

Options to Generate the State Share of Medicaid Expansion Costs

In 2020, states that expanded Medicaid will be required to pay for 10 percent of the program's costs, with the federal government picking up the remaining 90 percent of the costs of Medicaid expansion. While the federal share for Medicaid expansion is considerably higher than federal payments for Medicaid generally, and Medicaid expansion states have seen a positive effect on their economies, states must determine how to generate the 10 percent state share.^{1,2}

This short analysis identifies different strategies that Medicaid expansion states used to pay for the state share in 2018 - when the state share was 6 percent —and how states plan to generate the state share in subsequent years.

While most states used general fund revenue to cover the state share of expansion costs in 2018, several states used other funds, such as provider taxes or fees, cigarette taxes, or other specified taxes to pay for all or part of the state share.³ The appendix provides an overview of various approaches used by states that have expanded Medicaid. The vast majority of states rely on provider taxes to pay for some or all of the state share that is not drawn from general funds.

About Provider Taxes

Utilizing provider taxes as a mechanism to finance the state share of Medicaid costs is a common practice among states. In 2018, every state except Alaska used at least one provider tax.⁴ Thus, it is not surprising that such taxes are a leading source of funding for the state's share of expansion costs.

Provider taxes generate new in-state funds that are matched with federal funds, allowing states to receive additional Medicaid dollars. Providers generally experience the cost of the tax returned through increased Medicaid provider payments.

Federal Requirements

Taxes, assessments, fees or other mandatory payments for which at least 85 percent of the burden falls on health care providers are subject to federal provider tax regulations.⁵ For those taxes to be utilized as a mechanism to generate the state's Medicaid costs, the tax must meet the following three requirements:

1. **Be broad-based**—that is, imposed on all providers within a class (there are 19 provider classes under federal law).
2. **Be imposed uniformly**—in the same way on all providers in a class or jurisdiction.
3. **The tax cannot hold providers harmless**—there cannot be a guarantee that providers will see the tax revenue returned to them.⁶

The Centers for Medicare and Medicaid Services (CMS) apply a two-part test to determine whether the tax holds providers harmless:

- » Do the taxes collected exceed 6 percent of the net patient revenue for the class of health care providers being taxed (referred to as the 6 percent threshold or “safe harbor”)? If they do not, the tax is permissible. The vast majority of provider taxes fall within the 6 percent threshold.⁷
- » However, if the tax exceeds the 6 percent threshold, it may still be permissible if it passes a second test. Do 75 percent or more of all providers taxed recover 75 percent or more of their total costs as either enhanced Medicaid payments or other state payments (the 75/75 rule)? If they do, the rule has been violated and the tax is not permissible.⁸

Waivers

The Secretary of Health and Human Services can waive the law’s “broad-based” and “uniform” requirements (the first two federal requirements listed above). In statute, rural and sole practitioners are specifically listed as providers that may be exempted through a waiver.⁹ The Secretary does not have the authority under the Federal law to waive the requirement that the tax cannot hold providers harmless.

Approving and Implementing Provider Taxes

Provider taxes are usually passed through legislation. If a state is not asking for a waiver of any legal requirements, its Medicaid agency will submit a State Plan Amendment for federal approval to change its existing state Medicaid plan. Currently, the CMS approves 84 percent of State Plan Amendment applications within 90 days of receipt.¹⁰

Contributions and Donations Versus Taxes and Fees

Providers may make donations to fund state Medicaid programs **but only in very limited circumstances.**

- » The donations must be “bona fide” under federal law. This means there is no direct or indirect relationship to Medicaid provider payments or any class of providers, and that there are no agreements between the state and provider that link donations to Medicaid payments,¹¹ or
- » The donations are made by a hospital, clinic, or other entity for the direct cost of state or local personnel who are stationed at the organization to determine eligibility or provide outreach services.¹²

Two expansion states that have used provider donations in their Medicaid programs, Louisiana and New Hampshire, are profiled below. CMS approved Louisiana’s program in 2016; it notified New Hampshire by letter in 2017 that the state was out of compliance.

The differences in how Louisiana and New Hampshire would use the donations, and the connection to Medicaid expansion, were key to CMS’s determinations.

Any use of donations should be carefully structured and not connected to provider payments. Ideally, the state should seek CMS approval before the program is implemented to avoid the possibility of program or service shut-downs if the tax is found to be noncompliant.

LOUISIANA. In 2016, Louisiana asked for and received approval from CMS to use provider donations made to the Baton Rouge Area Foundation (BRAAF), and transmitted to the state anonymously, to fund the state share of its Medicaid administrative costs.¹³

The state provided CMS with assurance that 1) the donations would be used for administrative support only and not for provider payments; 2) the donations would be anonymous; 3) neither the state's Medicaid expansion nor any provider payments were predicated on receipt of donations; and 4) donations would flow through the BRAAF and be treated by the donating providers as charitable contributions, not business expenses. All of those assurances were critical to CMS's approval.

NEW HAMPSHIRE. In 2017, CMS sent a letter to New Hampshire notifying the state that its use of hospital donations was out of compliance with federal law.¹⁴ In its letter, CMS noted that the provider donations, which were made to the New Hampshire Health Protection Fund, were used to pay for Medicaid-related services costs and that state legislation conditioned expansion on the receipt of donations. Those links—to patient care and as a condition for expansion—led CMS to its determination.

As a result of the determination, the state has had to revisit how it pays for its share of expansion costs (see New Hampshire in the state profile section below).¹⁵

Provider Taxes not Regulated by CMS

Some states have passed taxes on health care providers that do not meet the definition of provider taxes requiring federal regulation. This can be done if the taxed group is a mix of health care and non-health care entities and the tax burden for health care providers is less than 85 percent of the total.

Medicaid Expansion State Share Funding: Profiles of Select States

ARIZONA. Arizona funds a large portion of its state share of Medicaid expansion costs with a hospital assessment. Several Republican lawmakers and the Goldwater Institute filed a lawsuit against the governor challenging the assessment as a new tax that lacked sufficient support to pass. Under Arizona law, new taxes require two-thirds approval in the legislature; the assessment was approved by a majority. The administration argued that the assessment was not a tax and therefore not subject to the two-thirds rule. The Arizona Supreme Court heard the case in 2017 and upheld the assessment, finding it was not a tax subject to the two-thirds rule.¹⁶

CALIFORNIA. In 2016, California voters passed Proposition 56, which increased the state tobacco tax. The tax was not designated specifically for Medicaid expansion but for funding “specified expenditures, including funding for existing programs administered by the Department of Health Care Services...”¹⁷

COLORADO. The bulk of expansion funding comes from the state's Hospital Provider Fee.¹⁸ In 2017, provider fees were on the table for a cut because the fees collected pushed the state over the Taxpayer Bill of Rights revenue cap (TABOR), which have triggered automatic refunds to taxpayers. A compromise bill was passed. That bill allowed for the reclassification of a fund to pay for health care, removing some provider taxes from the TABOR cap. As part of the compromise, Medicaid copays for prescription drugs and some outpatient services were added to the program.¹⁹ Based on the experience of other states in collecting copays, administrative costs may exceed any revenue generated.²⁰

INDIANA. To keep a promise that Medicaid expansion would not increase taxes, former Governor Pence's administration worked with the state hospital association to use tobacco tax revenue and increased provider taxes to fund the expansion. This is the same funding stream used for the state's initial Healthy Indiana Program in 2011. Taxes will increase automatically as federal funding for the expansion gradually declines to 90 percent. The Hospital Assessment Fee is levied against all licensed acute care hospitals and psychiatric hospitals. The formula to determine the assessment is overseen by the Hospital Assessment Fund Board, which includes two members from the state hospital association and two from the state.^{21, 22}

NEW HAMPSHIRE. Initially the expansion was paid for with funds from the New Hampshire Health Protection Trust Fund, which included insurance premium tax revenues attributable to new Medicaid expansion enrollees; a health insurance company assessment based on the number of covered individuals, set at a fixed amount each year previously associated with a high-risk pool; and voluntary contributions, primarily from hospitals.²³ As discussed above, CMS notified New Hampshire in July 2017 that its reliance on voluntary funds was not in compliance and gave the state until the end of 2018 to implement corrections.²⁴

Coming into compliance required New Hampshire to find additional funding. The trust fund will continue, funded by the insurance premium tax revenues and fees associated with the former high-risk pool. The state is ending its Medicaid expansion private option program and transitioning expansion enrollees to

traditional Medicaid, a move that is expected to save the state \$200 million.²⁵ It is asking CMS to allow it to recapture those savings. Additionally, New Hampshire is increasing the share of Liquor Commission profits transferred to the Alcohol Abuse Prevention and Treatment Fund from 1.7 percent to 5 percent of liquor profits. These funds will be used to fund the expansion.²⁶ (This is a transfer, not a new tax.)

OREGON. In a special election in January 2018, Oregon voters approved a tax on hospitals and insurance companies to fund the Medicaid expansion (Measure 101, Oregon Health Care Insurance Premiums Tax for Medicaid Referendum).²⁷ The measure passed with 61 percent of the vote. The ballot measure was the result of SB 229, which called for Measure 101 to be put before voters in January 2018. The temporary assessment (through 2019) on insurance companies, some hospitals, and other health coverage providers includes a provision that insurers cannot increase premiums by more than 1.5 percent as a result of the assessment.

UTAH. In November 2018, Utah voters passed Utah Proposition 3, the Medicaid Expansion Initiative. The ballot measure included an increase in the sales tax from 4.70 percent to 4.85 percent to finance the state's share of expansion costs.²⁸

VIRGINIA. A provider tax will apply to 69 private acute care hospitals to fund Medicaid expansion. Children's, public, critical access, and rehabilitation hospitals are exempt. As part of a compromise, a second provider tax, which the hospital association advocated, was passed. The funds raised will increase provider payments.²⁹ Virginia's provider taxes required waiver approval, which the state has secured.³⁰

APPENDIX

Snapshot: Medicaid Expansion States' Funding Sources Other than General Revenue, Select States, 2018

State	Funding Mechanism(s) for State Share Other than General Fund Revenue	% Not Covered by General Fund
Arizona	Hospital assessment.	79%
Arkansas	Provider taxes.	23%
California	Cigarette tax (approved by ballot measure), hospital fees.	51%
Colorado	Hospital provider fee; copays on prescription drugs and some outpatient services (copays added as part of compromise; see state discussion above).	100%
Illinois	Provider tax.	NA*
Indiana	Provider tax, cigarette tax.	100%
Louisiana	Tax on HMOs; donations through BRAF help offset administrative costs for the Medicaid program.	NA*
Nevada	Provider taxes.	3%
New Hampshire	Insurance premium tax; health insurance assessment based on former high-risk pool; transfer of liquor tax from general fund. New Hampshire is seeking federal approval to recapture savings realized by ending private option.	100%
Ohio	Provider tax.	11%
Oregon	Provider/insurance company tax (approved by ballot measure).	NA*
Utah	Sales tax.	NA
Virginia	Provider taxes (expansion not implemented until January 1, 2019).	NA
West Virginia	Funding for Medicaid program is from a variety of sources including provider taxes, lottery funds, and a Medical Services Trust Fund.	42%

Table notes on next page.

Notes: To identify most states using funding sources other than general revenue, we used the National Association of State Budget Officers (NASBO) 2018 annual report (see sources). However, not all expansion states reported funding detail to NASBO. For those, “NA” appears under “% Not Covered by General Revenue.” We identified states that did not report funding detail but that use sources other than general revenue funds through the sources listed below. “NA” also identifies two states (Utah and Virginia) that have expanded Medicaid through ballot measures or legislation but have not yet implemented those expansions. There may be states using additional funding sources that we did not capture.

*Funding allocation not reported to NASBO.

Sources: National Association of State Budget Officers, Fiscal Survey of the States Spring 2018, at https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Fiscal%20Survey/NASBO_Spring_2018_Fiscal_Survey_of_States-S.pdf (not all expansion states reported); detail on funding sources other than general revenue come from various sources, noted in the body of this paper, and provider tax information is, in part, from Kaiser Family Foundation, States and Medicaid provider taxes and fees, June 27, 2017, at <https://www.kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/> and the National Conference of State Legislatures, Health provider and industry state taxes and fees, at <http://www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx>.

ENDNOTES

¹ For traditional Medicaid, the federal share is adjusted annually based on state economic conditions. In 2016, it ranged from 50 percent, the statutory minimum, in 13 states, to a high of 74.1 percent in Mississippi. By law, the federal share cannot exceed 83 percent. See Medicaid and CHIP Payment and Access Commission, Matching Rates at <https://www.macpac.gov/subtopic/matching-rates/>.

² See: Antonisse, L., et al, The effects of Medicaid expansion under the ACA: Updated findings from a literature review (Washington, D.C.: Kaiser Family Foundation, March 2018) at <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/> and Japsen, B., “Study illustrates how Medicaid expansion can pay for itself,” Forbes, March 18, 2018, reporting on Montana’s and Michigan’s Medicaid expansions, at <https://www.forbes.com/sites/brucejapsen/2018/03/18/how-medicaid-expansion-pays-for-itself/#2805f2a25fdd>.

³ Quinn, M., “As federal Medicaid money fades, how are states funding expansion?” Governing, July 23, 2018, at <http://www.governing.com/topics/health-human-services/gov-medicaid-expansion-funding-states.html>.

⁴ Kaiser Family Foundation State Health Facts, States with at least one provider tax in place, 2018 data, accessed November 29, 2018 at <https://www.kff.org/medicaid/state-indicator/states-with-at-least-one-provider-tax-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22SFY%202009%22,%22sort%22:%22desc%22%7D>.

⁵ 42 CFR 433.55, Health care related taxes defined.

⁶ See Social Security Act Section 1903 (w), Payment to states and regulations at 42 CFR 433.68, Permissible health care related taxes. Provider classes are listed at 42 CFR 433.56.

⁷ Kaiser Family Foundation, States and Medicaid provider taxes and fees (Washington, D.C.: Kaiser Family Foundation, June 27, 2017) at <https://www.kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/>.

⁸ Kaiser Family Foundation, States and Medicaid Provider Taxes and Fees (Washington, D.C.: Kaiser Family Foundation, June 27, 2017) at <https://www.kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/>.

⁹ See Social Security Act Section 1903 (w), Payment to states and regulations at 42 CFR 433.72, Waiver provisions applicable to health-care related taxes.

¹⁰ CMCS Information Bulletin, “Update on state plan amendment

and Section 1915 waiver process improvements, August 16, 2018, at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib081618.pdf>; CMCS Information Bulletin, “State plan amendment and Section 1915 waiver process improvements to improve transparency and efficiency and reduce burden,” November 6, 2017 at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617-2.pdf>.

¹¹ Social Security Act Section 1903 (w); 42 CFR 433.54 Bona-fide donations. Donations from health care organizations that are less than \$50,000 per year are presumed to be bona fide.

¹² 42 CFR 433.66 Permissible provider-related donations.

¹³ National Conference of State Legislatures, Medicaid funding by voluntary donations, February 2016, at <http://www.ncsl.org/documents/health/MedicaidFundingVoluntarydonations-LA.pdf>.

¹⁴ Letter from Brian Neale, Director, Center for Medicaid and CHIP Services, to Jeffrey Myers, Commissioner, New Hampshire Department of Health and Human Services, July 25, 2017, at <https://www.governor.nh.gov/news-media/press-2017/documents/20170814-medicare-medicaid.pdf>.

¹⁵ Statement of New Hampshire Governor Chris Sununu, August 14 2017, at <https://www.governor.nh.gov/news-media/press-2017/20170814-medicare-medicaid.htm>.

¹⁶ Bob Christie, “Arizona high court rejects challenge to Medicaid expansion,” Associated Press, November 17, 2017, at <https://www.apnews.com/43b26359f33840e0850cbfac1ecc157a>.

¹⁷ Proposition 56, Tobacco Tax Increase 2016, Ballotpedia at [https://ballotpedia.org/California_Proposition_56_Tobacco_Tax_Increase_\(2016\)](https://ballotpedia.org/California_Proposition_56_Tobacco_Tax_Increase_(2016)).

¹⁸ Colorado Health Institute, Medicaid Expansion in Colorado, May 15, 2016; updated April 24, 2017, at <https://www.coloradohealthinstitute.org/research/medicaid-expansion-colorado>.

¹⁹ Colorado Public Radio, “Colorado’s rural hospitals pin their funding hopes on a bipartisan budget fix,” April 14, 2017, at <http://www.cpr.org/news/story/colorado-s-rural-hospitals-pin-their-funding-hopes-on-a-bipartisan-budget-fix>.

²⁰ Families USA, 1115 Medicaid waiver element: cost sharing, at <https://familiesusa.org/1115-waiver-element-cost-sharing>.

²¹ State of Indiana, HIP 2.0 financing overview, overview of hospital assessment fee, at https://www.in.gov/fssa/hip/files/HIP_2.0_Financing_Overview.pdf.

²² Alaska State Hospital and Nursing Home Association, Provider taxes: A comprehensive overview (Anchorage, Alaska: Alaska State Hospital and Nursing Home Association, April 2015) at <http://www.ashnha.com/wp-content/uploads/2012/11/Provider-Tax-Comprehensive-20152.pdf>.

²³ New Hampshire Fiscal Policy Institute, Medicaid expansion in New Hampshire and the state senate’s proposed changes, March 30, 2018, at <http://nhfpi.org/research/health-policy/medicaid-expansion-in-new-hampshire-and-the-state-senates-proposed-changes.html>.

²⁴ Statement of New Hampshire Governor Chris Sununu, op cit.

²⁵ The private option is a program through which New Hampshire was purchasing marketplace plans for Medicaid expansion enrollees rather than providing care directly through Medicaid or Medicaid contracted managed care plans.

²⁶ New Hampshire Fiscal Policy Institute, op cit.

²⁷ Ballotpedia, Oregon 2018 ballot measures, at https://ballotpedia.org/Oregon_2018_ballot_measures.

²⁸ Ballotpedia, Utah Proposition 3 ballot measure, at [https://ballotpedia.org/Utah_Proposition_3_Medicaid_Expansion_Initiative_\(2018\)](https://ballotpedia.org/Utah_Proposition_3_Medicaid_Expansion_Initiative_(2018)).

²⁹ Michael Martz, “A second hospital tax emerges as Senate struggles with budget,” Richmond Times Dispatch, May 15, 2018, at https://www.richmond.com/news/virginia/government-politics/a-second-hospital-tax-emerges-as-senate-struggles-with-budget/article_c8909c3c-8e12-5b18-a609-8725049c18c9.html.

³⁰ Michal Martz, “US approved new taxes to be paid by Virginia hospitals as state moves toward Medicaid expansion,” Richmond Times Dispatch, September 19, 2018, at https://www.richmond.com/news/virginia/government-politics/u-s-approves-new-taxes-to-be-paid-by-virginia/article_accae296-10b6-570a-98af-5e342f0560d4.html.

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