STRATEGIC HEALTH CARE

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HHS Officials Publicly Challenge Value of Provider Taxes, State Directed Payment

New ASPE Study: Provider taxes increase commercial insurance rates

Executive Summary

HHS officials from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) held a forum today specifically to discuss provider taxes and state directed payments. There were four primary speakers, which included one non-government person – Brian Blasé, who heads Paragon Health Institute. He is a primary driver of health policies that would have a negative impact on health care financing and is very influential within the Trump Administration and Republicans in Congress. It appears HHS is laying the groundwork against congressional Democrats who plan to push provider-friendly Medicaid reforms should their party retake Congress in the midterm elections.

Five Key Takeaways

- **Provider taxes may increase commercial health care costs.** An ASPE analysis presented at the event associated hospital provider-tax adoption with 1.6% higher employer-sponsored premiums and 2.2% higher hospital prices; a separate California analysis cited a 3%–4% price increase.
- **Federal Medicaid matching creates incentives for aggressive financing arrangements**. Panelists argued that provider taxes and associated payments allow states to draw additional federal dollars while limiting their own net contributions, potentially weakening spending discipline.
- **State-directed Medicaid payments have grown rapidly and face scrutiny**. Speakers criticized inconsistent "average commercial rate" benchmarks and cited some payments reaching 500%–800% of Medicare, raising concerns about oversight and fiscal accountability.
- **The 2025 financing reforms could materially affect hospitals and employers, but savings remain projections.** One presenter forecast 2.2% lower employer premiums, 3% lower hospital prices and approximately $630 in additional annual worker earnings; several provisions will not take effect until around 2028.
- **Actual effects are uncertain and may include cost shifting**. The follow-up discussion highlighted potential movement of financial pressure among Medicaid, Medicare Advantage and employer coverage, along with implementation disputes and the need to distinguish financing effects from utilization-driven cost growth.

The central empirical claim came from Dr. Eden Volkov of HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE): in a 2010–2019 staggered-adoption analysis, hospital provider taxes were associated with approximately 1.6% higher employer-sponsored insurance premiums and 2.2% higher implied hospital prices. Volkov also presented modeled benefits from 2025 federal reforms: roughly 2.2% lower employer premiums, 3% lower hospital prices, and $630 more in annual worker earnings. The first figures were described as historical research estimates; the latter are projections, not measured post-reform outcomes.

Other speakers—including Casey Mulligan, Brian Blase, and Caprice Knapp—argued that provider taxes and state-directed payments encourage states and providers to maximize federal matching dollars, potentially weakening accountability. Their interpretations were strongly critical of existing financing practices. The follow-up exchange explicitly underscored that many changes have not yet taken effect, with important implementation dates discussed around 2028.

1. Panel Participants and Scope

- Dr. Eden Volkov, economist at ASPE: research methodology, measured employer-premium and price effects, and projected reform benefits.
- Casey Mulligan, HHS Chief Economist and Chief Regulatory Officer: moderated economic and political incentives discussion.
- Dr. Brian Blase, president of the Paragon Health Institute: provider-tax criticism, federal-state matching incentives, California example and historical bipartisan critiques.
- Dr. Caprice Knapp, Principal Deputy Director of the Center for Medicaid and CHIP Services (CMCS): state-directed payment operations, average-commercial-rate calculations, California MCO tax and Proposition 35.

2. How Provider Taxes and Medicaid Matching Work

The introductory presentation reported that 49 states use health care provider taxes and 47 levy taxes on hospitals. States use tax receipts to finance part of their Medicaid programs, thereby qualifying for matching federal payments. The panel's concern was not simply the existence of taxes; it was the possibility that targeted Medicaid payments and tax structures effectively return money to the same sector while increasing federal contributions far beyond the state's apparent net financial commitment.

Blase characterized some of these arrangements as financing gimmicks and used the term "money laundering." He argued that the actual federal burden can exceed 70% once nominal state-financing arrangements are netted out. In the follow-up, Brian Blase used the illustration that states can sometimes spend one dollar to attract nine dollars of federal funds, and advocated higher marginal state responsibility or capped federal transfers.

The panel framed this as a marginal-incentive problem: when an additional dollar of Medicaid spending costs the state relatively little, states may have less reason to scrutinize the value of a spending increase. Casey Mulligan in the follow-up additionally argued that services priced at or near zero to users can increase utilization.

3. Economic Evidence: Employer Premiums and Hospital Prices

Historical ASPE analysis

Volkov described a staggered difference-in-differences design examining the adoption of hospital provider taxes across states during 2010–2019. According to the first summary, states adopting such taxes experienced estimated increases of 1.6% in employer-sponsored insurance premiums and 2.2% in implied hospital prices.

The speakers contrasted an "accounting view"—that net Medicaid payments largely offset taxes—with an "economics view" in which the tax-and-payment arrangement affects hospital supply or pricing incentives for patients outside Medicaid. Volkov said the findings were more consistent with the latter.

California price comparison

During the follow-up exchange, Brian Blase cited analysis by Eric Sun for Paragon reporting hospital prices approximately 3%–4% higher in California following a provider tax than in neighboring states. The summary gives no detailed study design, dates, controls or precise tax instrument for this comparison.

Commercial insurance mechanisms and competing explanations

The speakers asserted that financing incentives can affect hospital prices charged to commercial plans and therefore employers. Our firm's Duanne Pearson, who was in the audience, pressed the panel on an important alternative driver: increased service utilization and a reportedly sicker workforce. He did not receive a meaningful response.

4. Federal Reforms, Timing and Expected Effects

The panel linked policy changes to a 2025 presidential memorandum addressing Medicaid waste, fraud and abuse and to the legislation it called the Working Families Tax Cut Act. As described by participants, the legislation reduces the provider-tax safe-harbor maximum from 6% to 3.5% for Medicaid expansion states and constrains state-directed payments, with distinctions between expansion and non-expansion states.

Volkov modeled the impact of a roughly 2.5-percentage-point reduction in the relevant provider-tax rate and forecast a 2.2% reduction in employer-sponsored premiums, 3% decline in hospital prices, and $630 increase in annual worker earnings. These three estimated benefits are projections presented by Volkov; the panel did not report that insurers have reduced premiums or that wages have increased as a result of the reforms.

The follow-up explicitly raised implementation timing. Caprice Knapp said that some important provisions are not expected to take effect until approximately 2028, and anticipated litigation, lobbying or political and regulatory resistance. Consequently, any policy evaluation should separate enacted restrictions, effective dates, state compliance, and ultimate market outcomes.

5. State-Directed Payments and Average Commercial Rates

Knapp reported rapid expansion of Medicaid managed care state-directed payments and described inconsistent methods for calculating "average commercial rates." She cited examples reaching roughly 500%–800% of Medicare payment levels in certain settings. The concern expressed was that highly variable benchmarks could allow states and providers to claim unusually large payments while technically referencing a commercial rate measure.

Knapp also described consultants and provider associations as important promoters of increasingly complex arrangements and said agencies experienced a rush of payment submissions ahead of reforms. In her account, some activity occurred outside ordinary executive-budget decision-making. These observations are descriptions of state practice from the panel; neither source specifies the hospitals or states associated with the 500%–800% examples or includes the payment data needed to independently validate the figures.

6. California: Managed Care Organization Tax and Proposition 35

Blase offered California as a case study, citing $16.7 billion in Medicaid managed care organization (MCO) tax revenue and approximately $9.5 billion in federal matching funds. He argued that returning payments to health

plans through Medicaid arrangements allowed the state to secure substantial federal dollars, potentially creating room for other state policy decisions, including coverage expansions and changes to asset limits.

Knapp described the political conflict surrounding Proposition 35, which she said was intended to dedicate MCO tax resources to higher payments for designated health care providers. Her account alleged that funds instead supported the general budget, that a later tax restructuring failed to obtain a required three-quarters legislative vote, that health plans could face costs of up to $750 million annually, and that lawsuits were filed in October over compliance with Proposition 35 and promised rate increases. These are panel accounts of contested developments; the uploaded sources contain neither court filings nor current legal dispositions.

7. Structural Alternatives and Federal–State Accountability

The follow-up broadened the argument from particular tax rules to the federal-state fiscal relationship. Brian Blase proposed capping federal contributions and raising states' marginal share so decisions about additional spending are tied more closely to locally borne costs. Casey Mulligan contended that changing incentives on a durable basis would require Congress because regulators, consultants and affected parties could adjust practices in response to narrower administrative restrictions.

Blase also referenced earlier criticisms of provider taxes by Urban Institute scholars, the Simpson–Bowles Commission, Obama administration proposals and the Washington Post editorial board, arguing that concerns about the mechanism predated the current political debate. The source summaries list these references.

8. Implications for Hospitals, States and Employers

- Hospitals and health systems: Provider-tax and state-directed-payment restrictions could alter Medicaid supplemental revenue and managed care reimbursement, even if commercial price reductions are ultimately smaller or slower than projected.
- States: Reductions in financing flexibility may increase pressure to fund Medicaid commitments through ordinary revenues, reduce payments or reconfigure programs. Actual consequences depend on final rules, statutory limits and state choices.
- Employers and privately insured families: The panel predicts lower commercial hospital prices and premiums, but this remains unproven for the reforms under discussion. Utilization, underlying morbidity, benefit design and insurer contracting will also influence outcomes.
- Medicaid patients and providers: The discussions stress federal savings and financial discipline but provide little analysis of whether restrictions could affect provider participation, access, care delivery or clinical outcomes. These potential trade-offs remain central unanswered questions.
- Policy advocates: Assertions that supplemental Medicaid financing drives commercial prices should be distinguished from proof that cuts to Medicaid financing translate directly into lower employer premiums, particularly given the panel's own acknowledgement of cross-market spillovers.