Health Care-Related Taxes in Medicaid

Under the Medicaid statute, states may generate their share of Medicaid expenditures through multiple sources, including health care-related taxes, sometimes referred to as provider taxes, fees, or assessments. Such taxes are defined as those for which at least 85 percent of the tax burden falls on health care items or services (§ 1903(w)(3)(A) of the Social Security Act (the Act)). They include taxes imposed as a percentage of revenue and flat taxes (e.g., those imposed based on the number of facility beds or inpatient days). This issue brief describes the current use of health care-related taxes in Medicaid, the history and current state of the rules governing their use, and the potential effects of changes to these policies.

Health care-related taxes have become a more common funding source for state Medicaid programs over the past 15 years. In state fiscal year (SFY) 2019, 49 states and the District of Columbia imposed at least one health care-related tax, up from 35 states in SFY 2004. In SFY 2019, the most common health care-related taxes were levied on institutional providers, with 45 states imposing at least one tax on nursing facilities, 43 states imposing hospital taxes, and 35 states imposing taxes on intermediate care facilities for individuals with intellectual disabilities (Figure 1) (KFF 2019).

Data from SFYs 2008–2012 (the most recent years for which such data are available) indicate that health care-related taxes have been a rapidly growing financing source for states. In SFY 2012, 10 percent of state Medicaid funds came from health care-related taxes, 69 percent of funds from state general revenues, 15 percent from local governments, and 5 percent from other sources. Health care-related taxes raised $18.7 billion in non-federal share in SFY 2012, nearly doubling from $9.7 billion in SFY 2008. In percentage terms, this was an increase from 6.7 percent of total non-federal share in SFY 2008 to 10.4 percent in SFY 2012 (GAO 2014).

The use of health care-related taxes varies widely across states. In SFY 2012, health care-related taxes as a percentage of non-federal share (among states that reported any health care-related taxes) ranged from a marginal amount (0.5 percent) in South Dakota, Texas, and Virginia to more than half (51.6 percent) in Missouri. On average, provider taxes made up 13.3 percent of the non-federal share for the states that reported using provider taxes that year (GAO 2014).

States that established health care-related taxes between SFYs 2008 and 2012 cited a variety of purposes for the revenue. The most common were supporting base Medicaid payment rates, funding supplemental payments, averting Medicaid benefit cuts, and expanding Medicaid benefits (GAO 2014). As of January 2019, at least 14 states had used or were planning to use health care-related taxes to fund the non-federal share of the cost of expanding Medicaid coverage under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (Families USA 2019).
History and Current Policy for Health Care-Related Taxes

Health care-related taxes have been permissible as a source of state financing for Medicaid since the program’s inception. Use of such taxes grew during the 1980s as many states combined health care-related taxes with targeted supplemental payments, allowing them to increase federal contributions and fully reimburse providers for their contributions to the non-federal share of Medicaid (known as a hold harmless arrangement). In response to concerns about the growing federal financial liability created by these arrangements, Congress limited the use of health care-related taxes and donations in the Medicaid

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Under current federal regulations, states may use health care-related taxes as a source of non-federal share of Medicaid if they meet the following three requirements or qualify for a waiver (42 CFR 433.68):

**Broad based.** A broad-based tax is imposed on all the non-governmental health care entities, items, and services within a class and throughout the jurisdiction of the applicable unit of government. For example, the tax cannot be exclusive to hospitals that treat a high proportion of Medicaid patients.

**Uniform.** A uniform tax applies consistently in amount and scope to the entities, items, and services to which it applies. For example, the tax rate cannot be higher on a managed care plan’s Medicaid revenue than on its non-Medicaid revenue.

**Does not hold taxpayers harmless.** Taxpayers cannot be held harmless; that is, they cannot be given a direct or indirect guarantee that they will be repaid for all or a portion of the amount of taxes that they contribute. Additionally, Medicaid and non-Medicaid payments from states to providers must not vary based on the amount of tax revenue collected from these providers. An indirect hold harmless guarantee exists if a health care-related tax produces revenue that exceeds 6 percent of net patient revenue, what is referred to as the safe harbor threshold, and 75 percent or more of taxpayers in a class receive 75 percent or more of their total tax costs back from Medicaid.

**Waiver authority.** The Secretary of the U.S. Department of Health and Human Services may waive the broad-based and uniform requirements as long as states can demonstrate that the net impact of the tax program is generally redistributive (i.e., proportionally derived from Medicaid and non-Medicaid revenues within a class) and that the tax amount is not directly correlated with Medicaid payment amounts. From 2008 through 2012, CMS reviewed and approved health care tax waivers in 29 states (GAO 2014).

**Illustration of a permissible health care-related tax arrangement**

Actual health care-related tax amounts and the distribution of tax revenue vary across states and by each individual tax; however, the arrangement below is one illustrative example of a health care-related tax that satisfies the applicable federal requirements without a need for a waiver (Figure 2).

In this example, the state has only two hospitals. Each earned $1,000 in net patient revenue prior to the tax arrangement. Hospital 1 has high Medicaid volume (80 percent), so Medicaid accounts for $800 of net patient revenue. Hospital 2 has low Medicaid volume (20 percent), so Medicaid accounts for $200 of net patient revenue. Each hospital is assessed a tax that totals 6 percent of its net patient revenue, for a total tax assessment of $120. The state uses some of this tax revenue ($80) to increase its Medicaid payment rates to hospitals by 20 percent across the board. Because this state’s federal medical assistance percentage (FMAP)—that is, the federal share of a state’s Medicaid expenditures—is 60 percent, the federal government contributes 60 percent ($120) of the increased Medicaid payments to hospitals ($200 total).
FIGURE 2. Illustration of a Permissible Health Care-Related Tax Arrangement for Hospitals with Different Medicaid Volumes

Notes: FMAP is federal medical assistance percentage. This state’s FMAP is 60 percent. The above example is illustrative only.

**Net financial effects.** Permissible tax arrangements have potential financial benefits for states and providers, but these financial effects can vary based on differences in providers’ Medicaid revenues. In the above example, Hospital 1 has an increase in Medicaid revenue ($160) that is larger than its tax liability ($60). Hospital 2 has an increase in Medicaid revenue ($40) that is smaller than its tax liability ($60). The state’s health care tax collection ($120) is higher than the amount of taxes it collected and used as the non-federal share of its increased Medicaid payments to the two hospitals ($80). Because this state’s FMAP is 60 percent, the federal matching contribution for the state’s increased hospital payments totals $120 with no corresponding increase in federal tax revenue (Table 1).

**TABLE 1.** Summary of the Financial Effects of the Hospital Tax Arrangement on Stakeholders in Figure 2

<table>
<thead>
<tr>
<th>Financial transfer</th>
<th>Hospital 1 (high Medicaid volume)</th>
<th>Hospital 2 (low Medicaid volume)</th>
<th>State government</th>
<th>Federal government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax payment</td>
<td>-$60</td>
<td>-$60</td>
<td>+$120</td>
<td>NA</td>
</tr>
<tr>
<td>Medicaid payment increase</td>
<td>+160</td>
<td>+40</td>
<td>-80</td>
<td>-$120</td>
</tr>
<tr>
<td>Net financial effect</td>
<td>+100</td>
<td>-20</td>
<td>+40</td>
<td>-120</td>
</tr>
</tbody>
</table>

Notes: FMAP is federal medical assistance percentage. NA is not applicable. This state’s FMAP is 60 percent. The above example is illustrative only.

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Implications of Proposed Reductions to the Safe Harbor Threshold

As noted above, state financing arrangements that indirectly hold taxpayers harmless from taxes may be permissible, as long as those taxes remain below a maximum threshold of 6 percent of net patient revenue. There have been a number of efforts in recent years to reduce the safe harbor threshold, including enactment of a temporary reduction in the threshold to 5.5 percent for January 2008 through September 2011, before returning to its current level of 6 percent.5

Advocates for reducing the threshold argue that this would reduce federal expenditures and limit the federal budget exposure to state financing arrangements. However, estimated savings depend on the extent to which states replace their lost health care-related taxes with other revenue sources. In its December 2018 budget option compendium, the Congressional Budget Office (CBO) scored reducing the threshold to 5 percent, 2.5 percent, and eliminating the safe harbor beginning in federal fiscal year (FFY) 2021 as reducing federal outlays by $15 billion, $108 billion, and $344 billion respectively through FFY 2028. CBO assumed that half of the revenue lost from the reduction of the safe harbor threshold would be replaced by other revenues or from reductions to other parts of state budgets. The other half would be incurred through Medicaid program reductions, such as cutting payment rates and reductions to optional eligibility and benefits (CBO 2018).

While states with health care-related taxes near the safe harbor limit would be affected by even a modest reduction to the threshold, other states would only be affected by a more drastic reduction. Since the creation of the safe harbor, only one state has imposed a health care tax at a rate above 6 percent of net patient revenue.6 However, as of SFY 2017, 28 states had at least one tax that exceeded 5.5 percent of net patient revenue and 43 states and the District of Columbia had at least one health care tax that exceeded 3.5 percent of net patient revenue (KFF 2017). The extent of the effects on state budgets would depend on both the amount of tax revenue that would exceed a reduced safe harbor threshold and the states’ ability to modify their existing financing arrangements.

Endnotes

1 Federal regulations specify 18 separate provider and service classes, including hospitals, nursing facilities, and outpatient prescription drugs, as assessable for purposes of funding the Medicaid program. States are also allowed to define classes for health care items and services on which states have enacted licensing or certification fees (42 CFR 433.56). These requirements also apply to health care-related taxes used to finance CHIP. (See § 2107(e)(1)(K) of the Act, implemented at 42 CFR 457.628). Federal regulations also specify that if less than 85 percent of the tax burden falls on health care items or services, the tax may still be considered to be health care-related if differential treatment exists for entities providing or paying for health care items or services relative to other entities (42 CFR 433.55(c)).

2 Comparable comprehensive data is not available at the national level for more recent years.
In contrast to health care-related taxes, provider donations are now permitted only in limited circumstances, including reimbursement for the costs of Medicaid eligibility workers stationed at health care facilities (42 CFR 433.66). The donations must also be “bona fide”, meaning they are unrelated to Medicaid payments or fall below a de minimis threshold (42 CFR 433.54).

While the hold harmless test applies to the percentage of net patient revenues, many health care taxes are levied as fixed fees (such as per bed or per patient day assessments) or on revenues other than net patient revenue. In those cases, CMS requires states to perform calculations that demonstrate that the tax would fall at or below the safe harbor threshold if it were assessed as a percentage of net patient revenue (GAO 2014).


In June 2018, CMS approved Connecticut’s tax on outpatient hospital services that exceeded the 6 percent of net patient revenues (FMG 2019). As of 2016, no state had enacted any health care-related taxes in excess of the safe harbor threshold (CRS 2016).

References


Financial Management Group (FMG), Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. E-mail to MACPAC, October 31.


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