CAPITOL RESEARCH

Provider Taxes: A Revenue Source for Health Care

As revenues decline and Medicaid enrollment grows, states increasingly are turning to taxes on hospitals, nursing homes and other health care providers to generate funds to pay for their Medicaid programs. Medicaid provides health insurance for low-income families and long-term care services for the elderly and disabled. It is jointly financed by federal and state governments, but states must spend their own funds to receive a federal financial match. States generate those Medicaid matching funds from several sources, including income, property, sales and estate taxes, and other sources that generally make up states' and counties' general funds. But states can also raise Medicaid matching funds by imposing fees, assessments and other taxes on health care providers.

A growing number of states are turning to provider taxes to pay for health care. Revenue from these taxes is used as the state share to qualify for additional matching funds from the federal government. Each dollar of revenue raised from provider taxes equals between $1 and $3 in federal Medicaid matching funds, depending on the state's match rate. Additional federal funds are used to increase payments to the taxed providers as a means of incentivizing them for providing care to the Medicaid population. Most, but not all, providers will receive more in increased Medicaid payments than they paid in taxes, depending upon the amount of Medicaid services provided. The tax may also help states pursue other policy objectives within Medicaid, such as expanded coverage, and free up general funds to pay for other needed state services such as education and transportation.

The federal stimulus package of 2009 that provided an extra $87 billion to Medicaid by raising the federal Medicaid funding percentage made taxing providers even more attractive. The temporary stimulus legislation increased each state's federal match rate by at least 6.2 percentage points. Each dollar of revenue raised from provider taxes qualifies for the additional increase in federal matching funds.

In general, states implement provider taxes to generate state funds to draw down federal matching funds for their Medicaid programs. The new funds

are often used to increase rates for providers that lag below the actual cost of providing care to Medicaid patients, or to help achieve programmatic or policy goals, such as compensating providers for reductions in bed supply or covering the uninsured. States may also redirect a portion of the funds to pay for other health-related services or general state expenses. States are prohibited from making payments to providers that directly correlate with the amount of the tax paid, so some redistribution among providers is inevitable even if funds are not redistributed to the state general fund coffers. Those providers that provide little in Medicaid services must pay the tax without much reimbursement.

The federal government must review and approve provider tax programs before states implement them. The time of the review will depend on the complexity of the provider tax/assessment, but can take anywhere from six months to more than a year and can delay much-needed relief for a state.

CSG
The Council of State Governments
Sharing capitol ideas.

In 2009, Arkansas, California, Colorado, Missouri, Oregon and Wisconsin enacted provider tax legislation to generate millions in federal funds to expand coverage or increase provider payments.

Provider tax programs must comply with guidelines established in federal regulation:

- The tax must be broad-based and uniformly applied to all providers within specified classes; states cannot limit the provider taxes only to Medicaid providers;
- The tax cannot exceed 25 percent of the state share of Medicaid expenditures; and
- States cannot guarantee that providers be "held harmless." In other words, they cannot provide a direct or indirect guarantee that providers will receive their money back. This prohibition is presumed to be met if states tax providers at or below 5.5 percent on their revenues.

These taxes can apply to 19 different types of providers:

- Inpatient hospital services;
- Outpatient hospital services;
- Nursing facilities;
- Intermediate care facilities for the developmentally disabled;
- Physician services;
- Home health services;
- Managed care organizations;
- Prescription drugs;
- Ambulatory surgical center services;
- 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 health care services and items for which a state has a licensing or certification fee.

How Provider Taxes Work

A health care provider pays a tax or fee to the state government, which then uses the money as the state's necessary matching funds to bring in additional federal Medicaid money according to the individual state's match rate. The total funds are then distributed to health care providers.

A provider tax is illustrated as follows:

- Initial tax on health care services. The first step in the process is to adopt a tax on health care services. For this example, $10 million in increased revenue are generated by taxing providers.
- Medicaid payments. The second step is to use the increased revenue to increase Medicaid reimbursements, generating additional federal funds at the federal match rate. The matching rate is at least 50 percent of every dollar spent in each state. The rate is more in poorer states, climbing to more than 70 percent in some of the poorest states, and rises even more with the enhanced matching rates under the federal stimulus act. With a match rate of 50 percent, for every $10 million in taxes (state share) an additional $10 million in federal match are now available to pay providers. Now $20 million is available for distribution:
- Impact on providers and the state. The $20 million in new Medicaid reimbursements is typically split among providers who contributed to the tax and other classifications of providers who were not taxed.
  - Providers. Most providers that pay taxes end up as winners due to the increased Medicaid reimbursement. Because the federal government requires the tax result in some redistribution of funds, some providers will inevitably lose, such as those that provide few services to Medicaid patients. Non-taxed providers may also benefit from an increase in Medicaid reimbursement.
  - State budget. The net impact on the state budget is typically zero as this new revenue source is used to finance increased reimbursement or expansions in Medicaid.

Recent Developments

Using provider taxes as a way to generate the state matching share has become a common practice among states, particularly during economic downturns. States have shown renewed interest in provider taxes in the past several years as states look for a way to balance the books, avoid cuts in provider reimbursements and expand coverage to the uninsured. Several states have increased taxes or approved new taxes on hospitals, nursing homes or managed care plans. The number of states taxing at least one provider group has grown to 45, plus Washington, D.C. Thirty-six states tax more than one provider group. Only Alaska, Delaware, Hawaii, Virginia and Wyoming tax no provider group.

In 2009, Arkansas, California, Colorado, Missouri, Oregon and Wisconsin enacted provider tax legislation to generate millions in federal funds to expand coverage or increase provider payments.

Arkansas passed Senate Bill 582, which imposed an assessment fee on hospitals which will generate

an estimated $105 million in new revenue, and Senate Bill 354, which imposed a fee on intermediate care facilities for the developmentally disabled.

California passed Assembly Bill 1383, which imposes fees on hospitals to gain an additional $4.3 billion in federal funding to increase state Medicaid payments to public hospitals and to cover children.

Colorado's Healthcare Affordability Act assesses a provider fee on hospitals to draw an additional $600 million in federal funds annually. The combined $1.2 billion in federal and state funds will be used to expand eligibility to cover more than 100,000 uninsured through Medicaid and Colorado's Child Health Plan Plus, and to raise hospital reimbursement rates.

Missouri passed a number of bills in 2009 that extend or create health care provider taxes or fees. House Bill 740 taxes home health services; House Bill 395 extends several provider taxes; and Senate Bill 307 imposes a tax on providers of ambulance service and certain mental health providers.

Like Colorado, **Oregon** plans to expand coverage for children and low-income Oregonians from the additional funding generated from an increased hospital tax and a 1 percent tax on commercial insurance premiums. The hospital tax will fund approximately 35,000 adults and the insurers' tax will fund medical coverage for 80,000 additional children. The additional state funds will allow Oregon to receive nearly $2 billion in federal Medicaid matching funds. House Bill 2116

Wisconsin implemented a new 1.4 percent hospital tax on hospitals' and ambulatory surgical centers' gross revenue. The measure is expected to increase the state's Medicaid reimbursement funding by $300 million a year. Most of the revenues will be returned to the hospitals, but some of the revenue will be used to expand health coverage to low-income, childless adults.

As state budget deficits increased in 2010, additional states—including Georgia, Idaho, Iowa, Oklahoma, Tennessee, Utah, Washington and Wisconsin—passed legislation either imposing new taxes or expanding taxes on hospitals and generating millions in additional federal funds. Hospitals lobbied for taxes in the majority of the states as a way to avoid cuts for services they provide.

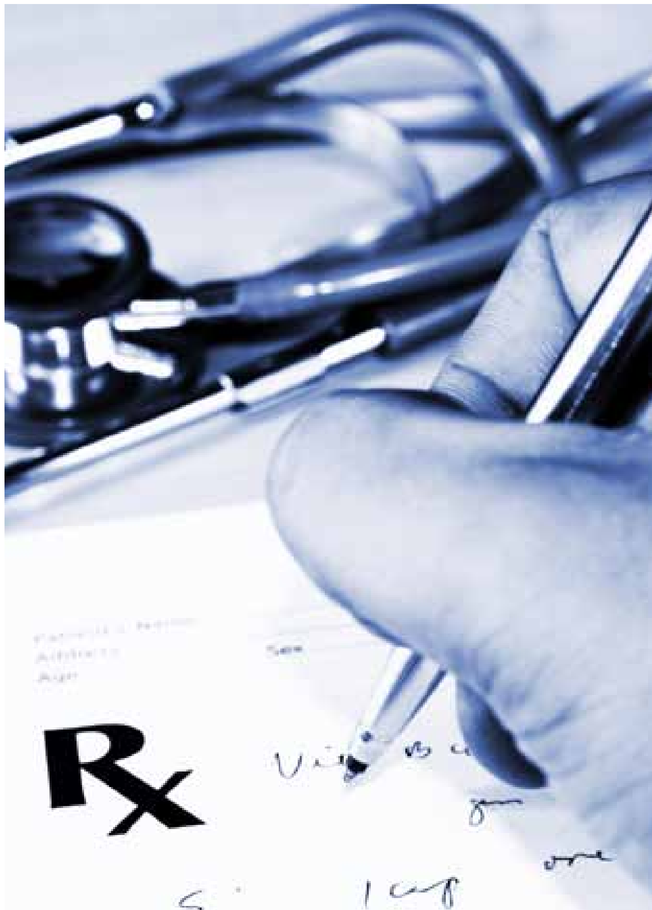
Georgia House Bill 307. Faced with the alternative of losing already low Medicaid reimbursement, Georgia hospitals agreed to a 1.45 percent fee or "bed tax" on patient revenue to remedy its worsening budget crisis. The new fee is expected to raise $225 million a year.

In **Idaho**, hospitals backed a bill that would require them to pay $25 million annually in the 2011 and 2012 fiscal years to offset a $47 million Medicaid budget hole. The $25 million is part of the plan lawmakers used in balancing the state budget. House Bill 656

Iowa Gov. Chet Culver signed into law Senate File 2388, which creates a new provider fee on medium and large hospitals that will generate about $48.6 million a year in extra federal matching money.

Hospitals will get $20.5 million back each year through rate increases, and the state will net about $19.4 million for other Medicaid expenses.

Oklahoma Gov. Brad Henry signed into law House Bill 2437, which imposes a one percent tax on all health care claims paid by health carriers, including private insurance companies, third-party administrators, and self-insured companies. The insurance fee will generate an estimated $78 million a year that will be matched with about $190 million in federal funds.



Hospitals lobbied for taxes in the majority of the states as a way to avoid cuts for services they provide.

As states grapple with hard choices and deep deficits, exploring effective revenue solutions is one answer for surviving the economic downturn.

Tennessee passed a 3.5 percent "coverage fee" on hospitals' net revenues, which is estimated to generate nearly $230 million for the state's Medicaid program that will be used to draw down federal matching dollars of $679 million. The coverage fee is a temporary, one-year fix proposed by the hospital association to avoid cuts in the Medicaid program. Senate Bill 3528/*House Bill 3310

Utah's enacted legislation will assess a fee on hospitals that will be used to prop up its Medicaid reimbursement rates. The assessment, which the hospitals lobbied for, is expected to generate $90 million in federal dollars in the 2011 fiscal year. Senate Bill 273.

Legislators in **Washington** approved a tax on hospitals that is expected to generate an estimated $500 million in federal funds. The hospital association lobbied for passage of the legislation, which will restore earlier Medicaid cuts. House Bill 2956

Wisconsin's hospital tax was extended to rural hospitals that were exempted from the 2009 tax. The rural hospital tax is expected to bring in about $10.6 million a year in additional federal matching funds. Assembly Bill 770

At least two more states—New Jersey and Connecticut—are either considering creating or increasing provider fees.

New Jersey Gov. Chris Christie's proposed budget for the 2011 fiscal year includes increased funding for charity care and struggling state hospitals. The governor wants to lift the cap on the existing 0.53 percent tax on hospital revenues in order to raise an additional $45 million in state revenues, which will generate $45 million in federal matching funds.

In **Connecticut**, Senate Bill 478 has moved through the Finance, Revenue and Bonding Committee. The legislation would institute a temporary hospital tax of 5.5 percent on gross hospital revenues. The proposed bill would realize a net gain of $83.5 million in federal reimbursements for Medicaid.

Conclusion

The federal government recognizes states' rights to impose taxes on health care providers and provides federal matching funds for those provider assessments through the Medicaid program. To ensure states are not attempting to circumvent their obligations for paying the non-federal share of the cost of Medicaid, federal law places strict requirements on state provider taxes—they must be broad-based, uniformly imposed, and cannot guarantee a provider will receive provider payments that will offset the amount of taxes paid. Provider taxes serve as an important revenue stream for states, particularly during economic downturns when states experience significant increases in Medicaid enrollment. As states grapple with hard choices and deep deficits, exploring effective revenue solutions is one answer for surviving the economic downturn.

Wanda Fowler, Senior Health Policy Analyst.
wfowler@csg.org

Provider Taxes in the States

State	Hospital	Nursing Facility	ICF/MR-DD	Managed Care Organizations	Any Provider Tax
Alabama	X	X			X
Alaska					
Arizona				X	X
Arkansas	X	X	X		X
California	X	X	X	X	X
Colorado	X	X	X		X
Connecticut		X			X
Delaware					
District of Columbia		X	X		X
Florida	X	X	X		X
Georgia	X	X		X	X
Hawaii					
Idaho	X	X			X
Illinois	X	X	X		X
Indiana		X	X		X
Iowa	X	X	X		X
Kansas	X	X			X
Kentucky	X	X	X	X	X
Louisiana		X	X		X
Maine	X	X	X		X
Maryland	X	X	X	X	X
Massachusetts	X	X			X
Michigan	X	X		X	X
Minnesota	X	X	X	X	X
Mississippi	X	X	X		X
Missouri	X	X	X	X	X
Montana	X	X	X		X
Nebraska		X			X
Nevada		X			X
New Hampshire	X	X			X
New Jersey	X	X	X		X
New Mexico				X	X
New York	X	X			X
North Carolina		X	X		X
North Dakota		X			X
Ohio	X	X	X	X	
Oklahoma		X			X
Oregon	X	X		X	X
Pennsylvania	X	X	X	X	X
Rhode Island	X	X	X	X	X
South Carolina	X		X		X
South Dakota			X		X
Tennessee	X	X	X	X	X
Texas			X	X	X
Utah	X	X	X		X
Vermont	X	X	X		X
Virginia					
Washington	X				X
West Virginia	X	X	X		X
Wisconsin	X	X	X		X
Wyoming					

Source: Kaiser Commission for Medicaid and the Uninsured; Independent research by The Council of State Governments