The Buckeye Institute FOR PUBLIC POLICY SOLUTIONS

Economic Research Center

February 23, 2015

Medicaid Expansion Relies on Uncertain Funding

Executive Summary

Ohio's Controlling Board took a risk when it authorized the state to fund Medicaid expansion with federal grants. Supporters of this plan claimed that expansion would actually yield a net gain to the state budget because large savings and revenue boosts would make up for the additional spending. Even the most optimistic projections assume that the fiscal feasibility of Medicaid expansion hinges upon revenues from a highly contentious state tax scheme. Renewed scrutiny of that state tax scheme by the federal government means the scheme may be outlawed, potentially costing the state billions of dollars in revenue and putting taxpayers at risk of higher taxes, fewer services, or both.

The key revenue stream in question is the state sales and use tax as applied to Medicaid managed care organization (MCO) premiums. The state takes advantage of a loophole in the Medicaid funding system through which taxing these premiums provides revenue to the state *and* increases the amount of federal grant money that Ohio receives. Thus far, this tax loophole has cost the federal government hundreds of millions of dollars, and allowed Ohio to reduce its share of total Medicaid expenditures and spend even more. But that loophole is about to close.

A recent investigation by the Office of the Inspector General of the Department of Health and Human Services (OIG) should warn states like Ohio currently using the loophole to fund expansion. Responding to OIG, the Centers for Medicare and Medicaid Services (CMS) stated it intention to bring wayward states into compliance. This means that Ohio will likely need to abolish its sales tax on Medicaid MCO premiums, and lose the critical revenue it provides.

Glowing fiscal projections of Medicaid expansion dim without this tax revenue. Independent analyses by pro-expansion groups projected expansion to cumulatively net over $1.8 billion for the state budget by fiscal year 2022. Extending the calculations another decade reveals a $2.5 billion gain by 2032. But if MCO taxes are abolished in 2016, Ohio will miss out on $1.3 billion in anticipated revenue over the next four budget cycles. Worse, if nothing changes, Medicaid expansion will lose up to $1.2 billion on net by 2032. Inevitably, Ohio taxpayers will be on the hook for this devastating shortfall.

Background

Medicaid is a massive program in fiscal terms—even before it was expanded under Obamacare it consumed 22% of state-source General Revenue Fund (GRF) appropriations and 44% of total GRF appropriations (including federal funds) in FY 2013.[1] Medicaid is also a massive program in terms of enrollment—2.9 million, or about 25% of Ohio's 11.6 million citizens, depend on Medicaid for health coverage.[2] The managed care program covered 2.3 million, or 80%, of all Medicaid beneficiaries.[3] Medicaid coverage was expanded in October 2013 to include able-bodied, childless adults with incomes up to 138% of the federal poverty line. The expansion population of 393,266 enrollees now makes up 17% of total managed care enrollment and is still growing.[4]

In a managed care system, Medicaid beneficiaries select a private firm approved by the state (called a Medicaid managed care organization or MCO) to coordinate their care through a provider network. The state pays per-member per-month (PMPM) or "capitated" premiums on behalf of each beneficiary to the MCO. Like other Medicaid expenditures, the state receives matching grants from the federal government for MCO premium payments.

Ohio subjects Medicaid managed care premiums to the state sales tax. The state received $465.1 million in MCO tax revenues in fiscal year (FY) 2014,[5] and this significant revenue from the MCO tax was projected to be a financial linchpin in the system that would make Medicaid expansion feasible. Most expansion population members are enrolled in managed care and arguably bring in more tax revenues and federal funds than they cost to cover. In addition, a loophole in the funding provisions of the law also causes the federal government to pay states more matching dollars when an MCO premium tax is in place. Between the tax revenues and increased federal funds, the MCO tax system reduces the state's share of its Medicaid burden and allows the state to spend more money.

Not surprisingly, however, the Center for Medicare and Medicaid Services (CMS) will likely issue a rule change that will prevent states from exploiting the system this way. The Buckeye Institute President Robert Alt warned in his testimony before the Ohio House of Representatives that such a change was likely.[6] Michigan Governor Rick Snyder also foresaw the federal fix and took proactive steps to protect his state from the foreseeable consequences.[7] Regrettably, Governor John Kasich and the state's Controlling Board ignored these warnings and rolled

---

1 Legislative Service Commission, *Historical Revenues and Expenditures*, Tables 2-3, http://www.lsc.state.oh.us/fiscal/revenuehistory/staterevenue.htm (accessed December 23, 2014).

2 Ohio Department of Medicaid, *Medicaid Monthly Caseload Report*, November 2014, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Caseload/2014/11-Caseload.pdf (accessed January 26, 2015).

3 As of November 2014, see Ohio Department of Medicaid, *Medicaid Managed Care Enrollment Reports*, http://medicaid.ohio.gov/Portals/0/Resources/Managed%20Care%20Reports/Medicaid%20Managed%20Health%20Care%20Reports/2014-Monthly/Enrollment-12.xlsx (accessed December 22, 2014).

4 *Ibid.*

5 Jean J. Botomogno, "Revenues," *LSC Budget Footnotes* (July 2014): 9, http://www.lsc.state.oh.us/fiscal/bfn/v37n11.pdf (accessed December 22, 2014).

6 Ohio House of Representatives, Finance Committee, Health and Human Services Subcommittee, *Expanding Medicaid: The Wrong Policy for Ohio,* March 13, 2013, 130th General Assembly, (testimony of Robert Alt, President, The Buckeye Institute), http://www.buckeyeinstitute.org/uploads/files/Robert%20Alt%20Testimony%20House%20HHS%203-13-13(Edited)%20(1)(1).pdf (accessed January 16, 2015).

7 Michigan Senate, Fiscal Agency, *Bill Analysis: Senate Bill 347*, October 19, 2011, http://www.legislature.mi.gov/documents/2011-2012/billanalysis/senate/pdf/2011-SFA-0347-N.pdf (accessed January 22, 2015).

the dice, choosing to go forward with Medicaid expansion in the hope of exploiting the legal loophole.

CMS is now threatening to close this loophole and the gamble could cost the state up to $1.3 billion in anticipated revenue over the next four budget cycles, leaving taxpayers to cover the projected loss.

The State's Medicaid Managed Care Premium Tax Scheme: An Illustration

To better understand the Medicaid managed care sales tax scheme, imagine that your neighbor is short on cash but desperately needs a new set of tires. You offer to split the cost of a new set of tires 60/40. The tire store sells a good set of tires for $500, but your neighbor notices a premium set selling for $750 with a $150 mail-in rebate. Under your generous cost-sharing arrangement, the premium set is the better deal and ultimately less expensive for your neighbor—and more expensive for you. If your neighbor buys the $500 tires, you will pay $300 and he will pay $200. But if he buys the $750 premium tires, you will pay $450 while your neighbor will pay $300—at first. He will then cash in the mail-in rebate and recoup $150, bringing his share of the new tires down to only $150. In the end, the more expensive set of tires costs you an extra $150 but saves your neighbor $50.

That is quite a scheme, and it is all too analogous to how the state and federal governments pay for Medicaid under the current rules: you represent the federal government, your neighbor represents the state, and the tire store stands in for the Medicaid managed care organization.

In actuality, Ohio makes premium payments on behalf of Medicaid recipients to the managed care companies that cover those recipients. Those same premium payments made by the state are then subjected to the state's sales and use tax. Accordingly, managed care organizations receive monthly premium payments from the state for each Medicaid beneficiary they cover, then remit some of that payment right back to the state as a sales tax payment—the mail-in rebate in our tire store example.[8] Under this scheme, Ohio is essentially taxing its own welfare expenditures.

Just as the mail-in rebate in our hypothetical illustration does not hurt the tire store (because the rebate is priced-in to the sale of the tires), the state's sales tax does not hurt the MCOs. Actuarial consultants set the premium payment amount so that it covers the MCO's costs for medical claims, administration, payroll, and the like. The actuaries also price-in the cost of the sales tax so that even after remitting the tax the MCOs still receive the same amount that they would have been paid without the tax in place.[9] For example, if the actuaries determine that MCOs need to retain a capitated payment of $475 and there is a 5% sales tax on those payments, then the state will actually pay MCOs a $500 premium, leaving them with the needed $475 after-tax.

---

8 Ohio Revised Code, sec. 5739.01(D)(7)

9 Ivy Chen, "Department of Medicaid," *LSC Redbook* (February 2013): 126, http://www.lsc.state.oh.us/fiscal/redbooks130/mcd.pdf (accessed December 22, 2014).

The beauty of this arrangement from the state's perspective is that the state not only keeps the $25 in sales tax revenue, but it also receives federal reimbursement based upon the full $500 premium—*including the $25 portion of the premium priced-in to pay the state's own tax.* Thus, the state receives more federal matching funds because the state's "costs" are higher. For example, if the federal government reimburses Ohio for 60% of Medicaid expenses and Ohio's premium is set at $475, the federal government reimburses Ohio $285 per payment, leaving Ohio responsible for $190. But if Ohio's premium is set at $500, the federal government's share becomes $300, while Ohio's share becomes $200. The extra $10, however, is offset and exceeded by the $25 sales tax that the state will collect from the MCO—its mail-in rebate. Ultimately, the state will reap a net gain of $15 per premium paid.

And this scheme is just one piece of a well-documented problem with the Medicaid matching grant system creating perverse incentives for states to increase spending just to increase federal revenues, with no regard for efficiency or federal taxpayers.[10]

Table 1 (below) further illustrates how the Medicaid managed care sales tax impacts the state, the federal government, and managed care organizations, with a capitated Medicaid managed care premium of $475 in year 1 and increasing to $500 in year 2 because of the 5% sales tax. The figures are calculated on an annual basis for 1 million Medicaid managed care enrollees.

Table 1: Example of MCO Sales Tax Impact

In Millions of Nominal Dollars

Year	Medicaid MCO		Federal	State		
	Gross Revenue	*Net Revenue*	*Gross Spending*	*MCO Tax Revenue*	*Gross Spending*	*Net Spending*
1	$5,700	$5,700	$3,420	$0	$2,280	$2,280
2	$6,000	$5,700	$3,600	$300	$2,400	$2,100
Change	**+$300**	**$0**	**+$180**	**+$300**	**+$120**	**–$180**

By subjecting MCO premiums to the state sales tax, the premiums increase by the amount of the tax—or $300 million. Federal spending in year 2 is $180 million *more* than year 1, but after tax revenue is accounted for, the sales tax allows the state to spend $180 million *less* than the year before despite higher expenses.

Ohio effectively increases total state Medicaid spending, foists the added burden on to federal taxpayers, and pockets the savings for itself. Meanwhile, net managed care revenues remain constant, preventing MCOs from providing additional services, but allowing the state to use its budget savings to raise Medicaid premium payments the next year.[11]

---

10 Joseph Antos, "The Structure of Medicaid," in *The Economics of Medicaid*, ed. Jason J. Fichtner (Arlington: The Mercatus Center at George Mason University, 2014), 9.

11 See Appendix I for more detail.

Despite this shell game, Ohioans should not lose sight of the fact that they are still paying for the state's gimmick through their federal taxes. The state budget savings frees up more money that can be used in turn for additional healthcare spending to siphon even more money from Washington. All of this is made possible by a legal loophole in state-federal Medicaid funding law that may soon be closed.

The Legal Loophole

Ohio is not the only state to try to squeeze a few more Medicaid dollars out of Washington. But in at least one other case, the outcome does not bode well for the future of Ohio's scheme.

The Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) recently completed an investigation of Pennsylvania's gross receipts tax on Medicaid managed care premiums. OIG found that Pennsylvania's tax structure violates two provisions of federal law: first, such a tax must be broad-based and apply to all members of a class of healthcare services equally,[12] and second, that the state cannot "hold harmless" the providers subjected to the tax by paying them back for the amount taxed.[13] If a state tax does not comply with these rules, the federal government is not required to reimburse the state for the cost of the tax.[14]

Medicaid funding rules separate the healthcare industry into discrete groups or "classes" of Medicaid providers. The joint federal-state Medicaid funding arrangement specifies that any state tax assessed against Medicaid providers—like Ohio's sales tax or Pennsylvania's gross receipts tax on premiums paid to Medicaid managed care organizations—must treat all members of that provider class equally.[15]

Managed care organizations are one of the classes of healthcare providers that states may tax. But in Pennsylvania and Ohio, as well as in a few other states, the provider tax is only assessed on *Medicaid* MCOs, rather than on *all* MCOs including those that do not cover Medicaid enrollees. States have been able to get away with this by subjecting only Medicaid managed care premiums (and excluding non-Medicaid managed care premiums) to a broad tax like Ohio's sales and use tax, which is assessed on many items and services, rather than singling out Medicaid MCOs for a separate and distinct tax.

Unfortunately, the OIG determined that this practice does not comply with the broad-based requirement.[16] All managed care organizations comprise one class, yet the tax treats only Medicaid managed care providers within that class differently from the other members who do not take Medicaid premiums. The OIG also reported that Pennsylvania violated the "hold

---

12 Social Security Act, U.S. Code 42, § 1396b(w)(7)
13 Social Security Act, U.S. Code 42, § 1396b(w)(4)
14 U.S. Department of Health and Human Services, Office of the Inspector General, *Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appears To Be an Impermissible Health-Care-Related Tax*, May 2014, http://oig.hhs.gov/oas/reports/region3/31300201.pdf (accessed December 22, 2014).
15 Ohio Revised Code, sec. 5739.01(B)(11)(a)
16 Cindy Mann, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, *State Health Official Letter #14-001*, July 25, 2014, http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-14-001.pdf (accessed December 23, 2014).

harmless" provision by guaranteeing to Medicaid MCOs that their tax payments would be returned to them. Although Ohio does not appear to have an explicit guarantee, in practice the state compensates the MCOs for the tax cost, and thus still contravenes funding rules.[17]

In response to the OIG's report on Pennsylvania, CMS announced that it agrees that Pennsylvania's tax system violates the law. This is bad news for Ohio inasmuch as Ohio's sales tax on Medicaid managed care is virtually identical to Pennsylvania's gross receipts tax. Indeed, in responding to the OIG investigation, Pennsylvania identified Ohio as another state that uses much the same practice. Accordingly, CMS almost certainly will cease reimbursing Ohio for the sales tax portion of its Medicaid managed care premiums. Without federal reimbursement, there is no incentive for the state to tax the premiums, which means there will be no more net gain for the state from MCO taxes.

The Impact of Losing Medicaid Managed Care Organization Sales Tax Revenue

Losing MCO premium tax revenue would be disastrous for Ohio. An influential report coauthored by pro-expansion groups estimated that Medicaid expansion would yield a net gain of up to $1.85 billion for the state budget from FY 2014 to FY 2022.[18] The report estimated $1.45 billion of the $2.79 billion in revenues would come from the MCO tax.[19] In other words, this one revenue source was expected to produce over 52% of the total revenue gain. If the loophole that allows this revenue is closed in FY 2016, the $1.85 *billion* projected gain would fall to a mere $518 *million* by 2022. This is a very slim margin for such a large program. And it only gets worse from there.

The report used economic modeling by Regional Economic Models, Inc. (REMI) to estimate that expansion will produce a net gain of nearly $400 million in FY 2016, but approximately a $70 million net gain in 2022. These shrinking margins include revenues from the MCO tax loophole. Cutting out this revenue stream would yield a net *loss* of up to $169 million in 2022 alone.

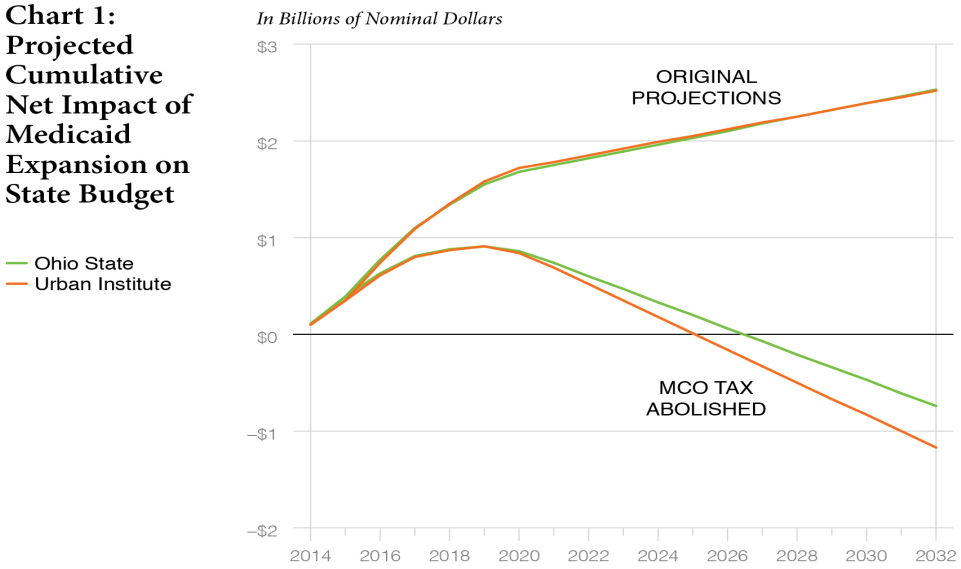
---

17 Chen, *LSC Redbook* ,126.

18 The Health Policy Institute of Ohio, The Ohio State University, The Urban Institute, and Regional Economic Models, Inc. (REMI), "Expanding Medicaid in Ohio: Analysis of Likely Effects," February 2013, http://www.urban.org/uploadedpdf/412772-Expanding-Medicaid-in-Ohio-Report.pdf (accessed December 18, 2014).

19 The Urban Institute and The Ohio State University combine the then-5.5 % MCO sales tax and the 1 % Health Insuring Corporation tax, for a total state tax rate of 6.5 %, to estimate revenues of $1.72 billion over FY 2014-2022. The legitimacy of the HIC tax is not in dispute because it is broad-based.

Chart 1: Projected Cumulative Net Impact of Medicaid Expansion on State Budget



The report's authors hypothesize that key cost drivers such as enrollment will stabilize in FY 2022. Therefore, they claim (rather optimistically) that the net fiscal effects of expansion will remain near 2022 levels thereafter. Even with such an optimistic assumption, the loss of MCO tax revenues would produce projected annual losses of up to $169 million per year, in each year beyond 2022. At that rate, if Ohio loses MCO tax revenue starting in 2016, all of the state's earlier gains would be wiped out by FY 2026. The program would then continue to deepen the fiscal hole year after year,[20] reaching a $1.2 billion cumulative net loss for taxpayers by FY 2032.

Two other pro-expansion groups also worked with REMI to model the effect of Medicaid expansion on Pennsylvania. Although the study does not explicitly estimate the illicit MCO tax revenues or net fiscal impact, it does project a $5.1 billion increase in "economic activity" in 2016 alone.[21] Similarly, although not using REMI modeling, RAND Corporation estimated that the impact of Medicaid expansion on Pennsylvania's budget would be to increase net state spending by $774 million from 2014-2020, even including $1.53 billion in state tax revenue.[22] If CMS outlaws the tax in 2016, Pennsylvania's spending will increase by $2.3 billion over that period.

---

20 Drew Gonshorowski of The Heritage Foundation has noted similar myopia at play in the Commonwealth Institute's analysis of Medicaid expansion in Virginia. While the overall numbers appear favorable in the first ten years of expansion, projecting farther into the future darkens the picture—Gonshorowski points out that expansion is expected to cost Virginia nearly $190 million annually past 2022. Drew Gonshorowski, "Medicaid Expansion and State-Level Evaluation in Virginia," August 16, 2013, http://www.heritage.org/research/reports/2013/08/medicaid-expansion-and-state-level-evaluation-in-virginia (accessed January 26, 2015).

21 Families USA and Pennsylvania Health Access Network, "Pennsylvania's Economy Will Benefit from Expanding Medicaid," February 2013, http://familiesusa.org/sites/default/files/product_documents/PA-and-Medicaid-Expansion.pdf (accessed January 23, 2015).

22 Price, Carter C., et. al, "The Economic Impact of Medicaid Expansion on Pennsylvania," *RAND Corporation*, March 28, 2013, http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR256/RAND_RR256.pdf (accessed January 23, 2015).

Conclusion

Expanding Medicaid to provide "free" coverage to able-bodied, childless adults earning up to 138% of the federal poverty level increases spending on an already mammoth program, crowds out other priorities such as education and public safety, and puts the state's economic future in jeopardy.

Rosy predictions of budget gains depend upon a funding stream that has long been at risk. If the federal government bans the sales tax on Medicaid managed care premiums in 2016, Ohio's Medicaid expansion will lose out on $1.3 billion in expected revenues by 2022 and incur a net loss of approximately $1.2 billion by 2032.

The Buckeye Institute warned of the long-term risks to Medicaid expansion before the policy was originally adopted. Regrettably, the state's leaders ignored these warnings. With the potential for an adverse decision from CMS looming on the horizon, Ohio taxpayers may soon learn that disregarding those warnings was an expensive mistake, likely requiring severe tax hikes or cuts to public services to make up for the loss.

Joe Nichols is the William and Helen Diehl Transparency Fellow at The Buckeye Institute for Public Policy Solutions.

The Economic Research Center (ERC) was established at The Buckeye Institute in 2014 to provide reliable economic research, data analysis, and econometric modeling at the state level.

Founded in 1989, The Buckeye Institute for Public Policy Solutions is an independent research and educational institution—a think tank—whose mission is to advance free-market public policy.

88 East Broad Street, Suite 1120 · Columbus, Ohio 43215 · 614-224-4422 · BuckeyeInstitute.org