

Medicaid Provider Taxes: The Gimmick That Exposes Flaws with Medicaid's Financing

Brian C. Blase



MERCATUS RESEARCH



MERCATUS CENTER
George Mason University

3434 Washington Blvd., 4th Floor, Arlington, Virginia 22201
www.mercatus.org

Brian C. Blase. "Medicaid Provider Taxes: The Gimmick That Exposes Flaws with Medicaid's Financing." *Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, February 2016.*

ABSTRACT

Since a large share of state Medicaid expenditures are reimbursed by the federal government, states have a strong incentive to create techniques, such as provider taxes, to limit the amount of those expenditures paid by the state tax base. Through provider taxes, states use money raised by healthcare providers in order to extract additional federal tax dollars. States then use the federal money to increase Medicaid payments or other areas of state spending. Both the Bush and the Obama administrations proposed limiting provider taxes, and the bipartisan Bowles-Simpson Commission endorsed phasing them out. This study demonstrates that provider taxes not only shift Medicaid costs from state governments to the federal government but also increase total Medicaid expenditures. Policymakers should consider moving Medicaid to a fixed-payment structure that would incentivize states to obtain greater value from Medicaid spending and would reflect the original intent that federal Medicaid payments be based on state per capita income.

JEL codes: H51, H75, H77, I18

Keywords: Medicaid, provider tax, intergovernmental transfer, entitlement reform, federalism, Medicaid maximization

The Mercatus Center gratefully acknowledges the financial support of the John Templeton Foundation for research on healthcare policy in the United States.

Copyright © 2016 by Brian C. Blase
and the Mercatus Center at George Mason University

Release: February 2016

The opinions expressed in Mercatus Research are the authors' and do not represent official positions of the Mercatus Center or George Mason University.

According to the Congressional Budget Office (CBO), in 2015 the federal government spent \$350 billion on Medicaid, the joint federal-state program that finances healthcare and long-term care services for generally lower-income people. CBO estimates that the federal share of overall Medicaid expenditures equaled 63 percent in 2015, meaning total Medicaid expenditures, including the state share, exceeded \$550 billion. CBO projects that federal Medicaid expenditures will continue to increase, partly because of the expansion contained in the Affordable Care Act (ACA)—reaching an estimated \$642 billion in 2026 with total spending exceeding \$1 trillion, assuming the federal share approximates 63 percent of total expenditures moving forward.¹

Medicaid is financed jointly by the states and the federal government. The federal government share is uncapped and equals a percentage of state Medicaid expenditures. Poorer states receive a higher reimbursement percentage than wealthier states, and the overall federal share of Medicaid expenditures has historically averaged about 57 percent.

The uncapped reimbursement, or financing match, provides states with an incentive to maximize federal Medicaid funds while minimizing contributions from the state tax base. The Government Accountability Office (GAO) has extensively documented techniques that states use that create the appearance of a Medicaid payment but are actually accounting gimmicks.² These techniques generally contain four elements: (1) payments from entities, often providers, within a state to the state government, (2) a large share of the payment returned to the entities by the state, (3) the state receiving the statutory federal Medicaid share for the payment returned to the entity, and (4) the state using the federal reimbursement to increase Medicaid payments received by providers within the state.

1. Congressional Budget Office, *The Budget and Economic Outlook: 2016 to 2026*, January 25, 2016.

2. Government Accountability Office, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection* (GAO Report 14-627, July 2014).

“Provider taxes were discussed as part of the high-profile deficit reduction negotiations between the Obama administration and congressional Republicans and Democrats in 2011, with Vice President Joe Biden reportedly referring to them as a ‘scam’ that should be eliminated.”

One technique used by states is intergovernmental transfers (IGTs), which are payments from local government entities, often Medicaid providers such as county nursing homes or state university hospitals, to the state government. Another technique increasingly used by states is assessments on healthcare providers, dubbed Medicaid provider taxes. Both IGTs and provider taxes allow states to receive revenue from providers and then spend that revenue on those same providers, spending that the federal government is required to match.

Every state except Alaska has at least one provider tax, with taxes on hospitals and nursing homes raising the most revenue. Although incomplete reporting makes the precise figures impossible to determine, states likely raised in excess of \$22 billion from provider taxes in fiscal year (FY) 2015—more than double the inflation-adjusted amount from FY 2008.³ States also generate about an equivalent amount from IGTs.⁴

As an illustration of how provider taxes work, assume a state assesses a hospital tax equal to \$100 million and after the state receives the revenue, it returns the funds to hospitals through higher Medicaid reimbursements. A state with a 60 percent reimbursement rate receives \$60 million from the federal government to cover this Medicaid expenditure. The state can then spend that \$60 million on hospitals, other Medicaid providers, or other government

3. In FY 2012, 41 of the 47 states with provider taxes reported revenue of \$18.8 billion. In FY 2008, this amount equaled \$9.7 billion. Ibid. Assuming the growth in provider tax revenue between 2008 and 2012 continued since 2012 and that not all states with provider taxes reported revenue, annual provider tax revenue almost certainly now exceeds \$20 billion. In testimony before the House Committee on Energy and Commerce, Subcommittee on Health, John Hagg, director of Medicaid audits in the Office of Audit Services in the Office of Inspector General at the Department of Health and Human Services, testified that states reported \$21.9 billion in provider tax revenue in FY 2015. Hagg, “Examining Medicaid and CHIP’s Federal Medical Assistance Percentage” (Testimony before the House Committee on Energy and Commerce: Subcommittee on Health, Department of Health and Human Services, Office of Inspector General, February 10, 2016).

4. GAO, *Medicaid Financing* (GAO Report 14-627).

programs. This illustration shows that states can use provider taxes to substantially increase federal Medicaid spending without any *real* state Medicaid expenditures. As a result, provider taxes, which also diminish the transparency of Medicaid financing, increase spending—particularly federal spending—above what it would otherwise be.

Health policy experts at both left-of-center and right-of-center research organizations have criticized provider taxes, in part because they appear to violate the intent of the statutory federal-state Medicaid cost-sharing formula by increasing the federal share of the bill.⁵ For example, at a December 2015 forum on healthcare reform, Urban Institute senior research fellow John Holahan called provider taxes “egregious,” “a national disgrace [that] is not as understood as well as it should be” and that “needs to be dealt with.”⁶

Federal policymakers have attempted to limit states’ ability to use such creative techniques for bringing federal funds into the state through Medicaid. For example, in 1991 Congress passed legislation that, among other aims, attempted to limit the ability of states to guarantee that providers receive their revenue back as higher reimbursements. More recently, the George W. Bush administration attempted—unsuccessfully—to reduce the amount that states could raise through provider taxes, an action consistent with a “central policy initiative . . . to ‘restore fiscal integrity’ to Medicaid.”⁷

As a consequence of legislative and regulatory action, the federal rules governing provider taxes are complicated and often subjective. This complexity has caused several states to implement a tax on managed care companies for close to a decade that does not comply with federal law. States, including California and Pennsylvania, have assessed a managed care tax, but only on Medicaid managed care plans.⁸ This tax violates federal requirements aimed at preventing states from limiting the tax to entities that benefit from the tax.

5. Teresa A. Coughlin, Stephen Zuckerman, and Joshua McFeeters, “Restoring Fiscal Integrity to Medicaid Financing?,” *Health Affairs* 26, no. 5 (September 2007): 1469–80; Teresa A. Coughlin and Stephen Zuckerman, “States’ Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences,” Urban Institute website, June 1, 2002; Alex Brill, “Medicaid Provider Taxes: Closing a Loophole,” *Tax Notes*, American Enterprise Institute, June 29, 2015, <https://www.aei.org/publication/medicaid-provider-taxes-closing-a-loophole/>.

6. “Improving Health and Health Care: An Agenda for Reform” (panel discussion, American Enterprise Institute, Washington, DC, December 9, 2015), 1:55:00ff., <https://www.aei.org/events/improving-health-and-health-care-an-agenda-for-reform/>.

7. Coughlin, Zuckerman, and McFeeters, “Restoring Fiscal Integrity to Medicaid Financing?”

8. Barbara Feder Ostrov, “Fight over Medicaid Managed Care Tax Punches Hole in California Budget,” *Kaiser Health News*, November 25, 2015, <http://khn.org/news/fight-over-medicaid-managed-care-tax-punches-hole-in-california-budget/>.

Like the George W. Bush administration, the Obama administration also proposed reducing states' ability to finance the state share of Medicaid from provider taxes.⁹ Provider taxes were discussed as part of the high-profile deficit reduction negotiations between the Obama administration and congressional Republicans and Democrats in 2011, with Vice President Joe Biden reportedly referring to them as a "scam" that should be eliminated.¹⁰ The National Commission on Fiscal Responsibility and Reform, established by an executive order from President Obama, also recommended eliminating them.¹¹

Proposals to limit the use of provider taxes tend to receive strong criticism from many interest groups that believe provider tax reform will result in lower Medicaid payments. CBO assumes that each dollar that states raise through provider taxes produces about 50 cents of Medicaid spending that would not have occurred in the absence of the provider tax.¹²

Although it is not legally binding, the 2015 budget resolution passed by Congress replaces the uncapped federal reimbursement of state Medicaid spending with capped allotments to states. One benefit of such a policy is that it would likely concentrate state efforts on improving the value enrollees receive from Medicaid rather than on creatively manipulating complex rules and regulations to maximize federal funding. It would also free the federal government from much of the administrative costs of monitoring how states are financing their share of Medicaid.

This study provides an overview of Medicaid's structure, describes provider taxes and their history, describes how provider taxes raise Medicaid spending (particularly federal spending), explains the political economy of provider taxes, estimates the revenue raised by provider taxes, outlines several proposals to reduce states' ability to use provider taxes, and discusses solutions that would remedy or reduce the problem. The appendix contains a case study of Arizona that shows how the state imposed provider taxes to pay for Medicaid expansion.

9. President Obama's FY 2013 budget proposed reducing the safe harbor threshold (explained below) from 6 percent to 3.5 percent between FY 2015 and FY 2017 and then keeping it at 3.5 percent in the future. Office of Management and Budget, *Fiscal Year 2013 Budget of the U.S. Government*, 36.

10. Bob Woodward, *The Price of Politics* (New York: Simon & Schuster, 2012).

11. National Commission on Fiscal Responsibility and Reform, *The Moment of Truth: Report of the National Commission on Fiscal Responsibility and Reform* (Washington, DC, December 2010), https://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12.1_2010.pdf.

12. Author's discussions with CBO staff while a senior professional staff member on the House Committee on Oversight and Government Reform.

OVERVIEW OF MEDICAID FEDERAL-STATE FINANCING STRUCTURE

States are not required to participate in Medicaid, but all 50 states and the District of Columbia have participated since 1982.¹³ The federal reimbursement of a substantial share of state Medicaid expenditures encourages state participation. Economic theory predicts that each state will spend more on health-care and long-term care services for lower-income residents than it otherwise would since a majority of Medicaid program expenditures are absorbed by taxpayers outside a state.

For most populations covered by Medicaid, the federal share of expenditures is determined by a formula that compares state per capita income with national per capita income.¹⁴ The reimbursement rate—the Federal Medical Assistance Percentage (FMAP)—varies inversely with state per capita income so that poorer states are reimbursed for a higher *percentage* of their Medicaid expenditures. The statutory FMAP minimum is 50 percent, and the states with the lowest per capita income generally have an FMAP around 75 percent.¹⁵

For some populations, states are not reimbursed at the standard FMAP.¹⁶ The most notable difference is an elevated FMAP for the ACA expansion population of generally able-bodied, working-age, childless adults in households with income below 133 percent of the federal poverty level (FPL). The FMAP for this population equals 100 percent from 2014 through 2016 before gradually phasing down to 90 percent in 2020, where it is scheduled to remain indefinitely. The ACA’s Medicaid expansion population was originally supposed to be a mandatory coverage population—like Supplemental Security Income recipients or lower-income pregnant women and children—but a 2012 Supreme Court decision made it an optional coverage population.¹⁷

13. In 1982 Arizona became the last state to participate in the Medicaid program.

14. $FMAP_{state} = 1 - [(Per\ capita\ income_{state})^2 / (Per\ capita\ income_{US})^2 \times 0.45]$. The 0.45 factor in the formula is designed to ensure that a state with per capita income equal to the US average has an FMAP of 55 percent with a state share of 45 percent.

15. Section 1905(b) of the Social Security Act.

16. Exceptions to the standard FMAP rate have been made for certain states (e.g., the District of Columbia and the territories), situations (e.g., during economic downturns), populations (e.g., certain women with breast or cervical cancer and individuals in the Qualifying Individuals program), providers (e.g., primary care physicians and Indian Health Service facilities), and services (e.g., family planning and home health services). In addition, the federal share for most Medicaid administrative costs does not vary by state and is generally 50 percent.

17. *National Federation of Independent Business v. Sebelius*, 133 S. Ct. 2568 (2012).

In addition to mandatory coverage populations, states must provide a specified benefit package,¹⁸ and federal statute allows up to 60 percent of the nonfederal share to come from sources other than state general funds. Once these federal requirements are satisfied, states have significant discretion over decisions regarding provider pay, managed care contracting, and benefit design.

MEDICAID PROVIDER TAXES

Every state except Alaska finances its Medicaid program, in part, with assessments or taxes on healthcare and long-term care providers.¹⁹ Provider taxes are legally defined as taxes in which at least 85 percent of the resulting revenue comes from healthcare providers.²⁰ Provider taxes do not have the typical properties of a tax, however, as the taxpayer tends to support the tax, often lobbying for it. The reason appears to be the explicit or implicit guarantee that providers will receive either higher Medicaid payment rates or increased supplemental payments as a result of the tax. Supplemental payments are payments beyond the normal payment rate schedule, and they can be targeted to specific providers.

The National Conference of State Legislatures has explained how states use provider taxes, at least in part, to increase Medicaid payments to providers by leveraging federal tax dollars through the federal government's reimbursement of state Medicaid expenditures:

In most states, [the provider tax] is used as a mechanism to generate new in-state funds and match them with federal funds so that the state gets additional federal Medicaid dollars. In a majority of cases, the cost of the tax is paid back to providers through an increase in the Medicaid reimbursement rate for their patient treatment and services.²¹

18. Center for Medicare and Medicaid Services, "Medicaid Benefits," Medicaid.gov, <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>.

19. Alaska awarded a contract to the firm Myers and Stauffer "to study and develop a health care provider tax proposal that will be presented to the Alaska Legislature for consideration in 2016." Alaska Department of Health and Social Services, *The Healthy Alaska Plan*, <http://dhss.alaska.gov/HealthyAlaska/Pages/Provider-Tax.aspx>.

20. Social Security Act § 1903(w)(3)(A); 42 C.F.R. 433.55.

21. National Conference of State Legislatures, *Health Provider and Industry State Taxes And Fees*, December 2015, <http://www.ncsl.org/issues-research/health/health-provider-and-industry-state-taxes-and-fees.aspx>.

GAO has provided several examples of how providers benefit from the use of provider taxes. Massachusetts reportedly increased payment rates by about 6.3 percent because of provider taxes.²² According to a 2014 GAO report, “In Illinois, a \$220 million payment increase for nursing homes funded by a tax on nursing facilities resulted in an estimated \$110 million increase in federal matching funds and no increase in state general funds, and a net payment increase to the facilities, after paying the taxes, of \$105 million.”²³

In a 2002 paper on the techniques states use to maximize federal Medicaid funds, Urban Institute senior research fellows Teresa Coughlin and Stephen Zuckerman argue that some techniques, such as shifting previously state-funded health programs into Medicaid, are relatively uncontroversial. However, they label provider taxes as a controversial method since “increased federal spending takes place with limited or no state contribution.”²⁴

Coughlin and Zuckerman argue that the failure of the state to make a *real* financial contribution “is contrary to a basic tenet of Medicaid: That is, it is a program in which the federal government and states or localities share the financial burden.”²⁵ In an article written last year, Alex Brill of the American Enterprise Institute agreed with this point, writing that provider taxes appear to violate the statutory design of the share of federal Medicaid spending, which was “intended to be a function of per capita income, not the ability of state lawmakers to distort prices.”²⁶

Provider Taxes Raise Rather Than Shift Costs

Policymakers, analysts, and commentators often make the mistake of focusing on how policies can “shift” costs from one entity to another, without considering how the policy change affects the incentives for people involved in the decision-making process. As an illustration, if a group of people ordering a meal at a restaurant decide beforehand to split the check, the bill will likely be larger than if the same group of people decided in advance to each get separate checks. Price consciousness changes depending on whether people pay for all their own spending or whether they can pass off a large portion of that spending to others.

22. Government Accountability Office, *Medicaid Nursing Home Payments: States' Payment Rates Largely Unaffected by Recent Fiscal Pressures* (Report to Congressional Requesters, October 2003), <http://www.gao.gov/assets/250/240199.pdf>.

23. GAO, *Medicaid Financing* (GAO Report 14-627).

24. Teresa A. Coughlin and Stephen Zuckerman, “States’ Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences,” Urban Institute, June 2002.

25. *Ibid.*

26. Brill, “Medicaid Provider Taxes.”

“Provider taxes shift costs from states to the federal government, but they also raise overall spending by lowering the relative price of Medicaid expenditures to states.”

In a similar way, provider taxes reduce the sensitivity of states to higher Medicaid spending by allowing them to effectively reduce the share of Medicaid expenditures that the state tax base absorbs. Therefore, provider taxes do not merely shift costs to the federal tax base; they also increase overall Medicaid expenditures, with about 60 percent of the marginal increase—the average state FMAP—financed by the federal tax base.

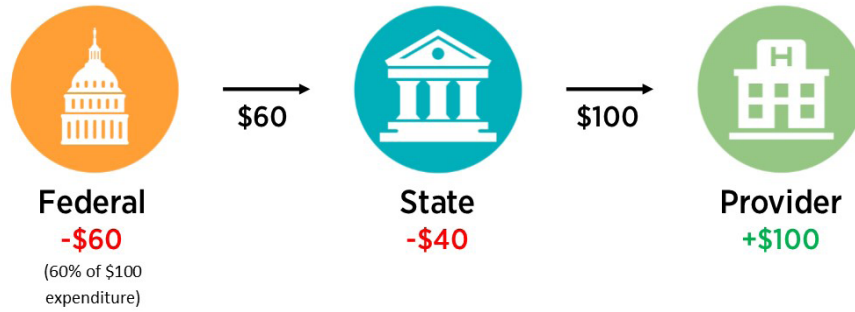
Figure 1 illustrates the effect of provider taxes, displaying their impact on three groups: the federal government, states, and providers. I assume a state with an FMAP of 60 percent. In the scenario without a provider tax, a state spends \$100 on a provider and receives \$60 from the federal government, so the net cost to the state tax base amounts to \$40.

The second scenario shows how a provider tax shifts costs to the federal government, *assuming states maintain the same level of spending as in the first scenario*. The state taxes the provider \$100 and then pays the provider \$200. Assuming negligible transaction costs, the provider is essentially as well off as in the scenario without a provider tax. The federal government is worse off because it is now reimbursing the state \$120 (60 percent of the \$200 expenditure). The state gains \$20 through these three transactions (receiving \$100 in provider tax revenue and \$120 reimbursement through the FMAP less \$200 in expenditure to the provider). But the state is actually better off by \$60 because it was paying \$40, on net, to the provider in the absence of the tax.

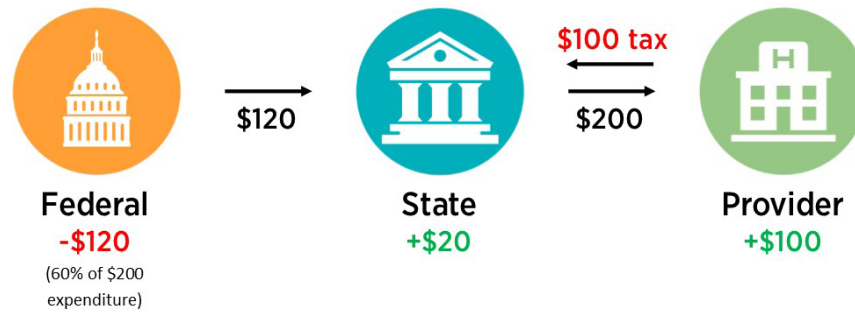
Provider taxes shift costs from states to the federal government, but they also raise overall spending by lowering the relative price of Medicaid expenditures to states. Provider taxes make state Medicaid programs cheaper because the revenue raised—even though the revenue is generally illusory—can be used as the state share of spending. Scenario 3 in the figure shows how provider taxes work if the provider tax mechanism generates an additional \$50 for the provider. The provider’s net gain is \$150, equal to the \$250 state payment minus the \$100

FIGURE 1. PROVIDER TAX SCENARIOS

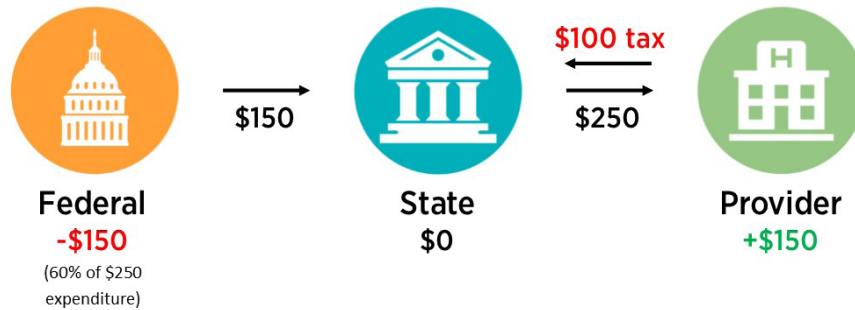
**Scenario 1:
No Provider Tax**



**Scenario 2:
Provider Tax Shifts Costs
from State to Federal Government**



**Scenario 3:
Provider Tax Increases
Overall Medicaid Expenditures**



paid through the provider tax. The federal government reimburses the state \$150 (60 percent of \$250), and the state's net payments sum to zero (\$100 in provider tax revenue and \$150 reimbursement through the FMAP less \$250 for the provider payment).

Comparing scenario 1 (no provider tax) with scenario 3 (provider tax with higher spending) shows that providers are better off from higher payments and the state is better off because of the higher federal reimbursement. The federal government, however, is worse off because it has to reimburse additional state Medicaid expenditures. Although provider taxes increase the federal share of Medicaid spending relative to the state share, the more that the state's Medicaid expenditures increase as a result of provider taxes, the greater the burden on both the federal and state tax base. It is worth noting that there are two effects on the state tax base financing burden: The provider tax shifts part of the previous burden to the federal tax base but the state bears its share of the financing burden for the marginal increase in Medicaid spending that results from the provider tax reducing the relative cost of Medicaid to the state.

Provider Tax Revenue and Federal Medicaid Spending Both Increase

Table 1 shows provider tax revenue and both the state and federal shares of Medicaid expenditures for fiscal years 2008 (adjusted for inflation using 2015 dollars) and 2015. The table shows that provider tax revenue—adjusted for inflation—more than doubled from 2008 through 2015. As provider tax revenue has increased substantially, so has federal Medicaid spending—by an inflation-adjusted 59 percent between FY 2008 and FY 2015. The enhanced federal Medicaid reimbursement for the Affordable Care Act expansion population is partly responsible for both the overall increase in Medicaid expenditures and the increasing federal share, but the growing use of provider taxes and similar accounting gimmicks is undoubtedly responsible for a large part of these increases as well.

TABLE 1. GROWTH IN PROVIDER TAXES AND MEDICAID SPENDING

Category	FY 2008	FY 2015	Increase	% increase
Provider tax revenue	\$10.7 bn	\$21.9 bn	\$11.2 bn	105%
State Medicaid spending	\$167.0 bn	\$205.6 bn	\$38.6 bn	23%
Federal Medicaid spending	\$220.4 bn	\$350 bn*	\$129.6 bn	59%
Total Medicaid spending	\$387.4 bn	\$555.6 bn	\$168.2 bn	43%
Federal share of spending	57%	63%*	6%	11%

* These figures are estimates from the Congressional Budget Office, *The Budget and Economic Outlook: 2016 to 2026*, January 25, 2016.

Note: The 2008 amounts have been adjusted for inflation and are shown in 2015 dollars.

Sources: Congressional Budget Office, *Budget and Economic Outlook: 2016 to 2026*; Government Accountability Office, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection* (GAO Report 14-627, July 2014); Department of Health and Human Services, *2010 Actuarial Report on the Financial Outlook for Medicaid*; John Hagg, "Examining Medicaid and CHIP's Federal Medical Assistance Percentage" (Testimony before the House Committee on Energy and Commerce: Subcommittee on Health, Department of Health and Human Services, Office of Inspector General, February 10, 2016).

PROVIDER TAX HISTORY

In 1984 Florida became the first state to establish a provider tax program.²⁷ In 1985 West Virginia became the first state to establish a provider donation program.²⁸ Provider donations are voluntary payments made to a state or unit of local government by a healthcare provider.²⁹ According to the Congressional Research Service (CRS), "In some cases, Medicaid providers initiated these provider tax and donation arrangements because states would often use the provider tax and donation revenue to raise Medicaid payment rates."³⁰ By 1990 six states had tax or donation programs.³¹

In the early 1990s, state Medicaid rolls grew as a result of both greater coverage requirements contained in the Medicare Catastrophic Coverage Act of 1988 and an economic recession.³² Most states were running budget deficits by 1991 or 1992. The budgetary pressure led many states to create or expand provider donations and provider taxes in order to reduce the state share of Medicaid spending and to increase the federal share. By 1992, 39 states had

27. National Conference of State Legislatures, "Health Provider and Industry State Taxes And Fees," December 20, 2015, <http://www.ncsl.org/issues-research/health/health-provider-and-industry-state-taxes-and-fees.aspx>.

28. Jean Donovan Gilman, *Medicaid and the Costs of Federalism, 1984–1992* (New York: Garland Publishing, 1998), 160.

29. Social Security Act § 1903(w)(2).

30. Alison Mitchell, Congressional Research Service, *Medicaid Provider Taxes* (CRS Report for Congress, March 15, 2012).

31. Leighton Ku and Teresa A. Coughlin, "Medicaid Disproportionate Share and Other Special Financing Programs," *Health Care Financing Review* 16, no. 3 (Spring 1995): 27–54.

32. Congressional Budget Office, "The Medicare Catastrophic Coverage Act of 1988" (staff working paper, October 1988).

provider taxes,³³ and tax and donation programs were generating an estimated \$8 billion in state revenue.³⁴ According to the CRS, “Provider taxes were often imposed only on Medicaid providers. These provider tax arrangements were agreed to (and sometimes initiated) by the Medicaid providers because the Medicaid providers could be held harmless from the cost of the tax through increased Medicaid payment rates.”³⁵

Washington Limits States’ Ability to Use Provider Taxes

States’ use of provider taxes and donations became a source of tension between policymakers in Washington and those in state capitols. In response to the increased use of provider taxes and related techniques, Congress passed and President Bush signed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (MVCPSTA) in 1991.³⁶ The MVCPSTA outlawed the use of most provider donations and made provider taxes more costly for healthcare providers who treated few, if any, Medicaid enrollees.

The MVCPSTA required that provider taxes be uniform (the same tax rate across all providers in a given class) and broad based (the tax would apply to all providers in one of the 19 specified classes of providers subject to the tax, even those who do not provide Medicaid services).³⁷ The MVCPSTA also attempted to limit the extent to which providers could be held harmless by the tax—providers who receive at least as much money back from the state in higher Medicaid payments as they had paid in tax. In addition to being complex, the rules governing provider taxes are also somewhat arbitrary. For example, the secretary of the Department of Health and Human Services (HHS) may waive the broad-based and uniform requirements if the tax is “generally redistributive”³⁸ and

33. Ku and Coughlin, “Medicaid Disproportionate Share.”

34. Teresa A. Coughlin and Leighton Ku, “Medicaid: Disproportionate Share and Other Special Financing Programs—A Fiscal Dilemma for States and the Federal Government,” Urban Institute, 1994.

35. Mitchell, Congressional Research Service, *Medicaid Provider Taxes*.

36. Section 1903(w)(5)(A) of the Social Security Act, amended by Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234).

37. The specified 19 classes of providers are those that provide the following: inpatient hospital services, outpatient hospital services, nursing facility services, services of intermediate care facilities for the mentally retarded, physicians’ services, home healthcare services, outpatient prescription drugs, services of Medicaid managed care organizations, ambulatory surgical centers, dental services, podiatric services, chiropractic services, optometric/optician services, psychological services, therapist services, nursing services, laboratory and x-ray services, emergency ambulance services, and other healthcare items or services for which the state has enacted a licensing or certification fee.

38. Generally redistributive means that there is a negative relationship between the amount of tax owed by the provider and the percentage of revenue the provider receives from Medicaid.

the amount of the tax is not directly correlated to Medicaid payments (although there is an exception for rural and sole community providers). States commonly apply for these waivers.

Three tests exist to determine whether a provider tax satisfies the “hold harmless” criteria. The key test—the guarantee test³⁹—only applies if the tax rate exceeds 6 percent of net patient revenue. The 6 percent threshold is generally referred to as the “safe harbor” provision.⁴⁰ While states can have provider tax rates that exceed the safe harbor threshold, neither the CRS nor GAO have identified any state that imposes a tax rate exceeding 6 percent of net patient service revenue.⁴¹

At least in the near term, the restrictions on provider taxes have made it more difficult politically for states to use them to finance their share of Medicaid expenditures.⁴² As a result, the number of states with provider taxes dropped from 39 in 1992 to 21 in 2003.⁴³

States Use Other Techniques to Minimize Their Share of Medicaid

Since the MVCPSTA made provider taxes less appealing, states have increasingly sought to maximize federal Medicaid funding through IGTs.⁴⁴ In a 2002 regulation, HHS explained how states combined IGTs with Medicaid upper payment limits (UPLs)—federal requirements that generally limit Medicaid reimbursements to no more than Medicare rates—to increase federal Medicaid funding:

By developing a payment methodology that set rates for proprietary and nonprofit facilities at lower levels, states were able to set rates for county or city facilities at substantially higher levels and still comply with the existing aggregate upper payment limits. The federal government matched these higher payment rates to public facilities. Because these facilities are public

39. “The guarantee test is violated if the state or other unit of government imposing the tax provides directly or indirectly for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.” Mitchell, Congressional Research Service, *Medicaid Provider Taxes*.

40. 42 C.F.R. 433.68(f)(3)(i)(A).

41. GAO, *Medicaid Financing* (GAO Report 14-627); Mitchell, Congressional Research Service, *Medicaid Provider Taxes*.

42. Coughlin, Zuckerman, and McFeeters, “Restoring Fiscal Integrity to Medicaid Financing?”

43. National Conference of State Legislatures, “Health Provider and Industry State Taxes And Fees.”

44. Teresa A. Coughlin, Brian K. Bruen, and Jennifer King, “States’ Use of Medicaid UPL and DSH Financing Mechanisms,” *Health Affairs* 23, no. 2 (March 2004): 245–57.

entities, funds to cover the state share were transferred from those facilities (or the government units that operate them) to the state, thus generating increased federal funding with no net increase in state expenditures.⁴⁵

It is worth noting that while this study analyzes Medicaid provider taxes, the economics of IGTs is essentially the same. Similar to the federal restrictions on provider taxes contained in the MVCPSA, Congress instructed the Centers for Medicare and Medicaid Services (CMS) to issue regulations limiting the use of IGT and UPL arrangements in 2000.⁴⁶ These regulations led many states to increase the use of provider taxes although they generally retained IGTs as well.

Several States Add or Raise Provider Taxes

Beginning in 2008, many states were confronting much lower state revenue because of the deep recession that followed the financial crisis. Part of the American Recovery and Reinvestment Act (ARRA), signed into law in February 2009, transferred tens of billions of dollars to states through FMAP increases.⁴⁷ In addition to higher FMAPs, several states implemented new provider taxes or increased existing provider taxes in order to alleviate budget shortfalls.

Table 2 illustrates the growth in Medicaid provider taxes following the recession. From FY 2007 to FY 2011, 6 states that did not already have any provider tax added one, 16 states added provider taxes on hospitals, and 9 states

45. 66 Fed. Reg. 3149–50 (2002).

46. As the UPL financing schemes came to light, Congress and the Health Care Financing Administration (HCFA)—the federal agency administering the Medicaid program at the time—took action through statute and regulation to curtail states' ability to claim excessive federal funds through these UPL financing schemes. The HCFA initiated policy changes to restrict states' UPL arrangements in an October 2000 proposed regulation. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) directed the HCFA to issue a final regulation to limit states' ability to claim excessive federal matching funds through UPL arrangements. BIPA also required that the HCFA's final regulation—established in January 2001—allow for transition periods as long as eight years, during which time excessive UPL payments would be phased out. Because some states may have come to rely on these excessive federal funds, the length of a state's transition period was based in part on how long the state had had a UPL arrangement meeting certain specified criteria. GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed* (Report to the Senate Committee on Finance, February 2004).

47. Vernon K. Smith et al., *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011*, Kaiser Commission on Medicaid and the Uninsured, September 2010.

added provider taxes on nursing homes.⁴⁸ By 2011, 47 states had at least one provider tax; of these 47 states, 34 had a hospital tax and 39 had a nursing home tax.⁴⁹ Between 2011 and 2015, states continued to add provider taxes, but the increase was not as great—likely because so many more states had taxes in place in 2011 relative to 2007. As of 2015, 39 states had a hospital tax, 44 states had a nursing home tax, 37 states had an intermediate care facility (ICF) tax, and 19 states had a tax on another kind of provider.⁵⁰

TABLE 2. STATES WITH MEDICAID PROVIDER TAXES, 2007–2015

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2007 to 2011	2011 to 2015
Hospital	18	20	23	29	34	38	39	40	39	+16	+5
Nursing home	30	33	35	37	39	42	44	44	44	+9	+5
ICF	22	29	28	33	33	36	37	37	37	+11	+4
Any tax	41	44	45	46	47	49	50	50	50	+6	+3

Source: The annual Kaiser Family Foundation surveys on state Medicaid programs.

Note: These numbers include the District of Columbia. ICF refers to intermediate care facility.

Table 3 shows the number of states with existing provider taxes in 2007 through 2015 that increased or decreased their tax rates. Three observations are clear. First, states were far more likely to increase than to decrease tax rates between FY 2007 and FY 2014. States with the three types of taxes listed—hospitals, nursing homes, and ICFs—increased rates 150 times and decreased rates 49 times. Second, more than half of the decreases occurred in 2008—the year that the safe harbor was temporarily reduced from 6 percent to 5.5 percent (discussed in more detail later). It is likely that most of the decreases were states adjusting their rates to conform to federal law. Third, more than half of the provider tax increases occurred in 2011 and 2012. This is likely the result of two factors: the allowable tax rate returning to 6 percent and the restoration of

48. Vernon K. Smith et al., *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008*, Kaiser Commission on Medicaid and the Uninsured, October 2007.

49. The three states without any provider taxes in FY 2011 were Alaska, Delaware, and Hawaii. Vernon K. Smith et al., *Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013*, Kaiser Commission on Medicaid and the Uninsured, October 2012.

50. Vernon K. Smith et al., *Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016*, Henry J. Kaiser Family Foundation, October 2015.

the normal FMAP rates from the elevated rates contained in the ARRA. When FMAP rates returned to their normal levels, several states increased provider taxes in order to avoid the reduction in federal Medicaid spending.⁵¹

TABLE 3. STATES CHANGING MEDICAID PROVIDER TAX RATES, 2007-2014

Increasing Taxes									
	2007	2008	2009	2010	2011	2012	2013	2014	Total
Hospital	2	2	6	5	13	18	7	5	58
Nursing home	2	4	3	7	11	23	8	4	62
ICF	1	2	1	3	3	14	4	2	30
Total	5	8	10	15	27	55	19	11	150

Decreasing Taxes									
	2007	2008	2009	2010	2011	2012	2013	2014	Total
Hospital	1	3	3	0	2	1	1	3	14
Nursing home	0	11	3	0	1	0	2	2	19
ICF	0	14	1	0	0	0	1	0	16
Total	1	28	7	0	3	1	4	5	49

Source: The annual Kaiser Family Foundation surveys on state Medicaid programs.

Note: These numbers include the District of Columbia. ICF refers to intermediate care facility.

In addition to taxes on providers of healthcare and long-term care services, many states also assess provider taxes on managed care companies. As an illustration of the problem that the federal government has in conducting oversight of the rules governing provider taxes, several states, including large states like California and Pennsylvania, have apparently been implementing a tax on managed care companies that does not comply with federal law. A July 2014 letter from the CMS to state Medicaid directors sought to clarify the use of provider taxes because of apparent “confusion among states as to what would or would not be considered” an appropriate tax on managed care companies.⁵² The letter indicated that states were likely out of compliance with a change in the law pertaining to provider taxes made by the Deficit Reduction Act of 2005 (DRA).⁵³ These states have been unlawfully targeting the tax to Medicaid managed care providers, which limits the burden of paying the tax only to

51. Smith et al., *Hoping for Economic Recovery, Preparing for Health Reform*.

52. Cindy Mann, director, Center for Medicaid and CHIP Services, letter to state Medicaid directors and health officials regarding health care-related taxes, July 25, 2014.

53. *Ibid.*

those managed care companies that receive higher capitated payment rates as a result of the tax.

POLITICAL ECONOMY OF MEDICAID PROVIDER TAXES

Providers who serve a significant number of Medicaid enrollees will tend to benefit from states' use of provider taxes since they generally receive at least as much state spending through a combination of higher Medicaid reimbursement rates and supplemental payments than they would have received in the absence of the tax. If the tax is broad based, however, providers who do not serve a significant number of Medicaid enrollees will tend to be worse off, and they will likely shift a great part of the tax to patients who pay privately. These providers may lobby for lower provider taxes or no such tax. As a recent example, many providers in Utah opposed a tax on healthcare providers—including hospitals, doctors, nurses, pharmacies, insurers, social workers, and optometrists—to finance the state share of expenses to cover the ACA Medicaid expansion population.⁵⁴ The Utah Hospital Association, which initially endorsed the plan, turned against it “because it doesn’t restrict how much taxes can climb to cover increases in enrollment.”⁵⁵

Impact of Provider Taxes on Politicians

Because of the federal-state Medicaid financing structure, provider taxes can be an appealing revenue option for state policymakers. Provider taxes allow states to increase provider payments while reducing the burden placed on the state tax base to finance Medicaid. Oregon state representative Mitch Greenlick refers to provider taxes as a “dream tax” for states—a strong indication of their appeal for state politicians. According to Greenlick, “We collect the tax from the hospitals, we put it up as a match for federal money, and then we give it back to the hospitals.”⁵⁶ State politicians are likely rewarded for having provider taxes by interest groups' contributions and potentially by voters.

54. Lisa Riley Roche, “Healthcare Providers Voice Opposition to Tax during Medicaid Expansion Hearing,” KSL.com, October 7, 2015, http://www.ksl.com/?sid=36844001&nid=148&title=healthcare-providers-voice-opposition-to-tax-during-medicaid-expansion-hearing&fm=related_story&_cid=article-related-2.

55. Ibid.

56. Quoted in Peter Wong, “Oregon House Extends Hospital Tax,” *Portland Tribune*, March 11, 2015, <http://portlandtribune.com/pt/9-news/253422-123198-oregon-house-extends-hospital-tax>.

Since provider taxes shift the burden for financing Medicaid from the states to the federal government, federal politicians and policymakers should be less supportive of them. In fact, both President George W. Bush and President Obama introduced proposals (discussed in detail below) to limit states' use of provider taxes. Investigative journalist Bob Woodward reports that during the 2011 budget and debt ceiling negotiations between the Obama administration and congressional Republicans and Democrats, congressional Republicans proposed reforming provider taxes as a way to reduce future federal budget deficits.⁵⁷ This is when Vice President Biden—agreeing that provider taxes needed reform—referred to them as a “scam,” saying, “If we can’t do this—come on!”⁵⁸ However, several congressional Democrats as well as senior Obama administration officials raised objections. Woodward reports that Jack Lew, then head of the Office of Management and Budget, and Gene Sperling, then director of the National Economic Council, said eliminating provider taxes would force states to provide fewer services to the poor.⁵⁹ Ultimately, provider tax reform was not part of the final budget deal.

Interest Groups' Interest in Provider Taxes

From interviews with officials representing hospitals and nursing homes, GAO found that hospital and nursing home associations have worked with states on the design of provider taxes. The associations' officials indicated that without the tax revenue, states would likely reduce Medicaid payments, and that states often provide assurances that tax revenue is used for Medicaid payments.⁶⁰

Nursing home taxes have historically been the most prevalent provider tax, largely because nursing homes receive about a third of their financing from Medicaid.⁶¹ In 2009, 94 percent of nursing homes were Medicaid-certified,⁶² and nearly two-thirds of nursing home residents relied on Medicaid as the

57. Woodward, *Price of Politics*.

58. *Ibid.*

59. *Ibid.*

60. GAO, *Medicaid Financing* (GAO Report 14-627).

61. In 2014 hospitals earned \$971.8 billion in revenue, of which \$168.0 billion was paid by Medicaid; nursing homes earned \$155.6 billion in revenue, of which \$49.6 billion was paid by Medicaid. Table 4, “National Health Expenditures by Source of Funds and Type of Expenditures: Calendar Years 2008–2014” (Centers for Medicare and Medicaid Services), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> by downloading “NHE Tables.”

62. Centers for Medicare and Medicaid Services, “Nursing Home Data Compendium,” 2010 ed.

primary payer of their care.⁶³ Since most nursing homes receive a sizeable amount of revenue from Medicaid, provider taxes can more easily be designed to ensure fewer net losers among nursing homes.

Edward Miller and Lili Wang assessed the factors that led 18 states to adopt nursing home taxes between 2000 and 2004.⁶⁴ They found that the strongest predictors of nursing home tax adoption were nursing home industry lobbying strength, a greater percentage of nursing home residents receiving services paid by Medicaid or Medicare, broader Medicaid eligibility, worse state fiscal conditions, and nursing home supply restrictions.

The American Health Care Association (AHCA), the largest nursing home interest group, commissioned a study in 2007 that estimated that nursing home taxes generated about \$3.8 billion in federal matching funds.⁶⁵ These extra funds produced a higher average Medicaid rate for nursing home patients of about \$14 per day. The AHCA report also found that most states with nursing home taxes (19 of the 32 states with nursing home taxes in 2007) were at or near the safe harbor maximum of 6 percent. A December 2011 report commissioned by the AHCA found that nursing home taxes generated \$6 billion in federal matching funds in 2011—a 58 percent increase from four years earlier.⁶⁶

Before the recession, nursing home taxes were much more common than hospital taxes. At the start of FY 2007, 18 states had hospital taxes compared to 30 states with taxes on nursing homes. Hospitals were likely not taxed

“Hospital and nursing home associations have worked with states on the design of provider taxes.”

63. Wendy Fox-Grage and Donald Redfoot, “Medicaid: A Program of Last Resort for People Who Need Long-Term Services and Supports” (Fact Sheet 223, AARP Public Policy Institute, May 2011).

64. Edward Alan Miller and Lili Wang, “Maximizing Federal Medicaid Dollars: Nursing Home Provider Tax Adoption, 2000–2004,” *Journal of Health Politics, Policy and Law* 34, no. 6 (December 2009).

65. BDO Seidman, LLP Accountants and Consultants, and Eljay, LLC, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care* (report for the American Health Care Association, September 2007).

66. Eljay, LLC, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care* (report for the American Health Care Association, December 2011).

to the same degree as nursing homes because hospitals only receive about half as much from Medicaid, as a percentage of their revenue. Since most states already had taxes on nursing homes, hospital taxes were more likely to be added by states in the aftermath of the financial crisis and state budget shortfalls. The number of states with hospital taxes more than doubled from 2007 to 2012.

According to the Medicaid and CHIP Payment and Access Commission (MACPAC), nursing home taxes have generally financed increased Medicaid payment rates while hospital taxes have generally financed increased supplemental payments directed toward hospitals.⁶⁷ Since the percentage of hospital revenue derived from Medicaid varies to a greater degree than does nursing home revenue, states have generally used supplemental payments to better target funding to hospitals that serve a higher proportion of Medicaid enrollees. As provider taxes have increased, so have supplemental payments. GAO found that supplemental payments totaled more than \$43 billion in FY 2011—nearly double the amount from five years prior.⁶⁸ In this same report, GAO also found that states have “maximized federal matching funds by making large payments—significantly above providers’ costs of providing services—to providers that were financing the nonfederal share.”

REVENUE RAISED BY PROVIDER TAXES

While the federal government does not have reliable data on the amount of revenue that states raise through provider taxes,⁶⁹ the available evidence suggests the amount is considerable and has increased over time. The portion of the state share of Medicaid spending derived from state general funds has declined from about 95 percent to about 75 percent over the past 25 years.⁷⁰ According to GAO, 13 states financed more than 30 percent of the state share of Medicaid with sources other than state general funds.⁷¹

67. Medicaid and CHIP Payment and Access Commission, “Chapter 3: State Approaches for Financing Medicaid and Update on Federal Financing of CHIP,” *Report to the Congress on Medicaid and CHIP* (Washington, DC, March 2012).

68. GAO, *Medicaid Financing* (GAO Report 14-627).

69. Medicaid and CHIP Payment and Access Commission, Chapter 3, *Report to the Congress on Medicaid and CHIP*.

70. National Association of State Budget Officers, *State Expenditure Report: Examining 2013–2015 State Spending* (Washington, DC, 2015); National Association of State Budget Officers, *State Expenditure Report*, 1990.

71. GAO, *Medicaid Financing* (GAO Report 14-627).

The federal government requires that states report their provider tax and provider donation revenue or else risk losing federal matching funds.⁷² However, GAO has documented that many states underreport provider tax revenue. According to a March 2014 GAO report, CMS officials “could not attest to the accuracy of the data reported” and no action had been taken to withhold federal Medicaid funding from states who were underreporting.⁷³

In FY 2010, 13 states did not report any provider tax revenue to the CMS, even though 45 states had at least one provider tax.⁷⁴ In FY 2012, 41 of the 47 states with provider taxes reported revenue of \$18.8 billion (including \$72 million from provider donations)—a significant increase from the \$9.7 billion in provider tax revenue in 2008.⁷⁵ Since six states with provider taxes did not report provider tax revenue to the CMS and states that did report revenue were more likely to underreport than to overreport the amount raised, states probably brought in more than \$20 billion through provider taxes in FY 2012. In addition to provider tax revenue, state governments received \$18.1 billion through IGTs in FY 2012 to finance Medicaid expenditures.⁷⁶

BIPARTISAN SUPPORT TO LIMIT OR ELIMINATE PROVIDER TAXES

Health policy experts across the political spectrum generally support provider tax reform. For example, John Holahan, an Institute fellow in the Health Policy Center at the Urban Institute, has said that states’ use of provider taxes is “egregious,” is “a national disgrace [that] is not as understood as well as it should be,” and “needs to be dealt with.”⁷⁷ Illinois Senator Richard Durbin, a Democrat, has referred to provider taxes as a “bit of a charade.”⁷⁸ Both the George W. Bush and Obama administrations proposed reducing the safe harbor threshold—in practice the maximum provider tax rate states can assess and receive federal reimbursement for. Moreover, the fiscal commission established by an executive order from President Obama made provider tax reform a central component of its plan to reduce federal budget deficits.

72. Ibid.

73. Ibid.

74. Mitchell, Congressional Research Service, *Medicaid Provider Taxes*.

75. GAO, *Medicaid Financing* (GAO Report 14-627).

76. Ibid.

77. “Improving Health and Health Care” panel discussion, 1:55:00ff.

78. Washington Post Editorial Board, “A Much-Needed Medicaid Reform,” *Washington Post*, November 29, 2012, https://www.washingtonpost.com/opinions/a-much-needed-medicare-reform/2012/11/29/b091d86e-399f-11e2-a263-f0ebffed2f15_story.html.

Bush Proposal

In 2006 the Bush administration intended to issue regulations that would have lowered the safe harbor threshold from 6 percent to 3 percent.⁷⁹ At the time, the Bush proposal was estimated to lower total Medicaid spending by \$10 billion over 10 years, with federal savings of \$6 billion.⁸⁰ An analysis sponsored by the nursing home industry estimated that the proposal would have an even larger effect, costing nursing homes an estimated \$1.5 billion in federal funds in 2006 alone.⁸¹

In August 2006, the *New York Times* reported that governors, provider groups, and beneficiary advocates lobbied aggressively against the regulation.⁸² The National Governors Association said it “would impose a huge financial burden on states.”⁸³ More than 200 Democratic members and more than 100 Republican members of Congress objected to the proposal.⁸⁴ The *Times* listed the objections of three Republican governors and three Democratic governors. According to the *Times*, “state officials said the changes would put pressure on states to reduce Medicaid benefits, restrict eligibility or lower payments to healthcare providers.” The American Hospital Association and the AHCA said the Bush administration plan was simply a way to cut Medicaid.⁸⁵

The lobbying effort proved successful. Section 403 of the Tax Relief and Health Care Act, signed into law on December 20, 2006, codified the maximum provider tax rate at 6 percent, except for the period from January 1, 2008, through September 30, 2011.⁸⁶ During this nearly four-year period, the maximum rate was temporarily reduced to 5.5 percent. At the time, CBO projected this reduction would save the federal government \$260 million.⁸⁷

79. Kaiser Family Foundation, “The President’s FY 2007 Budget Proposal: Overview and Briefing Charts,” Kaiser Family Foundation, February 27, 2006.

80. Kip Piper, “Medicaid Provider Taxes: Battle over Bush Proposal to Further Limit State Provider Taxes,” *Piper Report* website, October 17, 2006, <http://www.piperreport.com/blog/2006/10/17/post/>.

81. BDO Seidman, LLP Accountants and Consultants, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care* (report for the American Health Care Association), June 2006.

82. Robert Pear, “Planned Medicaid Cuts Cause Rift with States,” *New York Times*, August 13, 2006, http://www.nytimes.com/2006/08/13/washington/13medicaid.html?pagewanted=print&_r=1&.

83. National Governors Association, quoted in *ibid*.

84. Pear, “Planned Medicaid Cuts Cause Rift with States.”

85. *Ibid*.

86. Library of Congress, “Bill Summary & Status—109th Congress (2005–2006), H.R. 6111, CRS Summary,” <http://www.thomas.gov/cgi-bin/bdquery/z?d109:HR06111:@@D&summ2=m&>.

87. Congressional Budget Office Cost Estimate, “H.R. 6111, Tax Relief and Health Care Act of 2006,” December 28, 2006.

Obama Proposal

Citing the fact that “some States use [provider] tax revenues to increase payments to those same providers [taxed] and use that additional spending to increase their Federal Medicaid matching payments,” President Obama’s FY 2013 budget proposed reducing the safe harbor threshold from 6 percent to 3.5 percent between FY 2015 and FY 2017.⁸⁸ The Obama administration estimated that this would reduce federal Medicaid expenditures by \$22 billion over the subsequent decade relative to baseline expenditures.⁸⁹ CBO estimated the proposal would reduce federal Medicaid expenditures relative to baseline expenditures by \$48 billion from FY 2013 through FY 2022.⁹⁰

National Commission on Fiscal Responsibility and Reform (Bowles-Simpson) Proposal

Through an executive order in 2010, President Obama created a commission to identify “policies to improve the fiscal situation in the medium term and to achieve fiscal sustainability over the long run.”⁹¹ The commission contained an equal number of Democrats and Republicans and was chaired by Clinton White House Chief of Staff Erskine Bowles and former Republican Senator Alan Simpson. The commission released a plan on December 1, 2010, that was projected to reduce the debt to 60 percent of GDP by 2023 and to 40 percent of GDP by 2035.⁹² The major Medicaid recommendation was to “eliminate state gaming of [the] Medicaid tax gimmick.” According to the commission’s plan,

Many states finance a portion of their Medicaid spending by imposing taxes on the very same health care providers who are paid by the Medicaid program, increasing payments to those providers by the same amount and then using that additional “spending” to increase their federal match. We recommend restricting and eventually eliminating this practice.⁹³

88. Office of Management and Budget, “Cutting Waste, Reducing the Deficit,” 36.

89. Ibid.

90. Congressional Budget Office, “CBO Estimate of the Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President’s Budget Request for Fiscal Year 2013,” March 16, 2012.

91. Executive Order No. 13531—National Commission on Fiscal Responsibility and Reform, February 18, 2010, <https://www.whitehouse.gov/the-press-office/executive-order-national-commission-fiscal-responsibility-and-reform>.

92. National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*.

93. Ibid.

According to the commission’s estimates, this recommendation would have produced federal budget savings of \$5 billion in 2015 and \$44 billion from 2015 through 2020.⁹⁴

UNCERTAINTY OVER FEDERAL BUDGET SAVINGS FROM REFORMING PROVIDER TAXES

The large differences between CBO’s estimates of federal savings that would result from President Obama’s provider tax proposals and similar estimates produced by the Office of the Actuary at the CMS, which are approved by the Office of Management and Budget, indicate significant uncertainty among federal budget and program analysts about the impact of changing allowable provider tax rates. CBO acknowledges that the lack of empirical research makes it difficult to accurately estimate the budgetary impact of changing federal laws governing provider taxes.⁹⁵

When estimating the impact of changes to the safe harbor, CBO’s experts assume that about half the amount of revenue that the state raised through the provider tax and subsequently spent would have been spent even if the state had to raise the revenue from the state tax base.⁹⁶ Therefore, CBO estimates that reducing the provider tax threshold would reduce Medicaid expenditures by an amount equal to half the amount that the state raised between the previous safe harbor threshold and the new safe harbor threshold. CBO estimated that federal Medicaid expenditures would decline by \$11.3 billion over the 2012–2022 period if the provider tax threshold was lowered from 6 percent to 5.5 percent starting in 2013, an indication that a large number of provider taxes are currently at or near the 6 percent threshold.⁹⁷

FIXED MEDICAID PAYMENTS TO STATES WOULD MAKE PROVIDER TAXES OBSOLETE

As acknowledged by CBO, GAO, and most federal budget experts, the federal budget trajectory is unsustainable over the long term.⁹⁸ Federal spending on

94. Ibid.

95. Phone conversation between Congressional Budget Office staff and author.

96. Ibid.

97. Congressional Budget Office, “Reconciliation Recommendations of the House Committee on Energy and Commerce,” April 27, 2012.

98. Government Accountability Office, “Fiscal Outlook: Federal Fiscal Outlook,” http://www.gao.gov/fiscal_outlook/federal_fiscal_outlook/overview#t=0; Congressional Budget Office, *The 2015 Long-Term Budget Outlook*, June 2015.

entitlement programs is largely responsible for this unsustainable path. In 2015, federal spending on Medicare, Medicaid, and the ACA exceeded \$900 billion.⁹⁹ Federal spending on these three programs will grow nearly 6.5 percent per year over the next decade. Without reform, the increasing cost of these programs will lead to large tax increases or large reductions in spending on other public priorities, such as national defense and infrastructure.

One way to address these programs—aside from increased government regulation and price controls—is to realign the incentives created by the programs so that actors are more price and value conscious. Broadly, this can be accomplished by transitioning them from a defined benefit model to a defined contribution model. This has been the trend in the private sector, illustrated by how 401(k)s have largely replaced pension plans.

Medicaid is a two-tiered defined benefit program. One tier is made of state expenditures to insurers and providers to pay for services they deliver. The second tier consists of federal expenditures to states to reimburse them for their required share. While some view the federal-state Medicaid partnership as an example of federalism, Michael Greve refers to the partnership as “cartel federalism,” which “promotes the growth of government at all levels, creates impenetrable intergovernmental bureaucracies and a torrent of transfer payments, and destroys political accountability.”¹⁰⁰

From 2011 through 2014, the House Committee on Oversight and Government Reform conducted extensive oversight of techniques used by states to maximize federal Medicaid funding. The committee also examined problems that the federal government has ensuring that federal tax

“Without reform, the increasing cost of these programs will lead to large tax increases or large reductions in spending on other public priorities, such as national defense and infrastructure.”

99. In August 2015, CBO projected federal spending in fiscal year 2015 equal to \$541 billion for Medicare, \$350 billion for Medicaid, and \$37 billion for exchange subsidies. Congressional Budget Office, “An Update to the Budget and Economic Outlook: 2015 to 2025,” August 2015.

100. Michael Greve, *Federalism and the Constitution: Competition versus Cartels* (Arlington, VA: Mercatus Center at George Mason University, May 22, 2015).

dollars are not misspent.¹⁰¹ A bipartisan committee staff report from March 2013 discusses many of the same problems referenced by Greve:

CMS has struggled historically in protecting Federal tax dollars from being misspent through Medicaid. CMS has been hampered by poor data quality, but the agency has historically failed to often adequately detect and address major problems in state Medicaid programs. A Committee majority staff report from April 2012 detailed several examples of how CMS has failed to protect taxpayer dollars spent through the Medicaid program. Moreover, as GAO has widely reported, states have resorted to creative techniques such as provider taxes and large supplemental payments to draw down additional Federal dollars into their states through the Medicaid program without net State contributions. These techniques undermine the nature of joint Federal-state financial responsibility for the Medicaid program by significantly increasing the Federal share of Medicaid expenditures and further undermining State incentives to run efficient Medicaid programs.¹⁰²

The federal-state financing structure results in neither the states nor the federal government having a strong incentive to ensure that Medicaid spending provides recipients with value. Techniques such as provider taxes and IGTs exemplify the underlying problems with Medicaid's financing structure, which prioritizes higher spending and neglects value.

A 2015 study shows that people enrolled in Medicaid in Oregon through an earlier eligibility expansion receive low value from the program, on average.¹⁰³ Economists Amy Finkelstein, Nathaniel Hendren, and Erzo Luttmer found that "Medicaid's value to recipients is lower than the government's costs of the program, and usually substantially below." They estimated that recipients only benefit by 20 to 40 cents for each dollar of spending. Instead of benefiting lower-income people, the research suggests that large institutions, like

101. From May 2011 through August 2014, the author served as a senior professional staff member for the US House of Representatives Committee on Oversight and Government Reform.

102. House Committee on Oversight and Government Reform, *Billions of Federal Tax Dollars Misspent on New York's Medicaid Program*, March 5, 2013.

103. Amy Finkelstein, Nathaniel Hendren, and Erzo F. P. Luttmer, "The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment," June 2015, <http://economics.mit.edu/files/10580>.

hospitals, nursing homes, and insurance companies, receive the most benefit from Medicaid, as Medicaid largely replaces implicit insurance provided for the low-income uninsured.

In order to increase the incentives for states to obtain higher value for each dollar of Medicaid spending, federal policymakers should consider transitioning Medicaid's federal-state financing structure to a defined contribution model, in which the federal government provides fixed payments to states. One key advantage with a fixed-payment reimbursement structure is that all spending above that level would be paid from the state tax base, so states would be incentivized to create programs that provide better value for each dollar of spending. Financing reform could be coupled with additional flexibility for states to try innovative approaches and to better tailor their programs for their populations.

In addition to the deadweight loss that results from taxes needed to finance Medicaid, deadweight loss also results when states and local governments develop and implement financing techniques like provider taxes, IGTs, and supplemental payments. These techniques also reduce the transparency of the cost of the Medicaid program to state policymakers, which can lead the policymakers to make decisions based on misleading information. Moreover, a federal bureaucracy has formed with the task of reducing inappropriate or unlawful state methods to increase federal Medicaid funding. Part of this federal bureaucracy would be unnecessary if the incentives at the core of the Medicaid program were better aligned.

If the federal financing structure of Medicaid remains unchanged, states will continue to have an incentive to maximize federal funds rather than to seek value from the program. Replacing the open-ended federal reimbursement of state spending with fixed payments to states would make provider taxes and other techniques employed by states to raise federal financing costs obsolete. (It is worth noting that states might try to figure out ways to game the formula that would determine payments. However, the federal government could set an overall budgetary cap for program expenditures. This cap could be adjusted for economic conditions in order to alleviate the concern that states will require more federal assistance—obtained through federal borrowing—during economic downturns.)

CONCLUSION: ABSENT LARGE-SCALE REFORM, ADOPT SUGGESTIONS TO PHASE OUT PROVIDER TAXES

The root problem with Medicaid financing is the open-ended federal reimbursement of state expenditures, and phasing out provider taxes would address only a symptom of that problem. However, if confronting unsustainable federal

healthcare commitments is viewed as an important priority by policymakers, they should, at a minimum, implement the recommendation of the Bowles-Simpson Commission and begin phasing out provider taxes. This would both increase the transparency of the program's financing and move Medicaid in the direction of the original financing design, which based the share of federal financing on state per capita income and not on states' abilities to design creative financing techniques to maximize federal Medicaid funds.

APPENDIX: A CASE STUDY OF ARIZONA'S RECENT USE OF PROVIDER TAXES TO INCREASE FEDERAL FUNDING

In 1982, 17 years after Medicaid was created, Arizona became the last state to create a program.¹⁰⁴ From 1982 through 2000, Arizona's Medicaid program generally covered traditional populations, including lower-income children, pregnant women, the blind and disabled, and low-income elderly. In 2000, 63 percent of Arizona voters supported Proposition 204, a referendum to expand Medicaid coverage for all persons living at or below 100 percent of the FPL.¹⁰⁵ In December 2001, Arizona received federal approval for a Section 1115 waiver to expand Medicaid to nondisabled childless adults and parents with income below 100 percent of the FPL.¹⁰⁶

Arizona's Medicaid spending exploded after this expansion, rising an inflation-adjusted 233 percent from 2000 to 2010. This increase, the largest in the nation during this period, far exceeded the average inflation-adjusted increase of 53 percent for the rest of the country.

Figure A1 shows Medicaid spending growth in Arizona relative to the rest of the country since 1997. Between 1997 and 2000, Medicaid spending growth in Arizona tracks with the rest of the country. But in 2001 Arizona's Medicaid spending started to increase much more rapidly than it did in the rest of the country. Arizona's spending increase was driven by fast-growing Medicaid enrollment, which went from less than 500,000 people in 2000 to about 1.35 million people in 2010.¹⁰⁷

As in most states, the recession that followed the financial crisis in 2008 caused a steep decline in Arizona's state revenue. Although the federal government reimburses about two-thirds of Arizona's Medicaid expenditures, the deficit forced Arizona lawmakers to confront Medicaid's growing budgetary impact.¹⁰⁸ Then-governor Jan Brewer's proposed 2011 budget sought to eliminate coverage for 47,000 children and for more than 300,000 childless adults.¹⁰⁹

104. Arizona State Senate, "Arizona Health Care Cost Containment System," (issue paper, July 12, 2010).

105. Janet Napolitano, Arizona Attorney General Opinion No: I01-008 (R00-072) RE: Proposition 204, March 6, 2001, <https://www.azag.gov/sgo-opinions/proposition-204>.

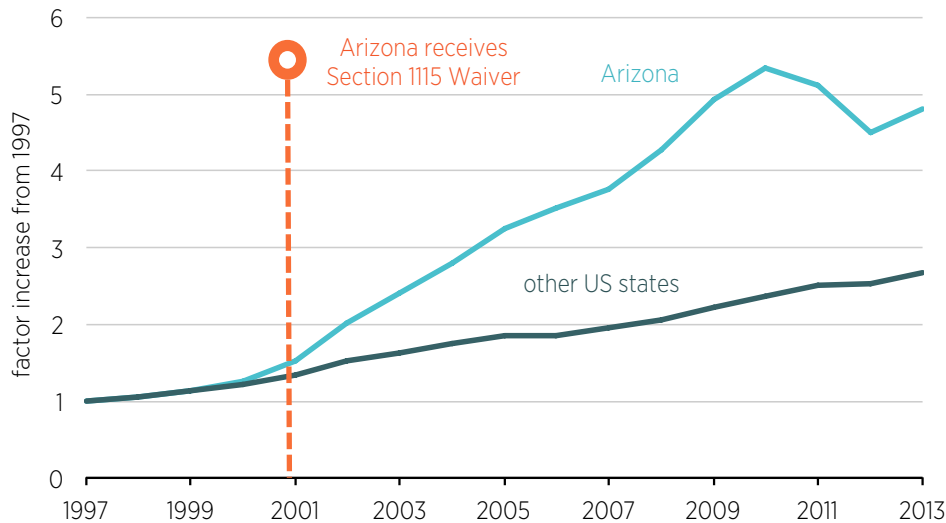
106. Chris McIsaac, "Insuring Arizona: Preserving AHCCCS Coverage in a Challenging Economy" (Arizona Chamber Foundation policy brief, July 2011).

107. Kaiser Family Foundation, "Monthly Medicaid Enrollment (in thousands)," accessed February 10, 2016, <http://kff.org/medicaid/state-indicator/monthly-medicaid-enrollment-in-thousands/>.

108. Nicholas Johnson, Phil Oliff, and Erica Williams, "An Update on State Budget Cuts," Center on Budget and Policy Priorities, February 9, 2011, <http://www.cbpp.org/research/an-update-on-state-budget-cuts?fa=view&id=1214>.

109. Janice K. Brewer, governor of Arizona, "The Executive Budget: Summary, Fiscal Year 2011," January 15, 2010.

FIGURE A1. ARIZONA MEDICAID SPENDING GROWTH VS. US MEDICAID SPENDING GROWTH



Source: Centers for Medicare and Medicaid Services Quarterly Expense Reports.

This proposal, however, was inconsistent with the ACA’s maintenance of effort (MOE) requirements and was stopped by Arizona’s Medicaid director.¹¹⁰

Brewer submitted a revised plan to freeze enrollment at existing levels and put new applicants on a waiting list until additional funding became available.¹¹¹ The CMS allowed Arizona to freeze enrollment for childless adults but did not allow the state to take other requested actions such as freezing enrollment of parents with income between 75 and 100 percent of the FPL or increasing cost sharing amounts. Figure A1 shows that these changes caused Arizona’s Medicaid spending to decline from 2010 to 2012 while spending in the rest of the country increased. The decline in Arizona’s Medicaid spending was significant—from nearly \$9.4 billion in 2010 to \$7.9 billion in 2012.

Arizona Turns to Provider Taxes

Since 2011, Arizona initiated taxes on nursing homes and hospitals so that the state could generate additional federal Medicaid matching funds. The hospital

110. Doug Trapp, “Health Reform Law, Arizona Medicaid Cuts at Odds,” *American Medical News*, April 5, 2010, <http://www.amednews.com/article/20100405/government/304059948/7/>.

111. Arizona Health Care Cost Containment System, “Arizona’s Medicaid Reform Plan: AHCCCS Activities,” <http://www.azahcccs.gov/shared/Downloads/News/AZReformProgressoverview.pdf>.

tax was specifically created to fund the state portion of the costs of Arizona’s decision to adopt the ACA Medicaid expansion.

First, Arizona approved a tax on nursing home facilities in 2012 “in order to obtain federal financial participation.”¹¹² The tax may not exceed 3.5 percent of a nursing home’s net patient revenue, and the state explicitly stated that 99 percent of the funds would return to nursing homes (after they are federally matched) via supplemental payments.¹¹³

In the first year, \$18 million in revenue was raised from the nursing home tax. Since Arizona’s FMAP equaled about 66 percent, Arizona was able to turn the provider tax revenue into about \$34 million of federal funds. (66 percent of \$52 million equals about \$34 million, so when the state spends \$52 million on Medicaid, the federal share is about \$34 million and the state share is about \$18 million.) In essence, the state turned \$18 million in “fake” revenue into \$34 million of seemingly “free” federal funding.

Arizona Expands Medicaid Under ACA Using a Hospital Tax

In early 2013, Brewer requested that the CMS allow Arizona to keep the enrollment freeze in place while retaining federal matching funds for its nondisabled, childless adult population. The CMS rejected the request, responding that such “enrollment caps” were not in line with the goals of Medicaid.¹¹⁴ Brewer then gave state lawmakers four options:¹¹⁵

1. Continue the enrollment freeze for childless adults and cover them using state funds only.
2. Restore coverage for all childless adults, receiving the regular FMAP.
3. Eliminate childless adult coverage.
4. Take the federal Medicaid expansion offered through the ACA and receive the enhanced FMAP for nondisabled, working-age adults.

Brewer’s preference was to adopt the ACA Medicaid expansion. Her proposal contained a new hospital assessment to finance the expansion, as well as

112. Arizona State Legislature, Chapter 213. House Bill 2526, April 5, 2012, http://www.azleg.gov/FormatDocument.asp?inDoc=/legtext/50leg/2r/laws/0213.htm&Session_ID=107.

113. Arizona Health Care Cost Containment System, “Notice of Exempt Rulemaking: Title 9, Health Services Chapter 28,” January 9, 2013.

114. Governor Janice Brewer, letter to Arizona State Senator Andy Biggs and Arizona State Representative Andy Tobin, April 25, 2013, <http://voiceforgreaterphoenix.com/uploads/sites/310/letter.pdf>.

115. *Ibid.*

a “circuit breaker” that would cancel the expansion plan if the federal government reneged on the elevated funding.¹¹⁶

Several state legislators objected to Brewer’s proposal, including Senate President Andy Biggs and then–House speaker Andy Tobin. Despite the objections of the leaders in both state legislative bodies, a slim majority of legislators in both bodies passed Brewer’s plan in June 2013. At the time, Arizona expected that its decision to expand Medicaid to all persons with income below 133 percent of the FPL would add an estimated 300,000 Arizonans to the program.¹¹⁷

Instead of statutorily setting a rate or a target revenue amount for the new hospital tax, the legislature delegated that task to the Medicaid director with the stipulation that it must be applied to “hospital revenues, discharges or bed days for the purpose of funding the nonfederal share of the costs” of the Medicaid program. As a result, Arizona’s Medicaid director sets the assessments after estimating the amount of revenue required to fund the state share of the expansion. For 2016, the Medicaid director has estimated that the state will need \$250 million in total hospital assessments.¹¹⁸ According to Arizona’s Medicaid agency, hospitals will receive more in additional Medicaid payments than the amount of the assessment:

In the aggregate, the Administration expects to return millions more in SFY 2016 in incremental payments for hospital services than will be collected through the assessment.¹¹⁹

State policymakers challenged the legality of the hospital tax because they believed it violates Arizona’s constitutional requirement that two-thirds of the state House and Senate support any “act that provides for a net increase in state revenues.”¹²⁰ On August 26, 2015, an Arizona Superior Court judge ruled against the plaintiffs, stating that the hospital assessment was not subject to the

116. Mary K. Reinhart, “Brewer Unveils Legislation to Broaden Medicaid Eligibility,” *Arizona Republic*, March 13, 2013, <http://www.azcentral.com/news/politics/articles/20130312brewer-unveils-legislation-broaden-medicaid-eligibility.html>.

117. Bob Christie and Cristina Silva, Associated Press, “Arizona Gov. Brewer Secures Medicaid Expansion,” *Yahoo News*, June 14, 2013, http://news.yahoo.com/arizona-gov-brewer-secures-medicaid-expansion-093852410.html;_ylt=A2KJ2UaJELtRUBMAmETQtDMD%20%20target=.

118. Arizona Health Care Cost Containment System, “Notice of Exempt Rulemaking: Title 9, Health Services Chapter 22,” July 2015.

119. *Ibid.*

120. Arizona Constitution, Article IX, Section 22.

two-thirds legislative requirement for new taxes.¹²¹ The judge explained that the hospital assessment was allowable, in part, because the assessments directly benefited the payees, that is, the hospitals. According to the judge’s decision, “that the assessment benefits the hospitals more than anyone or anything else is confirmed by plaintiffs’ own motion . . . which insists that the hospitals, and ‘not the people’ are the ‘*true beneficiaries* of Arizona’s Medicaid expansion.”¹²²

121. Mary Jo Pitzl, “Judge: Arizona Medicaid Expansion Was Constitutional,” Goldwater Institute, <http://goldwaterinstitute.org/en/work/topics/healthcare/medicaid/judge-arizona-medicaid-expansion-was-constitutiona/>.

122. Andy Biggs et al. v. Janice K. Brewer et al., Superior Court of Arizona, Maricopa County, August 26, 2015. Emphasis in the original.

ABOUT THE AUTHOR

Brian Blase is a senior research fellow focusing on healthcare policy with the Spending and Budget Initiative at the Mercatus Center at George Mason University. Previously, Blase was with the Senate Republican Policy Committee, where he served as a healthcare policy analyst. Before that he worked as senior professional staff for the House Committee on Oversight and Government Reform. Blase received his PhD in economics from George Mason University in 2013, with a dissertation focused on Medicaid financing.

ABOUT THE MERCATUS CENTER AT GEORGE MASON UNIVERSITY

The Mercatus Center at George Mason University is the world's premier university source for market-oriented ideas—bridging the gap between academic ideas and real-world problems.

A university-based research center, Mercatus advances knowledge about how markets work to improve people's lives by training graduate students, conducting research, and applying economics to offer solutions to society's most pressing problems.

Our mission is to generate knowledge and understanding of the institutions that affect the freedom to prosper and to find sustainable solutions that overcome the barriers preventing individuals from living free, prosperous, and peaceful lives.

Founded in 1980, the Mercatus Center is located on George Mason University's Arlington and Fairfax campuses.