National Tax Journal
Vol. 46, no. 3, (September, 1993), pp. 377-83

STATE PROVIDER ASSESSMENTS TO FUND MEDICAID

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The use of taxes or assessments on health care providers to help fund the Medicaid program has raised a new policy design question for federal and state officials.

Tax experts are accustomed to using the standard public finance criteria of equity, efficiency, and simplicity to evaluate taxes. These are subsidiary issues with Medicaid provider assessments. The real question is one that tax experts usually do not have to ask: is imposition of the tax politically costly?

Since it is not a common question, there is very little off-the-shelf technology that can be used to answer it. The analysis required is both political and economic.

What follows is a brief description of how states and the federal government have grappled with this question and an evaluation of the methodology the federal government has developed to deal with it.

BACKGROUND

Beginning in the late 1980s, states began making increasing use of an obscure 1985 revision of the federal Medicaid regulations that allowed "donations" by hospitals, nursing homes, and other providers to be used as part of the state share of Medicaid.[1]

These private donations enabled states to leverage substantial additional amounts of federal money for their Medicaid programs. In a state in which the federal share was 75 percent, for example, each $1 in private donations could bring in $3 in federal Medicaid matching funds. With a 50 percent federal share, states could raise $1 in new federal money for each $1 in provider donations. States could thus fully repay providers for their donations through higher reimbursement and still have substantial new federal money left over for other purposes.

The winners in this situation were the providers, who got back the amount they paid in taxes and, often, increased Medicaid reimbursement as well, and states, who were able to pay for increased Medicaid and other state expenditures without paying any of the political costs of raising taxes or cutting spending in other areas of the budget. The loser was, of course, the federal government, which ended up paying out more and more in federal Medicaid matching funds.

Beginning in 1987, the federal Health Care

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Financing Administration (HCFA) made repeated attempts to disallow federal matching payments for provider donations and provider-specific taxes (taxes that applied only to health care providers).[2] Congress countered with a series of measures from 1988 to 1990 designed to limit the HCFA's authority. Finally, in November 1991, Congress, the Bush administration, and the states reached agreement on legislation that permits voluntary contributions and provider-specific taxes to be used as the state share in certain specified circumstances.[3]

The main limitations are that taxes on providers must be broad-based and uniform and must not be combined with reimbursement increases or other measures that hold providers harmless in certain specified ways for the amount of tax they pay. The underlying purpose of these limitations is to make provider assessments politically costly to impose, just as other taxes are. The more opposition there is from providers, the more confidence the federal government can have that they are not willing coconspirators. And the more provider opposition there is, the less likely it is that states will be able to use provider assessments and the less drain there will be on the federal Medicaid budget.

FORMULAS FOR POLITICAL COST

For those in the HCFA and the Office of Management and Budget, who were involved in developing this legislative approach and the implementing regulations, the challenge was to embody the assurance of political cost in rules and formulas. Here is how they did it.

Broad-Based and Uniform

The 1991 legislation established eight provider classes and required that the tax or assessment on each class be uniform and broad-based with respect to that class. While taxes can be different for different classes, they must be uniform within each class and cover every provider in that class (with a few exceptions discussed below). The eight classes are as follows:

- inpatient hospital services;
- outpatient hospital services;
- nursing facility services;
- intermediate care facilities for the mentally retarded (ICFs/MR);
- physician services;
- home health care services;
- outpatient prescription drugs; and
- health maintenance organizations.

The Secretary of Health and Human Services (HHS) is authorized to add other classes that are "consistent with" those listed in the law. The Secretary has agreed with the National Governors' Association to add a number of additional classes, such as dental, podiatric, chiropractic, optometric, psychological, therapeutic, nursing, and lab and X-ray services.[4]

The key to the "political cost" analysis is that, for most of these classes of providers, Medicaid represents only a small portion of their total revenues. Medicaid accounts for only 6 percent of total physician revenues and 19 percent of total hospital revenues, for example, although the percentage may be much higher for individual hospitals and physicians.[5]

The tax must, however, apply equally to all revenues, beds, or whatever the tax base is. Non-Medicaid revenues or beds may not be excluded. This effectively thwarts any systematic effort to offset the burden of the tax by increasing Medicaid reimbursements, since Medicaid is too small a portion of total revenues for most providers for such an offset to work. All providers must therefore bear the cost of the tax, but only heavy Medicaid providers gain any benefit.

The legislation does permit Medicaid and Medicare revenues to be excluded from

National Tax Journal
Vol. 46, no. 3, (September, 1993), pp. 377-83

the tax base, but this normally just exacerbates the political problem.

For two classes of providers, however, the net political cost can be minimized, since the classes are made up primarily or exclusively of heavy Medicaid providers. Nursing facilities for the elderly receive over half of their total revenue from Medicaid, while ICFs/MR receive virtually 100 percent.[6]

For these providers, as well as others, increases in Medicaid reimbursement may serve to offset most or all of the burden of the tax or assessment. Because of this possibility, the 1991 legislation has additional provisions that bar specific types of hold harmless measures.

No Hold Harmless

Even if the tax itself is uniform and broad-based, it is "impermissible" (that is, the federal government will not match it) if providers in the class are held harmless in any of the following ways:

- the state provides directly or indirectly for a non-Medicaid payment to those paying the tax, and the amount of the payment is "positively correlated" to the amount of the tax;
- all or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the taxpayer's total tax payment; or
- the state provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

Exceptions. If, however, there is no "explicit guarantee" that a provider will be held harmless, the HCFA will not challenge the tax if it is no more than 6 percent of provider revenues. If it is more than 6 percent, the tax may still be permissible if less than 75 percent of the providers in the class receive less than 75 percent of their total tax costs back in increased Medicaid or other state payments.

Policy-Based Exceptions to the Uniform and Broad-Based Rules

Since Medicaid is a program that serves health policy goals, and since it is designed in a political environment, there are some exceptions to the uniform and broad-based rules that lessen the potential political cost of provider taxes. These exemptions are analogous to "tax expenditures" in the income tax laws: special provisions designed to serve nontax goals.

The 1991 statute allows the Secretary of HHS to grant "waivers" of the uniform and broad-based rules on a case-by-case basis for taxes that exempt some types of providers in a class. The statute cites "rural or sole-community providers" as examples.

Regulations issued in November 1992 allow such exemptions for rural hospitals, sole community hospitals, and physicians practicing primarily in medically underserved areas. Under the agreement with the National Governors' Association referred to earlier, the HCFA is expanding this list to include "financially distressed" hospitals and psychiatric hospitals and will allow regional variations in tax rates.

Before such waivers will be granted, however, the HCFA requires the application of some elaborate statistical tests to make certain the burden of the tax as a whole does not fall disproportionately on Medicaid providers. Again, the purpose is to make sure that the tax hits providers who cannot benefit substantially from the proceeds of the tax.

THE FORMULAS IN PRACTICE: DESIGNING A PERMISSIBLE PROVIDER ASSESSMENT

The questions that states seeking to use provider assessments must consider include the following

- How much revenue is needed?
- Which classes of providers should be included?

- How, if at all, should the tax burden on a class relate to its volume and share of Medicaid business?
- What is the ability to pay of different provider classes?
- Who will ultimately bear the burden of the tax?
- How does the provider assessment fit into the overall tax structure in the state?
- How should the proceeds of the tax be used?
  - Increased reimbursement? If so, for whom?
  - Expanded Medicaid services?
  - Deficit reduction/general fund relief?
- What is the political viability of the various options?

While it is not possible in this short paper to go through all of these questions systematically, what follows gives a flavor of the kinds of economic, political, and health policy considerations that go into making these decisions. The emphasis is on illustrating the kinds of tradeoffs that are forced by the political cost formulas.

Amount of Revenue Needed

The amount of provider assessment revenue a state "needs" depends to some extent on how dependent it had become on such revenue before the 1991 crackdown in federal Medicaid law. Many states filled very large holes in their Medicaid and state budgets with provider assessment funds. New Hampshire, for example, paid 58 percent of its state share of Medicaid with provider taxes and donations in fiscal year 1992, Tennessee, 48 percent, and Alabama, 43 percent.[7] Raising these amounts from involuntary provider assessments has proven to be a formidable task in a number of states.[8]

The amount states can raise in provider assessments is also explicitly constrained by the 1991 federal law, which limits the amount states can raise in provider assessments to 25 percent of their state share until September 30, 1995. States that raised larger percentages before the 1991 clampdown are generally allowed to continue with those higher limits.

Number of Provider Classes to be Covered

The more classes that are covered the smaller the assessment on each class can be, given a fixed revenue goal. Adding more classes can increase the perception of equity. ("Everyone is being treated the same; no one is exempt.") It also multiplies the number of provider opponents.

Distributing the Tax Burden

As discussed earlier, federal law and regulations severely limit states' ability to selectively distribute the burden of provider assessments within a class. The choices therefore involve almost entirely which classes to include in the assessment and what the tax formula should be for each class.

The illustrative menu of options in Table 1 was prepared for the governor and key legislators in Indiana. It shows the amounts that could be raised from various provider classes by different assessment formulas. The Medicaid Management Institute also prepared a survey of all states' use of provider assessments for the American Public Welfare Association in January 1993. Since state elected officials like to see what other states have done and are planning, this survey was also widely distributed in Indiana.

Share of Medicaid business. The assessment burden could be concentrated on providers with a high proportion of Medicaid business, such as ICFs/MR and nursing homes, on the theory that their heavy dependence on Medicaid increases their incentive and obligation to keep it adequately funded. On the other hand, the burden could be placed more on low-pro-

National Tax Journal
Vol. 46, no. 3, (September, 1993), pp. 377-83

TABLE 1
ILLUSTRATIVE MEDICAID ACCESS CHARGE OPTIONS

Provider	Assessment Formula	Amount Raised (State Dollars in Millions) FY 94	FY 95
Hospitals	1 percent of gross revenue[a]	100	110
	$1000 per bed per year[b]	25	25
Nursing facilities	1 percent of gross revenue[c]	12	13
	$1000 per bed per year[d]	53	53
ICFs/MR	1 percent of gross revenue[e]	2	3
Physicians	1 percent of gross revenue[f]	43	47
	$100 per physician[g]	1	1
Home health services	1 percent of gross revenue[h]	4	4
Prescription drugs	10 cents per prescription[i]	5	5
	1 percent increase in sales tax	not available	not available
	$100 per pharmacist[j]	0.5	0.5

Source: Office of Medicaid Policy and Planning, March 1993.
Note: These are not Bayh Administration recommendations; they are illustrative options.
[a]Gross revenue equals $10 billion for FY 94 and $11 billion for FY 95.
[b]Number of beds equals 25,000.
[c]Gross revenue equals $1.2 billion in FY 94 and $1.3 billion in FY 95.
[d]Number of beds equals 53,000.
[e]Gross revenue equals $240 million for FY 94 and $290 for FY 95.
[f]Total gross practice revenue equals $4.3 billion in FY 94 and $4.7 billion in FY 95.
[g]Number of licensed physicians equals 10,000.
[h]Gross revenue equals $360 million for FY 94 and $420 million for FY 95.
[i]Number of prescriptions equals 50 million.
[j]Number of pharmacists equals 5,000.

portion Medicaid providers, like hospitals and physicians, on the theory that, since their contribution to the Medicaid program through the provision of services is relatively limited, they can appropriately be required to provide greater support through assessments.

Ability to pay. Some providers have deeper pockets than others and/or greater opportunities to free up the resources to pay an assessment through more efficient and economical operation. Using these standards, hospitals would likely be judged to have a greater ability to pay than pharmacies.

Incidence of the tax burden. Providers will always assert that the burden of any assessment will fall on patients. The common provider characterization of assessments is "sick taxes" or (in the case of nursing homes) "granny taxes." Standard economic analysis says that the ultimate burden of such a tax will be distributed in some way among health care providers, insurance companies, employers, workers, and health care recipients, depending on the characteristics of specific markets and the relative market power of the participants in those markets. My own political analysis is that those who assert most adamantly that the burden will fall on someone else are the ones who are most convinced that it will actually fall on them. If they really thought they could pass the assessment on to someone else, they would keep quiet about it.

Relationship to overall tax structure. If a particular provider group is generally exempt from or lightly burdened by state and local taxes, the case for imposing an assessment on them is enhanced. In Indiana, for example, virtually all the hospitals are nonprofit and thus pay no income, property, or sales taxes.

Uses of Tax Proceeds

States have used the proceeds of provider assessments to increase provider reimbursement, expand Medicaid services, reduce the state general fund contribution to

National Tax Journal
Vol. 46, no. 3, (September, 1993), pp. 377-83

Medicaid, and fund non-Medicaid expenditures.

Fungibility of budget dollars. Since money in state budgets is ultimately fungible, it can be difficult to assess how the proceeds of an assessment have actually been used. If the assessment is used to substitute for state general fund dollars that otherwise would have been spent on Medicaid, for example, one could argue that the assessment is actually funding whatever the diverted general fund dollars are being used for.

Is the assessment bringing in "new" federal money? One key concept that can be confusing even to the initiated is the fact that provider assessments bring in new federal matching funds only when they are used to expand Medicaid services or reimbursement beyond what it otherwise would have been. If the assessments merely substitute for state general fund dollars, without expanding total state Medicaid spending, no new federal dollars are being brought into the state.

It is important to keep this distinction in mind when calculating the net gain to the state from a provider assessment. In a state with a 75 percent federal share, for example, Table 2 shows how the net gain to the state from a $100 million provider assessment would vary, depending on whether or not total Medicaid spending is increased.

Once these matters of budget mechanics are sorted through, the political, economic, and health policy considerations become very complicated. The potential combinations of assessments, reimbursement increases, service expansions, increases in non-Medicaid spending, and deficit reduction or general fund relief allow a wide range of political and policy goals to be achieved (or at least attempted).

Political Viability

Whenever a policy produces both winners and losers, a basic rule of politics is that winners are ingrates and losers bitter opponents. Political policy design must therefore seek to maximize winners and minimize losers, a task made deliberately difficult by the political cost rules of the 1991 Medicaid legislation.

Increasing Medicaid reimbursement to offset provider assessments only works to ease the cost for heavy Medicaid providers, like ICFs/MR and nursing homes, and even there the anti-hold-harmless rules can impose obstacles.

The scope of Medicaid services or eligibility can be expanded to cover costs that providers might previously have had to absorb as charity care or bad debts, but that approach as well has real limits. Providers

TABLE 2
Impact Of $100 Million Provider Assessment in State with 75 Percent Federal Share

	(Dollars in Millions)			
	Amount of Assessment (*a*)	Federal Match (*b*)	State Share of New Spending (*c*)	Net Gain to State (*a*+*b*-*c*)
Spending increased by amount of assessment plus federal match ($400 million)	100	300	100	300
Spending increased by $200 million	100	150	50	200
No spending increase	100	0	0	100

National Tax Journal
Vol. 46, no. 3, (September, 1993), pp. 377-83

tend to view the benefits to them of these expansions as somewhat remote and conjectural, while the costs of the assessment are immediate and obvious.

Another way to increase the percentage of perceived winners is to try to persuade providers that the consequences of not imposing an assessment will be exceedingly dire. The threat of deep cuts in Medicaid reimbursement has in some states convinced providers that an assessment is a preferable alternative. The percentage of perceived winners is increased by first creating potential losers.

LASTING PEACE OR CEASE-FIRE LINE?

Experience thusfar with the political cost rules embodied in the 1991 Medicaid legislation suggests that the federal government may have achieved its goal of limiting state use of provider assessments to obtain additional federal Medicaid dollars. Provider assessments are proving about as hard to enact as other forms of tax, although some states have been successful in doing so.[9]

But the larger question still remains: How can the ever-expanding costs of providing health care for the poor, the elderly, and the disabled be financed under a program in which the federal government imposes increasing burdens on the states while, at the same time, severely limiting states' ability to control costs and raise revenue?

Until that larger question is resolved, state-federal conflicts over Medicaid will continue to erupt, challenging the creativity and ingenuity of both policy designers and politicians.

ENDNOTES

I gratefully acknowledge my debt to Charles A. Miller, Frank Sullivan, Jr., and Marjorie A. Ruddon for their many contributions to my understanding of provider assessments and for their comments and suggestions on an earlier version of this paper.

[1] States pay from 17 to 50 percent of the total cost of the Medicaid program, depending on state per capita income, with the federal government paying the rest. The average state share nationwide is currently around 43 percent. (Health Care Financing Administration News Release, March 17, 1993.)

[2] For a brief summary of this history, see Congressional Research Service (March 27, 1992, pp. 31–34).

[3] Public Law 102–234 (December 12, 1991).

[4] Letter from HHS Secretary Donna E. Shalala to Raymond Scheppach, Executive Director, National Governors' Association, May 14, 1993.

[5] Health Care Financing Administration, Office of the Actuary (Fall, 1992).

[6] HCFA, "National Health Expenditure Projections."

[7] Congressional Research Service. *Medicaid: Recent Trends*, p. 35. See also Washington Post. "Medicaid Payments Add to Deficit," February 13, 1993; and "Medicaid Windfall Cut N.H. Deficit," February 28, 1993.

[8] See, for example, Washington Post. "Tennessee Medicaid Crunch Mirrors a National Ill," March 29, 1993.

[9] Bureau of National Affairs (June 7, 1993, p. 614).

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National Tax Journal
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