You Pay When Your State Taxes Hospitals

An HHS study finds ‘provider’ levies raise insurance premiums.

By
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Medicaid’s financing gimmicks have raised costs for Americans with private health insurance. A new Department of Health and Human Services study estimates that between 2003 and 2019 state provider taxes, which at adoption ran up to 3.5% of hospitals’ net patient revenue, raised premiums for employer-sponsored single coverage by 1.5% to 1.7%.

Provider taxes are supposed to finance the nonfederal share of Medicaid payments. States obtain federal matching funds based on those proceeds, then return money to providers through supplemental payments. Hospitals can receive more than they paid in taxes, while states draw additional money from Washington. Little wonder that hospitals sometimes lobby to be taxed.

A common defense of this system is that additional Medicaid money enables hospitals to charge privately insured patients less. But medicine isn’t an accounting exercise with a set revenue requirement. It’s a service supplied by people who respond to compensation. Nurses, physicians and resources don’t become more abundant merely because Washington contributes more dollars.

An HHS report released in August quantified how medical markets respond to taxes, prices and payment incentives. A hospital tax raises the cost of serving an additional commercially insured patient, while higher Medicaid payments increase the return on resources used for Medicaid services, making them more expensive for other purchasers. Together, these forces drive a 1.4% change in non-Medicaid provider prices for each percentage-point change in the provider tax rate.

In our new study, my colleagues and I examined private-employer survey data and compared states that adopted hospital taxes with those that didn’t. Our estimated 1.5% to 1.7% increase in single-coverage premiums accounts for national trends and differences in state unemployment.

Provider prices and insurance premiums are different measures, but the studies tell a consistent story. After accounting for the hospital component of insurance spending, the premium estimates align with the magnitude anticipated by the earlier analysis. The estimated premium effect appears with a lag, consistent with insurance prices adjusting after hospital costs change.

By targeting provider taxes, the 2025 Working Families Tax Cuts can help bring premiums back down. As of Oct. 1, states generally can't introduce new provider taxes, and tax thresholds are capped. The law also limits total payment rates under major state-directed arrangements so that they approximately match Medicare rates beginning in 2028, and it phases down the hospital-tax safe harbor in Medicaid-expansion states from 6% to 3.5% by 2032.

According to our research, the changes could reduce employer premiums as much as 2.5% in relevant markets by 2032 relative to the path without reform. Americans who want lower premiums should ask policymakers to keep the Medicaid reforms in place.

Medicaid policy should be evaluated for what it does to workers as well as to government budgets. The costs of financing gimmicks like provider taxes reach beyond government balance sheets and onto your paycheck.

Mr. Mulligan serves as HHS's chief economist and is an economics professor at the University of Chicago.