effective date, certified in writing by the Director of the Health Care Services, of the federal approval

necessary for receipt of federal financial participation in conjunction with the tax assessed pursuant to Article 6.7 (commencing with Section 14199.50) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code. The Director of Health Care Services shall post the certification of federal approval on the State Department of Health Care Services' Internet Web site and send a copy of the certification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, the Legislative Counsel, the State Board of Equalization, the Department of Insurance, and the Executive Officer of the Franchise Tax Board.

SEC. 7. Section 685.5 of the Insurance Code, and Sections 12202.2 and 24330 of the Revenue and Taxation Code, and Article 6.7 (commencing with Section 14199.50) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code shall cease to be operative the first day of the state fiscal year beginning on or after the date the Director of Health Care Services, in consultation with the Director of Finance, determines that the taxes have not met the intent as outlined in Section 14199.50 of the Welfare and Institutions Code for the purposes of providing funding for health care and prevention, or the state does not have the federal approval necessary for receipt of federal financial participation in conjunction with the tax assessed pursuant to Article 6.7 (commencing with Section 14199.50) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code. The Director of Health Care Services shall post the determination on the State Department of Health Care Services' Internet Web site and send a copy of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, the Legislative Counsel, the State Board of Equalization, the Department of Insurance, and the Executive Officer of the Franchise Tax Board.

SEC. 8. Section 685.5 of the Insurance Code, Sections 12202.2 and 24330 of the Revenue and Taxation Code, and Article 6.7 (commencing with Section 14199.50) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code shall cease to be operative the first day of the state fiscal year beginning on or after the effective date of a final judicial determination made by any court of appellate jurisdiction that Section 685.5 of the Insurance Code, Section 12202.2 or 24330 of the Revenue and Taxation Code, or the tax assessed pursuant to Article 6.7 (commencing with Section 14199.50) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, cannot be implemented. The Director of Health Care Services shall post a notification of that final judicial determination on the State Department of Health Care Services' Internet Web site and provide this notification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, the Legislative Counsel, the State Board of Equalization, the Department of Insurance, and the Executive Officer of the Franchise Tax Board.

O