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REVIEW ARTICLE

Is a Physician "Provider Tax" the Solution to Michigan's Medicaid Woes?

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Abstract *Background:* Michigan is facing a Medicaid budget shortfall. Evidence suggests that the underlying factors causing reliance on Medicaid and cost of treatment to increase are getting worse. A tax on Michigan physicians has been proposed by legislators to meet the budget demands of Michigan's Medicaid program. *Questions/Purposes:* This paper looks at the legal basis of such a tax, studies the successes and failures of other states that have implemented similar taxes, and attempts to assess the effect this tax would have on Michigan doctors and patients. *Conclusion:* With current Medicaid rules, such a tax would increase federal matching funds and potentially reimbursement rates. However, the cost of a tax on physicians would not be born equally, and there are no guarantees that the revenue would provide a funding solution.

Keywords Medicaid · Michigan · physician tax · Affordable Care Act

Introduction

Michigan Medicaid is projected to provide for two million Michiganders in 2012 [19]. This represents one in five residents (a 79% increase over the last decade) [29]. The program will be further strained because increased federal funds from the 2009 American Recovery and Reinvestment Act (ARRA) expired in June 2011 [30]. With the number of Medicaid recipients expanding and the cost of care rising, how will Michigan Medicaid survive?

A gross 3% revenue tax on Michigan physicians has been proposed. This paper explores the feasibility and potential impact of such a tax. First, the Medicaid program in Michigan will be reviewed, and the legal basis for a tax on physicians that can increase federal matching funds will be discussed. Second, this paper will survey other states that have implemented a physician provider tax and discuss the benefits and problems they experienced. Third, the effect of a physician tax on Michigan doctors and patients will be projected.

Medicaid is a federal–state partnership enacted in 1965 to finance health care for low-income American [28]. Michigan Medicaid serves federally mandated groups of persons in poverty and other medically dependant persons without means to pay for medical care [51]. As a result of their financial circumstances, patients needing Medicaid often have chronically neglected health conditions and poor support systems. Many physicians refuse to treat patients whose care is paid by Medicaid. This further limits access to persons whose access to medical care is already marginal [42].

The federal government provides funds to the states based on a statutory formula which funds at least half of the cost of the state's Medicaid expenses [27]. The rate at which each state receives funds is the Federal Medical Assistance Percentage (FMAP). The FMAP is based on the state's per capita income [27]. The lowest rate is 50%, and the maximum is 76%, although the ARRA temporarily increased contributions for 2009–2011 [25]. Michigan receives 65% of its Medicaid funding from the federal government, placing it 15th among the states [31]. The FMAP is applied to the sum of the state's Medicaid expenditures to determine the federal funds contributed.

There are two main causes to Michigan's Medicaid funding crisis: Michigan's poor economic condition and

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the increasing cost of health care. Michigan's dire economic circumstances have created the worst unemployment situation in the country.

From 2005 to 2009, Michigan's unemployment rate rose sharply from 6.8% in 2005 to 13.6% in 2009. Unemployment in Michigan increased the number of people who rely on Medicaid for health care. During the recent national recession in 2007–2009 (Michigan has been in a recession for much longer), Michigan added more than 284,000 to the Medicaid rolls, an increase of 19% [35]. From June 2009 to June 2010, the Medicaid rolls increased an additional 11% [29].

The second factor leading to the increased demand for Medicaid funds is the increasing cost of health care in the USA, and Michigan in particular. Along with general increases in costs (e.g., due to increases in caseload, utilization of services, and inflationary pressures on the costs of services) [14], Michigan is below the 50th percentile among states for many important health metrics and is in the bottom third for obesity, diabetes, and heart disease [59]. Poor health has been shown in several studies to be more prevalent among those with low income, and as a result, Michigan Medicaid will see significant cost increases because these patients need more treatment [5, 36, 40, 54]. Medicaid has become more expensive per individual, and if more individuals rely on Medicaid, the result is a drastic increase in Medicaid costs. Michigan cannot afford to pay the bill.

One mechanism for reducing Medicaid costs is to reduce Medicaid reimbursement rates. Since 2005, Michigan has twice resorted to cutting Medicaid reimbursement rates to care givers [11, 38]. Michigan Medicaid reimburses physicians at 60% of Medicare rates [7]. In 2008, Michigan Medicaid was 44th among states in Medicaid physician reimbursement [3, 7]. Although in June 2011, Michigan's 2012 budget maintained Medicaid reimbursement rates, the damage was already done. It is noteworthy that in order to maintain current Medicaid reimbursement rates, Governor Snyder signed legislation creating the Health Insurance Claims Assessment Act (P. A. 142 of 2011), creating an assessment on certain paid health care claims for third party administrators, carriers, and self-insured entities [22].

It is widely acknowledged that Medicaid reimbursement rates in Michigan are inadequate. "'Medicaid reimburses doctors at just 30–40% of their customary charge,' said Paul Reinhart, [Michigan's] Medicaid Director" [13]. Low reimbursement creates a disincentive to treat Medicaid recipients, reducing access to health care and increasing the likelihood of substandard care [17]. Some even argue that Michigan Medicaid reimbursements do not even cover the cost of providing patient care. "Doctors have been supporting the Medicaid system out of their own pockets for decades. Reimbursement is not sufficient to even cover costs," said John MacKeigan, immediate past president of the Michigan State Medical Society [3]. Others agree. Alan Mindlin, President of the Michigan State Medical Society, stated that "[r]eimbursement for helping Medicaid patients cannot happen because the numbers don't make sense." And Mindlin believes a provider tax will make matters worse: "[t]here's no way 3.5% more Medicaid patients will help physicians make more money." Mindlin fears that the tax could put physicians out of business because, according to him, many physicians can't afford it. "If the tax were put in place, I would have to stop practicing," he said. He maintains that the cost of the taxes the cost of one employee [20]. Those statements were made in 2005, before an 8% cut in the Medicaid reimbursement rate took effect in 2009–2010 [7].

Some argue that the path to raising Michigan's inadequate reimbursement rate is a tax on Michigan physicians. This "provider tax" is one of several mechanisms allowed in the federal statute to increase federal matching funds. This can be achieved if a state taxes a provider and then spends the revenue on Medicaid services. The result of the state increasing Medicaid spending is a larger contribution from the federal government.

After myriad abuses and gamesmanship of the provider tax system, restrictions on the nature and scope of these taxes were enacted in 1991 [41] and 2005 [10, 57]. President Obama proposed new restrictions on the use of provider taxes in his Framework for Shared Prosperity and Shared Fiscal Responsibility with the 2012 fiscal year budget.

Presently, for funds from a medical provider tax to qualify for federal matching, the tax must be (1) broad-based, (2) applied uniformly, and (3) must not contain any provision to "hold-harmless" the taxpayer [27]. There are eight classes of providers defined in the law, of which "Physicians" is one class. By quantity, hospitals and nursing facilities are much larger sources of provider taxes than physicians would or could be. Indeed, 38 states have provider taxes on nursing homes, and 34 states have taxes on hospitals and intermediate care facilities [27].

Over the last 10 years, Michigan has attempted to deal with Medicaid's increased cost mainly through the following: (1) provider taxes on hospitals and nursing homes [47], (2) narrowing Medicaid eligibility thresholds, and (3) reducing the reimbursement rate for Medicaid services [7]. A proposal to tax Michigan physicians was first seriously considered in 2005.

In 2005, the question of a physician provider tax on Michigan physicians was a topic of intense debate. Physician faculty of urban teaching hospitals debated the question among themselves and came out generally in favor of such a tax. But the Michigan State Medical Society came out strongly against the tax. By mid-summer 2005, physician opinion on was largely cemented, with a large majority opposing the tax. As an example of how important the physician vote was, urban proponents of the tax made an offer to a key legislator to mobilize 100,000 underserved Medicaid patients to demonstrate in favor of the tax. The legislator declined the offer, saying that even a large demonstration by potential patients would make no difference, but that his opinion, and his vote, might be swayed by 5,000 physicians demonstrating in favor of the tax (Stephen P. Desilva, President of the Wayne State University's University Physicians Group, personal communication). This sentiment was echoed in 2009 and 2010 when the tax was again up for debate, with one of the supporters of the bill, Democratic Senator Mickey Switalski, stating that "unless the doctors change their minds, it would not be possible to pass [this tax] in Michigan" [46].

With costs rising and no additional source of funds, Michigan Medicaid reimbursement rates were cut by 4% in 2005. In 2009, the physicians tax proposal, raised to 3% from an initial 2.3% proposal in 2005, was passed in Michigan's House before being voted down in the Senate. The money from the tax would have allowed Medicaid to reimburse at 80% of Medicare [12]. Medicaid reimbursements were again cut by 8% in 2010. The 3% physicians tax was once again the subject of debate early in 2010, but was never put to a vote in either chamber. Governor Snyder promised to maintain Medicaid reimbursements in his 2012 budget [9]. Signed into law in June 2011, Michigan's 2012 budget did maintain Medicaid reimbursements, contingent on the passing of a new 1% tax on all health care claims in the state. This new tax replaces the 6% tax on Medicaid health plans, which is being phased out in anticipation of new federal rules which will eliminate matching on such a tax [6, 22].

The Physician Provider Tax in Other States

Under federal law, a state may tax medical care providers (hospitals, nursing homes, physicians, etc.), subject to certain limitations, to generate new funds that will lead to increased federal contributions to the state's Medicaid program. Although provider taxes are used in 47 states, they are rarely imposed on individual physicians.

At least five states have attempted to tax physicians to increase federal Medicaid matching: Florida, Kentucky, Minnesota, New Mexico, and West Virginia. Of those five, Minnesota is the only state which continues to have such a tax. Those states that have repealed the tax generally based that decision on their experience that physician taxes drove doctors out of state, did not solve funding problems, and created inequitable burdens.

Kentucky

In 1994, the Kentucky General Assembly enacted a 2% tax on physicians to increase federal matching funds [58]. This tax was an amendment to the previous tax, which was levied against doctors treating Medicaid patients. Many Kentucky doctors ceased treating Medicaid patients, citing the fact that low Medicaid reimbursements did not cover the cost of service [60]. Doctors also protested that the revenues from the tax were not used to fund Medicaid. In at least one year, funds from the tax were used to finance construction projects [60]. There followed a great deal of political opposition to the tax and lawsuits claiming constitutional violations. Although the lawsuits failed, the political power of the physician lobby, and the view that the tax had failed in its purpose, made the repeal of the tax a priority for politicians from both sides of the aisle, and both Republican and Democratic gubernatorial candidates for the 1996 election both vowed to repeal the tax [2]. As promised, then Governor Patton eliminated the physician provider tax. The tax was phased out, starting in 1996, and was completely eliminated by 1999 [37, 50, 55].

West Virginia

West Virginia placed a tax on individual health care providers in 1992 to increase federal dollars for Medicaid. The West Virginia Chiropractic Society claimed credit for securing passage of the tax on individual providers—physicians, chiropractors, and others. The Chiropractic Society was able to secure a seat on the West Virginia General Medicaid Enhancement Board to make recommendations to the West Virginia Office of Medical Services. The Chiropractic Society had a second reason to promote the tax, more important than the cost of the tax. The Chiropractic Society obtained reimbursement for an expanded number of treatment visits under Medicaid, including reimbursement for chiropractic X-rays, and in the end, chiropractors were taxed at a rate lower than other individual providers (1.75%, compared to the physicians' tax rate of 2%).

The West Virginia Legislature initially believed that taxing individual physicians to increase Medicaid payments would allow recruitment and retention of physicians in West Virginia [3]. However, a 1994 survey (the physician provider tax was first passed in 1986) of all West Virginia medical students found that elimination of the 2% health care provider tax was one of the most important incentives that students stated would influence them to remain in the state [24]. The West Virginia State Medical Association, and other groups, claimed credit for successful lobbying in phasing out the physician tax, which it named “onerous” [61]. The tax was again eliminated in 2010 after a decade of continued reductions in the tax rate.

New Mexico

Until 2005, New Mexico assessed a 5% gross “sales tax” on medical services. The tax revenue was deposited in the state's general fund. The tax had an initial contribution of approximately 11 million dollars to the general fund and another 9 million to local governments, which often assessed a sales tax on top of the 5% that the state levied [48]. The tax was the subject of intense lobbying and legislative debate, as those opposed to the tax argued that it reduced the number of physicians in the state [43, 53]. Both sides of the argument cited survey data to support their arguments [43, 53]. A 2000 audit by the Legislative Finance Committee concluded that physicians were not leaving the state, but acknowledged a physician shortage in the state [6]. In 2005, after several years of efforts from state lawmakers, a bill went into effect that allowed physicians to deduct payments made by commercial managed care providers and health care insurers, essentially eliminating the tax burden on New Mexico physicians. New Mexico Medicaid however has not suffered. New Mexico reimburses physicians for Medicaid services at or above Medicare rates for all services [32]. This is likely due, in part, to New Mexico's relatively high federal matching rate.

Minnesota

In 1992, Minnesota enacted MinnesotaCare. This law created subsidized health insurance for qualifying Minnesotans

who worked, yet did not have access to employer-sponsored care [23]. The law also reformed employer-based group insurance policies. The principal goal of these reforms was to improve access to health care. The program is funded by the Health Care Access Fund (HCAF) which is primarily paid for by a 2% tax on physician providers, a 1% tax on HMOs and Blue Cross Products, and by federal matching funds. The legislature reasoned that redistributing monies toward primary care and preventative care would reduce costs by reducing the amount of care rendered in emergency rooms and more expensive late-treatment of illnesses.

Some argue that Minnesota's health care system has been extremely successful and should be a model for other states. They point out that Minnesota has one of the lowest uninsured rates and is one of the healthiest states in the country [16]. In 2009, Minnesota placed third in the country regarding percentage of uninsured at 9% (behind only Massachusetts and Hawaii). It is noteworthy, however, that this is the same rate as before the law was passed [56]. Michigan placed 16th with 13% uninsured [33].

The tax on physician providers and the MinnesotaCare program is controversial [44]. Opponents argue that the tax is regressive and discourages physicians from practicing in Minnesota [4]. Opponents point out that the HCAF is often used to fill budget gaps in the general fund [44]. For example, in 2008, $250 million was transferred to the general fund from the HCAF to cover a budget shortfall [21]. In the summer of 2011, Minnesota lawmakers voted to phase out the physician provider tax beginning in 2014 and lower Medicaid reimbursements [45].

Florida

In 1984, Florida became the first state to enact a provider tax program, initially taxing only hospitals [47]. The provider tax was broadened in the early 1990s to assess a 1.5% tax on net operating revenues on ambulatory surgical centers, clinical laboratories, free-standing radiation therapy centers, and diagnostic imaging centers. The tax was subject to nearly a decade of protracted litigation. The plaintiffs, providers subject to the broadened assessment, argued that the tax violated due process and equal protection guarantees of the US and Florida Constitutions. The tax was eventually ruled constitutional and still is assessed against those providers [1]. The Florida provider tax is different from the 3% tax proposed in Michigan because it applies to a narrow subset of providers (i.e., not all physicians), as the Michigan tax would. This may be one reason why the tax has survived.

Florida's provider tax regime is similar to Michigan's current system. Michigan taxes hospitals, nursing homes, and community mental health facilities. Florida taxes those organizations plus intermediate care facilities, ambulatory surgical centers, clinical laboratories, free-standing radiation therapy centers, and diagnostic imaging centers. Florida's Medicaid reimbursement rates are similar to Michigan's. In 2009, both states reimbursed Medicaid services at 63% of Medicare rates [34]. Although, Florida's provider taxes are not precisely on point to illustrate the effects of the proposed Michigan physician provider tax, they do provide an example of alternative entities that would be legal to tax.

Predicting the Effect on Michigan Doctors and Patients

A physician provider tax can increase federal matching dollars, and by raising Medicaid reimbursements, this may make patients and many doctors better off. If done properly, the negative financial impact on Michigan doctors could be mitigated. However, the Medicaid program would get a boost at the expense of doctors who do not treat enough Medicaid patients to be “made whole” via increased reimbursement. That the tax will burden doctors who do not treat enough Medicaid patients to recoup the tax through higher Medicaid reimbursement is unavoidable. Also, problematic is that the state could spend the money on non-health-related expenditures, and therefore not qualify for federal matching.

Indeed, using the provider tax revenue to shore-up non-Medicaid budget shortfalls is a major concern of opponents of a physician tax. Opponents point to Kentucky, Minnesota, and New Mexico, where revenues from provider taxes were deposited into the general fund or were used for projects not related to health care. But careful drafting of the provider tax bill is one solution to this problem. The new tax law could include a clause that would eliminate the tax if the Medicaid reimbursement rate fell below a certain level. A clause like this, often called a sunset provision, would ensure that Medicaid reimbursement rates are maintained as long as doctors are being taxed. Even for those doctors who believe the idea of a physician tax is sound, there is a distrust that Michigan will not follow through with its promises [39]. For example, the opposition often cites the failed lottery-for-education program as evidence that the Michigan government does not follow through on its promises. A sunset clause could help keep the tax revenues in the Medicaid system.

Another critical problem with a Medicaid provider tax is the unequal burden shouldered by those physicians who would not be reimbursed for the tax through increased Medicaid payments. Doctors with less profitable practices would be burdened even more than those with more lucrative practices. This is because the tax is a gross receipts tax and does not take into account the overhead costs of any particular practice. It is clear that not all physicians will bear the burden equally. In fact, approximately 15% of Michigan doctors do not treat Medicaid patients, with some estimates placing the number of doctors who will not treat enough Medicaid patients to break even between 35 and 45% [18]. These are not insignificant numbers.

But proponents of the tax have claimed that a 3% physician tax would result in reimbursement rates that would make whole the doctors whose gross receipts were 4% Medicaid. If this is true, then every physician whose practice is more than 4% Medicaid would see a windfall. Obviously, there are many complexities that this very basic formula does not take into account (e.g., length of time to receive reimbursement for Medicaid).

The Michigan physicians who would feel the pinch of a 3% provider tax the most would be those who treat no Medicaid patients. A simplified example would be as follows: a very efficient surgical practice may have an overhead of 50%. A typically inefficient medical practice may have an overhead of 80%. The tax is applied to the gross income of the practice, and the actual overhead expenses are not changed by the tax, so the more efficient surgeon would see a reduction in her take-home pay of 6%, while the unhappy internist would see a reduction in his take-home pay of 15% (surgeon pretax $1,000,000 gross income, overhead $500,000, take-home $500,000; surgeon post-tax $970,000 gross (reduced by 3%), overhead still $500,000, take-home now $470,000 or 6% less; internist pretax $1,000,000 gross income, overhead $800,000, take-home $200,000; internist post-tax $970,000 gross (reduced by 3%), overhead still $800,000, take-home now $170,000 or 15% less).

Those in favor of the tax argue that this will give physicians an incentive to treat Medicaid patients, thus increasing access to care in Michigan, a state that has seen the number of doctors treating Medicaid patients shrink substantially over the last decade [52]. Opponents would be quick to point out that it may not be possible for all physicians, especially those outside of southeastern Michigan, to serve the requisite number of Medicaid patients. Furthermore, this only addresses the effect on the individual physician if the program works flawlessly, an assumption that most will argue cannot be made.

Opponents of the tax point out that other states that have had a physician tax, in particular New Mexico and West Virginia, saw doctors leaving the state and medical school graduates planning to practice elsewhere because of a provider tax [48]. If the tax causes an exodus of doctors from the state, access to health care in Michigan would be further reduced. Even if doctors do not leave the state, those who are burdened by the tax may resort to layoffs or reduce expenditures that will negatively affect the fragile Michigan economy.

Are the concerns of a doctor exodus well founded? Looking to other states that have had taxes on physicians does not provide conclusive evidence. In West Virginia, those opposed to the provider tax often pointed to a doctor exodus or to surveys that showed new graduates were concerned about the tax. However, no data conclusively showed doctors or graduates leaving the state at a higher rate after the tax was passed. Even if there were such a trend, it would be difficult to control for other variables, for example the extremely high cost of malpractice insurance in West Virginia, which may have contributed to the trend [43, 53]. The same is true in New Mexico, where opponents of its provider tax cited physician migration as a reason to repeal the tax. In that case, some data concluded that the number of doctors actually increased in the state over the period in question [6].

Although a physician tax appears to be a solution to increase Medicaid funding, there are significant questions of fairness, execution, and efficacy. Once a new tax is passed, how long will it be until Medicaid costs again surpass available funds? If history is any guide, it will not be long.

In 2010 President Obama signed the Patient Protection and Affordable Care Act (PPACA) [49]. As it pertains to this discussion on provider taxes, the most notable provision of the PPACA is that it will significantly expand Medicaid to become the insurer for low-income citizens and legal residents [49]. This expansion will occur in 2014. If states, and Michigan in particular, are already struggling to pay for Medicaid, a drastic expansion of Medicaid without additional federal support would be impossible. Understanding this problem, the PPACA provides 100% of the dollars required to expand Medicaid to individuals and families up to 133% of the poverty level, for the first three years, then the federal contribution rate will be reduced to 92.8% by 2019 [8]. Also noteworthy is the requirement that states reimburse at 100% of Medicare rates for Medicaid primary care services. [26]. Provisions of the PPACA will require states to set aside additional funds for Medicaid when federal funds are rolled back in 2016. Some argue that the PPACA will drastically increase the cost of Medicaid in the next 20 years [15]. This may change aspects of the provider tax debate, but it will not change the demand for more money to pay for Medicaid.

Conclusions

A physician provider tax in Michigan can increase the funds available for Medicaid. If the new funds are actually spent on medical services, the increased tax revenue will result in more federal matching funds for Medicaid. However, in an era of constantly rising health care costs, an increasingly unhealthy population, and a Medicaid program already bursting at the seams, history has shown that, unless the root causes of the drastic increase in costs are addressed, no amount of money will ever be enough. The potential loss of doctors and associated jobs, the risk that a percentage of doctors will be unfairly burdened, and the reality that there is no “failsafe” guarantee that the revenues obtained from the provider tax will be dedicated to Medicaid services are significant concerns that must be balanced against the potential positives of a larger pot of money.

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