State Budgeting Matters

Volume 7, Number 9 The Center for Community Solutions December, 2011

The Sales Tax and Medicaid Managed Care: Short-run Revenues vs. Long-run Challenges

By Jon Honeck, Ph.D., Fellow & Director, Public Policy & Advocacy
The Center for Community Solutions

Highlights:

- Ohio's sales tax on Medicaid Managed Care Organizations (MCOs) is expected to generate $305.3 million for the state's General Revenue Fund in FY 2012. The amount will allow the state to draw down approximately $546 million in federal Medicaid matching funds that can be used to meet program expenses. MCOs are held harmless from the tax through higher capitation payments, so the net gain to the state is the federal match amount, less the amount of tax remitted to counties.

- Ohio may not be able to maintain a sales tax on Medicaid MCOs much longer. In response to federal pressure, Michigan replaced a similar MCO sales tax this year with a broad-based 1 percent tax on all public and private health insurers, including self-insuring employers. A broad-based health care tax with winners and losers is permitted under federal law. Ohio and Michigan applied their sales taxes to MCOs in 2009 because federal law disallowed their previous practice of charging Medicaid MCOs an insurance tax at a different rate than commercial health insurers.

- County add-on sales taxes also apply to Medicaid MCO premiums. Sales are credited according to the county of residence of the MCO enrollee. Counties received $67.9 million from taxing Medicaid MCO premiums in FY 2011, and are expected to receive $77 million in FY 2012. MCO premiums provided an important expansion of the county sales tax base during the recession.

- The federal government may impose additional restrictions on the use of Medicaid provider fees and taxes as part of deficit reduction plans. Most recently, the Obama Administration's proposal to the temporary Joint Select Committee on Deficit Reduction would have imposed a ceiling on provider fees of 4.5 percent of total revenues starting

in federal fiscal year 2015. The ceiling would decline to 3.5 percent in 2017. The committee was not able to reach agreement, but similar proposals will continue to surface.

- The increased use of Medicaid provider taxes creates a danger that short-run revenue needs will drive policy choices in directions that are at cross-purposes with the long-run needs of the program.

Medicaid Financing and Provider Taxes

Financing the Medicaid program has become one of the most important fiscal issues facing Ohio and other states. Program enrollment in Ohio rose by 23 percent from 2007 to 2011 (over 410,000 people), as families with private insurance lost their jobs and their employer-provided health insurance coverage.[1] Even as the economy recovers, health care costs continue to climb, and employers are cutting back on coverage. Medicaid appropriations across all agencies total approximately $19.8 billion in FY 2013.[2]

In this budget biennium, the federal government will pay for about 64 percent of program costs. The state meets the majority of its financial commitment with General Revenue Fund (GRF) funding, but this has become more difficult as large tax cuts continued through the recession. Ohio was temporarily aided by a large increase in the federal Medicaid matching rate during the Great Recession, which brought in billions above what the state would have normally received. The application of the enhanced federal match to state payments for Medicare premiums for individuals eligible for both Medicare Part D and Medicaid ("dual eligibles") also provided fiscal relief. These forms of temporary aid ended in June, 2011. Together, these policies brought $3.58 billion in fiscal relief to the state over a two-and-a-half-year period.[3]

Contracting with Managed Care Organization (MCOs) is a common way for states to bring a health maintenance organization model to the Medicaid program. MCOs play an increasingly important role in Ohio. The traditional fee-for-service model in which the state or other public sector organizations make payments directly to providers is being phased out, and now applies only to certain segments of the aged, blind, and disabled (ABD) enrollment category and specialty systems such as mental health and developmental disabilities. The state now has the authority to transfer most of the ABD population to managed care, but this has not yet occurred.[4] MCOs enroll approximately 1.5 million Ohioans in the Covered Families and Children (CFC) category, and about 125,000 individuals in the ABD category. Most of the latter are elderly individuals who require long-term care.

All but four states impose some kind of Medicaid provider fee to boost the amount of funds used to draw down federal matching dollars. Generally, providers get a portion of such fees returned to them through higher reimbursement rates. At present, Ohio has four such provider fees or taxes including the managed care sales tax.[5] The three non-GRF fees are shown in Table 1. Fees for nursing homes and Intermediate Care Facilities (ICF/MR) for the developmentally disabled were raised significantly in the FY 2010-2011 budget and currently are at their federal

maximum of 6 percent of revenue. The hospital fee was started in FY 2010, and was reconfigured for this biennium to include a higher rate but exclude Medicare payments.

Table 1. Ohio Medicaid Non- GRF Provider Franchise Fees and Taxes (in millions $)

Description	Base/Rate	FY 2012 (millions $)	FY 2013 (millions $)
Nursing Home and Hospital LTC Franchise Permit Fee	6% of revenue*	395.7	397.4
Hospital Assessment	2.57% of facility costs (excluding Medicare)	338.8	345.2
ICF/MR Franchise Permit Fee	6% of revenue**	27.1	30.1
Combined State Share	----	761.6	772.7
Combined Federal Share		1,353.2	1,376.6

Source: LSC, Fee Changes included in H.B. 153, As Enacted.
* $11.47 per bed day FY 2012, $11.67 in FY 2013
** $17.99 per bed day FY 2012, $18.32 in FY 2013

From 2006 to 2010, Medicaid MCOs were subject to a specialized non-GRF franchise fee assessment. This fee did not apply to non-Medicaid health insurers, even if they were related companies. The franchise fee was ended due to federal regulatory changes (see below). As a substitute, the regular state sales tax rate of 5.5 percent was applied to payments from the state to Medicaid MCOs. Because Medicaid is a public program, the tax is administered somewhat differently than a typical sales tax remittance by a private vendor. In this case, MCOs are considered the consumer, but "sales" are credited to the county of residence of the MCO enrollee for the purpose of applying county add-on sales taxes. The state collects the tax from the MCO and remits to the county.

Table 2 shows actual receipts from the tax in the previous biennium and estimated revenue from FY 2012. The tax was only collected for eight months in FY 2010. Revenues from the tax are expected to grow in the current biennium due to the expansion of MCO coverage in the budget bill to Medicaid pharmacy payments, and potential expansions to the aged, blind, and disabled eligibility category.[6]

Table 2. Revenues from Medicaid MCOs premiums, FY 2010- 2012 (in millions)

	FY 2010 (8 mos.)	FY 2011	FY 2012 (est.)
State GRF	$168.7	$281.1	$305.3
Counties	$40.8	$67.9	$77.0
Total	$209.5	$349.0	$382.3

Source: Ohio Department of Taxation; OBM

The revenues that counties receive from the Medicaid MCO sales tax are significant and should be taken into account if changes are made to the tax (Table 3). County receipts are proportional

to the county's share of residents enrolled in MCOs. For example, MCO premium receipts may account for about roughly 7 percent of Cuyahoga County's total of $217 million from the county sales tax in calendar year 2011.[7] MCO premiums helped to partially offset declines in Cuyahoga County sales tax base in 2010 and 2011, and undoubtedly played the same role in many other counties as well.[8] County revenues were reduced by the FY 2012-2013 budget bill's changes to the Local Government Fund, reimbursements for the tangible personal property tax and public utility taxes, and line item reductions in human service and criminal justice programs.

Table 3. Large County Receipts from the Medicaid MCO Sales Tax

County	SFY 2010 (8 mos.)	SFY 2011	Share of Total County MCO Sales Tax (SFY 2011)
Cuyahoga	$9.2	$15.5	22.8%
Franklin	$4.4	$7.5	11.1%
Hamilton	$2.3	$3.9	5.8%
All others	$24.8	$41.0	60.3%

Source: Ohio Department of Taxation.

States Respond to Federal Law Changes

The use of provider taxes to finance Medicaid has been a continual tug of war between the federal government and the states. States have continued to create new and inventive means of using provider taxes to bring in additional federal matching dollars. These financing schemes often return a portion of the fee or tax to the provider without necessarily increasing the availability or quality of services to consumers.

Health care provider taxes are governed by 1991 amendments to the Social Security Act that limited provider taxes to 25 percent of the non-federal share and required that such taxes (1) must be applied to a permitted class as defined in federal law and (2) must be broad-based and applied at a uniform rate on all providers in the class.[9] In addition, reimbursement rates cannot create a "hold harmless" situation in which taxes are returned to the providers, unless they amount to less than 6 percent of the revenues to the provider class.[10]

The language of the 1991 legislation created a loophole in defining the managed care health services class by restricting the definition to "Medicaid managed care organizations."[11] Ohio took advantage of this loophole starting in FY 2006 by applying a 5.5 percent rate to Medicaid MCOs under the state's domestic insurance taxes. In FY 2009, its final full year of operation, the tax yielded $221.5 million, with a federal match of $489.5 million.[12] Health insuring corporations that did not receive Medicaid funds paid just 1 percent of their premiums.[13]

The 2005 federal Deficit Reduction Act (DRA) changed the regulatory landscape for Medicaid provider taxes by closing the loophole and enlarging the MCO provider class to include commercial HMOs. The law contained a grandfather clause that permitted states to continue collecting special Medicaid MCO taxes until the end of Federal Fiscal Year 2009 (October 1, 2009).[14] Ohio was one of eight states that used a special MCO provider tax.

Ohio responded to the DRA in the FY 2010-2011 budget bill (H.B. 1, 2009) by placing Medicaid HMOs under the sales tax. MCOs were also made subject to the 1 percent domestic insurance tax, just as other health insuring corporations, yielding about $46.6 million in calendar year 2010.[15] By including both commercial and Medicaid insurers, the insurance tax conforms to the federal requirement for a broad-based provider tax. On the other hand, the application of the sales tax to Medicaid MCOs, as discussed below, has a precarious outlook under federal law.

At first glance, because the sales tax is deposited in the GRF, it does not appear to function in the same manner as other Medicaid provider taxes. Instead, it is part of a much larger revenue stream of $4.8 billion in GRF financing (All agencies) that provides the state's maintenance of effort. Nonetheless, federal Medicaid law creates a direct link with capitation payments to Medicaid MCOs because of a requirement that states pay an actuarially sound rate. This rule was part of the DRA and was meant to provide a protection against MCO default as larger segments of the Medicaid population were enrolled in managed care. Center for Medicare and Medicaid Services (CMS) regulations allow states to use the cost of a health care tax as one component in developing a payment rate but they cannot condition the rate solely on the state's receipt of the tax.[16]

The Medicaid actuary report for Ohio, which is used as a baseline to set capitation payment rates, includes both the sales tax and the health insuring corporation tax in the payment rates.[17] For the sales tax, the report establishes a representative combined state and local rate for each of the state's eight regions. These rates vary from a low of 6.4 percent for the east central region to a high of 6.93 percent for the west central region. When the 1 percent health insuring tax is added, reimbursement for these taxes increases capitation payments to between 7.40 and 7.93 percent. By way of comparison, general administrative reimbursement rates are 12.45 percent.

In other words, even though sales tax receipts are placed in the GRF, actuarial requirements create a circular flow of funds just as in other Medicaid provider taxes. The net revenue gain to the state is the federal share, less the amounts distributed to counties. For this reason, the MCO boost to the sales tax alone does not boost the state's bottom line. Between FY 2010 and FY 2011, for example, the state non-auto sales tax grew by almost $408 million. Extending the sales tax to MCOs accounted for over one-fourth of this increase, but these funds were eventually returned to MCOs via payments.

At expected FY 2012 levels, the sales tax on Medicaid MCOs will generate federal matching funds of approximately $546 million. About $77 million of these funds must be used to

compensate for the distribution add-on sales taxes to counties. The net gain to the state would be $469 million (leaving aside timing issues and lags in collection and distribution).

Another Round of Federal Regulatory Changes?

When the DRA's grandfather clause expired in 2009, Michigan was one of eight states with a special tax on Medicaid MCOs. Michigan responded to the DRA's requirement in a similar fashion to Ohio and extended the coverage of the state's 6 percent sales and use tax to Medicaid MCOs. During the 2011 budget process, the Snyder Administration warned of federal action to disallow the arrangement and proposed a substitute tax 1.0 percent tax on health care claims. The rationale for the change is that the new tax would be a broad-based provider tax that would satisfy federal rules.[18] The Michigan legislature accepted the proposal and enacted the Health Insurance Claims Assessment Act effective January 1, 2012.[19] The use tax on Medicaid claims is repealed as of March 31, 2012, leading to three months of overlap. The new tax will not be deposited into Michigan's general fund, but will be earmarked to support the Medicaid program.

The new law is temporary, expiring at the end of 2013. It is expected to raise between $375 million and $397 million per year, about the equivalent of the expiring use tax.[20] At the insistence of the Michigan Manufacturers' Association, it contains a trigger for reducing the rate in 2013 if the first year's collection amount exceeds 110 percent of $400 million as adjusted by the rate of medical inflation.[21] The tax base excludes federal non-Medicaid payments, i.e., Medicare, Veterans' Administration, and federal employee health insurance. It gives the executive the ability to include revenue streams from a waiver to improve services for dual-eligible consumers if the federal government approves the arrangement. Interestingly, the tax also applies to health plans of state and local governments, and to public and private employers that are self-insured. Private health insurers are permitted to pass the costs of the tax along to their customers without a separate rate filing with the Michigan Insurance Commissioner.[22]

Whether Michigan's action will start a trend remains to be seen. Pennsylvania, which enacted a 5.9 percent gross receipts tax (similar to a sales tax) in 2009 in response to the Deficit Reduction Act, has not followed suit.[23] Kentucky also maintains a 5.5 percent gross receipts tax.[24] CMS may delay formal action on provider taxes due to the political climate in Washington and the need to focus on other regulatory issues. Nonetheless, the financial sustainability of the Medicaid program has become a prominent political issue in deficit reduction talks. In December, 2010, the President's National Commission on Fiscal Responsibility and Reform proposed phasing out and eventually eliminating Medicaid provider taxes.[25]

In September 2011, President Obama's proposal to the Joint Select Committee on Deficit Reduction ("super committee") included a provision to reduce Medicaid provider tax rates from the current ceiling of 6 percent. The proposal would cap allowable provider tax rates at 4.5 percent starting in federal fiscal year 2015. A phase-down to 3.5 percent would be completed by 2017.[26] The failure of the super committee to reach agreement will prevent this proposal from moving forward, but even if the federal government does not act immediately

through CMS regulatory authority or future budget negotiations, the issue of Medicaid health care provider taxes will not go away. Fiscal pressures will lead the federal government to place further controls on the ability of states to "game the system" in a way that increases federal costs and allows the states to escape paying for their share of the program. The American health care system is struggling to control costs, but specialized provider taxes lead to a loss in transparency in pricing and allow self-interested providers to support rate increases that may not be in the best interests of the system.

From a state perspective, cost control requires minimizing patient care in more expensive institutional settings. Yet these settings – nursing homes, hospitals, and ICF/MRs – generate franchise fees that support the program, and create a long-run clash between financing and policy. Similarly, the use of a fee or tax on MCOs may create a bias toward the expansion of MCO coverage for financial reasons rather than policy.

A replacement tax for the Medicaid MCO sales tax would have to generate a combined $469 million to yield a net gain equivalent to current arrangements. MCOs are already subject to the 1 percent health insuring corporations (HIC) tax, which is a broad-based provider tax for purposes of federal Medicaid regulation. Raising the HIC rate, however, would create the same issues of price transparency and a circular flow of funds as other provider taxes. It would also trigger retaliatory insurance taxes in other states.

Policymakers should give thoughtful consideration to a combination of general tax increases and closing tax loopholes that would spread responsibility and would not impact MCO actuarial requirements. Using a GRF tax could also lessen the impact on counties if Local Government Fund distributions were adjusted accordingly. If these methods were used, the tax would have to raise about $168 million in state revenue annually with a resulting $300 million federal share. This amount of state revenue is a small increase over the $18.5 billion in GRF taxes expected in FY 2012. The final cut to income tax rates, in comparison, reduced GRF taxes by over $400 million.

Conclusion

Medicaid MCO premiums are currently subject to Ohio's state and county sales and use taxes. The state uses this tax to boost its GRF maintenance of effort for the Medicaid program. MCOs are reimbursed for the tax through capitation payments in order to comply with federal actuarial rules. The application of the sales tax to Medicaid MCOs but not to other health maintenance organizations appears to violate federal rules that require Medicaid provider taxes to be broad-based and include all providers in a class.

The state of Michigan employs a similar sales tax on Medicaid MCOs, but it will be phased out in 2012. The Snyder Administration recommended its repeal because of pressure from the federal government. In its place, the Michigan legislature approved a temporary 1 percent tax on all health insurance claims, with an exception for Medicare, Veterans' Administration, and

federal employee health plans. The tax is expected to raise almost $400 million each year that will be used to draw down federal matching funds.

The use of Medicaid provider taxes to increase federal matching funds is a long-running battle between the states and the federal government that will intensify as federal budget pressures grow. Specialized provider taxes lead to a loss in transparency in health care pricing and allow self-interested providers to support rate increases that may not be in the best interests of the system and potentially conflict with more cost-effective home- and community-based care options. Ohio should consider replacing its MCO sales tax with an increase in a broad-based GRF tax. The financial impact on counties should be taken into account in this process. A thorough review of the state's more than $7 billion in tax expenditures is a good place to start.

---

[1] ODJFS. Comparison of July 2007 and preliminary July 2011 total Medicaid caseloads. *JFS Medicaid Services – 600525 and Related Line Items. SFY 2011 – 2013. Budget as Passed. (*August 1, 2011) and SFY 2012 update.

[2] ODJFS. *JFS Medicaid Services – 600525 and Related Line Items. SFY 2011 – 2013. Budget as Passed. (*August 1, 2011), p. 235.

[3] Kaiser Commission on Medicaid and the Uninsured, *Impact of the Medicaid Fiscal Relief Provisions in the American Recovery and Reinvestment Act (ARRA)*, Oct. 2011, Table 2: ARRA Increased FMAP Drawdowns and Clawback Impact by State. Available at www.kff.org

[4] The budget contemplates transfer of 37,000 disabled children to managed care in FY 2013, but exempts Bureau for Children with Medical Handicaps (BCMH) participants from the change. (R.C. 5111.16 and Sec. 309.30.53, H.B. 153/129th G.A.)

[5] In addition, a small tax is charged on horse racing and dedicated to the PASSPORT program and a recent rule change set fees for provider applications.

[6] Pharmacy payments were "carved out" in H.B. 119, the FY 2010-2011 budget bill, as a cost-control measure, but put back under MCO administration by H.B. 153/129th G.A.

[7] *Cuyahoga County, Ohio. Executive's Recommended 2012-2013 Budget.* Office of the County Executive, Ed FitzGerald (October 14, 2011), Chart "2012-2013 Budget. All Funds Revenue," p. I-10. Note that the county's fiscal year is on a calendar year basis. If Cuyahoga's share of Medicaid MCO sales tax receipts holds steady at about 23 percent, the county's receipts from the tax may climb to about $17.7 million in the current state fiscal year.

[8] Economic Research Analyst George Zeller has noted that the MCO sales tax provided a boost to Cuyahoga County's tax base. *See* www.georgezeller.com.

[9] Medicaid Voluntary Contribution and Provider Specific Tax Amendments, Public Law 102-234, Amending section 1903 of the Social Security Act. U.S. Department of Health and Human Services regulations at 42 CFR 433.

[10] 42 U.S.C. 1968(w)(4)(C)(2).

[11] Elicia J. Herz, "Medicaid Provider Taxes," Congressional Research Service, p. 2. March 4, 2009. Available at http://aging.senate.gov/crs/medicaid9.pdf

[12] ODJFS. *JFS Medicaid Services – 600525 and Related Line Items. SFY 2011 – 2013. Budget as Passed.* (August 1, 2011), p. 3.

[13] LSC Red Book, Am. Sub. H.B. 1, As Passed by the 128th General Assembly.

[14] National Association of State Medicaid Directors, Letter to Chairman Max Baucus, Senate Finance Committee, June 16, 2009. Available at http://hsd.aphsa.org/Home/home_news.asp

[15] Ohio Department of Insurance communication with the author, 11-30-11.

[16] See 72 FR 13726, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Discussion of Proposed Rule 42 CFR Part 433 (March 23, 2007), p. 13730. Part of this rule was put on hold until July 1, 2010, first due to Congressional action and then an additional delay from HHS.

[17] Milliman, Inc. State of Ohio. Department of Job and Family Services. *Data Book for CY 2011. Risk Based Managed Care for Covered Families and Children.* September 2010.

[18] Michigan House Fiscal Agency. Legislative Analysis, S.B. 347 and 348. As Reported out of House Appropriations Committee.

[19] Michigan Senate Bill 348, 96th Legislature, 2010-2011 Regular Session.

[20] The executive estimated higher revenues. Michigan Senate Fiscal Agency, Bill Analysis. SB 347 and 348. Summary as Passed by the Senate. 6-30-11. Available at www.senate.michigan.gov/sfa.

[21] Michigan Manufacturers' Association, *Issue Brief: Health Insurance Claims Assessment (Senate Bills 347 and 348)*, September 22, 2011. Available at www.mma-net.org

[22] Michigan Senate Fiscal Agency. *Op. cit.*, p. 3.

[23] Deloitte. "Pennsylvania Adopts Tax Law Changes as Part of 2009-2010 Budget Process." October 23, 2009. Available at http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Tax/us_tax_Multistate_PA%20Tax%20Alert_10-26-09.pdf.

[24] Kentucky levies a tax of 5.5 percent of Medicaid managed care services. This tax predates the Deficit Reduction Act. Kentucky Department of Revenue *Annual Reports.*

[25] National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, (Dec. 2010), Recommendation 3.3.8, p. 39. Available at http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf

[26] U.S. Office of Management and Budget. September 2011. *Living within our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction*, p. 40. Available at http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf

State Budgeting Matters is published by The Center for Community Solutions. Comments and questions about this edition may be sent to the author at jhoneck@CommunitySolutions.com.

THE CENTER FOR COMMUNITY SOLUTIONS
RESEARCH • PLANNING • ACTION

1501 Euclid Ave., Ste. 310, Cleveland, OH 44115
P: 216-781-2944, F: 216-781-2988
www.CommunitySolutions.com