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ISSUE BRIEF

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Considerations in Determining the Fate of the Minnesota Provider Tax

Executive Summary

The fate of Minnesota's provider tax, scheduled for repeal effective January 1, 2020, is one of the headline issues of the 2019 legislative session. In this Issue Brief we take a closer look at several policy topics, questions, and claims regarding the tax itself and the arguments surrounding whether to reaffirm and extend the tax or allow the scheduled sunset to take place. We provide background on the tax's origins and legislative intent, discuss the evolution of its role in public health care finance, and evaluate its merits on several tax policy principles. We conclude with a brief discussion of a recently proposed alternative to the tax and other general alternative approaches through the lens of tax policy principles.

Primary Findings

The provider tax is unmoored from its original statutory intent and purpose, but still serves as an important revenue source for Minnesota's public health programs. The request and subsequent approval to operate MinnesotaCare as a "Basic Health Plan" under the federal Affordable Care Act essentially shifted funding responsibilities for this program to the federal government. As a result, the primary purpose of provider tax revenues today is to support Medical Assistance, Minnesota's Medicaid program. From FY 2018-21, the state's Health Care Access Fund – predominantly supported by provider tax revenues – is projected to provide roughly 1/3rd more support for Medical Assistance than the collection of surcharges that have been specifically enacted to support that program.

"Fairness" issues are more complicated than the standalone incidence analysis of the provider tax suggests. Provider taxes are one of the most regressive taxes in the state's revenue portfolio and its elimination would reduce the overall regressivity of the state/local tax system by about 20%. However, the "benefit incidence" of the tax falls disproportionately on lower income households resulting in net fiscal incidence that is highly progressive. Moreover, this net incidence offsets the regressive characteristics of health-care related tax expenditures which research has shown to skew disproportionately to higher income households.

As a gross receipts tax, the provider tax features inherent transparency problems and tax administration complications. The provider tax's legislative history suggests "invisibility" was a policy objective when it was first enacted and that objective continues to be met today. The tax is embedded in health care services, and imposing the tax on wholesale drug distributors increases the cost of prescription drugs while most Minnesotans likely believe their prescriptions are exempt from sales taxes. The provider tax requires a separate auditing, administrative, and compliance infrastructure for both organizations subject to it and the state. And, as a recent court case has shown, moving a tax upstream from consumers to providers increases the likelihood of administrative and legal disputes inherent to the intersection of business structures/activities with conflicting interpretations of often ambiguous and imprecise statutory language.

Although revenue adequacy is driving the debate over the tax, the implications for the stability and responsiveness of the state's tax system also merits consideration. Overall, state tax revenues have not grown as fast as the state economy, but the provider tax is an exception. Real provider tax revenues have grown 3 times faster than real state GDP over the past 20 years reflecting health care's growing share of the state economy. The provider tax plays a substantive role in improving the responsiveness of Minnesota's tax system to changes in the overall economy. That role is magnified by the fact that the health care sector currently escapes a lot of taxation that other business sectors do not while at the same time a primary driver of public spending is health care delivery.

The "claims expenditure assessment" proposed as a provider tax substitute may address some provider tax disadvantages but also may introduce some new issues. Shifting collection and remittance away from providers and onto insurers would improve the administrative efficiency of the tax and might trigger some ability-to-pay gains through preferential treatment of out-of-pocket health care delivery. However, such an approach might conflict with federal requirements that state taxes used to support state shares of Medicaid spending must be uniformly imposed. Perhaps more significantly, another state's experience suggests these "claims assessments" introduce market distortions with appreciable revenue impacts. Michigan repealed its claims assessment program in part because the assessment collected only 2/3rds of its anticipated revenues.

An interest in provider tax replacement or partial backfill should include a state tax expenditure review. Such a review is long overdue – a blue ribbon commission blueprint from 2011 for reviewing, evaluating, and incorporating state tax expenditures into the budget process has received no attention or action. Doing so now would be an effective marriage of political need and good tax policy. Moreover, the timing for undertaking such a review is especially ripe given the federal conformity decisions that must also be made in 2019.

Historical Overview of the "Provider Tax" [1]

In 1992 Minnesota took dramatic steps to improve the delivery of health care in the state. Reacting to rising costs and growing concern for the uninsured, the legislature enacted a package of ambitious reforms called "MinnesotaCare."[2] The reforms aimed to create a "new coverage for the delivery and financing of health care in Minnesota" by increasing health care coverage for low-income persons, reducing the growth in health care costs through various cost-containment programs, implementing rural health initiatives, and creating new data collection systems. This was to be financed by "capturing dollars now lost to inefficiencies in Minnesota's health care system."[3]

Among the strategies designed to capture dollars lost to inefficiencies was to tax the health care industry itself to pay for these health care initiatives. New taxes imposed on the industry included the so-called "provider taxes", a 2.0% tax on the patient revenues of hospitals, surgical centers, most other health care providers, and on the gross revenues wholesale drug distributors realize from the sale or distribution of prescription drugs delivered in Minnesota.[4] Major exemptions from the tax on providers, hospitals, and surgical centers currently include:

- Payments from Medicare
- Payments received from hospitals, surgical centers, and health care providers who are themselves subject to the MinnesotaCare taxes
- Payments related to home health care and hospice services

As with the enactment of many new taxes, especially those associated with specific spending initiatives like MinnesotaCare, the new health care taxes were not subjected to rigorous tax policy analysis. Instead, the new taxes were developed on the following premises:

- Funds for reform could be raised by capturing the savings from greater efficiencies and reduced uncompensated care costs.
- By taxing the gross receipts of the healthcare industry, the industry itself would be motivated to control costs and fees and be more likely to resist the expansion of government health care mandates.
- Broad-based taxes on providers would not conflict with ERISA (the federal Employees Retirement Income Securities Act, which prohibit states from regulating or taxing self-insured health coverage.)
- There was broad-based opposition to any increase in general fund taxes.

Over time, the legislature has made numerous modifications to the tax including temporary rate reductions, tax base adjustments, and additional exemptions. Such regular tweaking reflects the underlying and longstanding displeasure many policymakers and special interests have had with the provider taxes. In 2011 the legislature repealed the MinnesotaCare provider taxes, effective January 1, 2020, as part of its omnibus health and human services bill.[5] According to the Department of Revenue, in 2016 8,198 providers of health care patient services, plus 176 hospitals and surgical centers paid the tax.[6] As Table 1 indicates, while most of the provider tax revenues come from hospitals, wholesale drug distributors, and medical clinics and medical doctors/osteopaths, there are a variety of other providers that remit provider taxes to the state.

[1]This issue brief deals exclusively with MinnesotaCare Provider Taxes (which collectively have become known as the "Provider Tax.") We use "provider taxes" and "Provider Tax" interchangeably. Note: Minnesota also has health care provider surcharges on licensed nursing homes, hospitals, HMOs, and other care facilities to pay for state Medicaid services and which are outside the scope of this Issue Brief.

[2] Laws of Minnesota, 1992, Chapter 549. In policy discussions, the term "MinnesotaCare" is used to mean the whole package of reforms enacted in 1992 and also used to mean, more broadly, the subsidized health program created by the same law. For purposes of this Issue Brief we use the term in the broader sense.

[3] Ibid.

[4] Although these taxes are located in different subdivisions of the same chapter of Minnesota Statutes (Chapter 295), we will follow the convention that treats them as one coherent tax.

[5] Laws 2011, First Special Session chapter 9, article 6, section 97.

[6]*Minnesota Tax Handbook, 2016 Edition*, Minnesota Department of Revenue

Table 1: Tax Year 2017 Provider Taxes Reported by Provider Type

Provider Type	Total Tax Reported	Provider Type	Total Tax Reported
Acupuncture Practitioner	$413,958	Optician/Optical Supplier	$4,573,549
Ambulance Service	1,475,043	Optometrist	7,879,628
Audiologist	630,625	Orthodontist	1,234,961
Chemical Dependency Center	1,407,344	Other	2,082,522
Chiropractor	7,659,577	Physical Therapist	1,413,393
Counselor	645,650	Physician Assistant	369,184
Dental Clinic	4,549,393	Podiatrist	345,677
Dental Care Provider	40,307,923	Psychologist	7,823,934
Dietician/Nutritionist	44,562	Rehabilitation Center	2,654,985
Hearing Aid Dispenser	708,937	Social Service Agency	234,890
Hospital	234,240,304	Social Worker	1,455,373
Medical Clinic	63,774,570	Speech Therapist/Pathologist	266,941
Medical Doctor/Osteopath	84,303,669	Surgical Center	9,276,441
Medical Lab	3,250,068	Wholesale Drug Distributor*	149,122,999
Nurse	478,814		
Occupational Therapist	648,016	**Total**	**$633,272,926**

* Net of pharmacy refund
Source: Unpublished data provided by Minnesota Department of Revenue Tax Research Division.

The Evolution of the Provider Tax in Health Care Finance

As part of MinnesotaCare's creation, legislators established the Health Care Access Fund (HCAF) – a special fund in the state's treasury that accounts for the provider tax revenues and their dedication. For many years, money from this fund was primarily spent to finance MinnesotaCare expenses. In fiscal year 2006, the roughly $250 million direct appropriation from the fund for MinnesotaCare was equal to 53% of the HCAF's $471 million in net income (after refunds) that year; with another $102 million in HCAF revenues redirected to the state's General Fund (Table 2).

Part of the discomfort with and opposition to the tax can be explained by this table, which shows provider taxes grew significantly faster than did MinnesotaCare-related needs over the course of the past decade. While net provider tax collections grew by about $200 million between FY 2006 and FY 2015, the direct appropriation of the MinnesotaCare program grew by only $25 million during that same period. By FY 2015, the direct appropriation for MinnesotaCare had fallen to 41% of net HCAF revenues (again excluding General Fund transfers in and prior year balance).

If the relationship between provider tax revenue trends and MinnesotaCare expenses fueled increasing misgivings about the merits of the tax as currently designed, changes made to the MinnesotaCare program in light of federal Affordable Care Act (ACA) provisions have raised them to another level. The ACA allows states to operate "Basic Health Programs" (BHP), which provide health coverage to persons with incomes between 133% and 200% of the federal poverty guidelines – largely overlapping the clientele MinnesotaCare had already been serving. To incentivize states to operate these programs, the federal government awards them 95% of the advanced premium tax credits and cost-sharing subsidies individuals enrolled in the BHP would have received if they had instead purchased coverage through the state's insurance exchange (in Minnesota's case; MNSure).

In 2013, the legislature instructed the state's Department of Human Services to seek authorization from the federal government to operate MinnesotaCare as a BHP, and modified the program's provisions accordingly. The state began operating MinnesotaCare as a BHP on January 1, 2015,[7] and Table 2 shows the fiscal impact. As federal funds have become available to finance the program, direct appropriations from the HCAF for MinnesotaCare have plummeted – falling from $275 million in FY 2015 to $11.5 million in FY 2017. Absent major changes to the ACA, this reduction

[7] As of this writing, only Minnesota and New York have sought and been granted approval to operate a BHP.

in the need for direct state appropriations for MinnesotaCare is likely to continue. While MMB is forecasting an increase in the appropriation to $27 million by FY 2021[8], this is nowhere near the historic levels seen before the program's conversion to a BHP.

Table 2: Health Care Access Fund Income and Expenses, FY 2006 and FY 2012-17 ($000)[9]

	FY 06	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17
Sources of Funds							
Prior Year Balance*	53,938	22,917	115,333	51,770	56,374	673,191	496,780
2% Provider Tax	382,818	500,733	526,248	538,669	573,178	598,544	635,473
1% Gross Premiums Tax	69,201	67,696	70,163	73,934	83,629	85,965	94,148
Provider/Premium Tax Refunds	(11,039)	(16,572)	(12,484)	(13,427)	(19,468)	(14,627)	(22,087)
Other Revenues	29,689	7,647	20,243	31,314	30,180	47,791	54,787
General Fund Transfers	--	40,000	--	--	511,998	--	--
Special Funds Transfers	--	2,800	1,200	--	--	--	--
Total Sources of Funds	**524,607**	**625,221**	**721,037**	**682,262**	**1,235,891**	**1,390,863**	**1,259,101**
Uses of Funds							
MinnesotaCare: Direct Appropriation	251,614	263,973	278,601	246,899	275,004	114,843	11,501
MinnesotaCare: Other	20,670	--	--	15,677	15,634	30,059	36,140
Medical Assistance**	--	189,041	334,150	292,294	199,211	667,029	406,833
State Agency Funding	29,683	52,321	44,668	57,623	71,510	68,051	76,791
Other Expenditures	496	324	4,108	7,335	239	432	576
Other General Fund Transfers	102,356	--	854	--	--	127	--
Other Special Fund Transfers	4,226	8,016	8,795	10,987	11,905	14,719	14,295
Total Uses of Funds	**409,085**	**513,675**	**671,174**	**630,814**	**573,504**	**895,259**	**546,259**
Balance	**115,522**	**111,546**	**49,862**	**51,448**	**662,387**	**495,604**	**712,964**

* Includes adjustments made to prior year closing balance
** Include both direct spending on Medical Assistance and transfers to the General Fund to finance Medical Assistance
Note: Does not include any federal dollars passed through the fund.
Source: Health Care Access Fund statements prepared by Minnesota Management and Budget; table created by MCFE.

As Table 2 shows, the primary purpose for the HCAF – and therefore provider taxes – has become over time to provide financial support for Medical Assistance, Minnesota's Medicaid program. Medical Assistance (MA) is also a public health coverage program, with funding provided by both the state and federal governments. The state finances its share with General Fund revenues; about 6-7% of which come from a separate set of health care provider surcharges on the number of nursing home and intermediate care facility beds, a small percentage (1.56%) of net patient revenues from hospitals, and HMO premium revenues. These provider surcharges have raised about $280 to $295 million in recent years[10] – somewhere around half as much as the MinnesotaCare provider taxes. MA targets the lowest-income Minnesotans – effectively, those whose incomes are below MinnesotaCare's thresholds. Between FY 2012 and FY 2017, the HCAF has provided about $350 million per year for MA. MMB projects that HCAF support for MA will continue into the near future – to the tune of about $400 million per year from FY 2018 through

[8] Source: *End of Session 2018 Health Care Access Fund Financial Statement*, Minnesota Management and Budget.
[9] Fiscal year information prior to 2012 is not available on the MMB website. 2006 information comes from historical MCFE files.
[10] Source: *Minnesota Tax Handbook, 2016 edition and 2017 supplement*, Minnesota Department of Revenue.

FY 2021[11] – or put another way, roughly one-third more than what the MA-related health care provider surcharges raise.

As many point out, the provider tax is now unmoored from its original statutory intent and purpose. Yet it still serves as an important source of revenue for state public health programs. If the provider tax's planned 2020 sunset becomes a reality, the HCAF will continue to receive receipts from the 1% tax on the gross premiums collected by HMOs and nonprofit health service plan corporations, but lose about $700 million in annual provider tax receipts and revenue growth that would have occurred over time. As a result, after FY 2021, MMB projects the fund will have a balance of only $61 million – meaning that lawmakers will need to choose from a variety of non-mutually exclusive options with regard to the Medical Assistance program:

- Provide funding by reinstating the Provider Tax in some form
- Provide funding by creating and dedicating an alternative revenue source
- Provide additional funding by appropriating additional General Fund resources
- Reduce funding for Medical Assistance

Evaluating the Provider Tax on Tax Policy Principles

Equity and Tax Fairness

"Ability to pay" and the progressive/regressive nature of taxation typically are the first issues raised in any tax debate. Recent history has shown the provider tax is no exception to this rule. Like all taxes, Minnesota's provider taxes are ultimately paid by individuals, not the health care businesses which remit the tax to government. This basic principle of tax policy – "tax incidence" – recognizes that taxes are an operating cost for businesses. Like any other cost, businesses shift their tax burdens to one of three groups: to investors in the form of a lower return on investment, to labor in the form of lower compensation, or to consumers in the form of higher prices. The Minnesota Department of Revenue's *2017 Tax Incidence Study* analyzes how household and business taxes imposed by the state are distributed across different income groups. The report assumes that the provider taxes are either paid by consumers in higher out-of-pocket medical costs or higher costs for insurance (except for Medicare premiums), or that higher employer-provided health care costs are borne by households through reductions in wages or other fringe benefits.[12]

Table 3 shows provider tax collections in 2014 relative to the total income for each of ten "population deciles" – where each of Minnesota's 2.66 million households are essentially ordered from lowest to highest income and then divided into 10 equally-sized groups. As the table demonstrates, the provider tax is regressive, meaning that it falls proportionately more heavily on low income persons. In this case, the provider tax that people in the first decile (i.e., those with the lowest incomes) end up paying is equal to 0.80% of their income, while for the top decile (i.e., those with the highest incomes) it is equal to 0.10% of income – effectively one-eighth of the bite.

Not only are the provider taxes regressive, they are heavily regressive when compared to most other forms of state and local taxation in Minnesota. The mathematical measure used to determine how progressive or regressive a tax is called a "Suits Index". A tax with a Suits Index between 0 and -1 is regressive, with regressivity increasing as the index nears -1. Similarly, a tax with a Suits Index between 0 and +1 is progressive, with progressivity increasing as the index nears +1. When looking at population deciles, Minnesota's total state and local tax system is slightly regressive (Suits Index of -0.028), but the provider taxes are much more regressive (Suits Index of -0.296). In fact, only four taxes – those on gas, cigarettes and tobacco, gambling, and solid waste – are more regressive than the provider taxes. Eliminating the provider taxes would have an appreciable impact on the overall regressivity of Minnesota's state/local tax system – reducing it by about 20%. The state's planned elimination of the tax is therefore likely to make the Minnesota tax system "fairer," if fairness is measured exclusively on a relative ability to pay basis.

[11] Ibid.
[12] *2017 Minnesota Tax Incidence Study*, p. 97.

Table 3: Distribution of the Provider Tax Burden by Population Decile, 2014 Collections

Population Decile	Household Income	Provider Taxes as % of Income
1	$11,262 and under	0.80%
2	$11,263 – $18,218	0.54%
3	$18,219 – $26,140	0.47%
4	$26,141 – $35,360	0.42%
5	$35,361 – $46,141	0.38%
6	$46,142 – $59,617	0.33%
7	$59,618 – $77,665	0.32%
8	$77,666 – $102,785	0.31%
9	$102,786 – $147,968	0.26%
10	$147,969 and over	0.10%
Total	**N.A.**	**0.24%**

Source: *2017 Tax Incidence Study*, Minnesota Department of Revenue Tax Research Division.

However, looking at the incidence of how the provider taxes are raised is only half of the public finance story. A more complete picture of how these taxes impact Minnesotans needs to examine the incidence of the benefits paid for by these taxes.

As previously highlighted, Minnesota's provider taxes originally financed the state's MinnesotaCare program, but are now being used primarily to finance Minnesota's Medical Assistance (Medicaid) program. If the tax is preserved, this situation would likely continue. A complete public finance incidence picture of provider tax revenues, therefore, examines how Medical Assistance benefits financed with these revenues are distributed back to Minnesotans.

Recent research offers insights on this important topic.[13] Based on *Current Population Survey* data analyzed by the Congressional Budget Office, researchers concluded 44% of Medicaid spending nationwide accrues to the lowest quintile[14] of households, with 27% accruing to the second quintile, 15% accruing to the third quintile, 8% accruing to the fourth quintile, and 5% accruing to the highest quintile.[15]

If we assume that 1) all provider taxes are used only to pay for Medical Assistance benefits[16]; and 2) that Medical Assistance payments are passed along to Minnesotans similarly to the nationwide average, we can estimate the "net incidence" of the provider taxes and Medical Assistance spending using the state's *Tax Incidence Study*.

As Figure 1 illustrates, adding the effect of Medical Assistance spending radically changes the perspective on the tax. The top line in the figure shows the incidence by quintile, which is regressive as it moves from claiming 0.62% of income in the first quintile to 0.15% of income in the top quintile. However, the net effect of including Medical Assistance spending is highly progressive[17], resulting in a -3.2% effective tax rate (ETR) for the first quintile (i.e., the value of the benefits received exceed the taxes paid), with the ETR rising to -0.51% for the second quintile; to +0.06% for the third quintile; and to +0.22% for the fourth quintile before falling back to 0.12% for the top quintile.

It is also worth noting that the highly progressive nature of the provider taxes' net incidence also works to offset the regressive feature of health care-related tax expenditures. Such favorable tax treatments include the exclusion of employer contributions for medical insurance premiums from taxable income, contributions to tax-preferred health

[13] *The Rise of the Middle Class Safety Net*, Richard Reeves and Christopher Pulliam, Brookings Institute, September 4, 2018. Accessed November 15, 2018 at https://www.brookings.edu/research/the-rise-of-the-middle-class-safety-net/.

[14] We note that the authors' population quintiles are determined using population counts (with roughly 62.1 million people in each quintile), which is slightly different than the methodology the Department of Revenue uses for its *Tax Incidence Study*, where the population deciles are based on household counts. This methodological difference is unlikely to have a major impact on the overall findings.

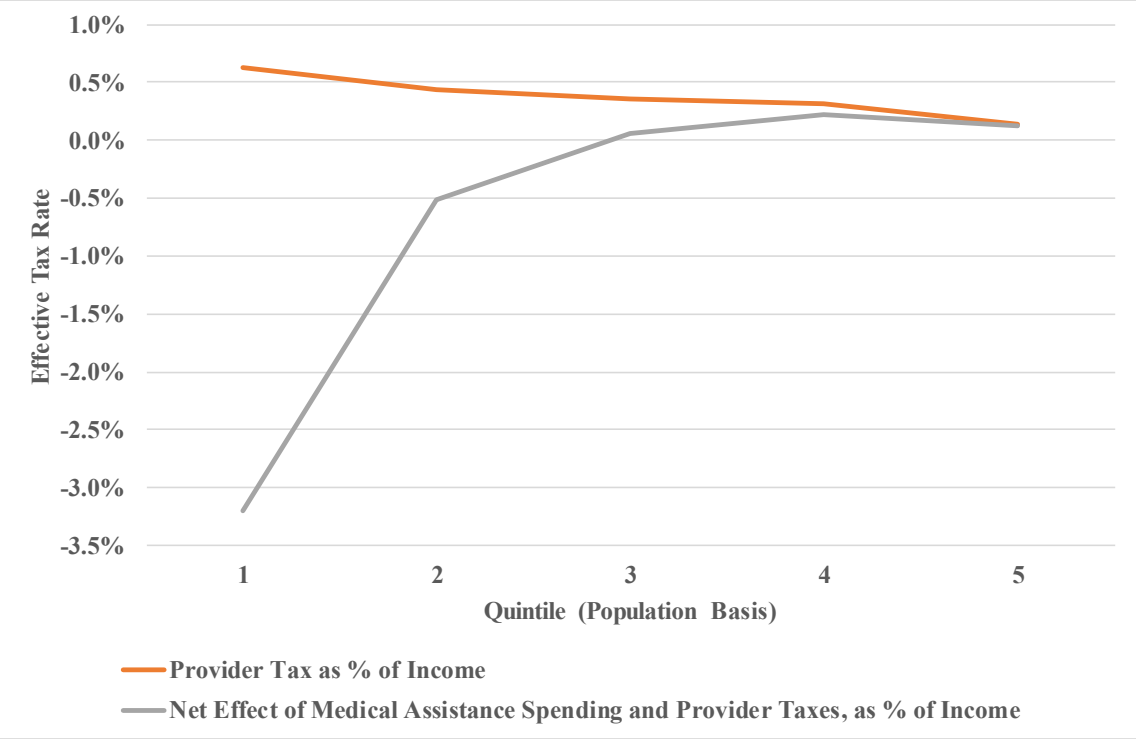
[15] Medicaid spending is based in part on medical need rather than exclusively on income, which explains why some Medicaid benefits accrue to even the top quintiles.

[16] In FY 16-17 HCAF supported Medicaid spending consumed 87% of HCAF provider tax revenues.

[17] Although we have not calculated a Suits Index for the net effect, the graph demonstrates that the tax rate rises across the first four quintiles – sometimes substantially – as income rises, and clearly demonstrates a progressive effect.

spending accounts, and deductions for self-employment health insurance premiums. One recent study finds that while about half of all U.S. households receive some benefit from health-related tax expenditures, their distribution is skewed toward higher-income households. These favorable tax treatments provide a tax cut for 85% of households in the highest quintile of earners, while only 9% of households in the bottom quintile of earners benefit.[18] Putting all these considerations together, the regressivity and fairness issues underlying provider taxes are much more complicated than what standalone tax incidence analysis of the taxes themselves would suggest.

Figure 1: Effective Tax Rates by Population Quintile, Provider Taxes as Imposed and Net Effect of Provider Taxes and Medical Assistance Spending



Sources: Incidence of Provider Taxes from *2017 Minnesota Tax Incidence Study*, Minnesota Department of Revenue; Incidence of Medical Assistance Spending from *The Rise of the Middle Class Safety Net*, Richard Reeves and Christopher Pulliam, Brookings Institute, September 4, 2018. Calculations by MCFE.

Transparency and Administrative Efficiency

Provider taxes are gross receipts taxes – taxes on gross revenues at the firm level. Tax economists generally disapprove of such taxes, humorously defined by one tax expert as "an increasingly popular form of taxation created by people who weren't paying attention in their public finance classes."[19] The primary criticism is the potential for tax pyramiding – the layering of sales taxes through every step of a supply chain. That concern is mitigated with Minnesota's provider taxes because, with one primary exception,[20] the provider tax economically functions more or less as a replacement for a general sales tax on the consumption of these health services, and no such layering potential exists.

However, the fact that the provider tax could effectively be replicated by expanding the general sales tax base onto the health care goods and services currently subject to the provider tax highlights two relevant issues. First is the

[18] *Who Benefits from Health Care-Related Tax Expenditures?* Urban Brookings Tax Policy Center, September, 2016
[19] "The Devil's Dictionary of Taxation," Billy Hamilton, *State Tax Notes*, October 13, 2008
[20] Statutory language to prevent pyramiding notwithstanding, the potential exists for the portion of the provider tax levied on wholesale drug distributors if providers purchase from non-wholesalers.

lack of transparency, which appears to be one of the primary reasons for employing this approach to raising revenues in the first place. Remarkably, the law creating the provider tax statute explicitly prohibited it from being separately stated on bills to patients[21] which suggests "invisibility" was a policy objective of interest to lawmakers. (Lawmakers subsequently amended the statutory language to prohibit entities subject to the provider taxes from stating the tax obligation "in a deceptive or misleading manner", and further prohibits separate statement of tax obligations on "bills provided to patients, consumers, or other payers when the amount received for the services or goods is not subject to tax".[22]) As a result, some providers itemize the provider tax on their bills, making those customers/patients aware of it. The provider tax on wholesale drug distribution increases the cost of prescription drugs, yet the general sales tax exemption for those drugs likely gives many Minnesotans the impression their prescription drugs are not taxed. Although the purchase and consumption of health care is defined and plagued by much bigger pricing and transparency problems, the provider tax is a small but real contributor to the issue.

Another relevant policy consideration is tax administration. The provider tax requires both companies subject to the tax and the state to create a distinct auditing, administrative, and compliance infrastructure dedicated to this tax – all of which comes at a cost. Moreover, moving the tax upstream from the consumer to the provider increases the likelihood of administrative disputes and legal battles surrounding the intersection of ever-present complexities in business structure/activities with conflicting interpretations of often ambiguous and imprecise statutory language. Such were the circumstances in a recent Minnesota Tax Court decision subsequently appealed to the Minnesota Supreme Court regarding the taxability of drugs sold in another state but shipped for use in Minnesota. Fourteen million dollars of provider tax receipts hung in the balance over a legal parsing of words and phrases and a dispute over when a delivery becomes a receipt.

Adequacy and Stability

Lawmakers are very aware of the approximately $700 million in current annual revenues at risk with the demise of the provider tax and the possible implications for public health care financing. Although there is no near-term indication that the federal funds now used to provide the majority of support for MinnesotaCare are in jeopardy, the unpredictability of the federal budget environment is causing many to view the preservation of the provider tax as a necessary insurance policy against future federal health care policy actions. The fact that only Minnesota and New York receive these funds creates additional exposure in the context of negotiations over any broader potential federal/state health care finance restructuring. Similar concerns exist with respect to the future of Medicaid. Any future tweaks by the Center for Medicaid Services affecting cost sharing design and state waivers could have fiscal repercussions for the state.

But a related and underappreciated issue is the provider tax's contribution to the overall stability of the state revenue system. Like most states, Minnesota's state tax revenues do not grow as fast as the economy. Over the past 20 years, real state GDP grew 52%[23] while real state government tax revenues grew only 44%.[24] However, real provider tax revenues grew 169%,[25] reflecting health care's growing share of the state gross domestic product. These numbers demonstrate that the provider tax plays a substantive role in improving the responsiveness of Minnesota's tax system to changes in the overall economy.

This role is magnified when recognizing that although segments of the health care industry help pay for Medicaid with provider surcharges, the sector currently escapes a lot of taxation that other business sectors do not:

- Most hospitals are non-profit and therefore exempt from property taxes and business entity taxes.
- Health care services taxed under the provider tax are exempt from the general sales tax with its over 3 times higher rate.
- Employer-paid health care benefits are not subject to income tax.
- Taxing self-insured health coverage is prohibited under ERISA.

[21] See Minnesota Statutes 1993 Supplement, §295.53, Subd, 3 which contains the language of the original law.
[22] Minnesota Statutes 2018, §295.53, Subd, 3.
[23] Source: Bureau of Economic Analysis' Regional Economic Accounts, chained 2012 dollars.
[24] Source: Nominal data from Minnesota Department of Revenue Tax Research Division, chained by MCFE using CPI (base FY 2012)
[25] Same data source and chaining mechanism as reported in footnote 24.

- Most health insurance coverage purchased through HMOs or non-profit health service corporations pay one-half the rate of tax that purchasers of other types of insurance pay.
- Prescription and over-the-counter drugs, medical devices and their replacement parts, and prescription eyeglasses / contact lenses are all exempt from the general sales tax.

As a result, a large and growing sector of the state's economy is paying a relatively lower percentage of state and local taxes. At the same time, much of our primary public spending growth is driven by health care costs – creating opportunity costs and crowding out pressures on other public goods and services. According to the state's November 2018 economic forecast, the health and human services budget now constitutes 30% of General Fund spending but under current law is projected to consume over 50% of new General Fund revenues. This is in spite of forecasters actually lowering their estimate for general fund spending on Medical Assistance (Medicaid) in FY 20-21 by $383 million, primarily because of lower managed care rates. Together, all these factors present circumstances ripe for considerable future budget stress.

Analysis of Potential Funding Alternatives

Policymakers have crucial decisions about how to handle the impending repeal of the MinnesotaCare provider taxes and the roughly $1.2 billion they raised in the FY 16-17 biennium. Lawmakers could reduce state spending, but even if some bipartisan strategy and agreement could be reached on how to do this, some form and level of replacement revenue will likely be necessary if the full repeal is allowed to go through. Following is a brief examination of some of the options available and an evaluation of their merits from a tax policy perspective.

Claims Expenditure Assessment

At the very top of the alternatives list is the proposal offered by the influential Minnesota Medical Association (MMA) to replace the provider tax with a fee set at some percentage of the claims processed by insurance companies and administrators of self-insurance plans for Minnesota residents.

- Equity and Tax Fairness: Overall fiscal incidence would not seem to be materially affected by this proposal, and some ability-to-pay improvements might be realized since cash-based, out of pocket health services would be no longer taxed. However, this proposal creates the potential for a different equity problem – one of horizontal equity (i.e. treating similar taxpayers similarly). Such horizontal equity concerns are not just an abstract, theoretical matter. Under reform measures designed to prevent states from gaming the Medicaid reimbursement system, states may not use provider tax revenues for the state share of Medicaid spending unless the tax is uniformly imposed. As a result, there is some reason to question whether such a "fee" could pass federal muster and receive approval.
- Administrative Efficiency and Transparency: A 2% fee on processed claims is economically similar but administratively very different from the current provider tax. That the MMA is advocating this approach suggests that concerns about the administrative burden and cost of collecting and remitting the provider tax are just as important as, if not greater than, concerns about the amount of the tax itself. Shifting the responsibility to insurers and away from providers would improve the administrative efficiency much in the same way the tax administration of e-commerce "post Wayfair" is likely assisted by large marketplace providers assuming this responsibility for small sellers. It is doubtful any transparency gains would be realized.
- Adequacy and Stability: By the MMA's own calculations, at the recommended fee level its proposal would raise about $100 million less than what the current provider tax generates. Whether that sufficiently fills the potential fiscal hole, provides the necessary spending support, and mitigates general budget risk is in the eye of the beholder. However, an important consideration is whether the establishment of this fee introduces market distortions that would have a longer-term impact on revenue collections. Some evidence that this potential exists comes from Michigan, which instituted its own Health Insurance Claims Assessment in 2012 only to repeal it shortly thereafter in part because the assessment collected only 2/3rds of the anticipated revenues. According the Michigan House Fiscal Agency, the gap between the original estimate and actual

collections "was due to several factors, including out-of-state policies being larger than expected and an underestimation of the impact of increasing health care deductibles and co-pays (which are not taxed)"[26] That latter issue suggests that one market consequence of a proposal such as this is that insurers will become more aggressive in offering policies with higher point of service deductibles and co-pays.

Other Options

Table 4 highlights three other, but by no means exhaustive, approaches to replacing the provider tax. None of them would be popular; all of them would experience tremendous political and public resistance. But a consideration of alternatives does help point out the occasional intellectual conveniences that are used to market and frame tax debates. For example, one of the chief arguments expressed in opposition to the provider tax is that broad based general fund revenues should be used instead to finance public health care programs that benefit all Minnesotans. That objective could be accomplished through the second option by simply expanding the state's general sales tax base to include the current list of health care services now subject to the provider tax but establishing a lower (probably near 2%) general sales tax rate on those health care services as permitted by the Streamlined Sales Tax agreement. Thus, the desired goal of using "broad based, general fund revenues to support public health care programs" would be achieved yet the defunct "provider tax" would essentially continue to function as is – only in another administrative form. It's a "who pays" objection articulated as principle.

Table 4: Potential Alternative Funding Sources for the Provider Tax
(To raise $800 million in FY 2021)

Replacement Revenue	Rate Required	Arguments For	Arguments Against
General sales tax increase	0.95%	• Very visible • Less regressive than provider taxes	• Not as stable as provider taxes (more subject to business cycles) • Creates competitiveness issues (7.825% state rate would be highest in the country)
Expand general sales tax base	Unknown; depends on what is included	• More visible than provider taxes • Less loss in stability than other alternatives	• Reduces simplicity by requiring additional vendors to collect/ remit sales taxes
Eliminate tax expenditure for one-half of employer-paid health insurance premiums	No change (base expansion)	• Improves fairness (horizontal equity) by removing tax differential based on how the benefit is provided) • Likely progressive • Improves efficiency by removing market distortions • More visible	• Not as stable as provider taxes (more subject to business cycles) • Reduces simplicity – creates non conforming income tax change that would be unique to Minnesota • Creates competitiveness issues – additional taxable income would raise income taxes on many filers

Sources: Minnesota Department of Revenue, Tax Research Division, *Tax Expenditure Study: FY 2018-2021;* Minnesota Department of Revenue, Tax Research Division, unpublished estimates of revenue impacts of potential tax law changes. Calculations of rate required by MCFE.

Options two and three in this table are examples of what may be a broader and more productive strategy to explore replacement revenues – a more systematic review of state tax expenditures. There are two reasons for this.

First of all, such a review is long overdue. In 2011 a blue ribbon commission under the auspices of the Minnesota Department of Revenue published *Tax Expenditure Review Report: Bringing Tax Expenditures Into the Budget*

[26] "Legislative Analysis: Create the Insurance Provider Assessment Act", Michigan House Fiscal Agency, 2018.

Process – a detailed guide for reviewing, evaluating, and incorporating state tax expenditures into the budget process.[27] No progress or action has ever been taken on this excellent report, but doing so now would seem to be a perfect marriage of political need and good tax policy.

Second, the timing and opportunity to undertake such an effort is especially ripe because of outstanding federal conformity decisions that must be made in 2019. Minnesota needs to determine whether and how to conform to the myriad of changes associated with the TCJA, which in turn requires a systematic analysis of, among other things, tax expenditures in current law using good tax policy and budgeting principles.

Regardless of the advantages and disadvantages of alternate revenue approaches, the fate of the provider tax is fundamentally political and as old as government itself. It will be a battle between those who want revenue to support public spending versus those who either want lower taxes or want someone or something else to finance the spending. As such the provider tax debate is a microcosm of the bigger and pressing debate: just what do we want our public health care programs to look like and just how do we expect to pay for them.

[27] Available at https://www.revenue.state.mn.us/research_stats/Documents/TE_Review_Report_02_15_11.pdf