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Commentary: Limiting State Provider Taxes Would Shift Costs to States and Weaken Medicaid

By Edwin Park

This week, the House Energy and Commerce Committee approved legislation (H.R. 4725) that would restrict states' ability to use taxes on health care providers such as hospitals and nursing facilities, as well as managed care plans, to help finance state Medicaid programs. Such a proposal, which would affect about half of the states,[1] would likely result in damaging Medicaid cuts and undermine health reform's Medicaid expansion.

Every state except Alaska uses provider taxes to help finance its Medicaid program.[2] Critics argue, however, that the federal government should curtail or bar this practice because states use provider taxes to manipulate federal Medicaid financing: states can levy a tax on providers, the argument goes, use the revenue to qualify for more federal matching funds, and then return the tax revenues to the providers in the form of higher Medicaid reimbursements. Sharply restricting (or ending) states' ability to use these revenues would secure federal savings without adversely affecting low-income beneficiaries, critics claim. They also claim that states could institute efficiencies in their Medicaid programs to make up for the reductions in federal funding.

This argument, however, doesn't stand up under scrutiny. Provider taxes today don't actually work like these critics claim. Federal laws enacted in 1991 and in 2006, along with tougher federal regulations, have reined in manipulative state practices. Also, restricting or ending states' ability to use these revenues would almost certainly have serious consequences for low-income Medicaid beneficiaries and would likely cause several million other poor people to remain uninsured by discouraging states from adopting the Medicaid expansion. That's why the Obama Administration, which once proposed restrictions in this area, no longer supports them.

Criticisms of Provider Taxes Are Misinformed

Let's start by dispelling some misunderstanding. To be sure, provider taxes used to be a source of some abuse, with some states designing them so the tax payments were indeed returned to the

[1] Kaiser Family Foundation, "State and Medicaid Provider Taxes or Fees," March 14, 2016, http://kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/.

[2] Kaiser Family Foundation, *op cit.*

providers that paid them. But the federal government clamped down on such practices, which are now illegal.

Today, any state that wants to impose a tax on various types of providers and use the revenues to help finance Medicaid must impose the tax on *all* providers in a given category (e.g., all hospitals or all nursing homes) and on a *uniform basis,* regardless of whether the providers serve many, few, or no Medicaid patients. States may *not* structure provider taxes so the providers paying the taxes are made whole.

As the Kaiser Commission on Medicaid and the Uninsured has explained, federal provider tax rules are now "designed to ensure that provider taxes are, in fact, taxes generating revenue for a state rather than a mechanism for drawing down federal Medicaid matching funds without a state contribution." Provider taxes "must be broad-based, uniformly imposed, and cannot hold providers harmless," Kaiser noted.[3] Policymakers should not be misled by critics' simplistic descriptions that portray the taxes as working in ways that the law no longer permits.

Restricting Use of Taxes Would Harm Low-Income Beneficiaries

Moreover, whatever one thinks of provider taxes, it's critical to examine the impacts on low-income people of denying states the ability to use this financing source.

If states could simply replace provider tax revenues with other financing for their Medicaid programs, then federal Medicaid spending — which covers a specified share of a state's Medicaid costs — would remain unchanged. But the Congressional Budget Office (CBO) estimates that barring or sharply restricting states from using provider taxes would produce federal savings — because CBO expects that states would *not* be able to replace all the lost revenue and *would cut their Medicaid programs to offset the loss of funds.*

Indeed, for each federal dollar saved by denying states access to this funding source, state Medicaid programs would shrink by about *$2.* The federal government pays a little over half of Medicaid costs, so state Medicaid programs must shrink by about $2 for the federal government to realize $1 in savings. Without provider taxes, states would either have to come up with substantial new revenue or — as CBO expects — institute further Medicaid cuts.

Where would these cuts come from? Many states have already made substantial Medicaid cuts in recent years to help balance their budgets during the recession and its aftermath, when state revenues fell while the need for Medicaid increased. These cuts included eliminating dental or vision care for many beneficiaries, limiting coverage of essential medical equipment, restricting personal care for people who are frail or have disabilities, and limiting access to nursing homes and other long-term services and supports.

It's hard to see how states could wring additional efficiencies out of Medicaid to offset the impact of a provider tax cut without reducing beneficiaries' access to care or further cutting provider payment rates, which already are well below those of Medicare and private insurance. As research shows, Medicaid is quite lean to begin with: it spends 27 percent less, on average, per child than the

[3] Kaiser Family Foundation, "Medicaid Financing Issues: Provider Taxes," May 2011, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8193.pdf.

cost of private insurance for children of similar health status and 20 percent less per adult.[4] That's due largely to its lower provider payment rates — some states say they have trouble attracting enough providers to serve Medicaid beneficiaries — and its much lower administrative costs.

Moreover, as Kaiser has noted, provider taxes also help finance provider reimbursement adjustments needed to keep pace with increases in health costs. And these taxes help to avoid (or reduce the size of) provider reimbursement rate *cuts* that states would otherwise make to help close budget deficits.

Of particular importance, provider taxes also help finance Medicaid coverage expansions. For example, states like Arizona, Indiana, and Ohio have used provider tax increases to help finance their Medicaid expansions under the Affordable Care Act (ACA).[5] Additional states plan to use provider tax increases to help fund the state share of Medicaid expansion costs once the federal matching rate for expansion costs phases down from 100 percent starting in 2017 (but to no less than 90 percent on a permanent basis).[6]

Indeed, restricting states' use of provider taxes would likely reduce state take-up of the Medicaid expansion, leaving more poor Americans uninsured. The ACA was designed to address one of the most glaring holes in the U.S. safety net: the fact that we, alone among Western democracies, allowed tens of millions of poor citizens to go without health insurance because they can't afford it. While the ACA has substantially reduced the ranks of the uninsured, those gains can and should be much greater.

To date, only 31 states and the District of Columbia have adopted the ACA's Medicaid expansion (including Louisiana, which is scheduled to implement the expansion later this year). While the federal government will pick up nearly all of the cost, expansion opponents argue that it will renege on that commitment and alter Medicaid financing rules to shift costs to states.

Federal action to restrict or bar state provider taxes would almost certainly discourage some other states from adopting the Medicaid expansion. As a result, *the nearly 3 million poor Americans in non-expansion states who lack health coverage and aren't eligible for subsidized marketplace coverage would likely remain uninsured.*[7] Moreover, some states that are using a provider tax increase to help finance their share of expansion costs could drop their expansions as a result, casting more poor Americans into the ranks of the uninsured.

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[4] Leighton Ku and Matthew Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* (web exclusive), June 24, 2008.

[5] Community Catalyst, "Health Care Provider Assessments: A State-Based Funding Solution for Closing the Coverage Gap," June 2015, http://www.communitycatalyst.org/resources/publications/document/ProviderAssessmentsforCTG_06.10.15.pdf.

[6] According to a 2015 survey of state Medicaid programs conducted by the Kaiser Family Foundation, at least four additional states — California, Colorado, Kentucky, and Nevada — reported that they plan to institute provider tax increases in order to fund at least some of the state share of expansion costs when the federal expansion matching rate declines from 100 percent starting in 2017. See Kaiser Family Foundation, "State and Medicaid Provider Taxes or Fees."

[7] Rachel Garfield and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States that Did Not Expand Medicaid — An Update," Kaiser Family Foundation, January 21, 2016, http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.