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)).[1] 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 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.

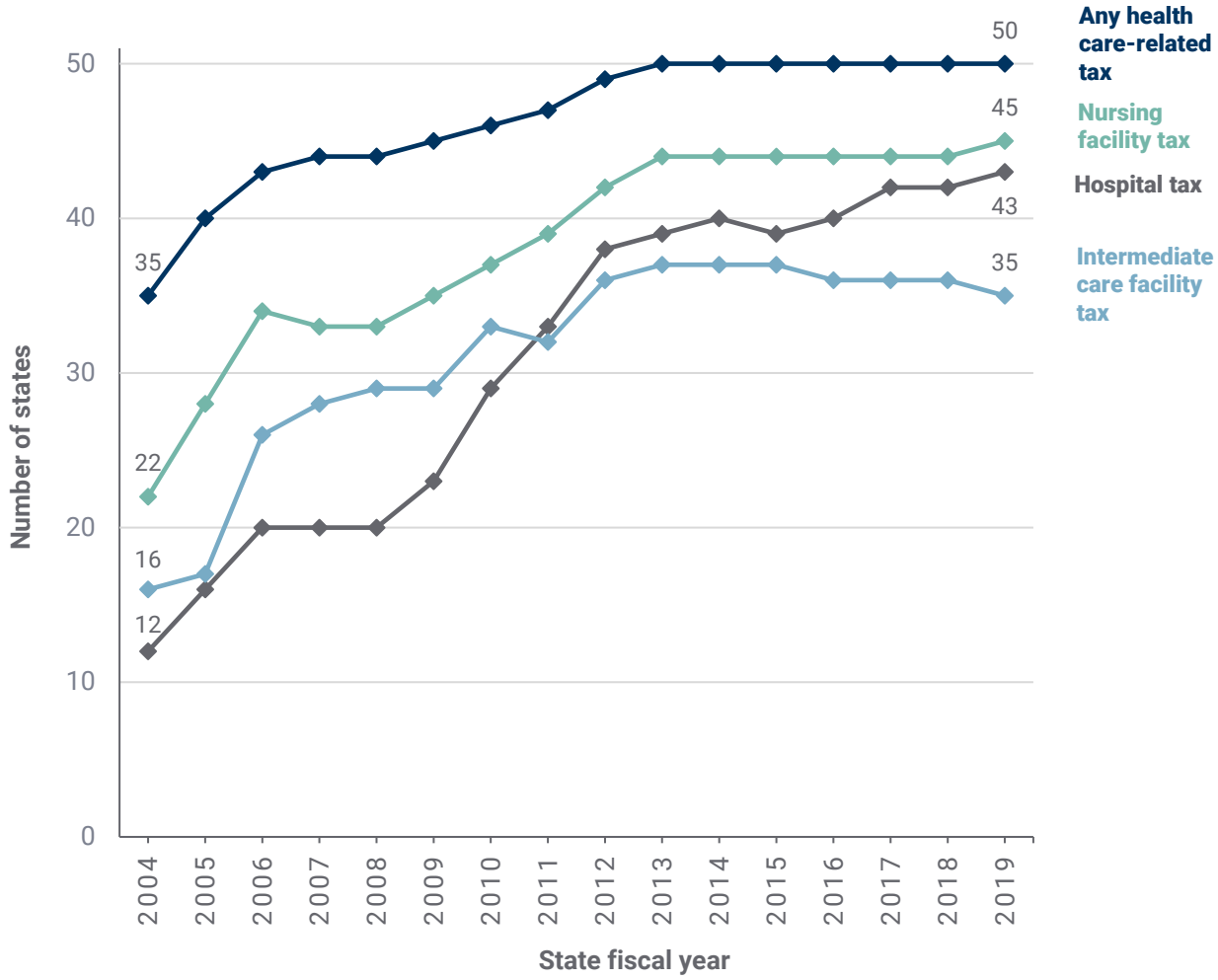
Health care-related taxes have become a more common funding source for state Medicaid programs over the past 15 years. In state fiscal year (SFY) 2019, 49 states and the District of Columbia imposed at least one health care-related tax, up from 35 states in SFY 2004. In SFY 2019, the most common health 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 2008–2018 (the most recent years for which such data are available) indicate that health care-related taxes have been a growing financing source for states. In SFY 2018, 17 percent of state Medicaid funds came from health care-related taxes, an increase from 7 percent in SFY 2008 (GAO 2015, 2021). Overall, health care-related taxes raised $36.9 billion in non-federal share in SFY 2018 (GAO 2021).

The use of health care-related taxes varies widely across states. As a percentage of the non-federal share, health care-related taxes in SFY 2018 ranged from less than 0.5 percent in Alaska, New Mexico, South Dakota, Texas, and Virginia to more than 30 percent in Michigan, New Hampshire, and Ohio (GAO 2021).[2]

States that established health care-related taxes between 2008 and 2018 cited a variety of uses 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, GAO 2020). 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).

FIGURE 1. Number of States with Health Care-Related Taxes by Type of Provider, SFYs 2004–2019



Notes: Number of states includes the District of Columbia. States can impose health care-related taxes on multiple types of providers.
Source: KFF 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 inception of the program. 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 Voluntary Contribution and Provider-Specific Tax Amendments of 1991(P.L. 102-234) (Matherlee 2002, Schneider 2002).[3]

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

1. **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.
2. **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.
3. **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.[4]

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. Specifically, states must provide a statistical analysis that demonstrates the tax burden on Medicaid under the proposed approach meets or exceeds a 95 percent correlation with a perfectly redistributive tax. From 2008 through 2012, Centers for Medicare & Medicaid Services (CMS) reviewed and approved health care tax waivers in 29 states (GAO 2014).

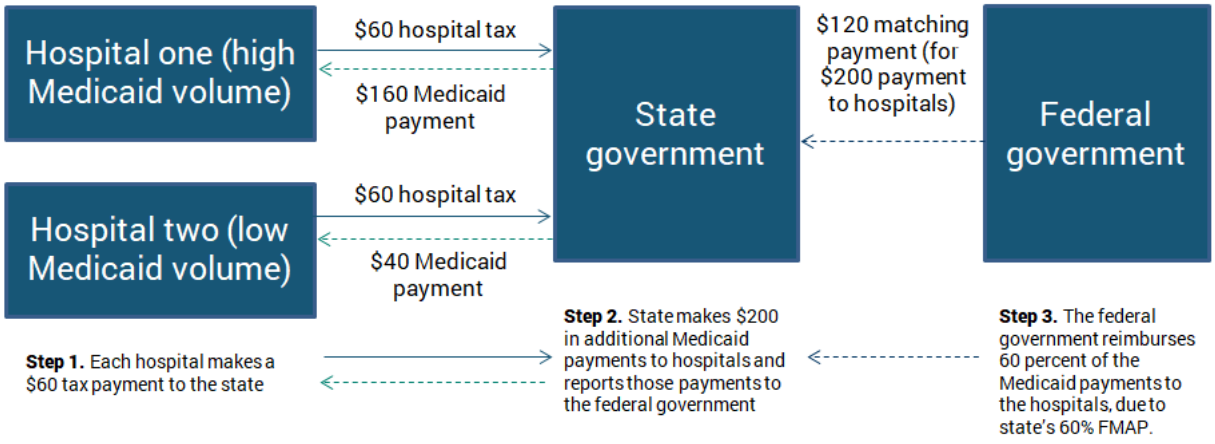
Illustration of a permissible health care-related tax arrangement

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 an illustrative example of a health care-related tax that would satisfy 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 and Medicaid accounts for $800 of net patient revenue. Hospital 2 has low Medicaid volume and Medicaid accounts for $200 of net patient revenue. Each hospital is assessed a uniform and broad-based tax that totals 6 percent of its net patient revenue (the safe harbor threshold for the hold harmless provision), for a total tax assessment of $120.

The state uses some of this tax revenue ($80) as the state share of a $200 increase in Medicaid payment rates to hospitals. Because the state's federal medical assistance percentage (FMAP) is 60 percent, the federal government contributes 60 percent ($120) of the $200 in increased Medicaid payments to hospitals. In this scenario, the payment increase is distributed proportionally to each hospital's Medicaid patient volume, resulting in a 20 percent increase in Medicaid payments for each hospital.

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 (20 percent of $800, or $160) that is larger than its tax liability ($60). Hospital 2 has the same percentage increase in Medicaid revenue (20 percent of $200, or $40), but it is smaller than its tax liability ($60).

The revenue effects on the state and federal governments also differ. The state's health care tax collection ($120) is higher than the amount used as the non-federal share of increased Medicaid payments to the two hospitals ($80), and this excess could be used to offset other program expenditures otherwise funded by general revenue. The federal matching contribution for the state's increased hospital payments had a corresponding increase of $120, although there was 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

Financial transfer	Hospital 1 (high Medicaid volume)	Hospital 2 (low Medicaid volume)	State government	Federal government
Tax payment	-$60	-$60	+$120	NA
Medicaid payment increase	+160	+40	-80	-$120
Net financial effect	**+100**	**-20**	**+40**	**-120**

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

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 safe harbor 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 2020 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 $32 billion, $176 billion, and $429 billion respectively through FFY 2030. 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 reducing optional eligibility groups and optional benefits (CBO 2020).

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 July 1, 2019, 32 states had at least one tax that exceeded 5.5 percent of net patient revenue and 45 states and the District of Columbia had at least one health care tax that exceeded 3.5 percent of net patient revenue (KFF 2020). 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.

[3] 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).

[4] 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

would require the 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).

[5] Enacted in the Tax Relief and Health Care Act of 2006 (P.L. 109-432). See § 1903 (w)(4)(c)(ii)) of the Act.

[6] 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).

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