Health Provider Taxes: State Actions

Presentation to
Montana Legislative Finance Committee
September 15, 2010

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

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NCSL, Denver
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Overview of Presentation

- Funding Health Care - a never-ending debate
- Medicaid budgeting
  - FMAP and beyond
- Provider Taxes/Fees
  - Current review, 50-states
  - Special issues; CMS roles
  - The CO example
- National health reform
  - Medicaid changes coming
  - Cost containment options

BUSINESS

Health care may gobble 20% of economy by 2015

By Kevin Freking
The Associated Press

Washington — Within a decade, an aging America will be spending one of every five dollars on health care, according to government analysts.

The nation's total health-care bill by 2015: more than $4 trillion. Consumers will foot about half the bill, the government the rest.

Hospital costs will rise more quickly than previously anticipated, reflecting a construction boom for urban hospitals.

Meanwhile, drug costs are expected to be somewhat restrained, in part because of the new Medicare prescription drug program.

The projections, published in the journal Health Affairs, come as President Bush focuses on the rising cost of health care. In his State of the Union address last month, the president pushed health savings accounts and the high-deductible insurance plans that go with them. The administration predicts Americans would become more thrifty if they had to pay more of the upfront costs, which occurs with health savings accounts.

The report, written by analysts with the Centers for Medicare and Medicaid Services, attributes rising costs to the aging of the baby-boom population and the changing nature of health insurance. They forecast a 7.2 percent annual increase in health-care costs over the coming decade. That's in line with the 7.4 percent increase in 2005.

Still, the overall economy is projected to grow at a rate of 5.1 percent over the coming decade, which means health care will play an ever-growing role.

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Health Provider Taxes: Actions by the States

Materials and supplement for the Presentation by
Richard Cauchi, NCSL Health Program Director
To the Montana Legislative Finance Committee
September 15, 2010

State Medicaid programs in FY 2011. Medicaid is financed jointly by federal and state funds, with the majority of policies and administrative responsibilities in the hands of the states. Even as the overall economy begins to recover, Medicaid caseload and spending growth in most states remain high, state revenue growth remains weak and almost all states are likely to continue to face budget gaps and shortfalls heading into state FY 2011 and beyond. It is often projected that it could take several years for revenues to return to pre-recession levels. [i] For 2009-2011, extra Medicaid matching funds became a central part of states' access to recovery funding, with a final 50-state "enhanced" share totaling $87 billion. As a result of congressional votes and broad state support, more than half of the states assumed an extension of the ARRA enhanced FMAP through June 30, 2011 (an additional six months) in the SFY 2011 budget; this was approved but with reduced percentages, on August 10, 2010.

State-created health provider taxes, also called provider "assessments" or "fees," have been a staple part of state fiscal strategies for almost 20 years, based on a 1991 federal law which authorized such state-to-federal matching fund arrangements for Medicaid. Especially in times of fiscal downturns or crisis, states frequently turn to provider taxes to raise non-federal dollars to support Medicaid programs. This state money is matched with federal money, which increases funds for Medicaid operations or expansions and allows for higher provider reimbursement.

FMAP matching demystified. The percentage and amount of federal fund contribution to each state is known as "FMAP". The recent economic downturn prompted the federal government to increase their match rate. This rate is calculated on an increasingly complex formula and always varies by state. The 15-17 more financially affluent states traditionally received a basic match rate of 50 percent federal (to 50 percent state). Less affluent states receive a higher rate.

While the state Medicaid program has to show and certify its expenditures "up front," the resulting federal matching fund payment is not literally earmarked for Medicaid and becomes state revenue.[ii]

The Children's Health Insurance Program (CHIP) provides insurance for certain children who are ineligible for Medicaid but cannot afford private insurance. States receive a higher federal match to pay for CHIP coverage than for their Medicaid programs. This match can either be used to expand a CHIP program or to create an expansion of the state's Medicaid program, which raises the Medicaid eligibility level for children.

Three western state examples, for comparison --

• **For 2010** the base FMAP is	MT = 67.42% ▫	CO = 50%	AZ = 65.75%
• Base CHIP FMAP	**MT = 77.19%**	CO = 65%	AZ = 76.03%
• The ARRA "enhanced FMAP" increased to	**MT = 77.99%.**	CO = 61.59%	AZ = 75.93%

On October 1, 2010, the annual rates change ---

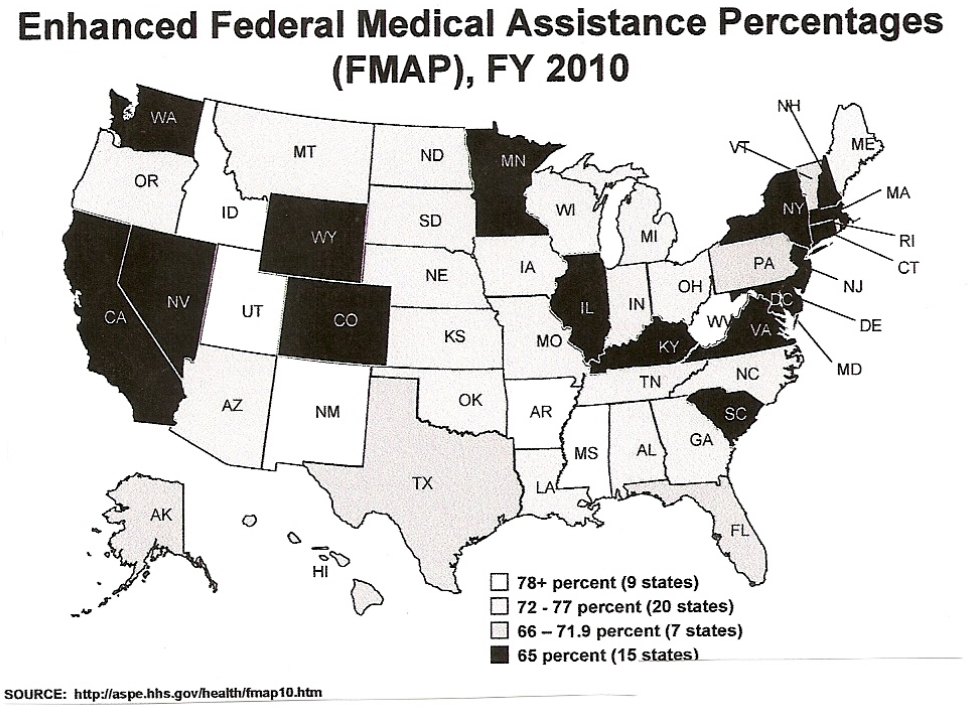
• **For 2011** (to 10/1/11) the "base FMAP[iii] is	MT = 66.81% ▫	CO = 50%	AZ = 65.85%
• The ARRA "enhanced FMAP" changes to	**MT = 76.77%** ▫	CO = 65%	AZ = 76.10%

(UPDATE 9/13: SUBJECT TO PHASED REDUCTION AS OF 1/1/2011, BY VOTE OF THE US CONGRESS)

Some expenses have separate ongoing matching rates:

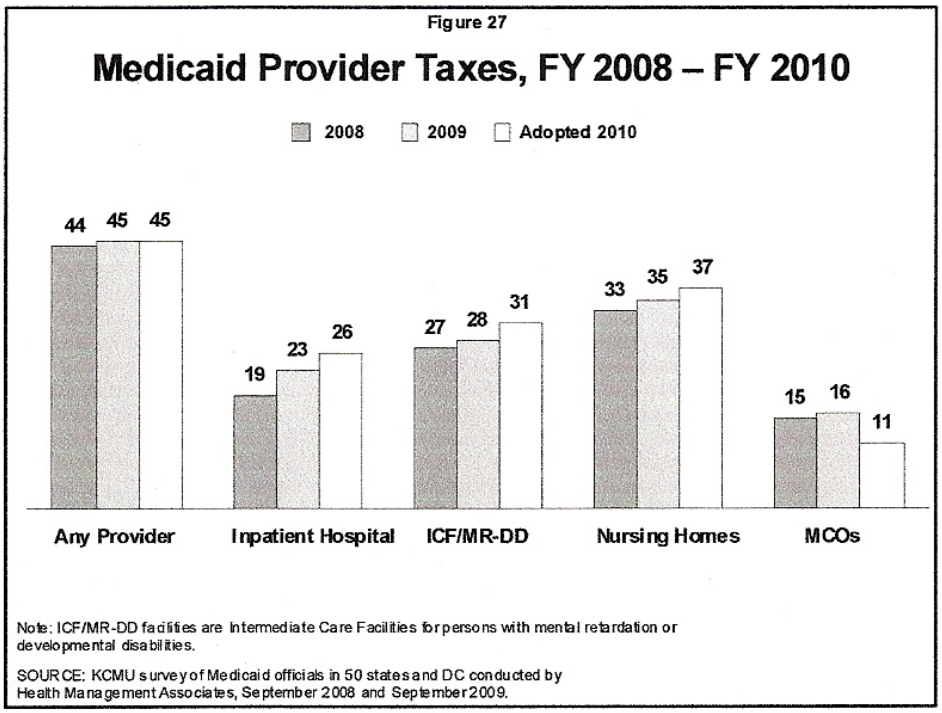
• CHIP (Children's Health) receive	Up to 30% higher, varies by state (Not subject to ARRA increase)
• HIT claims upgrades receive	90% (all states)
• Administrative expenses receive	50% (all states)

UPDATE: In mid-August Congress approved H.R. 1586 containing a six-month extension of the ARRA enhanced match for Medicaid. The law provides the states $16.1 billion through a "phased-down" enhanced match -- adding 3.1 percent from 1/1/2011 to 3/31/2011; then drops to 1.2 percent from 4/1/2011 to 6/30/2011.



Expanded Use of Provider Taxes In a majority of cases, states have designed their provider tax as part of a rate or reimbursement adjustment for health providers, including those paying the new tax.

The number of states and DC taxing at least one provider category reached 44 at the end of FY 2008, and increased to 45 states & DC for FY 2009 and FY 2010. 33 of these taxed more than one category of providers in FY 2009, by FY 2010 36 have more than one provider tax.
Montana is included in this tally. *[Figure 27 below]*



Compared to FY 2008, in FY 2010 approximately . . .

- an additional seven states were set to have hospital taxes,
- four more states will have taxes on nursing facilities, and
- four more states will have taxes on Intermediate Care Facilities for the Developmentally Disabled (ICF/MRDD).

In their effort to find additional revenue sources for Medicaid, states not only increased the number of provider groups that were taxed, but also increased the size of some of those taxes. For FY 2010 the rate of provider taxes were increased for seven nursing facility taxes, five hospital taxes, three ICF/MR-DD taxes and two MCO taxes. The only taxes being reduced in FY 2010 are two MCO taxes that are being reduced to meet the new federal limits.[iv]

Two state examples:

- California proposed a 2010 hospital tax that would generate up to $2 billion in federal funds to be used to help finance Medi-Cal.
- Colorado new hospital provider fee law, 2009. *[See "A Colorado Story"]*

Also see the attached two 50-state tables + NCSL 2009 & 2010 New Laws for state-specific information on provider taxes.]

Federal Limits on Use. There also are limits on a state's ability to use provider-specific taxes to fund their state share of Medicaid expenditures. The Voluntary Contribution and Provider-Specific Tax Amendments of 1991 places restrictions (known as "provider-specific caps") on states' use of provider-generated revenues (from provider taxes) as a source of state matching funds. Under the legislation, the federal match available to a state can be denied, unless the taxes were:

1) **"broad-based"** A tax was judged to be broad-based if it met two criteria; it must apply to all items or services within the same class of providers and it must apply uniformly, meaning that the tax was imposed on all gross revenues of the providers that were subject to it.
2) **"permissible"** Under federal law and regulations, there are eight classes of health care on which states may impose a provider tax and another nine that have been approved by federal regulation. [v] *[See list at Appendix A"]*

3) **contain no "hold-harmless" provisions.** A tax was deemed to hold providers harmless (and therefore be impermissible) if it in any way *guaranteed* that providers subject to the tax would not be liable for its true burden.
4) **The rate of state taxation** frequently is set at not more than 5.5% of receipts, a standard federal maximum. Any provider tax at a higher rate must meet a much closer sets of federal tests, which most states avoid invoking. This nominal maximum rate had been 6% until January 1, 2008 and will go back to 6% on October 1, 2011.[vi]

Managed Care Organization (HMO) Taxes. Federal Medicaid law was changed effective July 1, 2009 to restrict the use of Medicaid provider taxes on managed care organizations such as HMOs.

- As a result the number of states reporting a Medicaid provider tax on HMOs decreased from 16 states to 11 states for FY 2010.
- Several of those 11 states report that their HMO taxes were already broad-based taxes that were not limited to just Medicaid HMOs. Four states of the 11 states report that they are replacing taxes that applied only to Medicaid HMOs with new taxes that apply to all HMOs or they are removing provisions that previously exempted Medicaid HMOs from broad-based insurance or premium taxes.

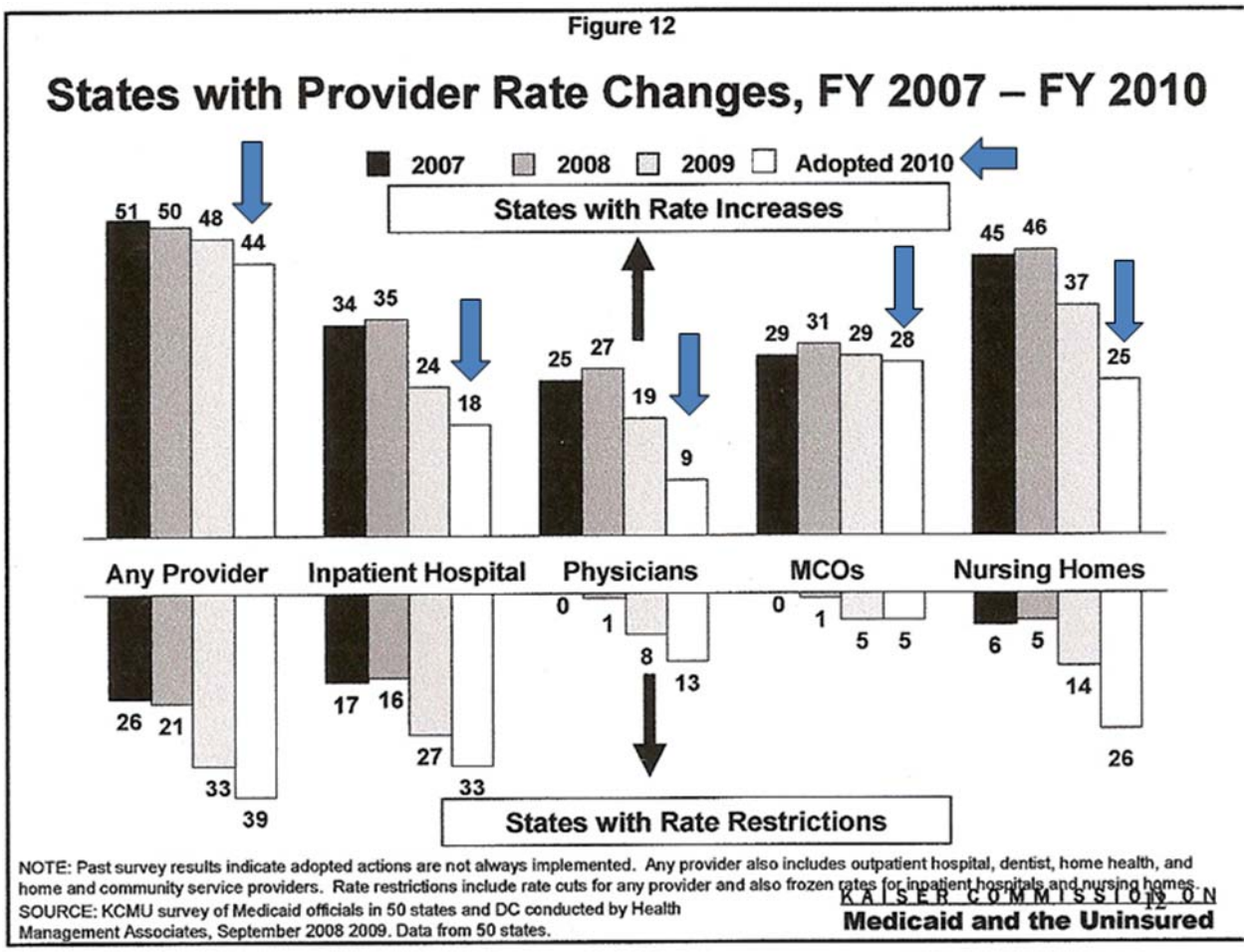
Federal proposed regulations were issued on May 6, 2009. *[Attached: 42 CFR Part 433]*[vii]
It delayed enforcement of certain portions of the February 22, 2008, final rule on Medicaid Provider Taxes until June 30, 2010. Among those provisions was a change in the definition of the class of managed care provider which had been mandated in the Deficit Reduction of 2005. The managed care provision had a compliance date of October 1, 2009. The final enforcement deadline was June 30, 2010.

Approximately eight states were out of compliance with the managed care provisions when these regulations were issued. The states include CA, KY, MI, MO, OH, OR and PA.

- Pennsylvania resolved this non-compliance by enacting a gross receipts tax on the managed care plans tied to the amount of revenue they received from Medicaid. A tax of 59 mills is imposed on each dollar of gross receipts received by managed care organizations pursuant to a contract with the PA Department of Public Welfare. Effective October 1, 2009.

During the federal health reform discussions and during other Congressional discussions, there was a push to allow them to retain their managed care provider tax plans as "grandfathered" plans. No such provision was included in the health reform law.

Medicaid Provider Rates - Recent State Increases and Restrictions by Year.



Expected Impacts of Federal Health Reform

One of the major changes enacted in the federal Patient Protection and Affordable Care Act (PPACA) law is the expansion of Medicaid to most people with incomes up to 133 percent of the federal poverty guidelines ($14,404 for an individual and $29,327 for a family of four in 2009-10). This will remove the state-by-state variability for the lowest income people in the nation and will, for the first time, require states to extend eligibility to childless adults. The new federal law will provide federal financing (FMAP) for all newly eligible individuals according to the following schedule:

- 100 percent FMAP for 2014 to 2016; (0 percent state funds)
- 95 percent FMAP for 2017;
- 94 percent FMAP for 2018; and
- 90 percent FMAP for 2020 and beyond.

A number of states are concerned that the 2017 and beyond required state spending will be a financial burden with uncertain or unknown impact.

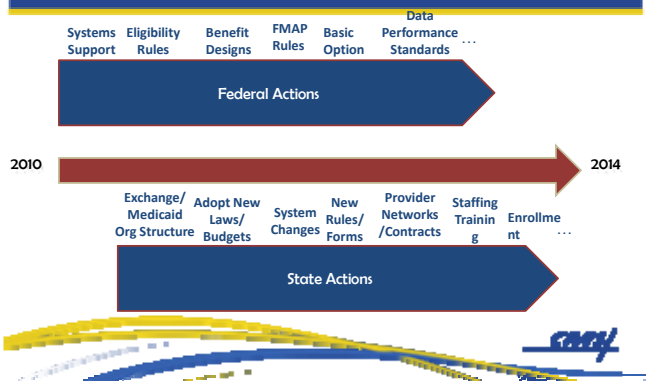
Medicaid reform policy examples as presented by Cindy Mann, CMS Deputy Administrator, Director, Center for Medicaid, CHIP & Survey & Certification, Centers for Medicare & Medicaid Services, HHS.

Health Reform: State Financial Impacts

Significant increase in federal support for Medicaid/CHIP

- 100% match for "newly eligible" group for 3 years and 95-90% match thereafter
- Increased match for "childless adults" in "expansion" states (reaches 93%/90% in 2019/2020)
- Increased match for CHIP in 2016 (enhanced plus 23 percentage points)
- Regular federal match for remaining currently eligible groups

Collaboration with States is Essential



Presented at NCSL meetings, April 9, 2010 and July 25, 2010.

Notes and Sources:

[i] State Medicaid Agencies Prepare for Health Care Reform While Continuing to Face Challenges from the Recession -KCMU, August 2, 2010

[ii] For example, 36 states reported that they used funds from the ARRA FMAP increase to close or reduce their Medicaid budget shortfall; 36 states also reported using the funds to avoid benefit cuts. However, 44 states used the funds to close or reduce state general fund shortfalls. See Kaiser Commission on Medicaid and the Uninsured, *State Fiscal Conditions and Medicaid*, September 2009, at http://www.kff.org/medicaid/upload/7580-05.pdf.

[iii] HHS Regulation in Federal Register http://aspe.hhs.gov/health/fmap11.htm

[iv] Vern Smith, *The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession.* Kaiser Commission on Medicaid and the Uninsured. *(November 2009)* http://www.kff.org/medicaid/upload/7985.pdf

[v] Eight provider classes exist in Medicaid law; they include inpatient and outpatient hospital services, nursing homes, intermediate care facilities for the mentally retarded, physician services, home health, prescription drugs, and health maintenance organizations. Additional provider classes that may be taxed include dentistry, podiatry, chiropractic, optometry, psychological, therapeutic, nursing, laboratory and radiology services. *[See Appendix A, reprinted from California analysis, Nov. 2008.]*

[vi] Jean Herne, Congressional Research Service. Medicaid Provider Rates. April 28, 2008.

[vii] CMS–2275–P2] RIN 0938–AP74 federal rule revised the threshold levels under the regulatory indirect guarantee hold harmless arrangement test to reflect the provisions of the Tax Relief and Health Care Act of 2006, amended the definition of the ''class of managed care organization services.''

Federal Medical Assistance (FMAP) Percentages And Enhanced Federal Medical Assistance Percentages, Effective October 1, 2010–September 30, 2011 [Federal FY 2011]

State	Federal Medical assistance percentages	Enhanced Federal medical assistance percentages (limited period 2010)
Alabama.	68.54	77.98
Alaska.	50.00	65.00
Arizona	65.85	76.10
Arkansas	71.37	79.96
California	50.00	65.00
Colorado	50.00	65.00
Connecticut	50.00	65.00
Delaware	53.15	67.21
District of Columbia **	70.00	79.00
Florida	55.45	68.82
Georgia	65.33	75.73
Hawaii	51.79	66.25
Idaho	68.85	78.20
Illinois	50.20	65.14
Indiana	66.52	76.56
Iowa	62.63	73.84
Kansas	59.05	71.34
Kentucky	71.49	80.04
Louisiana	63.61	74.53
Maine	63.80	74.66
Maryland	50.00	65.00
Massachusetts	50.00	65.00
Michigan	65.79	76.05
Minnesota	50.00	65.00
Mississippi	74.73	82.31
Missouri	63.29	74.30
Montana	66.81	76.77
Nebraska	58.44	70.91
Nevada	51.61	66.13
New Hampshire	50.00	65.00
New Jersey	50.00	65.00
New Mexico	**69.78**	**78.85**
New York	50.00	65.00
North Carolina	64.71	75.30
North Dakota	60.35	72.25
Ohio	63.69	74.58
Oklahoma	64.94	75.46
Oregon	62.85	74.00
Pennsylvania	55.64	68.95
Puerto Rico *	50.00	65.00
Rhode Island	52.97	67.08
South Carolina	70.04	79.03
South Dakota	61.25	72.88
Tennessee	65.85	76.10
Texas	60.56	72.39
Utah	71.13	79.79
Vermont	58.71	71.10
Virginia	50.00	65.00
Washington	50.00	65.00
West Virginia	73.24	81.27
Wisconsin	60.16	72.11
Wyoming	50.00	65.00

* For purposes of section 1118 of the Social Security Act, the % used under titles I, X, XIV, and XVI will be 75%. http://aspe.hhs.gov/health/fmap11.htm

Appendix A: Classes of Health Care on Which States May Impose a Provider Tax under Federal Law

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Nursing facility services (other than services of intermediate care facilities for the mentally retarded);
4. Intermediate care facility services for the mentally retarded, and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915 (c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICFs/MRs prior to the grant of the waiver;
5. Physician services;
6. Home health care services;
7. Outpatient prescription drugs;
8. Services of managed care organizations (including health maintenance organizations, preferred provider organizations);
9. Ambulatory surgical center services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;
10. Dental services;
11. Podiatric services;
12. Chiropractic services;
13. Optometric/optician services;
14. Psychological services;
15. Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services and rehabilitative specialist services;
16. Nursing services, defined to include all nursing services including services of nurse midwives, nurse practitioners, and private duty nurses;
17. Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department;
18. Emergency ambulance services; and
19. Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following: The fee must be broad based and uniform or the State must receive a waiver of these requirements; the payer of the fee cannot be held harmless; and the aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

Source: 42 CFR 433.56

Appendix A-10: Provider Taxes in Place in the 50 States and District of Columbia FY 2009 and FY 2010

States	Hospitals		ICF/MR-DD		Nursing Facilities		Managed Care Organizations		"Other"		Any Provider Tax	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
Alabama		X			X	X			X	X	X	X
Alaska												
Arizona							X	X			X	X
Arkansas		X		X	X	X					X	X
California			X	X	X	X	X				X	X
Colorado		X	X	X	X	X					X	X
Connecticut					X	X					X	X
Delaware												
District of Columbia				X	X	X					X	X
Florida	X	X		X	X	X					X	X
Georgia					X	X	X				X	X
Hawaii												
Idaho	X	X				X					X	X
Illinois	X	X	X	X	X	X			X		X	X
Indiana			X	X	X	X					X	X
Iowa			X	X		X					X	X
Kansas	X	X									X	X
Kentucky	X	X	X	X	X	X	X		X	X	X	X
Louisiana			X	X	X	X			X	X	X	X
Maine	X	X	X	X	X	X			X	X	X	X
Maryland	X	X	X	X	X	X	X	X			X	X
Massachusetts	X	X			X	X					X	X
Michigan	X	X			X	X	X				X	X
Minnesota	X	X	X	X	X	X	X	X	X	X	X	X
Mississippi	X	X	X	X	X	X					X	X
Missouri	X	X	X	X	X	X	X		X	X	X	X
Montana	X	X	X	X	X	X					X	X
Nebraska			X	X							X	X
Nevada					X	X					X	X
New Hampshire	X	X			X	X					X	X
New Jersey			X	X	X	X	X	X			X	X
New Mexico							X	X	X	X	X	X
New York	X	X			X	X			X	X	X	X
North Carolina			X	X	X	X					X	X
North Dakota			X	X							X	X
Ohio	X	X	X	X	X	X	X	X			X	X
Oklahoma					X	X					X	X
Oregon	X	X			X	X	X	X		X	X	X
Pennsylvania	X	X	X	X	X	X	X	X			X	X
Rhode Island	X	X	X	X	X	X	X	X			X	X
South Carolina	X	X	X	X							X	X
South Dakota			X	X							X	X
Tennessee			X	X	X	X	X	X			X	X
Texas			X	X			X	X			X	X
Utah			X	X	X	X					X	X
Vermont	X	X	X	X	X	X			X	X	X	X
Virginia												
Washington												
West Virginia	X	X	X	X	X	X					X	X
Wisconsin	X	X	X	X	X	X				X	X	X
Wyoming												
Total	**23**	**26**	**28**	**31**	**35**	**37**	**16**	**11**	**10**	**11**	**45**	**45**

*Kentucky, Minnesota, Missouri, New York & Vermont all reported multiple "other" provider tax in both 2009 and 2010

2010 Health Care Provider Tax Changes				
Appendix F. Health Taxes				
State	**FY 2011 Amount** (in millions)	**FY 2012 Amount** (in millions)	**Effective Date**	**Description**
Alabama	$20.9	$20.9		Raised the nursing home bed tax.
Idaho	$18.0	$18.0		Approved the Idaho Hospital Assessment Act, which calls for calls for private hospitals to pay an extra hospital tax for Idaho's Medicaid program for two years.
Kansas	$15.3	$15.3		Created a new assessment on skilled nursing facilities.
Maine	$4.2 $11.4	$15.6		Approved a one-time hospital assessment. Updated hospital tax base year from 2006 to 2008.
New Jersey	$45.2	$45.2		Lifted the cap on hospital and ambulatory facilities assessments.
Ohio	$32.4	$32.4		Raised the tax assessed on hospitals for one year from 1.52 percent to 1.61 percent.
Tennessee	$286.0	$286.0		Adopted a new hospital assessment fee of 3.52 percent.
Utah	$30.9	$30.9		Imposed new assessments on hospitals.
Washington	$352.0	$352.0		Increased the hospital safety net assessment.
Wisconsin	$10.6	$10.6		Created a 1.6 percent assessment on gross inpatient revenues of critical access hospitals.

2009 Health Care Provider Tax Changes				
Appendix F. Health Taxes				
State	**FY 2010 Amount** (in millions)	**FY 2011 Amount** (in millions)	**Effective Date**	**Description**
Alabama	$200.0	$200.0	10/1/2009	Establishes a hospital tax.
Arizona	$0.0	$0.0		Adds insurance providers to the existing corporate income tax credit for contributions made to school tuition organizations.
Colorado	$336.5	$389.8	4/21/2009	Authorizes collection of provider fees from hospitals to obtain federal financial participation for the state's medical assistance programs.
Florida	$8.0	$12.1		Provides for a quality assessment to be imposed upon privately operated intermediate care facilities for the developmentally disabled.
Indiana	$101.0	$99.9	7/1/2009	Extends the Medicaid health facility quality assessment fee.

2009 Health Care Provider Tax Changes				
Appendix F. Health Taxes				
State	FY 2010 Amount (in millions)	FY 2011 Amount (in millions)	Effective Date	Description
Iowa	$33.0	$33.0	TY 2009	Creates a nursing facility quality assurance fee (requires federal approval before implementation).
Mississippi	$60.0	$60.0	7/1/2009	Provides a hospital assessment tax.
New Mexico	-$11.0**	-$16.1**		Phases in the hospital gross receipts tax credit (phased in completely in FY 2012, from 2007 session).
New York	$124.3	$135.6	4/1/2009	Changes the hospital assessment tax.
	$14.2	$16.0	4/1/2009	Changes the home care assessment.
	$99.0	$108.0	4/1/2009	Raises the hospital surcharge.
	$240.0	$120.0	10/1/2008	Adjusts a covered lives assessment (insurance surcharge).
	$5.0	$5.0	4/7/2009	Changes an out-of-state covered lives assessment.
Ohio	$100.0	$100.0	7/1/2009	Raises the franchise fee for nursing facilities.
	$338.5	$370.9	10/1/2009	Changes the hospital assessment.
	$3.0	$3.0	8/1/2009	Increases the franchise fee for intermediate care facilities for the mentally retarded.
Oregon	$102.0	$204.0	10/1/2009	Raises the hospital assessment tax.
	$85.0	$78.0	10/1/2009	Changes to insurance premium for Medicaid managed care.
Pennsylvania	$528.0	$529.0		Changes the gross receipts tax on managed care to draw additional federal matching funds for medical assistance.
Rhode Island	-$12.7	$0.0		Changes the Medicaid global waiver and eliminates the group home tax.
Rhode Island,	$13.6	$0.0	1/1/2009	Increases health industry gross premiums tax and base expansion to managed care health plans.
Continued	$0.0	$0.0		Sets the recurring hospital license fee for FY 2010.
Wisconsin	$31.8	$40.0	7/1/2009	Raises the nursing home bed assessment.
	$103.2	$139.1	7/1/2009	Imposes a hospital assessment.
	$22.0	$22.0	7/1/2009	Imposes a tax on ambulatory surgical centers.