Health Care Taxes in Minnesota
An Analysis

February 2000

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Minnesota Medical Association

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About the Minnesota Taxpayers Association

The Minnesota Taxpayers Association is a non-profit, nonpartisan member-supported organization dedicated to the advancement of efficient, economical government. Since 1926, its mission has been to educate and inform Minnesotans about sound fiscal policy; to provide state and local policy makers with objective, nonpartisan research about the impacts of tax and spending policies; and to advocate for the adoption of rational public fiscal policy.

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Health Care Taxes in Minnesota--An Analysis

Executive Summary

This report provides a comprehensive analysis of the health care taxes in Minnesota. It includes an analysis of taxes on the delivery of health care (provider taxes) as well as taxes on health insurance (various insurance premium taxes).

Most of the taxes studied were enacted by the 1992 Legislature as part of a package of reforms generally referred to as MinnesotaCare. These were the provider taxes and the premium tax on HMOs and nonprofit health service plan corporations. Others, like the MA surcharges, MCHA assessments, and the 2% gross premiums tax on private indemnity insurance carriers predate MinnesotaCare. The taxes covered in this report are shown in the table below.

Table 1. Health Care Taxes Analyzed in This Report

Type of Health Care Tax	Disposition	FY2001 Amount (thousands)
MinnesotaCare Taxes:		
1.5% Hospital Tax	HCAF	$41,855
1.5% Surgical Center Tax	HCAF	569
1.5% Other Health Care Providers Tax	HCAF	75,657
1.5% Wholesale Drug Distributor Tax	HCAF	22,695
1.5% Prescription Drug Use Tax	HCAF	0
1.0% HMO, CISN, and other non-profit gross premium tax	HCAF	16,189
Refunds		(10,806)
Subtotal, Net MinnesotaCare Taxes		**$ 146,159**
Medical Assistance Surcharges:		
1.56% Hospital Surcharge (includes special surcharges for HCMC and Fairview-University Hospitals)	General Fund	$78,476
$625 per bed Nursing Home Surcharge (includes the $5,723 per bed special surcharge for county nursing homes)	General Fund	35,533
0.6% HMO Surcharge	General Fund	14,120
Subtotal, Medical Assistance Surcharges		**$128,129**
Insurance Taxes and Assessments:		
Insurance Gross Premium Taxes (Health only)	General Fund	$23,000
MCHA Assessment*	MCHA	65,000
Subtotal, Insurance Taxes and Assessments		**$88,000**
Grand Total		**$362,288**

Source: Minnesota Department of Revenue, November 1999 forecast.
HCAF--Health Care Access Fund.
*The MCHA (Minnesota Comprehensive Health Association) assessment is for calendar year 2000.

Why a Study?

In 1992, the specific set of taxes enacted to fund the health care reforms associated with MinnesotaCare were selected because (1) it was thought that the funding should come from within the health care industry, partly because the reforms aimed to reduce uncompensated care costs borne by the industry; (2) taxing the gross receipts of providers would motivate them to control costs and charges; (3) the provider tax would not conflict with the federal law (ERISA)

which prohibits state taxation of self-insurers; and (4) Governor Arne Carlson refused to support any new state general fund taxes or tax increases.

The full set of health care taxes, including the older ones, have never been analyzed as a group and have not been evaluated in a comprehensive way against standard principles of good tax policy. This report provides such analysis.

This report is timely. The health care taxes are becoming increasingly controversial and new data collection efforts have identified industry trends toward self-insuring and rapidly rising MCHA assessments that will challenge the current system of state health care financing. Further, surpluses in the state general fund and health care access fund provide an opportunity to "re-finance" the health care reform initiatives of the early 1990s.

Scope of Report

This report will (1) review and clarify how Minnesota health care access is currently funded, (2) assess the appropriateness of each tax using generally accepted tax policy principles, and (3) list options for improving how Minnesota finances health care access.

It is important to note that this is a report on the financing aspects of health care. It is not a critique of the MinnesotaCare program.

The Minnesota Health Care Industry

The health care industry in Minnesota accounts for $18 billion in public and private sector spending annually. The diagram on page 4 is a simplified map of the key elements of the industry.

While even the simple diagram on page 4 looks complex, certain truths are obvious and central to a clear understanding of health care economics and taxation.

- People pay health care taxes, not entities, public or private, though the flow of health care funds is quite circuitous. Higher taxes or charges imposed at any point in the system eventually fall on households.

- The more invisible health care taxes and charges are to the ultimate consumer, the less stable health care costs are likely to be. The Minnesota Department of Health estimates that only 21% of health care spending takes a direct route from final consumers (health care recipient) to health care providers.

Standard Tax Principles Used in Evaluation of Health Care Taxes

This report uses a widely accepted set of tax principles to evaluate the strengths and weaknesses of the health care taxes. These principles are:

- ***Equity***-- relates to various notions of fairness. In tax policy, there are two competing notions of equity, (1) benefits-received, and (2) ability to pay. The benefits-received principle views taxes as payments for benefits and compares both. Where a benefit rationale cannot be justified, the ability-to-pay concept of fairness is generally applied. The ability-to-pay concept of equity takes on two dimensions, (1) horizontal equity, and (2) vertical equity. A tax is said to be horizontally equitable if the tax paid by two or more entities in the same

economic circumstances (income, consumption, or wealth, depending on the tax) pay identical tax amounts. Vertical equity looks at the other dimension of fairness--how tax burdens compare across people with different amounts of tax base (usually income).

- ***Efficiency--***relates directly to the condition of "economic efficiency". It is important that tax policy not distort private market decisions, unless distortion is an explicit goal.
- ***Visibility--***relates to how apparent taxes are to taxpayers. The visibility principle is often overlooked, particularly in legislative settings. The reasons are clear. Taxpayers rarely complain about hidden taxes. But if taxpayers don't know they're paying taxes they can't provide the important citizen oversight presumed by our founding fathers. Taxpayers need to be able to make informed judgements about the cost of government and how their tax burden will change as a result of personal and policy decisions. This principle is fundamental to the notion of accountability.
- ***Simplicity--*** reduces administrative and compliance costs and breeds an increased sense of fairness, better compliance and more accountability.
- ***Stability and adequacy--*** means that taxes should raise the required amount of revenue and not fluctuate wildly from year to year, both for the program's sake and the taxpayer's, since taxes are assessed to meet public funding needs.
- ***Competitiveness--***setting rates without ignoring the tax rates and policies of other states, especially since new information technologies and other advances are reducing the significance of "place" in the conduct of economic activity.

Key Findings (Overall System)

- **Health care taxes are paid by people.** The Department of Revenue's tax incidence study shows that the final burden of the $362 million in Minnesota health care taxes that will be collected in FY2001 will ultimately fall on Minnesotans.

- **Health care taxes are regressive.** The table below summarizes the conclusions of the Minnesota Department of Revenue regarding the incidence (ultimate burden) of the provider taxes and the long-standing 2% gross premiums tax on indemnity insurance companies across the ten deciles of Minnesota population in 1996.

  The table shows that for the two taxes combined, lower-income taxpayers pay two to three times greater share of their income for these taxes than taxpayers with the highest income.

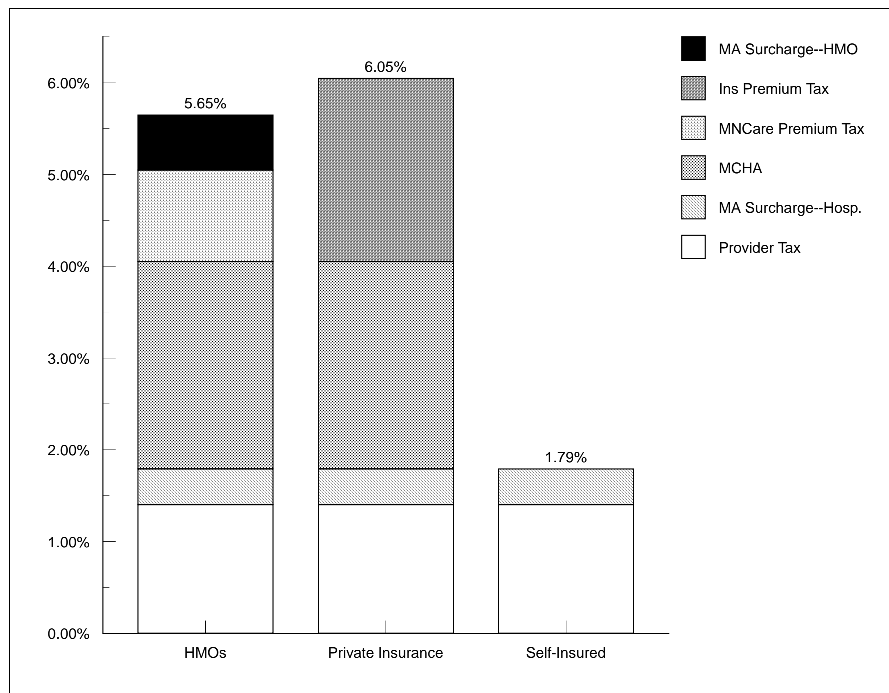
Distribution of the Tax Burden for the Provider and Insurance Premium Taxes by Population Decile, 1996

Population Decile	Household Income	Provider Tax as a % of Income	Ins. Premium Tax as a % of Income	Both Taxes as a % of Income
1	$6,817 and under	0.40%	0.32%	0.72%
2	6,817 - 11,166	0.27%	0.23%	0.50%
3	11,166 - 15,828	0.23%	0.22%	0.45%
4	15,828 - 21,634	0.23%	0.21%	0.44%
5	21,634 - 27,866	0.23%	0.21%	0.44%
6	27,866 - 35,486	0.21%	0.19%	0.40%
7	35,486 - 45,144	0.20%	0.19%	0.39%
8	45,144 - 57,697	0.19%	0.18%	0.37%
9	57,697 - 78,618	0.17%	0.17%	0.34%
10	78,618 and over	0.08%	0.11%	0.19%
Total	**All**	**0.15%**	**0.16%**	**0.31%**

Source: Unpublished background data from the Minnesota Department of Revenue's *Tax Incidence Study 1999.*

- **Health Care Taxes Boost Health Care Costs.** Taxes boost the cost of health care and consequently health insurance premiums for consumers. The Minnesota Council of Health Plans estimates that in 2001, the combined effect of the provider tax, the MA surcharges, the MCHA assessments, and the premiums taxes on HMOs and other insurers will boost premiums by 5.65% for HMO coverage, and by 6.05% for private indemnity coverage. (See the figure below.)

Minnesota Health Care Taxes as a Percent of Health Plan Premiums
By Type of Health Plan, 2001



Source: Minnesota Council of Health Plans

Summary of Provider Tax Evaluations

Fairness Conclusion

- According to the latest preliminary estimates, from 1992 to 1996, providers paid roughly $100 million more in provider taxes than they saved in uncompensated care costs. This means that the provider tax has so far failed the benefits-received principle, at least for hospitals and likely for most other providers given their lower rates of uncompensated care.
- The provider tax is not horizontally equitable, because of Medicare, Medicaid, and other exemptions. These exemptions mean that providers with equal revenues may not pay equal taxes.
- The provider tax is not vertically equitable. It falls more heavily on lower-income taxpayers than on those with higher incomes and therefore is regressive. Lower-income taxpayers pay as much as five times more in provider taxes as a percentage of their income than taxpayers with the highest income.

Efficiency Conclusion

- The provider tax is generally allocatively efficient, with the possible exception of discouraging providers from locating in Minnesota.

- The provider tax has no significant administrative efficiency problems compared to all other taxes for most providers, but for providers which also pay the Medical Assistance surcharges (hospitals, HMOs, and nursing homes), the tax is administratively complex, due to tax bases and rates which are different from the surcharges.

Visibility Conclusion

- The provider tax fails the tax principle of visibility because it is not at all visible for most health care services. It is generally not itemized in fees or in insurance reimbursement schedules, leaving many Minnesotans in the dark even as to its existence.

Simplicity Conclusion

- The provider tax is relatively simple.

Adequacy and Stability Conclusion

- The provider tax is stable, raising more revenue as health care expenses rise.
- The provider tax raises more money than needed for the programs it supports.

Competitive Conclusion

- Because competition in the medical industry is based primarily on reputation and not price, the provider tax *generally* does not negatively effect the competitiveness of Minnesota's providers.
- There are competitive issues with providers near other states' borders, especially when the medical assistance surcharges are considered, too.

Summary of Wholesale Drug Distributor Tax Evaluations

(similar to the provider tax above, but with these additional considerations)

Fairness Conclusion

- The wholesale drug distributor tax is not equitable under the benefits-received principle because it does not provide, nor evidently was ever intended to provide, benefits either to consumers or distributors in proportion to the revenue it raises.
- The wholesale drug distributor tax is not horizontally equitable due to the unequal enforcement of the use tax on out-of-state wholesalers, and wholesalers with federal contracts.

Competitive Conclusion

- The wholesale drug distributor tax puts Minnesota wholesalers at a competitive disadvantage.

Summary of Medical Assistance Surcharge Evaluations

(similar to the provider tax above, but with these additional considerations)

Fairness Conclusion

- Medical assistance surcharges are inequitable under the benefits-received principle, even though they were enacted under the premise of equitable benefits. Federal regulations now prohibit providers from receiving benefits in proportion to the tax.

Efficiency Conclusion

- Medical assistance surcharges had no significant administrative efficiency problems compared to all other taxes before the enactment of the provider tax, but are now administratively complex due to tax bases and rates which are different from the provider tax.

Competitive Conclusion

- Medical assistance surcharges raise competitive issues when combined with the provider tax, especially in border communities.

Summary of Health Insurance Premium Taxes and MCHA Assessment Evaluations

Fairness Conclusion

- The insurance premium taxes and MCHA assessments are not horizontally equitable. Health plans with the same amount of tax base pay different amounts of premium tax. The horizontal tax disparities are most extreme between indemnity carriers, who currently pay a total of 4.1% in insurance premium taxes and MCHA assessments, and self-insurers, who pay no premium taxes.
- Because larger employers tend to self-insure, the initial impact of health insurance premium taxes and MCHA assessments tends to fall increasingly on small employers, the self-employed, and individual policyholders.
- Premium taxes are not vertically equitable. All premium taxes are paid by consumers. According to the Minnesota Department of Revenue, the insurance gross premium tax is regressive in that it falls most heavily on lower income families. MCHA assessments, the 1% HMO premium tax, and the 0.6% MA surcharge on HMO premiums are also assumed to be regressive.

Statutory Tax Rates on Health Plans, Years 2000-2002

Type of Company	Gross Premiums Rate	MCHA Assessment Rate*	Medical Assistance Surcharges	Total Rate
Private indemnity insurers				
2000	2%	2.10%	0%	4.10%
2001	2%	2.26%	0%	4.26%
2002	2%	2.43%	0%	4.43%
HMOs and other non-profits				
2000	0%	2.10%	0.6%	2.70%
2001	1%	2.26%	0.6%	3.86%
2002	1%	2.43%	0.6%	4.03%
Self-insurers				
2000	0%	0%	0%	0.0%
2001	0%	0%	0%	0.0%
2002	0%	0%	0%	0.0%

*The MCHA assessment rates for 2001 and 2002 are MTA projections based on the average annual growth of assessments and premium bases from 1990-2000, provided to MTA by MCHA.

Efficiency Conclusion

- Current health insurance premium taxes and MCHA assessments create market distortions, and are therefore not efficient. The distortions are most severe between indemnity insurers and self-insurers.

Visibility Conclusion

- Health insurance taxes are not at all visible to employers and other purchasers. They are not itemized in premiums, and thus like the provider tax, leave many Minnesotans in the dark even as to their existence.

Simplicity Conclusion

- There are no unusual administrative or taxpayer complexities associated with current insurance premium taxes and MCHA assessments.

Stability and Adequacy Conclusion

- Revenues from the 2% gross premiums tax on indemnity carriers, the 1% premium tax, and the 0.6% surcharge on HMOs and non-profit carriers will be fairly stable and predictable. Health insurance premium taxes rise to reflect increases in health care costs, but decline as the growth of self insurance continues to erode the premium tax bases.
- Revenues from the 2% gross premiums tax and the 0.6% surcharge on HMOs are general fund revenues. Because they comprise such a small percentage of the general fund, they cannot be analyzed as to adequacy.
- If the trend to self-insurance continues, revenues from all health insurance premium taxes will fall as a percentage of total tax collections.
- MCHA assessments are neither stable, nor sustainable. Without reforms, rising assessments and diminishing taxable premiums will continue to push the MCHA assessment rate up without limit, causing heavier burdens for many smaller employers who can't self-insure, and others who purchase health insurance in the market.

Competitive Conclusion

- Premium taxes are not competitive. A growing number of out-of-state insurance companies enjoy a competitive advantage relative to Minnesota companies based on lower premium tax rates and MCHA assessments. Though these companies must pay Minnesota's 2% rate on business written in Minnesota, their home state's lower rate can enable them to offer lower-priced products in Minnesota.
- Minnesota-based companies were at a competitive disadvantage in at least 12 states as of the end of 1998, based on lower gross premiums tax rates in those states than our 2%.
- The MCHA assessment roughly doubles the gross premiums tax for insured health plans, further reducing the competitiveness of Minnesota-based insurance companies.

Options For Reform

Minnesota's system for financing its health care system has some serious flaws. The fact that a major public program is financed nearly invisibly is its most serious shortcoming. Horizontal inequities from taxing competing providers at different rates are also a major concern, especially for those companies subject to the MCHA assessment. Based on the evaluations of the MinnesotaCare and insurance taxes in this report, we provide the following options for reform.

- **Repeal all health care related taxes.** The benefits of the programs funded by these taxes are enjoyed by all Minnesotans, but the funding itself is invisible to most taxpayers. It is not yet possible to measure whether the benefits Minnesotans have enjoyed match the costs of the taxes they are paying. If every Minnesotan benefits from the health care taxes through lowered costs of uncompensated care and increased insurance coverage and preventive care for the newly insured, the tax should be a more direct, broad-based tax rather than the hodge-podge of indirect health care taxes.

Payments to providers for previously uninsured patients have failed to offset the MinnesotaCare tax burdens on providers, which are now simply increasing the cost of health care. Revisions to federal law have negated many of the key points that encouraged the enactment of the Medical Assistance surcharges. The insurance taxes have created horizontal inequities. The simplest solution would be to repeal all of the taxes. This would require an estimated $362 million per year in total replacement revenues.

- **Repeal all provider taxes, including the wholesale drug distributor tax, and repeal all MA surcharges**. This would reduce revenues to the Health Care Access Fund (HCAF) in FY2001 by approximately $146 million in for the provider taxes, and $128 million in general fund revenue for the surcharges. Revenue replacement options are listed below.

- **Repeal all health insurance premium taxes, including MCHA assessments and the 1% and 0.6% taxes on HMOs and other non-profit plans.** This would solve the most pressing problems with these taxes, which are the horizontal inequity among the various types of insurers and the rapidly rising MCHA assessments relative to the base. It would require replacement revenue of approximately $118 million per year. ($23 million for the 2% gross premium tax, $65 million for MCHA, $16 million for the 1% HMO tax, and $14 million for the 0.6% MA surcharge). As long as ERISA exists in its current form, this is the only way to level the playing field and remove the tax bias to self-insure.

- **Reduce the health insurance portion of the gross premium tax rate on private indemnity companies to equal that paid by HMOs**. The rate for HMOs is 0.6% in 2000 (for the surcharge only) and under current law will be 1.6% starting 1/1/2001. This change would reduce general fund receipts by about $16 million in FY2000 and $5 million in FY2001.

- **Reinstate the tax offset of the MCHA assessment against the gross premiums tax.** There was an offset allowed between 1976 and 1987, when only indemnity insurance carriers paid the MCHA assessment. The fiscal impact of this is likely to be about $65 million per year. This would constitute general fund support for MCHA.

Potential Funding Sources

- **Use HCAF and general fund surpluses**. The HCAF reserves are estimated to be $208.4 million for fiscal year 2001, including the $150 million federal welfare reform contingency reserve that has been shown by events to be unnecessary. That amount provides more than one full year of replacement revenue for the MinnesotaCare program ($194.4 million for FY2001) and almost enough for all uses of the HCAF ($238 million for the same year). The Finance Department in its November 1999 forecast estimates that there will be a $500 million annual structural surplus in the general fund.

- **Use ongoing general fund tobacco settlement money to fund MinnesotaCare.** This would provide an estimated $115 million per year for the 2000-01 biennium, and over $330 million per year in the 2002-03 biennium, under current law.

- **Subject medical services to the general sales tax**. A sales tax rate between 1%-1.5% would raise revenues comparable to the provider tax and Medical Assistance surcharges, and a 2% rate would raise approximately enough revenue to replace all health care taxes. However, no other state in the nation now subjects medical services to the sales tax.

I. Introduction

In 1992 Minnesota took dramatic steps to change the economics of the state's health care industry. Reacting to soaring costs and growing concern for the uninsured, the legislature enacted a package of ambitious reforms called MinnesotaCare.[1] The reforms aimed to create a "new foundation 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 care 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."[2]

Among the strategies designed to capture dollars lost to inefficiencies was to tax the health care industry itself to pay for the new health care initiatives. New taxes imposed on the health care industry included:[3]

- **Provider Taxes:** 2.0% tax on the patient revenues of hospitals, surgical centers, most other health care providers, wholesale drug distributors, and on the use or resale of prescription drugs in Minnesota, all with certain exemptions (use tax).[4]

- **HMO Insurance Gross Premiums Tax:** 1% of premiums paid to HMOs (health maintenance organizations) and nonprofit health service corporations (this extended existing health insurance premium taxes to non-profit carriers, but at a lower rate.)[5]

The provider tax took effect January 1, 1993, for hospitals and surgical centers and on January 1, 1994, for all other providers. The HMO insurance gross premiums tax took effect January 1, 1996. The provider tax rate was reduced to 1.5% for calendar years 1998 through 2001, and under current law is scheduled to return to 2% on January 1, 2002. The HMO premium tax is currently not being assessed. It is scheduled to return to 1% on January 1, 2001.

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.[6] Instead, the new taxes were selected on the premise that:

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[1] Laws of Minnesota 1992, Chapter 549.

[2] Ibid.

[3] In addition to new taxes, the state cigarette tax was increased from 43 cents to 48 cents per pack, with the increased revenue transferred from the state general fund to the health care access fund between July 1, 1992 and January 1, 1994.

[4] With the exception of the HMO premiums tax, the whole set of MinnesotaCare taxes are commonly referred to as "provider taxes." The original bill listed the hospital tax and wholesale drug distributor tax separately, and also included a pharmacy tax which was subsequently repealed.

[5] Effective January 1, 1998, non-profit health service plans, HMOs, and CISNs that met certain cost containment goals were made exempt from the 1% premium tax. But starting in calendar 2000, the tax rate is linked to the status of the Health Care Access Fund. On Sept. 1, 1999, had the Commissioner of Finance determined that no "structural deficit" existed for fiscal year 2001, the exemption from this tax would have remained in effect for calendar year 2000. If the Commissioner had declared the fund to be in structural deficit, tax rate increases of ¼% to 1% would have been triggered. In September of 1999, the Commissioner in fact determined that the fund was not in structural deficit. As a result, HMOs and non-profits will continue to be exempted from the 1% gross premium tax through calendar year 2000.

[6] In policy discussions, the term "MinnesotaCare" is used to mean the whole package of reforms enacted in 1992 and also used to mean the subsidized health program created by the same law. It is used here in the broader sense.

- 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 health care 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 prohibits states from regulating or taxing self-insured health coverage).

- There was broad-based opposition to any increase in general fund taxes.

Purpose and Scope of the Report

The purpose of this report is to provide a systematic analysis of the health care taxes with the benefit of hindsight and actual experience with the various health care taxes. In addition to the tax increases associated with the enactment of MinnesotaCare, the analysis will include assessments for the Minnesota Comprehensive Health Association (MCHA) in existence since 1977, the Medical Assistance (MA) surcharges first enacted in 1991, and the insurance gross premiums tax, first enacted in 1872 on domestic insurance companies. MCHA assessments are equivalent to premium taxes and the MA surcharges are functionally similar to both the provider tax and insurance premium taxes.

Specifically, this report will (1) review and clarify how Minnesota health care access is currently funded, (2) assess the appropriateness of each tax using generally accepted tax policy principles, and (3) list options for improving how Minnesota finances health care access.

At the outset, it is important to note that this is a report on the financing aspects of health care. It is not a critique of the MinnesotaCare program. While there are obviously disagreements on the programmatic details of MinnesotaCare, few would disagree with the goals of the program--fewer uninsured persons and reduced rates of growth in health care costs.

The remainder of this report is organized into ten additional sections. Section III provides an overview of the health care industry in Minnesota. Section IV and V describe Minnesota's health care taxes and Health Care Access Fund, the fund dedicated to receive most of the new tax revenues. Section VI presents the principles by which taxes are generally evaluated and section VII applies those principles to Minnesota's health care taxes. Sections VIII and IX summarize our evaluations and present a short list of options for reform. Finally, appendix sections X through XII contain a brief description of the health care industry in Minnesota, tables comparing other states' health care taxes, and a glossary of terms used in this report.

II. Health Care Spending in Minnesota[7]

In 1998, U.S. spending on health care (excluding research, education, and construction costs) exceeded $1 trillion, 13% of the Gross Domestic Product (GDP). Minnesota's share, $17.6 billion (1.6%) accounted for 11% of the state's GDP. That's about $3,400 per person, 7.6% or $280 per person less than the U.S. average.

Increases in the annual rate of growth of health care spending in the late 1980s and early 1990s spurred the national debate on health care access and finance. This produced a number of state-level policy experiments aimed at controlling costs and finding ways to provide affordable health insurance for low-income and high-risk persons. The MinnesotaCare program was perhaps the most comprehensive of those initiatives.

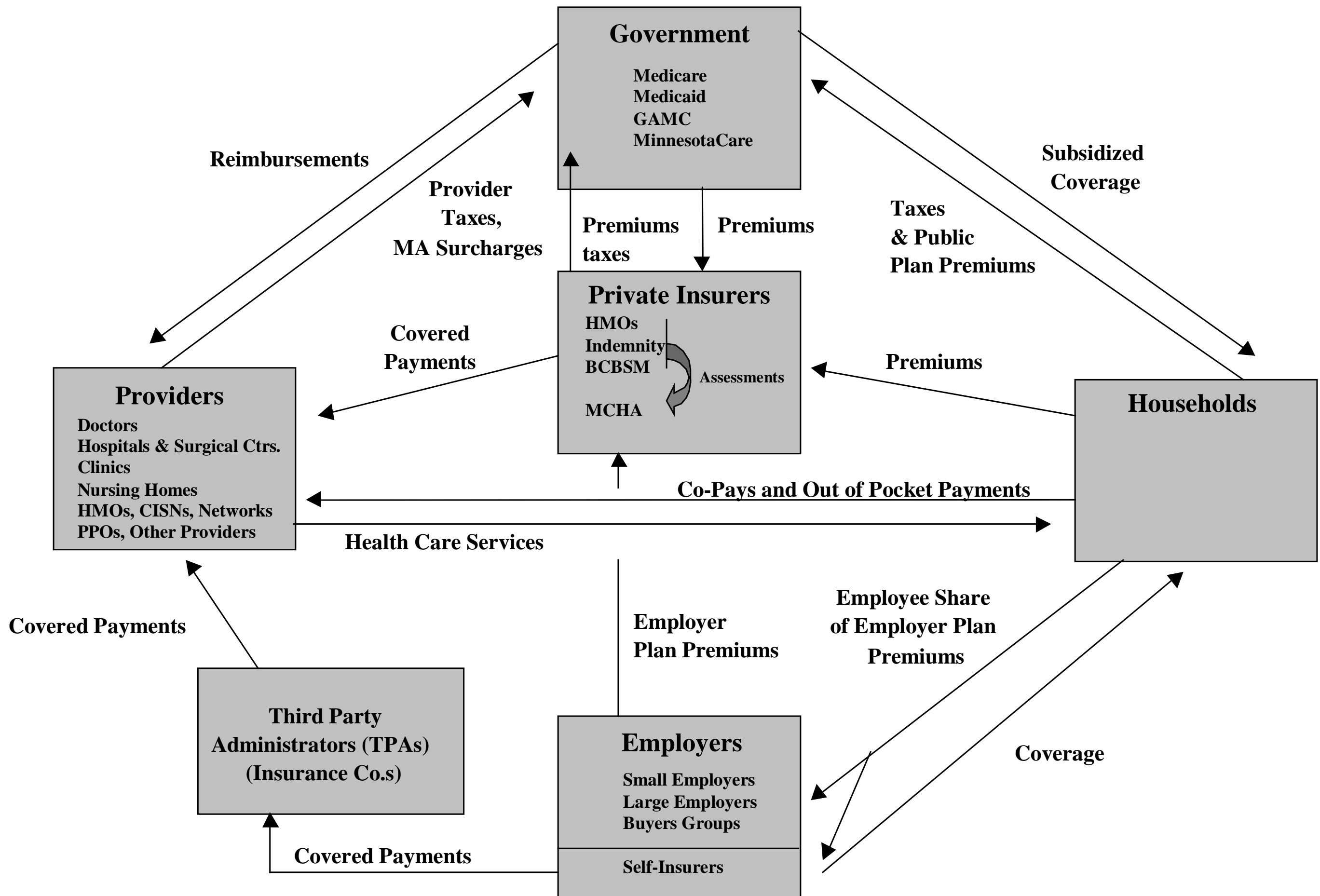
In 1993, the Congressional Budget Office (CBO) predicted that health care spending would rise from about 6% of GDP in 1965 to over 20% by 2002. In the mid-1990s growth rates slowed as a result of the introduction of managed care and other public and private initiatives to reduce costs. More recent CBO projections now indicate that health care spending will remain below 15% of GDP well into the next century.

Between 1993 and 1996, growth in Minnesota health care spending exceeded the national rate. However, the public portion grew less rapidly. The higher growth in the private sector here is attributed to the fact that Minnesota got an earlier start on managed care, and thus had realized initial cost savings from managed care earlier than the rest of the country.

Figure 1 on page 4 provides a simplified picture of the health care industry in Minnesota. In general, $17.6 billion in health care expenditures flows, directly or indirectly, from households to the providers of health care. Between the consumers and providers of health care are numerous intermediaries that facilitate the pooling of risks and provide subsidies to those who, because of inadequate income or unusual health risks, cannot buy health insurance in the marketplace. These public and private insurers and employers provide 79% ($14 billion) of the payments received by providers. The other 21% come directly from patients who make out-of-pocket payments.

[7] This section and Appendix 2 summarize information from various reports of the Minnesota Department of Health's Health Economics Program.

Figure 1. A Schematic of the Health Care Industry in Minnesota



Minnesota Public and Private Health Care Spending[8]

In Minnesota, about 60% of all health care spending is financed from private sources--private health insurance ($6 billion in 1996) and out-of-pocket expenditures ($3.3 billion). The remaining 40% comes from public sources, mainly Medicare, Medicaid, and MinnesotaCare. On the private side, from 1993 to 1996, there has been a distinct shift away from commercial indemnity insurance products (13.9% to 11.8% of private-source spending) and toward fully-insured HMOs and self-insured products (34.7% to 38.4%). As a share of private-source spending, out-of-pocket expenditures have remained fairly constant from 1993 to 1996 at about 35%.

On the public side, there has been little change in shares of spending since 1993. The federal government provided $4.4 billion in 1996 (70% of all public spending), Minnesota state government provided $1.7 billion, and Minnesota local governments provided $0.15 billion ((27% and 2.4% of public spending respectively).

The big federal public programs are Medicare and Medicaid (55% and 34% of federal health care spending respectively). The state's portion of Medicaid (called Medical Assistance or MA) accounts for nearly 75% of state health care spending. MinnesotaCare, the financing of which is the focus of this paper, accounts for only 1.7% of Minnesota's public health care spending at $77 million in 1996, the latest year available, and only one-half of one percent of all public health care spending in Minnesota. Comprehensive health care spending numbers are shown in Table 1 on the next page.

The major categories of health care spending in 1996 in Minnesota include hospital expenditures (31%), physician services (22%), long-term care (19%), dental services (7%), prescription drugs (5%), and other expenditures (16%).

According to the Minnesota Department of Health, the future of health care spending in Minnesota will be determined by three key drivers:

- The price of health care goods and services (generally growing faster than inflation)
- The quantity of health care consumed (driven by population and consumer needs and demands)
- The quality of health care provided (changes in diagnosis and treatment technologies)

Appendix 1 provides more detail about Minnesota's health care industry.

[8] "Health care spending" in this context is defined by the Minnesota Department of Health's Health Economics Program as funds paid out for health care claims. These are basically payments from insurance entities, including government and self-insurers, plus out-of-pocket payments. In the simplified schematic of Figure 1, health care spending consists of the funds coming into the "provider box" from all sources.

Table 1. Estimated Minnesota Health Care Spending, 1993-1996

(in millions)

Public	1993	1994	1995	1996
Federal				
Medicare	$1,910	$2,001	$2,189	$2,396
Medicaid	$1,243	$1,370	$1,461	$1,509
Other	$408	$427	$444	$461
MinnesotaCare	$0	$0	$8	$13
State				
Medicaid	$1,022	$1,136	$1,237	$1,293
GAMC	$159	$155	$155	$149
MinnesotaCare	$23	$45	$60	$77
Other	$162	$164	$169	$165
Local	$147	$138	$139	$150
Public Subtotal	**$5,074**	**$5,436**	**$5,865**	**$6,211**
Private	1993	1994	1995	1996
Private Health Insurance				
Fully-Insured HMOs	$1,218	$1,232	$1,443	$1,625
Commercial/Blue Cross	$1,114	$1,105	$1,119	$1,112
Self-Insured Products	$1,560	$1,790	$1,889	$2,070
Medicare Supplemental	$340	$331	$353	$368
Out-of-pocket	$2,876	$3,023	$3,247	$3,327
Other private	$882	$862	$995	$938
Private Subtotal	**$7,990**	**$8,343**	**$9,046**	**$9,440**
Total	**$13,064**	**$13,779**	**$14,912**	**$15,652**
Source: Minnesota Dept. of Health *Health Economics Program*				

Tax Expenditures

In addition to the public and private spending for health care shown in the table above, additional "implicit" expenditures on health care are made through "tax expenditures." Tax expenditures are tax provisions that "provide preferential income definitions, deductions, exemptions, credits, or rates for certain taxpayers that result in reduced tax revenue."[9]

Since they reduce state revenue, tax expenditures have the same effect as direct state appropriations, but because they are less visible, they are not subject to the same scrutiny as appropriations. To combat this, the current law requires the Department of Revenue to prepare a biennial Tax Expenditure Report listing all tax expenditures and their revenue impacts.[10]

Like other expenditures, tax expenditures are not necessarily bad. Many have wide support and serve popular public policy objectives.

In fiscal year 2000 close to $650 million in health-related tax expenditures have been identified by the Department's Tax Expenditure Study.

Eight of the ten largest health care tax expenditures are a result of federal income tax policy.[11] The largest ten tax expenditures are shown in Table 2 on the following page.

[9] Minnesota Statutes, Section 270.067, Subd. 6(1).

[10] Technically, a tax expenditure is an explicit exception from the generally defined base of a given tax.

[11] These are correctly considered Minnesota tax expenditures because the Minnesota income tax uses federal taxable income (FTI) as the starting point for the state tax calculation. The legislature can choose to eliminate any of these pass-through tax expenditures by simply passing a bill requiring that the federal exclusion or deduction be added back to FTI in calculating the state tax. Not doing so constitutes an implicit endorsement of federal policy and the state revenue loss that results. Repeal of these popular tax

Table 2. Ten Largest Health Care Tax Expenditures

Tax Expenditure	Type of Expenditure	Minnesota State Revenue Foregone for FY2000 (millions)
1. Employer contributions for medical ins. premiums & medical care	Federal Income Tax	$364
2. Medicare benefits	Federal Income Tax	$109
3. Exemption for prescription drugs, medicines, insulin, and analgesics	State Sales Tax[12]	$98
4. Cafeteria plans	Federal Income Tax	$42
5. Workers compensation benefits	Federal Income Tax	$31
6. Veterans benefits	Federal Income Tax	$20
7. Medical and Dental Expenses	Federal Income Tax	$20
8. Payments by self-employed for health insurance	Federal Income Tax	$16
9. Employer paid accident and disability premiums	Federal Income Tax	$11
10. Sales tax exemption for prescription eyeglasses	State Sales Tax	$11
Source: Minnesota Department of Revenue, *Minnesota Tax Expenditure Budget, 1998*		

expenditures would add complexity to the state income tax by requiring additional lines and instructions to the Minnesota tax forms and instruction booklets.

[12] Until recently, the Department's study counted as a tax expenditure revenue foregone from the sales tax due to the exemption of health care services. The latest study excluded health care services from the list of sales tax expenditures because health care services are subject to alternative taxes--MinnesotaCare taxes. If health care services had remained in the study, total health care tax expenditures for fiscal year 2000 would nearly double (evaluated at the current 6.5% sales tax rate).

III. A Brief Description of Minnesota Health Care Taxes

The phrase "Health Care Taxes" is generally used in this report to refer to the taxes that were enacted in 1992 and survive today as the source of funding for the initiatives enacted that year, plus additional taxes on providers and health plans that predate the 1992 taxes. Revenues from the taxes enacted in 1992 are generally referred to as the MinnesotaCare taxes and are dedicated to the Health Care Access Fund (HCAF) from which appropriations for selected expenditures are made. Revenue from the other taxes goes into the general fund without any special dedication.

Table 3 below lists the taxes analyzed in this report, the revenues they generate, and their disposition.

Table 3. Health Care Taxes Analyzed in This Report

Type of Health Care Tax	Disposition	FY2001 Amount (thousands)
MinnesotaCare Taxes:		
1.5% Hospital Tax	HCAF	$41,855
1.5% Surgical Center Tax	HCAF	569
1.5% Other Health Care Providers Tax	HCAF	75,657
1.5% Wholesale Drug Distributor Tax	HCAF	22,695
1.5% Prescription Drug Use Tax	HCAF	0
1.0% HMO, CISN, and other non-profit gross premium tax	HCAF	16,189
Refunds		(10,806)
Subtotal, Net MinnesotaCare Taxes		**$146,159**
Medical Assistance Surcharges:		
1.56% Hospital Surcharge (includes special surcharges for HCMC and Fairview-University Hospitals)	General Fund	$78,476
$625 per bed Nursing Home Surcharge (includes the $5,723 per bed special surcharge for county nursing homes)	General Fund	35,533
0.6% HMO Surcharge	General Fund	14,120
Subtotal, Medical Assistance Surcharges		**$128,129**
Insurance Taxes and Assessments:		
Insurance Gross Premium Taxes (Health only)	General Fund	$23,000
MCHA Assessment*	MCHA	65,000
Subtotal, Insurance Taxes and Assessments		**$88,000**
Grand Total		**$362,288**

Source: Minnesota Department of Revenue, November 1999 forecast.
HCAF--Health Care Access Fund.
*The MCHA (Minnesota Comprehensive Health Association) assessment is for calendar year 2000.

General Fund Tax Support for Health Care

Before discussing the MinnesotaCare taxes and the insurance gross premiums tax, which will be the focus of this report, we note here that publicly funded health care expenditures in Minnesota are supported by more than just the health care taxes analyzed in this report. They are also supported by general fund taxes (income tax, sales tax, etc.) and revenue from federal sources. General fund and federally supported health care expenditures include Medicaid (Medical Assistance), General Assistance Medical Care, U of M hospitals, Regional Treatment Centers, and health expenditures associated with correctional facilities, public health, workers compensation, Head Start, Crime Victims Reparation, and numerous other programs.

MinnesotaCare Taxes

Provider Tax on Hospitals, Surgical Centers, and Other Health Care Providers

There are actually three major groups in the health care industry that are subject to the provider tax: (1) hospitals and surgical centers; (2) health care providers other than hospitals and surgical centers; and (3) wholesalers, and in some cases retailers, of prescription drugs.

A tax of 1.5% of gross revenues is levied on all hospitals, surgical centers, and other health care providers through calendar year 2001. Under current law, the tax is scheduled to revert to the 2% rate that was in effect from 1993 until 1997. Hospitals are defined as hospitals licensed under chapter 144, or a hospital providing inpatient or outpatient services licensed by any other state or province or territory of Canada, or a surgical center.[13] A surgical center is an outpatient surgical center as defined in Minnesota Rules, Chapter 4675, or a similar facility located in another state or in Canada.[14]

Physicians, part of the second group, are the single biggest payers of the provider tax, followed closely by hospitals. A complete listing of the types of providers and the amount of tax they pay are shown in Table 4 below.

Table 4. 1998 Provider Tax Paid by Provider Type

Provider Type	Number of Returns	Total Tax Paid	Provider Type	Number of Returns	Total Tax Paid
Acupuncturist	40	$ 25,241	Nurse Practitioner	18	$ 817
Ambul./ Spec. Trans. Serv.	44	392,622	Nursing	124	89,812
Anesthesiologists and CRNA	19	108,970	Nursing Home-ICF-MR	10	9,185
Audiologist	30	109,319	Occupational Therapist	29	75,209
Certified Nurse Midwife	5	10,384	Optician/Optical Supply	143	1,221,655
Chiropractor	1,158	2,706,447	Optometrist	280	5,164,221
Comm. Mental Health Center	26	24,251	Orthodontist	10	63,219
Cons. Chem.Dep.Tmt. Fund	7	7,977	Physical Therapist	103	416,884
Dentist	1,874	14,557,546	Physician/Osteopath	1,525	40,555,049
Diag. Lab/Radiology Lab	40	576,694	Podiatrist	57	701,106
Dietician	16	466	Psychiatric Nurse	7	7,371
Hearing Aid Dispenser	70	257,157	Psychiatrist	28	64,932
Hospice/Home Health Care	104	20,311	Psychologist	1,059	1,483,690
Hospital (Inpatient)	151	32,294,139	Pub/Comm. Hlth Clinic	16	69,008
Lic. Chem. Dep. Counselor	12	9,202	Reg. Treatment Center	10	81,930
Lic. Mrg. & Fam. Therapist	40	25,925	Rehabilitation Center	46	681,478
Licensed Social Worker	185	140,253	Rural Health Clinic	8	44,036
Massage Therapist	25	8,041	Speech Therapist	23	20,285.50
Medical Equipment Supplier	47	90,768	Surg. Ctr. (Outpatient)	15	736,867
Miscellaneous	139	3,030,265	Utilization Review	5	6,180
Miscellaneous Social Services	63	35,618	Wholesale Drug Distributor	124	24,630,827
Source: Minnesota Department of Revenue			**Total**	**7,735**	**$130,555,361**

A broad range of other health care providers are also subject to a 1.5% tax on gross revenues. The tax applies to all regulated health care professionals, others providing health care goods and services that qualify for reimbursement under the Medical Assistance (MA) program, licensed ambulance services, staff model health plan companies, and persons selling or repairing hearing

[13] Minn. Statutes 295.52, Subd. 1, 1a and 295.50, Subd. 7
[14] Minn. Statutes 295.50, Subd. 13

aids or prescription eyewear.[15] This tax covers self-employed doctors, dentists, chiropractors, various medical specialists, therapists, professional assistants, dietitians, licensed social workers, nurses, and many others.

The provider tax is imposed on the gross revenues of health care providers, with a limited number of exemptions. A partial list of exemptions from the tax is shown in Table 5 below.

Table 5. Exemptions from Hospital and Health Care Provider Taxes

Payments exempt from the provider tax include (but are not limited to) the following:

- Payments for Medicare-covered services
- Medical Assistance payments
- Payments received under General Assistance Medical Care (GAMC)
- Payments for services provided by nursing homes or in supervised living facilities and home health care products
- Payments received from hospitals and health care providers for goods and services already taxed under the taxes listed above
- Amounts paid for prescription drugs to a wholesale distributor reduced by reimbursements received for prescription drugs from Medicare, Medical Assistance, General Assistance Medical Care, or the Children's Health Program.
- Payments received by a Minnesota health care provider for care provided to non-Minnesotans outside of Minnesota.

In addition, HMOs are allowed to deduct amounts added to reserves if total reserves do not exceed 25% of gross revenues for the previous year, assessments paid for the Minnesota Comprehensive Health Insurance Plan (MCHA), and an allowance for administration and underwriting.[16]

Itemization and Pass-Through

The original Health Right Act included a provision explicitly prohibiting hospitals and health care providers from separately stating the provider tax obligation on individual patient bills. This was to assure that the provider tax would not be made to appear as a sales tax on consumers' bills. The itemization prohibition, however, was struck down in U.S. District Court.[17]

The current language regarding itemization reads as follows:

"A hospital, surgical center, or health care provider must not state the tax obligation under section 295.52 [Minnesota Care Taxes] in a deceptive or misleading manner. It must not separately state 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."[18]

On the other hand, it was perfectly clear from the start that the legislature expected providers to recover the provider tax from third party payers. The original bill stated:

[15] Minn., Statutes 295.50, Subd. 4
[16] A complete list of exemptions, deductions, and credits is found in Minn. Statutes 295.53.
[17] *Sheldon H. Bloom, et. al. vs. Mary Jo O'Brien, Commissioners of Health and Morris J. Anderson, Commissioner of Revenue*, 4-11-94.
[18] Minnesota Statutes 295.53, Sub. 3

A hospital that is subject to [the provider tax] may transfer additional expense generated by [it] on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer.[19]

Disposition of the Provider Tax Funds

Funds collected from all provider taxes are deposited into the Health Care Access Fund (HCAF) in the state treasury. HCAF revenues can only be used for expenditures associated with MinnesotaCare or for expenditures related to certain health care reform waivers submitted to the federal Health Care Financing Administration. (The status of the HCAF is described at the end of this section.)

Wholesale Drug Distributor Tax

Wholesale drug distributors required to be licensed under Minnesota Statutes 151.42 to 151.51 are also subject to a 1.5% tax on gross revenues, as part of the provider tax. The tax applies to anyone selling or distributing prescription (legend) drugs to persons in Minnesota other than a consumer or patient.[20]

The tax also applies to non-Minnesota pharmacies that are required to have a nonresident pharmacy license to sell prescription drugs at retail to consumers in Minnesota, including mail order sales. Also subject to tax are non-Minnesota businesses that transport prescription drugs, directly or indirectly, to an affiliated pharmacy in Minnesota.

The wholesale drug distributor tax was enacted to include prescription drugs as part of the provider tax. For administrative simplicity, its initial impact was designed to fall on the relatively small number of wholesale drug distributors, rather than the thousands of retail pharmacies in Minnesota.

Exemptions from this tax are the same as those for the provider taxes described above in Table 5 on page 10. Also specifically exempt are direct sales of legend drugs to veterinarians or veterinary bulk purchasing organizations.

Collections from the wholesale drug distributor tax are deposited in the Health Care Access Fund and their use restricted to funding MinnesotaCare expenses.

Use Tax on Prescription Drugs

To tax sales of prescription drugs from other than wholesalers subject to the wholesale drug distributor tax or from registered nonresident pharmacies, a 1.5% tax is imposed on the wholesale price of prescription drugs purchased for use or resale in Minnesota, or the price received by a nonresident pharmacy, which ever is lower. Liability for the tax is incurred when the prescription drugs are received in Minnesota.

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[19] Laws of MN 1992, 549, Art. 9, Sec. 19)

[20] Exceptions include sales between related companies or hospitals, member purchases from group purchasing organizations, sales between 501(c)(3) organizations, transactions for medical emergencies, transactions pursuant to a prescription, certain inter pharmacy transactions, distribution of samples, and the sale or trade of blood or blood components.

Exemptions from this tax and the disposition of revenues are the same as that of the provider tax.

Insurance Gross Premiums Tax On Non-Profit Health Service Plan Corporations, Health Maintenance Organizations (HMOs) And Community Integrated Service Networks (CISNs).[21]

The 1992 Health Right Act extended the existing insurance gross premiums tax to HMOs and nonprofit health service corporations beginning January 1, 1996, at a rate of 1%. The tax rate for indemnity insurance companies remained at 2%.

Premiums paid under Medical Assistance, General Assistance Medical Care, MinnesotaCare, the MCHA plan, and revenues and reimbursements received from the federal government for Medicare-related coverage, are not taxable.

All for-profit insurance premium tax revenues from the long-standing gross premium tax, including the tax on health insurance premiums, are deposited in the state's general fund. Premium tax collections from the non-profit health insurance premium tax are deposited in the Health Care Access Fund.

Effective in 1998, non-profit health service plans, HMOs, and CISNs that met certain cost containment goals were made exempt from the 1% premium tax. But starting in calendar 2000, the tax rate is linked to the status of the Health Care Access Fund. On Sept. 1, 1999, had the Commissioner of Finance determined that no "structural deficit" existed for fiscal year 2001, the exemption from this tax would have remained in effect for calendar year 2000. If the Commissioner had declared the fund to be in structural deficit, tax rate increases of ¼% to 1% would have been triggered. In September of 1999, the Commissioner in fact determined that the fund was not in structural deficit. As a result, HMOs and non-profits will continue to be exempted from the 1% gross premium tax through calendar year 2000.

Medical Assistance Surcharges

There is a subset of provider taxes known collectively as Medical Assistance surcharges. These apply to hospitals, surgical centers, HMOs, CISNs, and nursing homes. Though they were enacted before the MinnesotaCare taxes and revenue from them is not dedicated to the MinnesotaCare program, they are similar in character to the MinnesotaCare taxes. The surcharges on hospitals and nursing homes will be analyzed as part of the provider taxes, and the surcharge on HMOs will be analyzed as part of the insurance taxes, except when unique aspects of the surcharges require separate evaluations.

In the mid 1980s, states began to exploit a loophole in the federal system of reimbursing states for Medicaid costs. As a way to leverage more federal money, states began enacting health care provider taxes and increasing rates of reimbursement to providers, effectively neutralizing, or at least diminishing the effect of the tax.

Minnesota initially resisted the move to capture more federal Medicaid funds, fearing that if the federal rules were changed, the state would be forced to fund the increased reimbursement rates

[21] CISNs, or Community Integrated Service Networks are networks of providers and payers which provide care and compete with other systems for enrollees in their community. Systems can include hospitals, primary care physicians, specialty care physicians, and other providers and sites that can offer a full range of preventive and treatment services.

without federal help. But in 1991, facing budget difficulties, the Minnesota legislature enacted the Medical Assistance surcharges on health care providers, listed in Table 6 below:

Table 6. Medical Assistance Surcharges

Type of Health Care Provider	Year Effective	Rate of Surcharge as Enacted	Current Rate of Surcharge
Hospitals	1992	1.4% of net patient revenues, excluding Medicare	1.56%
Hennepin County Medical Center (HCMC)	1992	Same as hospitals, plus 2.0% of net revenues, plus $1 million per month	Same, except 1.8% and $1.5 million per month
Fairview-University of Minnesota Hospital	1994	Same as HCMC	Same, except 1.8% and $500,000 per month
Health Maintenance Organizations	1992	0.6% of total premium revenues	Same
Community Integrated Service Networks	1993	0.6% of total premium revenues	Same
Licensed Nursing Homes, not operated by the state	1993	$620 per licensed bed	$625 per licensed bed
County Operated Nursing Homes	1994	$5,723 per licensed bed	Same
Physicians	1992	$400 license fee per year	Repealed in 1997
Source: Minnesota Department of Revenue *Tax handbook.*			

By 1992, the federal government began restricting this practice of the states by requiring that payments of matching federal funds be distributed to providers on the basis of their proportion of Medicaid patient treatment costs. This ended the "hold harmless" effect of the states' provider taxes in which providers received slightly more payments back from the state than surcharges they had paid to the state.

The federal government changed the rules restricting the "hold harmless" aspect of federal reimbursement with respect to surcharges, making them less attractive to providers. However, remain in effect to date. The following table shows the most recent fiscal year collections from these surcharges.

Table 7. Minnesota Medical Assistance Surcharges, Fiscal Year 1999

Health Care Surcharge	Amount Collected
Hospitals (includes HCMC and Fairview-U of M)	$74,081,654
HMOs and Integrated Service Networks	10,936,437
Nursing Homes (includes county owned)	35,400,292
Total	**$120,418,383**
Source: Minnesota Department of Revenue	

MCHA Assessments

In 1976, the Minnesota legislature created the independent, non-profit Minnesota Comprehensive Health Association (MCHA) to provide individual health insurance policies to Minnesota residents unable to buy insurance due to pre-existing conditions. This law created the nation's

second state-supported high-risk health insurance pool. Today there are 27 such state programs nationwide. Minnesota's is the largest.
Since its start in 1977, MCHA has provided health coverage to over 200,000 Minnesotans. Over the 20-year period from 1977 to 1997, enrollment in MCHA rose to a high of 36,000 in 1993, then fell steadily to 25,000 by the end of 1998. This constitutes about 1% of Minnesota's insured adult population. The reduction in enrollment since 1993 is largely attributed to the insurance reforms of MinnesotaCare, including the prohibition of exclusionary riders, guaranteed renewals, and guaranteed-issue in the small group insurance market.

MCHA serves as an insurance safety net for persons who want insurance, but for various reasons are unable to get it. The circumstances that bring persons to MCHA include:[22]

- Pre-existing health conditions
- Exhaustion of COBRA benefits
- Leaving employer group coverage
- Lack of dependent coverage at place of employment
- Changes in self-insured or union plan benefits for retirees under age 65
- Reaching policy lifetime benefit maximums
- Working for employers who do not offer coverage
- Termination of employment with self-insurer that does not offer conversion policies
- Waiting for coverage during employment probationary periods
- Employer Bankruptcies

Minnesotans with certain "presumptive" conditions such as AIDS, Leukemia, Parkinson's disease, and others are automatically eligible for coverage under MCHA.

Enrollees can choose from four different MCHA insurance plans. Premiums for each range from 101% to 125% of the average individual health insurance policy sold.[23] MCHA policies have a lifetime benefit of $2.8 million.

Because MCHA enrollees generally need higher-cost care, the limit on premiums results in annual MCHA deficits. In 2000, MCHA premiums will provide only 47% of the revenue needed to cover MCHA costs. Deficits have consistently risen from $1 million in 1981 to $65 million in 2000. A one-time legislative appropriation of $30 million, the first significant direct legislative appropriation since the start of MCHA, reduced deficits and assessments by $15 million per year in both fiscal years 1998 and 1999.

Paying for MCHA Deficits

State law requires "contributing members" to pay annual assessments to cover MCHA deficits. When MCHA was first created in 1976, all insurers were considered contributing members, including indemnity insurance carriers, self-insurers, fraternal organizations, nonprofit health service plan corporations, and HMOs. The assessments on self-insurers ran afoul of ERISA, the 1974 federal law prohibiting states from regulating or taxing employer-based health plans.

From 1979 to 1987, only indemnity insurance carriers were contributing members of MCHA. During this period, self-insurers, HMOs, fraternal organizations, and nonprofit health service plan

[22] Minnesota Comprehensive Health Association, Annual Report, 1997/1998
[23] Except in the late 1980s, premiums have been less than 125% of market.

corporations were exempt from MCHA assessments, and indemnity insurance carriers were allowed to deduct MCHA assessments from either their 2% insurance gross premiums tax or state income tax. By allowing the deduction, the state, in effect, dedicated a portion of the insurance gross premiums tax to pay for MCHA deficits.

This indirect general fund subsidy for MCHA ended in 1987 when the tax offset was repealed. At the time MCHA deficit was $11.2 million.

Also in 1987, HMOs, fraternal organizations, and nonprofit health service corporations were again made contributing members of MCHA.

There were only two other instances of state funding for MCHA deficits. One was in 1978 when the state legislature provided seed funding for the first $200,000 in claims. The other was in 1998 and 1999 when MCHA losses were reduced by $15 million each year as a result of a one-time state appropriation from the Health Care Access Fund.

Assessments are levied against contributing members in direct proportion to their market share (the ratio of each company's total accident and health insurance premiums received on behalf of Minnesota residents divided by the total of the same).[24]

In 1998, 223 member insurance companies with a total premium base of just under $3 billion paid MCHA assessments. Because the insurance market has become more concentrated since the enactment of MinnesotaCare, nearly 87% of annual MCHA assessment revenue is paid by the top 10 insurers, with the top 3 paying over 79%, as shown in Table 8 below.

Table 8. Share of MCHA Assessments

(Top Ten Contributing Members)

Member	**1998 Market Share** (Share of Total Assessment)
1. Medica/Medica Insurance Co.	29.75%
2. Blue Cross Blue Shield of MN/Blue Plus	25.04
3. HealthPartners, Inc./Group Health, Inc./Central MN Group Health	24.36
4. Principal Life Insurance Co.	1.84
5. Federated Mutual Insurance Co.	1.33
6. Fortis Insurance Company	0.98
7. United Healthcare Insurance Co.	0.96
8. State Farm Mutual Auto	0.91
9. Preferred One Community Health Plan	0.82
10. United Wisconsin Insurance Co.	0.77
Top Ten Total	**86.76%**

Source: Minnesota Comprehensive Health Association

MCHA Assessments--a Tax?

The "extra cost" of insuring high-risk MCHA enrollees is levied against the insured market. As such, it falls mostly on smaller employers and individual insurance purchasers, and excludes the

[24] For assessment purposes, the calculation of market share excludes state payments to contributing members for Medical Assistance, MinnesotaCare, and General Assistance Medical Care services.

public programs and self-insured employers. This report appropriately views the assessment as a tax, and evaluates it as such.

Insurance Gross Premiums Tax on Commercial Health Insurance Carriers

Commercial health insurance carriers have been subject to a 2% insurance gross premiums tax since 1872. Collections from this tax are deposited in the general fund and are available for any state general fund expenditure.

As noted above, from 1979 to 1987 indemnity insurance companies were allowed to deduct assessments paid for the Minnesota Comprehensive Health Association insurance plan (MCHA plan) from their insurance gross premiums tax or state income tax liability. In effect, the deduction provided an indirect general fund subsidy for MCHA operating deficits, spreading the burden of financing the state's high risk insurance pool to all Minnesota taxpayers.

In 1987, the state moved away from general-fund financing of MCHA by repealing the tax deduction for MCHA assessments.

IV. The Health Care Access Fund

The Health Care Access Fund (HCAF) is a specially dedicated account set up to account for all revenues from the MinnesotaCare taxes. The use of funds which accumulate in the account are restricted to "*purposes that are consistent with past and current MinnesotaCare appropriations in Laws 1992, chapter 549; Laws 1993, chapter 345; Laws 1994, chapter 625; and Laws 1995, chapter 234, or for initiatives that are part of the section 1115 of the Social Security Act health care reform waiver submitted to the federal health care financing administration by the commissioner of human services as appropriated in Laws 1995, chapter 234.*"[25] The HCAF's resources and expenditures for the current and next biennia are shown in Table 9 below.

Table 9. Summary of Minnesota's Health Care Access Fund

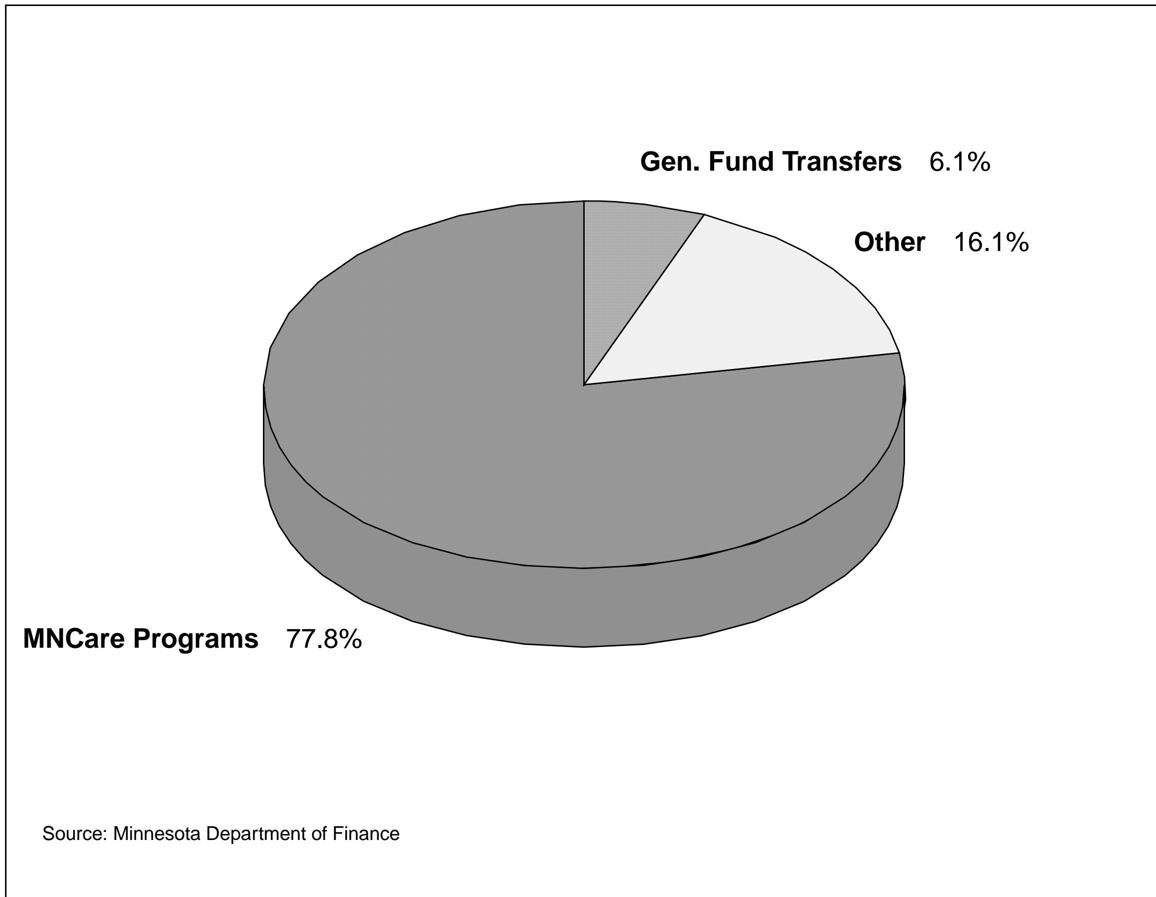
Actual and Estimated Resources	**FY2000**	**FY2001**	**FY2002**	**FY2003**
Adjusted Balance Forward From Prior Year	$274,022	$252,786	$208,422	$188,627
Receipts:				
1.5% Provider Tax	137,978	140,669	161,174	199,751
1% Gross Premium Tax	0	16,189	31,049	32,368
MNCare Premiums: Individuals	27,768	31,958	34,996	37,481
Other (includes refunds)	7,310	5,593	3,394	(1,171)
Subtotal, Net Receipts	173,056	194,409	230,613	268,429
Total Resources Available	**447,078**	**447,195**	**439,035**	**457,056**
Actual and Estimated Uses				
Expenditures:				
MNCare Direct Appropriation	119,527	157,564	183,002	208,648
MNCare Costs Paid by Enrollees	27,768	31,958	34,996	37,481
University of Minnesota (training)	2,837	2,837	2,908	2,981
Department of Human Services (admin.)	19,990	19,692	19,928	20,426
Department of Health (Health Economics, Rural Hospital grants, etc.)	10,003	10,114	7,394	7,579
Other	14,167	16,608	2,180	2,324
Total Uses	**194,292**	**238,773**	**250,408**	**279,439**
Annual Structural Surplus (Deficit)	**(21,236)**	**(44,364)**	**(19,795)**	**(11,010)**
Fund Reserves				
Federal Contingency Reserve	$126,573	$118,962	$150,000	$150,000
Premium Reserve	0	0	0	0
Balance After Reserves	**$126,214**	**$89,460**	**$38,627**	**$27,617**

Source: Minnesota Department of Finance, November 1999 forecast. Items may not add to totals due to rounding.

[25] M. S. 295.581

A graphic presentation of forecasted HCAF revenue spending by major category for the 2000-01 biennium is shown in Figure 2 below. Sixty-nine percent of the fund is expected to be spent on the MinnesotaCare program in the current biennium.

Figure 2. Spending from HCAF by Type of Spending, Fiscal Years 2000-01



V. Principles of Tax Analysis

Importance of Analyzing Taxes

Public finance economists use a nearly-standard set of principles to evaluate the strengths and weaknesses of public sector taxes. The principles normally include equity, efficiency, simplicity, visibility, stability, adequacy, and competitiveness.

Underlying Premise of Most Tax Principles

Since the competitive market model provides the context for most public sector tax analysis and forms the basis for most of the evaluation principles used, a brief overview of the market paradigm is useful.

In well-functioning markets, prices are determined by the free interplay of buyers and sellers, no one of which has sufficient market power to significantly affect supply, demand, prices, or profits. In such a market, capital moves freely from one industry to another in response to differences in rates of return on capital. Abnormally high profits in one industry lead to more investment, higher output levels, and lower prices and profits. The chain of events is reversed in industries with abnormally low profits.

Competitive markets connect the individual decisions of consumers with those of producers to provide what consumers want, when they want it, in sufficient quantities and at the lowest possible cost-based prices, given existing technologies and resource constraints.

It is generally accepted that competitive markets tend to produce the greatest level of goods and services (GDP) possible from the stock of productive resources (land, labor, capital, risk-taking). Economists call this outcome "economic efficiency" or "allocative efficiency." The belief that competitive markets bring economic efficiency gives rise to several of the principles used to evaluate taxes.

But not all markets are perfect, and those that are can sometimes produce an outcome that is politically unacceptable. In some cases government intervenes to correct the causes of "market failure" (allocative policy). In others, it might act to change the market-determined distribution of income (distributive policy).

The enactment of MinnesotaCare was largely based on the premise that Minnesota health care markets were for various reasons either not sufficiently competitive, or in some cases, too competitive. Intervention to reduce the number of low-income uninsured is an example of redistributive policy, while policies designed to create a strong small employer insurance plan market could be considered allocative policies.

If markets are not working well, allocative interventions must be carefully designed to treat the causes of market failure without degrading or destroying those markets that work well. If markets are working well, distributive interventions to "correct" the distribution of income should be designed to minimize market distortions.

In this context, public policy is largely evaluated on how it deals with the difficult trade-off between allocative efficiency and distributive equity. Overemphasis of either will detract from the other. Allocative efficiency (the outcome of ideal markets) requires sufficient competition,

fully informed consumers, and near-frictionless movement of investment capital among industries. Distributive equity is a subjective concept. A "correct" or "acceptable" distribution of income can only be defined through the legislative process.

Standard tax principles reflect this reality and focus on minimizing allocative distortions associated with public policies, including redistributive ones.

Tax Principles

Equity (Fairness)

Equity is in the eye of the beholder. Definitions and concepts of equity are numerous, and attitudes about it diverse. But it is clear that policymakers care about equity. Because equity debates are often emotionally charged and personalized, they provide more political drama than the more arcane notions of allocative efficiency.

Broadly defined, equity relates to the distribution of income and people's ability to buy things, especially necessities, in the marketplace.

In tax policy, there are two competing notions of equity, (1) benefits-received, and (2) ability to pay. The first of these forms the basis of many fees, but also can pay a role in the design of taxes. When benefits are less direct and more difficult to define, the case for more general taxation is strengthened.

In the evaluation of taxes, the ability-to-pay notion of equity takes on two dimensions, (1) horizontal equity, and (2) vertical equity. A tax is said to be horizontally equitable if the tax paid by two or more entities in the same economic circumstances (income, consumption, or wealth, depending on the tax) pay identical tax amounts. The Minnesota Department of Revenue, in its 1992 report entitled Model Revenue System for Minnesota, asserts that horizontal equity is achieved when tax bases are broad; deductions, exclusions and exemptions are minimized; and differential tax rates on essentially similar activities or tax bases are avoided. This particular notion of fairness is related to efficiency because when equals are treated equally, it's more likely that the tax will be economically neutral and hence less likely to disrupt private economic decisions.

Vertical equity looks at the other dimension of fairness--how tax burdens compare across people with different amounts of tax base (usually income). A tax is said to be progressive, regressive, or proportional if the tax burden as a percentage of income rises, falls, or stays constant, respectively, as income rises. Whether taxes should be progressive, regressive, or proportional requires a value judgement. Generally, some amount of tax progressivity is widely accepted, particularly as it relates to the extremes of the income distribution. Regressivity can be a policy outcome, but it's rarely, if ever, a policy goal. It is important to note that while some taxes, like the gas tax and cigarette tax, have flat rates, their "incidence" with respect to income is progressive or regressive depending on how consumption (and hence taxes paid) varies by income class.

The Department of Revenue's *Tax Incidence Study 1999* estimates that the incidence of Minnesota's state and local tax system is barely proportional--the personal income tax largely offsets the regressivity of the property, sales and excise taxes.[26] A 50-state study of tax system

[26] Minnesota Department of Revenue, 1999 Minnesota Tax Incidence Study (Advance Copy), March 1999.

incidence prepared for the Citizens for Tax Justice shows that most other state tax systems are markedly regressive.[27]

Efficiency

The principle of efficiency relates directly to the condition of "economic efficiency" discussed at the beginning of this section. It is important that tax policy not distort private market decisions, unless distortion is an explicit goal (as might be the case with a cigarette tax increase enacted to reduce smoking, for example).

Market distortion can occur when taxes change the price of some products or inputs, relatively more than others, causing private decisions about production and consumption to change. Tax-induced distortion (economic inefficiency) occurs when, for example, an employer elects to self-insure in order to avoid the increasing burden of MCHA assessments and state insurance regulation.

To promote economic efficiency, the Department of Revenue generally recommends broad-based taxes with low rates, as opposed to narrow ones with high rates.

Taxes should also be administratively efficient, meaning they should be designed to minimize the cost of collection. Lower collection costs reduce government spending and taxes. Taxes should be designed to maximize voluntary compliance, and minimize taxpayer compliance costs.

Visibility

The important principle of visibility is often overlooked, particularly in legislative settings. The reasons are clear. Taxpayers rarely complain about hidden taxes. But if taxpayers don't know they're paying taxes they can't provide the important citizen oversight presumed by our founding fathers. Taxpayers need to be able to make informed judgements about the cost of government and how their tax burden will change as a result of personal and policy decisions. This principle is fundamental to the notion of accountability.

Because the principle of visibility is often overlooked, many taxpayers suffer from what can be called a "fiscal illusion." They're convinced that a tax diverted to business, health care providers, or insurance companies, is a tax avoided. In reality, taxes are paid by people, not entities. Through a process of "tax shifting", taxes on businesses or other organizations are eventually paid by people in the form of higher prices, lower wages or lower investment returns.

Hidden taxes mask the true cost of government and facilitate its growth beyond what taxpayers might knowingly support. Economic efficiency, accountability, and the health of democracy are improved when taxes are made more visible.

Simplicity

A good tax is also a simple tax. Taxpayers should know why the tax is being levied, who's responsible for the tax, and how it's calculated and paid. Tax administrators should know the same. Besides reducing administrative and compliance costs, simplicity breeds an increased sense of fairness, better compliance and more accountability.

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[27] *Who Pays? A Distributional Analysis of the Tax Systems in All 50 States*, Citizens for Tax Justice and The Institute on Taxation and Economic Policy, June 1996.

If over exercised, the simplicity principle can produce inequities. Equity and simplicity are two tax principles most in conflict. Blind pursuit of either can lead to too little of the other.

To further the goal of simplicity, the Department of Revenue recommends that tax systems minimize the use of deductions, exclusions, and exemptions. Simplicity is particularly important for taxes in which taxpayers must initially determine their own tax assessment or when they are responsible for recognizing what constitutes a taxable transaction.

Stability and Adequacy

Taxes are assessed to meet public funding needs. As such, they should raise the required amount of revenue. This is usually no problem in the short run, since tax bases can generally be forecasted a short time ahead with sufficient accuracy.

The issues here are long run. The public finance literature generally says the demand for public services rises when incomes rise. Though the cost of income support and human service programs tend to fall in good times, public support for enhancing program benefits and enacting new spending commitments increases when the economy is strong. Consequently, tax collections that grow proportionately with income will more likely provide adequate revenues over time. Tax revenues dedicated to specific programs, like health care or transportation, must likewise grow as program expenditures grow.

The principle favoring stable and adequate taxes is understandable. No one likes disruption. Government employees like to get paid, the state has near contract-like arrangements with local governments and human service and health care providers, and businesses and other taxpayers hate the sudden, unexpected changes in the tax code that often accompany budget crises.

Competitiveness

New information technologies and other advances are reducing the significance of "place" in the conduct of economic activity. No state can afford to ignore this. John Shannon, a veteran public finance practitioner, compares the states to a convoy of ships. When the seas get rough, they stay closer together. In times of rapid change and uncertainty, he advises states not to fall too far behind in providing quality education and important public infrastructure like roads and telecommunications facilities. He also warns states not to get too far ahead of the convoy in assessing new or unusually high tax burdens.

The Department of Revenue's Model Revenue report advises that Minnesota should "make the general tax structure competitive for all types of businesses and their employees, rather than to devise special targeted tax breaks for particular businesses or business expansions."

VI. Evaluating the Health Care Taxes

Who Really Pays Health Care Taxes?

Before evaluating the individual health care taxes, it is important to clarify the distinction between the initial "impact" of a tax on health care or insurance premiums (that is, who collects and remits the tax), and the final "incidence" of the tax.

Incidence

In general, taxes are always "shifted" either backward to suppliers and investors, or forward to consumers. Taxes on health care providers and insurance premiums are taxes on people, not companies. This truth is central to a complete understanding of the impact of health care taxes and to the making of good tax policy.

Though they may differ in their character or their initial impact, the various health care taxes are generally paid by consumers of health care. Provider taxes, whether or not they are itemized, or explicitly passed-through, raise the cost of health care and ultimately raise health insurance premiums. Insurance premium taxes increase premiums more directly.

The Minnesota Council of Health Plans estimates that the various health care taxes discussed in this report result in an aggregate tax on health insurance premiums ranging from about 5.65% on HMOs to over 6% on indemnity insurers. As Table 10 shows, even the tax exempt self-insurers and their employees indirectly pay the equivalent of nearly a 1.8% tax on self-insurance, because the provider taxes and MA surcharges increase the cost of self-insured health care.

Table 10. Minnesota Health Care Taxes as a Percent of Health Plan Premiums, Projected to 2001, Assuming No Change in Current Law*

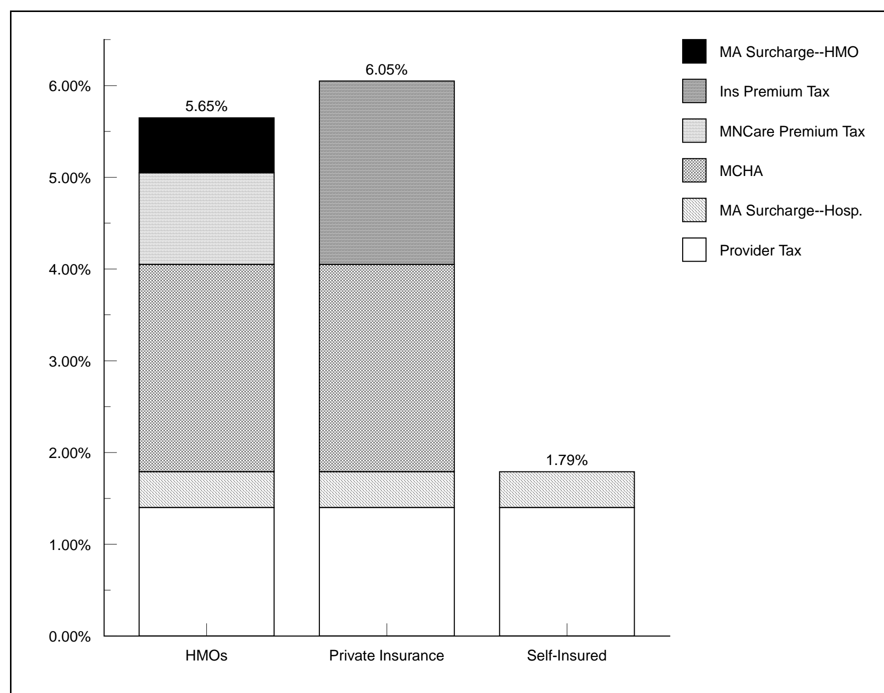
Type of Health Care Tax	Type of Health Plan		
	HMOs	Private Insurance	Self-insured
Provider Tax[28]	1.36%	1.36%	1.36%
MA Hospital Surcharge[28]	0.43%	0.43%	0.43%
MCHA Assessment*	2.26%	2.26%	--
MNCare Premium Tax	1.00%	--	--
Ins. Premium Tax	--	2.00%	--
MA HMO Surcharge	0.60%	--	--
Total	**5.65%**	**6.05%**	**1.79%**

*The MCHA assessment is an MTA projection based on the average annual growth of assessments and premium bases from 1990-2000, provided to MTA by MCHA.
.Source of all other percentages: Minnesota Council of Health Plans.

Figure 3 on the next page is a graphic representation of the data contained in Table 10.

[28] The provider tax rate and Medical Assistance hospital surcharge are shown as 1.4% and 0.39% respectively, instead of their statutory 1.5% and 1.56% rates because not all of a health plan's premiums are spent on provider or hospital services. Using data provided by the Department of Health and its members' data, the Minnesota Council of Health Plans has estimated that 90.45% of HMO premiums are spent on provider services subject to the 1.5% tax (1.5% x 0.9045=1.36%), while only 31% of premiums are spent on hospital services subject to the 1.56% Medical Assistance surcharge (1.56% x 0.9045 x 0.31=0.44%).

Figure 3. Minnesota Health Care Taxes as a Percent of Health Plan Premiums By Type of Health Plan, 2001*



*The MCHA assessment rate for 2001 is an MTA projection. See note on Table 10.
Source of all other rates: Minnesota Council of Health Plans.

This impact of this "piling on" of health care taxes is fairly clear. A 1999 Minnesota Department of Revenue study of tax incidence assumes that MinnesotaCare taxes move downstream to consumers in the form of out-of-pocket medical costs or higher insurance premiums. The higher cost of employer-provided insurance is assumed to be borne by households in reduced wages or reduced fringe benefits or higher prices.

Table 11 below shows their conclusion that the provider tax and insurance premium taxes are regressive in that they fall proportionately more heavily on low-income persons.

Table 11. Distribution of the Tax Burden for the Provider and Insurance Premium Taxes by Population Decile, 1996

Population Decile	Household Income	Provider Tax as a % of Income	Ins. Premium Tax as a % of Income	Both Taxes as a % of Income
1	$6,817 and under	0.40%	0.32%	0.72%
2	6,817 - 11,166	0.27%	0.23%	0.50%
3	11,166 - 15,828	0.23%	0.22%	0.45%
4	15,828 - 21,634	0.23%	0.21%	0.44%
5	21,634 - 27,866	0.23%	0.21%	0.44%
6	27,866 - 35,486	0.21%	0.19%	0.40%
7	35,486 - 45,144	0.20%	0.19%	0.39%
8	45,144 - 57,697	0.19%	0.18%	0.37%
9	57,697 - 78,618	0.17%	0.17%	0.34%
10	78,618 and over	0.08%	0.11%	0.19%
Total	**All**	**0.15%**	**0.16%**	**0.31%**

Source: Unpublished background data from the Minnesota Department of Revenue's *Tax Incidence Study 1999.*

The table shows, for example, that Minnesotans in the first decile of household income, with incomes between $0 and $6,817, paid an estimated 0.72% of their income (indirectly) in provider and insurance premium taxes, while the top income decile paid 0.19% of their income in those taxes.

In summary, there are two important points about the incidence of Minnesota health care taxes:

- Health care taxes are largely shifted to consumers.
- Minnesota health care taxes are regressive, in that the lowest income taxpayers pay two to three times more in health care taxes as a proportion of their income than the highest income taxpayers.

The incidence of health care taxes raises a significant policy question. Did we intend for low-income taxpayers to pay a higher percentage of their income in the form of health care taxes?

Impact

The initial impact of health care taxes, as distinct from their incidence, can have significant unintended consequences. For example, in highly competitive markets, if a tax has an initial impact on only a subset of competitors, they may be disadvantaged in the market, causing them to pass the tax back to investors or employees in an attempt to stay competitive, instead of forward to consumers. In this way, initial impacts can affect tax incidence. If a tax is passed back instead of forward, the pattern of tax incidence will generally change, simply because investors tend to have higher incomes than typical consumers or employees, at least in many markets.

In the following analysis, we note the problems caused by the initial impact of certain health care taxes, particularly as they may affect competitive outcomes or produce unintended consequences, but we accept the Department of Revenue’s assumption that health care taxes are ultimately passed forward to consumers.

Evaluating the Provider Tax

The provider tax is, in reality, a gross earnings tax because it is imposed on the gross receipts of the providers with certain exemptions.

Gross earnings taxes have been used in Minnesota since even before statehood when the Territory of Minnesota granted a charter to the Minnesota and Pacific Railroad Company in 1857 and subjected its gross earnings to a 3% tax in lieu of all other taxes and assessments.[29] The gross earnings tax originated in Minnesota primarily as an alternative to the property tax. Railroads and later telephone and telegraph companies had unique kinds of property that made their valuation under a property tax system problematical. The gross receipts tax was seen as a much simpler way to assess these companies than the property tax. The only industries still subject to a gross earnings tax besides the medical industry are insurance companies and various lawful gambling organizations.

The provider tax did not replace other taxes, except that in theory it was partially to replace the hidden tax of uncompensated health care costs. Part of the purpose of MinnesotaCare was to provide a more efficient and visible way of paying for health care for the uninsured or underinsured. These medical costs were already part of the system in the form of higher insurance premiums and hospital and provider losses. By designing an insurance program for low-income persons, it was hoped that the costs of uncompensated care would be reduced or eliminated. Hence, reductions in uncompensated care costs would offset the provider tax.

It should be noted that non-profit providers are exempt from taxes except for payroll taxes and the provider tax, and that those taxes avoided might have provided additional motivation for enacting a tax on providers.

Is the Provider Tax Fair?--Benefits Received

The benefits-received principle says a good tax is one that taxes according to benefits received from government.

The main purported benefit of the provider tax from state government's perspective is that providers' uncompensated care costs are lowered as a direct result of the programs funded by the original 2% and current 1.5% tax.

Comparable tax and uncompensated care data for measuring whether providers have benefited from the tax in proportion to their tax payments is available only in preliminary form and only for hospitals. According to the interim *Uncompensated Care Report*, cost-based uncompensated care as a percent of total hospital expenses was about 2.06% in 1992 (the year the MinnesotaCare program was enacted), or about $86 million out of $4.2 billion of hospital expenses[30]. That percentage had dropped to 1.7% of expenses in 1996, or $81.2 million out of $4.8 billion in hospital expenses. The following table shows an estimate of what uncompensated care would have been if it had remained constant at the estimated 1992 level of 2.06% of hospital expenses throughout the time period compared to the accumulated amount of provider taxes hospitals have

[29] *Final Report of the Minnesota Tax Study Commission, Findings and Recommendations*, "Gross Earnings Taxation", p. 347., Butterworth Legal Publishers, St. Paul, 1986.
[30] *Uncompensated Health Care in Minnesota, An Interim Report to the Legislature*, Health Economics Program, Minnesota Department of Health, February 1999.

paid. Table 12 shows that hospitals paid about $100 million more in provider taxes than they saved in estimated uncompensated care costs through 1996.

Table 12. Hospital Uncompensated Cost Savings 1993-96

(dollars in thousands)

Year	Estimated Uncompensated Care			Accumulated Uncompensated Care Savings	Accumulated Provider Tax Collected from Hospitals	Net Gain (or Loss) to Hospitals (Uncompensated Care minus Provider Tax)
	Percent of Hospital Expenses*	Amount	At 2.06% of Hospital Expenses (1992 level)			
1993	1.97%	$85,147	$ 88,580	$ 3,433	$ 11,843	$ (8,410)
1994	1.88%	84,710	92,014	10,737	54,545	(43,808)
1995	1.79%	82,937	95,447	23,247	97,085	(73,838)
1996	1.70%	81,300	98,880	40,827	141,527	(100,700)

Source: *Uncompensated Health Care in Minnesota, An Interim Report to the Legislature*, Health Economics Program, Minnesota Department of Health, February, 1999.
*Estimated percentages of uncompensated care for each year are calculated by using the end points discussed in the Uncompensated Care Report of 1987 (2.5%) and 1996 (1.7%) and assuming a uniform decrease over the 9 years. Total hospital expenses are estimated dividing the uncompensated care numbers in the report for 1987 and 1996 by the percentages of uncompensated care then assuming a constant increase over the nine years.

If uncompensated care costs continue to fall as a percentage of hospital expenses as presented in the preliminary report, accumulated savings may perhaps eventually surpass the total provider taxes hospitals will pay. That is unlikely, however, especially if the provider tax reverts back to a 2% rate in 2002. A more complete estimate of savings verses taxes paid will have to wait until the release of the final report. However, in the first four years of the provider tax, it appears that hospitals have paid much more in taxes than they have saved from a decrease in uncompensated care. It is also incorrect to attribute all of the reduction in uncompensated care directly to the MinnesotaCare program, since such costs were already falling before its enactment.

Further complicating the connection between benefits received and taxes paid is that not all providers have experienced a reduction in uncompensated care according to the preliminary report. In 1996, Hennepin County Medical Center (HCMC) and Regions Hospital in St. Paul provided 35% of all hospital-based uncompensated care in the state. Their uncompensated care costs have increased during the 1990s. Additionally, health care providers other than hospitals have also paid the provider tax and have never had the acute problem of uncompensated care that large central city hospitals do. The theory that this tax should be neutral on providers is not valid, either statewide, or especially from one provider to the next.

As for health care providers as a whole, the Uncompensated Care Report notes that "Aggregate uncompensated care of Minnesota's health care providers has stabilized or declined since 1990"[31], but there is no data shown in the report to support that statement. The report states that total uncompensated cost-based care amounted to $165 million in 1996. That same year, the provider tax collections totaled $153.6 million from all sources. No data is available to estimate the accumulated savings in uncompensated care since 1993, the first year of the provider tax.

[31] Op. Cit., page 5.

Is the Provider Tax Fair?--Ability to Pay

Recall that there are two aspects of ability to pay--horizontal equity and vertical equity.

Horizontal Equity

A tax is said to be horizontally equitable if the tax paid by two or more entities in the same economic circumstances (income, consumption, or wealth, depending on the tax) pay identical tax amounts. A gross earnings tax is generally considered to be horizontally equitable in terms of its initial impact because as a flat percentage on gross earnings, the only variable is the level of earnings. All earnings are taxed at the same rate, therefore those with similar earnings will pay a similar tax.

The provider tax, however, has special exemptions from the tax base (gross earnings) which affect horizontal equity. Because receipts from Medicare and Medicaid are excluded from the provider tax base, providers with a large portion of their earnings from such sources will pay a smaller amount of tax than providers with very little government reimbursed costs. Two providers with such a variance in base, even though nearly identical in terms of the amount of gross receipts, will pay different tax amounts. The tax advantage for providers with proportionately more Medicare or Medicaid patients is partially offset by the fact that reimbursements for those two programs never fully compensate providers for their costs--a point further discussed under allocative efficiency on the next page. This offset, however, does not negate the fact of horizontal inequity.

There are additional horizontal equity issues unique to the wholesale drug distributor tax. See that section for a discussion of those issues.

Vertical Equity

Vertical equity looks at the other dimension of fairness--how tax burdens compare across people with different amounts of tax base (usually income), and because of its focus, is usually considered in terms of a tax's final incidence. As the Department of Revenue's *Tax Incidence Study 1999* shows, the provider tax is regressive. Table 13 below shows that MinnesotaCare taxes are regressive in that they fall proportionately more heavily on low-income persons. Taxpayers in the lowest income decile paid an estimated 0.40% of their income (indirectly) in provider taxes, while the top income decile paid 0.08% of their income in provider taxes. Since vertical equity at the very least presumes that higher income taxpayers should pay no less a proportion of income than lower income taxpayers, the provider tax is not vertically equitable.

Table 13. Distribution of the Tax Burden for the Provider Tax, 1996

Population Decile	Household Income	Percent of Total Tax Paid	Taxes as a Percent of Income
1	$6,817 and under	2.6%	0.40%
2	6,817 - 11,166	3.7%	0.27%
3	11,166 - 15,828	4.7%	0.23%
4	15,828 - 21,634	6.6%	0.23%
5	21,634 - 27,866	8.6%	0.23%
6	27,866 - 35,486	9.9%	0.21%
7	35,486 - 45,144	12.5%	0.20%
8	45,144 - 57,697	14.9%	0.19%
9	57,697 - 78,618	17.4%	0.17%
10	78,618 and over	18.9%	0.08%
Total	All	100.0%	0.15%

Source: Unpublished background data from the Minnesota Department of Revenue's *Tax Incidence Study 1999.*

Fairness Conclusion

- According to the latest preliminary estimates, from 1992 to 1996, providers paid roughly $100 million more in provider taxes than they saved in uncompensated care costs. This means that the provider tax has so far failed the benefits-received principle, at least for hospitals and likely for most other providers given their lower rates of uncompensated care.

- The provider tax is not horizontally equitable, because of Medicare, Medicaid, and other exemptions. These exemptions mean that providers with equal revenues may not pay equal taxes.

- The provider tax is not vertically equitable. It falls more heavily on lower-income taxpayers than on those with higher incomes and therefore is regressive. Lower-income taxpayers pay as much as five times more in provider taxes as a percentage of their income than taxpayers with the highest income.

Is the Provider Tax Efficient?

Allocative Efficiency

The principle of efficiency is often presented in two parts--allocative efficiency and administrative efficiency. Considering allocative efficiency first, to what extent does the provider tax distort private market decisions? The intent of the framers of the MinnesotaCare program was that taxes should be sufficiently broad for rates to be low, helping to insure that the cost of the tax could easily be absorbed by lowering costs that the subsidized insurance program is supposed to accomplish. Considering that spending in Minnesota for health care programs total approximately $18 billion, and that all MinnesotaCare taxes combined raised only about $171 million in the peak year of Fiscal Year 1997, or less than 1% of expenditures, these taxes are not likely to be very distorting, particularly since they apply to almost all medical providers.

Because receipts from government are not included in the provider tax base, there is some incentive to accept patients funded by government. Reimbursement rates for such care are low enough, however, to offset any tax avoidance incentive.

Though there is no data to quantify this affect, it is possible that the provider tax is affecting the state's ability to attract qualified physicians. Considering the few number of states that have provider taxes, physicians could decide to locate in a state where there is no provider tax to deal with. This would affect those considering a rural location especially, since small physician groups or sole practitioners are more negatively impacted by the cost of the tax and its administrative burden than staff physicians of large health care providers.

Administrative Efficiency

Administrative efficiency is important, too. Taxes should be designed to maximize voluntary compliance, minimize taxpayer compliance costs, and minimize administrative costs of collecting taxes. The Department of Revenue indicates that MinnesotaCare taxes are "one of the easiest and most efficient taxes to administer, costing around 80 cents for every $100 collected."[32]

Providers paying the tax tell a different story, however. Quarterly tax returns are required to be filed by those providing medical services subject to the tax. The task of distinguishing services subject to the tax from those exempt adds a degree of administrative complexity.

Consider several examples of complicating factors. Is utilization review provided by a third party a covered medical service or not? If a physician receives a payment for a second opinion, has the tax already been paid as part of the receipts from providing the first opinion? In the pharmaceutical industry, wholesale drug distributors are required to pay the tax. They pass this tax along to retail pharmacies. Drugs sold to providers outside Minnesota are not subject to the tax. Pharmacies must therefore keep track of whether the tax has been paid or not at the wholesale level. If the drug is purchased from a distributor outside of Minnesota, a use tax must be paid.

Complaints by providers are numerous regarding their difficulty in administering and complying with the provider tax. Compared to a tax like the corporate income or sales tax, however, the provider tax is relatively simple to administer.

Efficiency Conclusion

- The provider tax is generally allocatively efficient, with the possible exception of discouraging providers from locating in Minnesota.

- The provider tax has no significant administrative efficiency problems compared to all other taxes for most providers, but for providers which also pay the Medical Assistance surcharges (hospitals, HMOs, and nursing homes), the tax is administratively complex, due to tax bases and rates which are different from the surcharges.

Is the Provider Tax Visible?

Taxpayers need to be able to make informed judgements about the cost of government and how their tax burden will be changed as a result of their decisions. The principle of visibility is most fundamental to this notion of accountability. The provider tax fails when evaluated against the tax policy principle of visibility.

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[32] Governor's letter to a constituent, signed by Revenue Commissioner Matt Smith and dated April 30, 1999.

The original Health Right Act included a provision prohibiting hospitals and health care providers from separately stating the provider tax obligation on individual patient bills. This prohibition was removed in subsequent legislation, but even with its removal, the experience of health care providers varies substantially from one type of provider to another as to whether or not they are able to itemize the bill to make it visible to the taxpayer.

Generally, the "retail-level" provider whose fees are not primarily reimbursed by third party payers has been able to show the tax as a separate part of the bill to make it very visible to the consumer of medical care services. The group that has most successfully and consistently shown the tax on patients' bills is dentists. Pharmacists are able to itemize it, but most choose not to in order to avoid any customer alienation.

Providers whose revenues come mostly through third party reimbursement are in many cases not able to itemize the tax. Third party payers are required to pay the passed through costs of the provider tax when they are included in payment rates, but in some cases, claims are rejected when the tax is listed separately.

The payers might reject the claim, or the tax portion of it, because the tax isn't considered to be a legitimate reimbursable expense, or because the reimbursement rates were negotiated in advance under the assumption that the tax was included in the negotiated fee. (There are some instances of out-of-state third party payers subtracting 1.5% from the bill even without an itemization of the tax for the same two reasons.)

These and other billing complications arising from attempts to itemize the tax separately reinforce the bias of the original legislation to keep the tax invisible as part of health care costs.

Of the $131 million in provider tax collected in 1998, it is safe to assume that the overwhelming majority of the tax paid for inpatient hospital and physician-provided services, as well as for prescription drugs, is invisible to the patient. These three groups subject to the tax accounted for nearly three-fourths of the tax paid that year.

Providers who negotiate fee schedules with third party payers or self-insured employers generally include the tax in the schedules. If they did not, self-insured companies especially would likely not pay the tax, because they are protected from state taxes by ERISA. Including the tax in the fee schedules decreases its visibility from third-party payers and self-insured employers.

One additional factor that mitigates against the visibility principle is the fact that it is a gross earnings tax. All receipts except those specifically exempted are counted in the base, including receipts of the tax that are itemized and paid directly by consumers of medical services. For example, if a visit to a dentist costs a patient $100 and the dentist lists the $1.50 provider tax as a separate item on the bill, the dentist then must pay 1.5% of the entire bill to the Department of Revenue. The dentist will have to remit 1.5% of $101.50, or $1.52, rather than the $1.50 the patient paid.

If the goal of the legislature was to bury the tax in the system of providing health care services, it has been largely successful. In terms of the tax principle of visibility and accountability, though, the provider tax is a general failure.

Visibility Conclusion

- The provider tax fails the tax principle of visibility because it is not at all visible for most health care services. It is generally not itemized in fees or in insurance reimbursement schedules, leaving many Minnesotans in the dark even as to its existence.

Is the Provider Tax Simple?

The simplicity principle has already been touched on with respect to the principle of administrative efficiency above. The fact is that for the Minnesota Department of Revenue and consumers of medical services, the tax is very simple. Most consumers probably do not know that it exists.

Again, as we have previously said, providers have a different view of the tax. A fair summary of their view would be that it is nearly impossible to pay the exact amount of tax owed. The cost in administration to ensure they are not overpaying the tax would be prohibitive for the providers. Since the rate is only 1.5%, most providers decide to pay overstated amounts rather than spend the money to make sure all allowable deductions are made from the base. Nevertheless, the provider tax is relatively simple compared to other taxes.

Simplicity Conclusion

- The provider tax is relatively simple.

Is the Provider Tax Stable and Adequate?

Taxes are assessed to meet public funding needs. Does the provider tax provide enough revenue growth to match the MinnesotaCare funding needs it supports?

As of this writing, forecasted revenues for the current FY2000 from the provider tax alone are approximately $138 million, with another $28 million expected from premiums paid by enrollees, for a total of $166 million. Spending on the MinnesotaCare program (direct appropriations plus enrollee premiums) is expected to be $147.3 million. The combined receipts and spending just on the MinnesotaCare program are shown for four fiscal years in Table 14.

Table 14. Receipts vs. Expenditures, MinnesotaCare Program and HCAF Totals

(in millions)

MinnesotaCare Program	FY2000	FY2001	FY2002	FY2003	Totals
Receipts:					
Provider tax	$138.0	$140.7	$161.2	$199.8	$639.7
Enrollee premiums	27.8	32.0	35.0	37.5	132.3
Total	$165.8	$172.7	$196.2	$237.3	$772.0
Expenditures	$147.3	$189.5	$218.0	$246.1	$800.9
Surplus/(Deficit)	+18.5	($16.8)	($21.8)	($8.8)	($28.9)

Additional HCAF Information	FY2000	FY2001	FY2002	FY2003
Other receipts:				
Balance forward	$274.0	$252.8	$208.4	$188.7
HMO gross premiums tax	0.0	16.2	31.0	32.4
Investment income	14.2	12.9	10.8	9.8
Federal match--admin. costs	3.1	2.9	2.9	2.9
Other income	0.8	0.6	0.6	0.6
Refunds	(10.8)	(10.8)	(10.8)	(14.4)
Total Resources Available	**$447.1**	**$447.2**	**$439.1**	**$457.2**
Non-MinnesotaCare Program Uses	$ 47.0	$ 49.3	$ 32.4	$ 33.3
Total Uses	**$194.3**	**$238.8**	**$250.4**	**$279.4**
Total Resources minus Total Uses	**$ 252.8**	**$ 208.4**	**$ 188.7**	**$ 177.7**
Federal Contingency Reserve	$ 126.6	$ 119.0	$ 150.0	$ 150.0

Source: Minnesota Department of Finance, November 1999 forecast. Items may not add to totals due to rounding.

With four-year revenues within 3.6% ($28.9 million in this case) of expected program spending, the MinnesotaCare program might be considered slightly underfunded. However, the second part of the table shows the long-term solvency of the program. Other revenue sources available to the Health Care Access Fund besides the provider tax, including the 1% premium tax on HMOs scheduled to blink on January 1, 2001, have already resulted in the accumulation of significant long-term surpluses.

When total uses of revenue from the fund are subtracted from total resources available to the fund, a surplus totaling nearly $178 million is projected for the end of FY2003. The Federal Contingency Reserve was enacted in anticipation of potential shortfalls from federal welfare reform a few years ago. These shortfalls have not occurred, and contribute to the total surplus.

Accumulation of such surpluses invites additional spending not necessarily related to the MinnesotaCare program. For FY2000, spending totaling $47 million is forecast for categories not directly under the heading of the MinnesotaCare program. Some of the spending has been associated with the program since its enactment (such as the Health Care Economics program and rural hospital grants), but there have also been several years of transfer payments to programs such as the Pregnant Women and Children program under Medical Assistance.

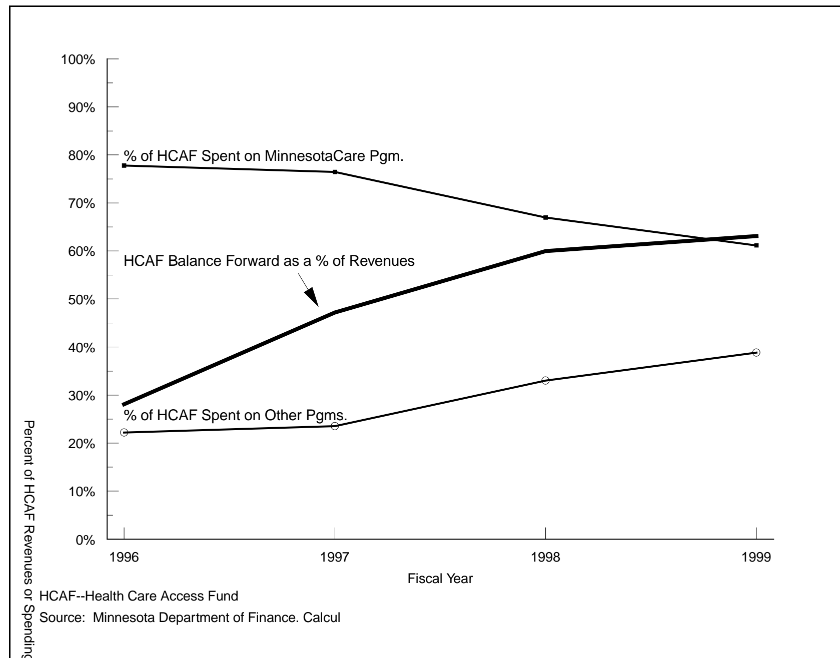
The point is not that these additional spending items are useless or wasteful, but that they were added to the HCAF later and were not necessarily a part of the original program. The MinnesotaCare program was enacted partly to lower the cost to providers by reducing uncompensated care. To the extent that other programs not part of the original legislation are being funded from the HCAF simply because there is a surplus of revenue, that line of reasoning is weakened, and the accountability of the program is reduced.

Figure 4 below shows spending patterns from the HCAF for the period from FY1996 through FY1999. The heavy line shows balances forward as a percent of total revenues available to the

HCAF. The other two lines show MinnesotaCare program and other spending as percents of total uses. What is clear at a glance is that as balances forward increase, non-MinnesotaCare spending as a percent of total uses of the HCAF also increase. When the balances forward fall, so does non-MinnesotaCare spending.

As long as there are significant surpluses in the HCAF, the temptation to find ways to spend the money will be strong.

Figure 4. Relationship of HCAF Spending Patterns to HCAF Balance Forward



Adequacy and Stability Conclusion

- The provider tax is stable, raising more revenue as health care expenses rise.
- The provider tax raises more money than needed for the programs it supports.

Is the Provider Tax Competitive?

Competition in the medical industry is more commonly based on reputation for excellence in providing medical care rather than on price. In some sense, this is unfortunate. Consumers of medical services have been largely left out of any price consciousness due in substantial part to the exclusion from taxable income of employer-paid health insurance premiums. Even the employee-paid portion of premiums in many cases is now paid by the employee in pre-tax dollars. Too often, the perception of the consumer of medical services is that the cost of the services is free or very low to them because the bills are paid by a third party.

Employer buyer groups have been forming in Minnesota within the 1990s. These buyer groups are bringing a sense of competitive pricing to health care providers, in that they are able to

negotiate with providers for the best package of insurance benefits for their employees. Self-insured businesses are also on the increase, and bring a measure of competition to the medical industry as well.

Because providers are competing for contracts with buyer groups and self-insured companies, they have to be price conscious, but most of the competition is with providers who pay the provider tax. Only providers that serve patients from outside Minnesota, such as Mayo Clinic (which estimates up to 60% of its provider tax is due to revenues received from treating out-of-state patients), are competing with providers who may or may not pay a similar kind of tax in another state. In those cases, it is still the reputation of the provider that overwhelms cost as a factor in whether a particular hospital or clinic is chosen for service.

Because most competition for patients occurs among providers that pay the tax, and because providers who do "compete" for patients outside Minnesota do so primarily on the basis of medical reputation, the provider tax is probably not a serious factor in Minnesota health care providers' ability to compete. This is especially true for large providers not near Minnesota's borders. The low rate of tax is also a mitigating factor in evaluating the competitiveness of the tax.

However, for providers close to Minnesota's border (such as in Moorhead, Duluth, Worthington, etc.) the combination of the 1.5% provider tax and the 1.56% health care surcharge can encourage expansion of clinics and hospitals across state borders, especially when there are significant border cities quite near Minnesota cities, such as in Moorhead and Duluth.

Tables in Appendix 2 show the status of health care taxes in the states as an indication of how Minnesota's provider taxes compare with the rest of the states. It should be noted that about half of the states with provider taxes enacted them in order to qualify for additional federal matching money. Only those states in Appendix Table 1 appear to have a general provider tax for a separate health care program.

Competitiveness Conclusion

- Because competition in the medical industry is based primarily on reputation and not price, the provider tax *generally* does not negatively effect the competitiveness of Minnesota's providers.

- There are competitive issues with providers near other states' borders, especially when the medical assistance surcharges are considered, too.

Evaluating the Wholesale Drug Distributor Tax

The portion of the provider tax which falls on wholesale drug distributors is a tax on a type of business that bears little resemblance to other parts of the health care industry. Because of this uniqueness, the provider tax affects these distributors differently than health care providers in general. This section evaluates the provider tax on two tax policy principles which have different implications for the wholesale drug industry compared to other health care providers.

As mentioned elsewhere in this analysis, when the original MinnesotaCare legislation was enacted in 1992, one of the primary purposes for its enactment was "to limit the growth of health care expenditures, reform insurance practices, and finance a plan that offers access to affordable health care for our permanent residents by capturing dollars now lost to inefficiencies in Minnesota's health care system."[33] There was a consensus among those knowledgeable that there were enough dollars in the health care system to finance reform and rearrange delivery and payment of health care services to put downward pressure on costs.

The tax on wholesale drug distributors was included as part of the financing package evidently to raise the additional revenue from that health care sector and to bring prescription drugs under the same cost containment strategy that would be applied to the rest of the industry. It is possible that there was not a great deal of specific thought given to potential consequences of the provider tax to the wholesale drug industry other than a desire to include them as part of the health care system. However, by including the wholesale drug distributors as providers subject to the tax, the tax policy principles of benefits received and competitiveness become especially relevant to evaluate as applied to the distributors.

Is the Wholesale Drug Distributor Tax Fair?

Horizontal Equity

Prescription drugs can be ordered from any wholesaler around the world. Minnesota has about ten distributors, but there are a number of other out-of-state distributors competing for business in the state. All pharmacies purchasing prescription drugs from out-of-state wholesalers are required to pay a use tax of 1.5% of the purchase price so that the tax is not avoided. Enforcement of this requirement was very weak during the first months and years after the tax was enacted. The Revenue Department still has no actual authority to require out-of-state wholesalers to pay the tax. In order for there to be horizontal equity, every supplier of prescription drugs to Minnesota should be equally subject to the tax, and that is not the case to date.

Another example of horizontal inequity is regarding a wholesale drug distributor which has the contract for distributing prescription drugs to the federal hospital system (VA and Indian tribes). Such a wholesaler is not allowed to pass the tax to the federal government because states cannot tax the federal government. The tax was initially passed in the middle of a contract period in which previously negotiated prices were already in effect. The 2% provider tax in effect at the time had to be absorbed by that company. Wholesale drug distributors are not part of the health care provider network in delivering health care services, and therefore do not benefit from initiatives of the MinnesotaCare program and other cost containment strategies.

[33] Laws of Minnesota for 1992, Chapter 549, Article 1, Section 1 [62J.014].

Fairness Conclusion
(similar to the provider tax above, but with these additional considerations)

- The wholesale drug distributor tax is not equitable under the benefits-received principle because it does not provide, nor evidently was ever intended to provide, benefits either to consumers or distributors in proportion to the revenue it raises.

- The wholesale drug distributor tax is not horizontally equitable due to the unequal enforcement of the use tax on out-of-state wholesalers, and wholesalers with federal contracts.

Is the Wholesale Drug Distributor Tax Competitive?

It is with regard to competitiveness that the most glaring weakness of this tax is revealed. According to industry representatives, margins in the wholesale drug distribution business are under 2%. The most recent average for the nation as a whole was 1.28%. When the 1.5% provider tax is added to the cost of prescription drugs to be purchased from Minnesota, Minnesota wholesalers' visible price to pharmacies is 1.5% higher than for out-of-state suppliers. As stated above, purchasers of drugs from out-of-state wholesalers are supposed to pay a use tax of 1.5% of the price, but this use tax is not in the out-of-state prices, and is not easily enforced.

Competitive Conclusion

- The wholesale drug distributor tax puts Minnesota wholesalers at a competitive disadvantage.

Evaluating the Medical Assistance Surcharges

Even though medical assistance surcharges were enacted before the provider tax and for a different purpose, there is nothing so unique about them that they need to be *generally* discussed apart from the provider tax. Because they are similar, all of the comments in the section above on evaluating the provider tax (for the hospital and nursing home surcharges), or below on evaluating the insurance taxes (for the HMO surcharge) apply to the surcharges as well, and in some cases, the surcharges are mentioned specifically in that section (see under "Competitiveness" for example).

However, their separate enactment and the federal changes that have altered that purpose require that the surcharges be considered separately regarding some of the tax policy principles listed below. (Note: the 0.6% HMO premium tax is part of the medical assistance surcharges but will be discussed under the insurance gross premiums tax discussion below.)

Are the Medical Assistance Surcharges Fair?

Benefits Received

Federal rule changes actually prohibited providers paying the surcharges from receiving the benefits of the tax as direct payment for the tax. Since the surcharges were initially "sold" to providers on the basis of additional federal funds and state payments which would hold the providers harmless, the surcharge clearly violates the "benefits-received" principal.

Fairness Conclusion
(similar to the provider tax above, but with this additional consideration)

- Medical assistance surcharges are inequitable under the benefits-received principle, even though they were enacted under the premise of equitable benefits. Federal regulations now prohibit providers from receiving benefits in proportion to the tax.

Are the Medical Assistance Surcharges Efficient?

Administrative Efficiency

The medical assistance surcharges were enacted prior to the any other health care tax. One year after they had been in effect, the provider tax was enacted. Since the hospital portion of both the surcharge and provider tax are a simple percentage of certain receipts, it would seem that the surcharges would not be unusually inefficient from an administrative and compliance point of view. However, a complicating factor in the surcharges is that the definition of "net patient revenues" is different from that of the provider tax

The base is different primarily in three ways. First, the surcharge base is for receipts one year prior to that for the provider tax. Also, the surcharge base excludes only receipts for Medicare patients, while the provider tax excludes receipts from both Medicare and Medicaid. The rate for the surcharge for hospitals is 1.56% while the provider tax rate is 1.5%. The layering of these two similar taxes, enacted for two entirely different purposes, with different tax bases and rates, adds to the administrative complexity of both taxes.

Efficiency Conclusion

- Medical assistance surcharges had no significant administrative efficiency problems compared to all other taxes before the enactment of the provider tax, but are now administratively complex due to tax bases and rates which are different from the provider tax.

Are the Medical Assistance Surcharges Competitive?

When added to the provider tax, hospitals (besides HCMC and Fairview-University) are paying 3.06% of their patient revenues in provider taxes and surcharges. HCMC and Fairview-University are paying 4.86% plus $1.5 million and $0.5 million per month respectively (primarily to receive matching federal funds using the mechanism of disproportionate share applied to Medicaid patient payments). For hospitals close to the Minnesota border, these taxes represent significant additional costs to their operations that hospitals across the state's borders do not have to pay. (None of Minnesota's bordering states has any provider taxes or surcharges. See Appendix 2, Tables 1 and 2.)

Competitive Conclusion
(similar to the provider tax above, but with this additional consideration)

- Medical assistance surcharges raise competitive issues when combined with the provider tax, especially in border communities.

Evaluating the Health Insurance Premium Taxes and MCHA Assessments

Since the health insurance market is affected by all types of premiums taxes, the 2% gross premiums tax on private indemnity insurers, the 1% tax on HMOs and other non-profit carriers, the 0.6% MA surcharge on HMOs and CISNs, and the MCHA assessments, will all be evaluated together in this section.

We assume that health insurance premium taxes and MCHA assessments are shifted forward to consumers. Insurance rate regulation makes this is a plausible assumption. For plans purchased directly by individuals, the effect is direct and obvious. For employer-sponsored plans, higher insurance premiums are passed on to employees in the form of higher payroll deductions for the employees' share of the higher premiums, lower wages, or reduced benefits, including health benefits. Employers may also pass on the some of the premium taxes to their customers in the form of higher prices.

Are Insurance Premium Taxes and MCHA Assessments Fair?

Horizontal Equity

Health insurance premium taxes are horizontally inequitable. Insurance companies with the same premiums base pay different gross premiums tax amounts.

The biggest disparity in tax liability is found between the indemnity carriers and the self-insured. Table 15 shows that indemnity carriers pay the long-standing 2% gross premiums tax plus the MCHA assessment, estimated to be 2.1% in calendar year 2000, for a total premiums tax of 4.1%. This is expected to jump to 4.43% in 2002 with no law changes. Self-insurers, on the other hand, pay no taxes on the insurance they provide to their employees since they are protected from state taxation by ERISA.[34]

Table 15. Statutory Tax Rates on Health Plans, Years 2000-2002

Type of Company	Gross Premiums Rate	MCHA Assessment Rate*	Medical Assistance Surcharges	Total Rate
Private indemnity insurers				
2000	2%	2.10%	0%	4.10%
2001	2%	2.26%	0%	4.26%
2002	2%	2.43%	0%	4.43%
HMOs and other non-profits				
2000	0%	2.10%	0.6%	2.70%
2001	1%	2.26%	0.6%	3.86%
2002	1%	2.43%	0.6%	4.03%
Self-insurers				
2000	0%	0%	0%	0.0%
2001	0%	0%	0%	0.0%
2002	0%	0%	0%	0.0%

*The MCHA assessment rates for 2001 and 2002 are MTA projections based on the average annual growth of assessments and premium bases from 1990-2000, provided to MTA by MCHA.

[34] In calendar year 2001, when all health care taxes, including provider taxes and surcharges, are considered, the total premiums burden is estimated to be 5.65%, 6.05%, and 1.79% for HMOs and other non-profits, private indemnity insurers, and self-insured companies, respectively, assuming the HMO 1% premium tax blinks back on January 1, 2001. See Figure 3 on page 24.

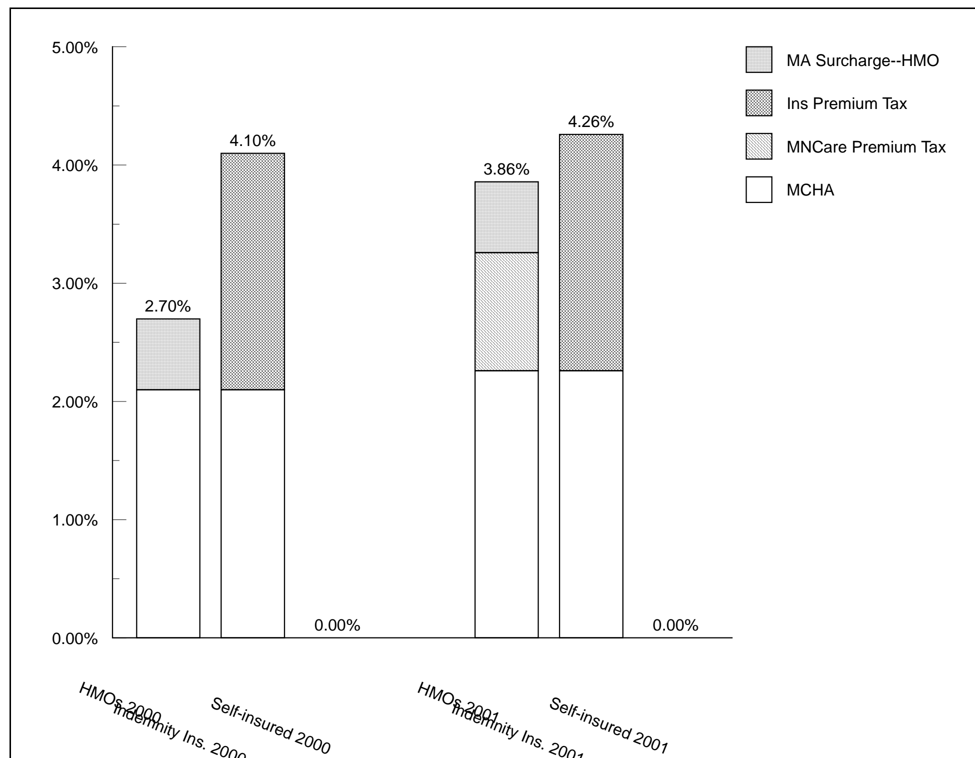
In actual dollars, this 4.1% disparity is as large as $4.5 million in tax liability for the biggest indemnity carrier (Medica Insurance Company).

Percentage wise, the insurance tax disparity between HMOs and self-insurers is slightly smaller. In 2000, HMOs and other non-profit carriers will pay insurance premium taxes, MCHA assessments, and MA surcharge taxes totaling 2.7%, 1.4% less than indemnity carriers. In 2001 when the 1% premiums tax on HMOs is expected to be reintroduced, this disparity will fall to 0.4%.

The actual dollar tax disparity relative to self-insurers can be quite large. The state's largest two non-profit carriers, Medica HMO and HealthPartners, Inc., each pay about $25 million in insurance premium taxes, MCHA assessments, and MA surcharges.

Combining all health insurance premium taxes, including HMO taxes and surcharges and MCHA assessments, total insurance tax rates for HMOs and other non-profits will be 2.7% and 3.86% for calendar years 2000 and 2001 respectively. Private indemnity insurers will pay 4.1% and 4.26% for those years. Self-insurers pay no insurance premium taxes. Figure 5 illustrates these differences.

Figure 5. Minnesota Health Care Taxes as a Percent of Health Plan Premiums By Type of Health Plan, 2000-01*



*See Table 15 on page 40 for sources and method of projection of MCHA assessment rate.

These horizontal tax inequities in the insurance market create a strong incentive for companies to self-insure. By self-insuring, companies, and groups of companies, escape certain state insurance regulations and avoid increasing MCHA assessments. As more firms self-insure, rising MCHA deficits are assessed on a shrinking insured market premiums base, thus causing the MCHA

assessment to rise, further increasing the incentive to self-insure. These higher MCHA assessments are increasingly borne by small businesses, the self-employed, and individual policyholders, because the self-insured, which are not subject to MCHA assessments, tend to be larger companies.

As to the disparity between indemnity insurers and HMOs, the 1.4% difference in 2000 and 0.4% in 2001 may be partly offset by the fact that in order to sell coverage to employees of the State of Minnesota, HMOs must serve clients of government health care programs for which reimbursement rates are often below actual cost.[35] It is worth noting, however, that rapidly changing health care alliances and new health care products make it increasingly difficult to justify separate policy treatment for HMOs and for-profit carriers. Health plan products that are essentially the same pay different rates of tax depending on the type of license, and therefore tax status the insurance carrier has.

The enactment of ERISA encouraged the growth of self-funded employer-provided plans. Self-insurers now provide health insurance coverage for about 30% of the Minnesota population, including government programs. So the premiums taxes, MCHA assessments, and MA surcharges on premiums fall on only about 38% of the state's population.

Vertical Equity

According to the Department of Revenue's *Tax Incidence Study 1999*, insurance premium taxes fall more heavily on lower income Minnesotans than on Minnesotans with higher incomes. The estimated incidence of insurance premium taxes is shown in Table 16 below. It shows the incidence of all insurance premium taxes and not just those on health insurance premiums, but the incidence is not likely to be significantly different for that subset of premiums.

Table 16. Distribution of the Tax Burden for Total Insurance Premium Taxes, 1996

Population Decile	Household Income	Percent of Total Tax Paid	Tax as a Percent of Income
1	$6,817 and under	2.0%	0.32%
2	6,817 - 11,166	3.1%	0.23%
3	11,166 - 15,828	4.4%	0.22%
4	15,828 - 21,634	5.9%	0.21%
5	21,634 - 27,866	7.7%	0.21%
6	27,866 - 35,486	9.0%	0.19%
7	35,486 - 45,144	11.3%	0.19%
8	45,144 - 57,697	13.8%	0.18%
9	57,697 - 78,618	16.9%	0.17%
10	78,618 and over	25.9%	0.11%
Totals	**All**	**100.0%**	**0.16%**

Source: Background data from the Minnesota Department of Revenue *Tax Incidence Study 1999*.

This means that relative to their incomes, lower income Minnesotans pay a disproportionate share of insurance premiums and MCHA assessments. The table above shows that taxpayers in the lowest income decile paid an estimated 0.32% of their income (indirectly) in insurance premium taxes, while the top income decile paid 0.11% of their income in those taxes. Since vertical equity

[35] A conclusion on this requires further research. There are other differences between indemnity carriers and HMOs that would need to be assessed in determining the extent to which the tax disparities are effectively offset.

at the very least presumes that lower income taxpayers should pay no more as a portion of their income than higher income taxpayers, the insurance gross premium tax is not vertically equitable.

Fairness Conclusions

- The insurance premium taxes and MCHA assessments are not horizontally equitable. Health plans with the same amount of tax base pay different amounts of premium tax. The horizontal tax disparities are most extreme between indemnity carriers, who currently pay a total of 4.1% in insurance premium taxes and MCHA assessments, and self-insurers, who pay no premium taxes.

- Because larger employers tend to self-insure, the initial impact of health insurance premium taxes and MCHA assessments tends to fall increasingly on small employers, the self-employed, and individual policyholders.

- Premium taxes are not vertically equitable. All premium taxes are paid by consumers. According to the Minnesota Department of Revenue, the insurance gross premium tax is regressive in that it falls most heavily on lower income families. MCHA assessments, the 1% HMO premium tax, and the 0.6% MA surcharge on HMO premiums are also assumed to be regressive.

Are the Insurance Taxes Efficient?

The rationale of taxing the insurance industry in order to make insurance more affordable to consumers is self-defeating because, in the end, it's the insured who wind up paying the taxes. Taxes increase costs and reduce supply, or in this case, insurance coverage.

If taxes are levied uniformly across the entire health insurance industry, market distortions might be avoided. But current premium taxes and MCHA assessments are not uniform.

All else constant, higher insurance premium taxes and MCHA assessments on traditional indemnity insurance companies, HMOs, and other health plans reduce the demand for such coverage, and increase the demand for self-insurance coverage and even government programs.

The market distortions are obvious, and some are deliberate. State policy has deliberately created a small tax bias in favor of HMOs and other non-profit carriers, and federal policy, through ERISA, has created a significant bias in favor of self-insurers. In theory, the provider tax was designed to "get around" the ERISA prohibition against taxing self-insurers, effectively levying a tax on self-insurers by raising the cost of medical services to the insured. But the provider taxes merely ratchet up all insurance premiums, leaving the tax rate disparities unaffected. As noted earlier, it has been estimated that the provider tax and surcharges result in a uniform 1.79% premiums tax on all insurers, including self-insurers. (See Figure 3 on page 24.)

Efficiency Conclusion

- Current health insurance premium taxes and MCHA assessments create market distortions, and are therefore not efficient. The distortions are most severe between indemnity insurers and self-insurers.

Are the Insurance Taxes Visible?

Like many business taxes, the premiums taxes and MCHA assessments are hidden taxes. Few fully insured consumers are aware that they are paying 4.1% more in insurance premiums in calendar year 2000 to finance public expenditures.[36]

While many of the health care initiatives and insurance reforms have a strong public purpose, financing them with hidden insurance premium taxes and MCHA assessments disguises the public subsidy and desensitizes the public to the actual cost of the programs. Hidden taxes only make sense when viewed from a political perspective. They allow officials to raise revenue without the public debate that normally attends attempts to increase taxes.

In general, the only justification for indirect taxes (taxes on businesses) is to recover the value of government benefits provided to business, or to achieve a certain tax incidence that cannot be attained through other means.

Visibility Conclusion

- Health insurance taxes are not at all visible to employers and other purchasers. They are not itemized in premiums, and thus like the provider tax, leave many Minnesotans in the dark even as to their existence.

Are the Insurance Taxes Simple?

The 2% insurance gross premiums tax is fairly straightforward. It does not seem to be fraught with complexity, at least in relation to other taxes.

The administration of MCHA is delegated to a "writing carrier" selected from among the MCHA members through a bidding process. The writing carrier performs all the administrative functions of a typical insurance company. Current law allows up to 15% of MCHA premiums revenues to be used to pay the carrier's expense. Today, MCHA pays 8.5% of premium revenues to Blue Cross Blue Shield of Minnesota, the current writing carrier.

Simplicity Conclusion

- There are no unusual administrative or taxpayer complexities associated with current insurance premium taxes or MCHA assessments.

Are the Insurance Taxes Stable and Adequate?

From the tax collector's point of view, revenues from the 2% gross premium tax on indemnity carriers, the 1% premium tax on HMOs and non-profits, and the 0.6% surcharge on HMO premiums are fairly stable and predictable. Taxable health insurance premiums generally track changes in medical costs, which rise over time.

[36] Higher general fund spending in the case of the 2% gross premiums tax; public health care initiatives in the case of the 1% premiums tax on HMOs and other non-profit carriers; and subsidized insurance for those who can't or won't buy it in the case of MCHA assessments. When all health care taxes are considered, including the provider taxes and surcharges, indemnity insurance premiums are over 6% higher than they would otherwise be.

This stability has characterized the premium taxes in the past when the premium base was rising from year to year. Even now, when the premium base is being eroded due to incentives toward self-insuring (in which case health plan payments are not subject to the premium taxes or MCHA assessments), the erosion is gradual enough that the revenue derived from the taxes is still predictable and stable.

Adequacy is more difficult to assess. The Department of Revenue estimates that the 2% gross premium tax contributes $23 million in non-dedicated tax revenue each year to the state's general fund. This is 0.2% of total state non-dedicated revenue. Because collections are not dedicated to specific spending programs, the adequacy of revenues from this tax can only be assessed relative to other state general fund revenues. The general fund as a whole, however, has enjoyed significant budget surpluses for the past seven years.

The total premium base of indemnity carriers has been declining consistently over the past several years. Calculations by MCHA administrators show that private indemnity carriers' premiums as a percent of total premiums subject to the MCHA assessment dropped from 25.6% of premiums in 1993 to only 22.4% of those premiums in 1998. If this trend toward HMOs and self-insurers continues, revenue from the 2% premium tax on health insurance will fall as a share of total general fund revenue.

The same can be said of the adequacy of the 0.6% premiums surcharge on HMO's and non-profit plans, since revenues from all Medical Assistance surcharges, including this premium surcharge, are deposited in the state's general fund.

In contrast, the 1% tax on HMOs is deposited in the Health Care Access Fund. Growth in expenditures from this fund will tend to follow the inflation rate associated with medical care, which are ultimately reflected in health insurance premiums. However, revenues from the 1% HMO tax can be expected to lag behind other Health Care Access Fund revenues to the extent that the market share of HMOs is being eroded again by the move to self-insuring. Revenues from this tax will likely be a smaller percentage of all Health Care Access Fund revenues.

The MCHA assessment bears special analysis. In a purely technical sense, revenues from MCHA are adequate to cover MCHA deficits, since the assessment rate is mathematically derived to cover the assessment. And since MCHA deficits seem to rise with predictability, so do the assessments.

But while MCHA deficits and assessments are predictable and adequate, they are neither stable nor sustainable.

Mechanically, MCHA assessment rates are determined in the same manner as property tax rates. Each year a predetermined assessment amount is divided by the total premiums base of indemnity, HMO and non-profit insurance carriers, just as local property tax rates are derived by dividing local levies by total taxable property values. With the property tax, rising local levies are usually accompanied by rising total valuations, keeping property tax rates relatively stable.

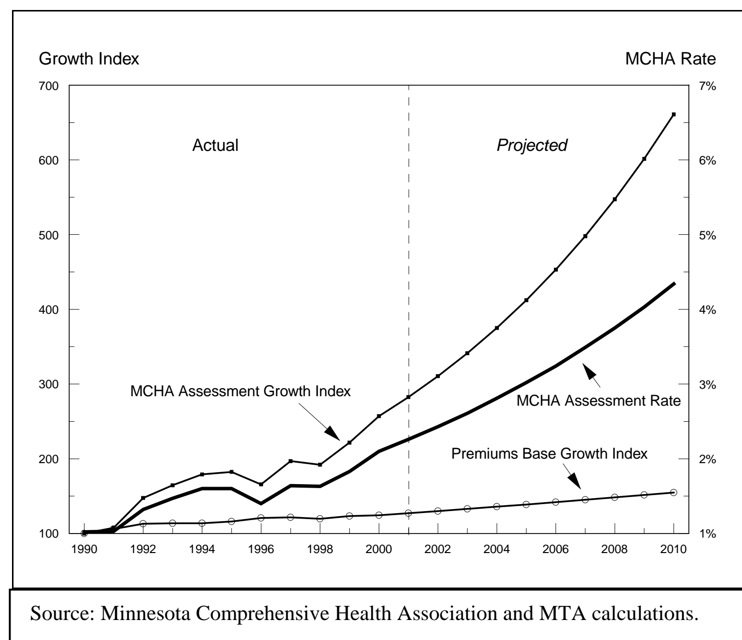
With MCHA, rising annual assessments that result from an increasing deficit are usually accompanied by a taxable premium base that grows much more slowly as more of the insured shift from fully-insured plans to self-insurance, partly in response to incentives created by public policy (see Figure 6 below). In 2000, for example, the contributing members of MCHA will pay an additional $5 million because the State of Minnesota has decided to self-insure its own employees. The insurance premiums once paid by the state to insurance carriers who are

contributing members of MCHA, disappear from the taxable premiums base for purposes of calculating the MCHA assessment. Effectively, this means that health plans, and thus employers, especially smaller employers, and consumers who buy their products, will experience a $5 million premium tax increase so that the State of Minnesota can cut its insurance expenses.

Unless MCHA financing is reformed, the MCHA assessment rate will continue to grow without limit. From 1990 to 2000, annual MCHA assessments will have increased from $25 million to nearly $65 million, an average increase of 9.9% per year.[37] Over that same period, the taxable premiums base will have risen by an average of only 2.2% per year.

If these rates of change continue over the next ten years, the MCHA assessment rate will more than double, rising from 2.1% in 2000 to 4.34% in 2010. The actual dollar amount of annual assessments under this scenario, would rise from nearly $65 million in 2000 to $167 million by 2010. Over the 10-year period to 2010, small employers, their employees, self-employed persons, and individual policy holders will be assessed nearly $400 million more than they would pay if the 2.1% rate of 2000 is held constant throughout the 10 year period, and over $750 million more if the general-fund subsidized rate of 1.12% in 1998 and 1999, were held constant to 2010. These growth trends are illustrated in Figure 6 below.

Figure 6. MCHA Assessment Rate Projections Using 1990-2000 Growth Indices (1990=100)



Source: Minnesota Comprehensive Health Association and MTA calculations.

It's unfair to force a diminishing base of smaller employers and their employees, self-employed persons, and individual policyholders to shoulder this rising burden for a public program with broad public benefits.

[37] Assessments for 1998 and 1999 are before reductions resulting from legislative appropriations of $15 million in 1998 and $15 million in 1999. Appropriations were ignored to illustrate the structural growth that would occur in the assessment rates if no further appropriations are forthcoming.

Stability and Adequacy Conclusions

- Revenues from the 2% gross premiums tax on indemnity carriers, the 1% premium tax, and the 0.6% surcharge on HMOs and non-profit carriers will be fairly stable and predictable. Health insurance premium taxes rise to reflect increases in health care costs, but decline as the growth of self insurance continues to erode the premium tax bases.

- Revenues from the 2% gross premiums tax and the 0.6% surcharge on HMOs are general fund revenues. Because they comprise such a small percentage of the general fund, they cannot be analyzed as to adequacy.

- If the trend to self-insurance continues, revenues from all health insurance premium taxes will fall as a percentage of total tax collections.

- MCHA assessments are neither stable, nor sustainable. Without reforms, rising assessments and diminishing taxable premiums will continue to push the MCHA assessment rate up without limit, causing heavier burdens for many smaller employers who can't self-insure, and others who purchase health insurance in the market.

Are the Insurance Taxes Competitive?

The interstate aspect of insurance taxation is somewhat unique to insurance, including health insurance. Minnesota and the other states have "retaliatory insurance tax" laws which attempt to protect local insurance markets from the competitive effects of lower insurance taxes in other states. In a given state, these provisions make insurance taxes on "foreign" or non-domiciled insurance companies that are located in lower-taxed states equal to the taxes paid by "domestic" companies. For example, if another state taxes its insurance companies' premiums at 1.75%, those companies will pay a 0.25% retaliatory tax on insurance business sold to Minnesotans, making the total tax 2%, the same as that levied on Minnesota companies.[38]

The retaliatory provisions in other states, however, also require Minnesota insurance companies to continue to pay our state's 2% rate on business in the lower-rate state, putting Minnesota-based companies at a competitive disadvantage.

Furthermore, if the bulk of an out-of-state company's business is in a state with a lower gross premiums tax rate, that company can still have a competitive advantage over Minnesota-based companies even though it must pay our 2% retaliatory rate on its business in the state. They may still be able to offer products with lower premiums in Minnesota due to the fact that most of their business is taxed at a lower rate, lowering their overall cost of doing business.

According to the American Council of Life Insurance, as of the end of 1998, 12 states either did not tax insurance premiums or had a rate lower than Minnesota's 2%. Nineteen states had rates higher than Minnesota's, and the rest taxed premiums at the same 2% rate. Eighteen states lowered their rates or were considering lowering them between 1985 and 1998. States with lower rates included most of the very populous states, such as New York, Florida, Texas, and Michigan,

[38] States, to varying degrees, include most insurance-specific taxes in the retaliatory tax calculations, including such taxes as guarantee assessments, assessments for high-risk pools, and insurance company fees.

while the states with a higher rate were generally less populous with the exception of California. Nevada had the highest rate at 3.5%.

When combined with the MCHA assessment for 2000, the gross premiums rate in Minnesota is effectively 4.1% for private indemnity insurance companies. Most states with programs similar to MCHA do not enroll nearly as many in the program and have enrollees pay a greater share of the cost. Though assessment rates comparable to MCHA for other states are not available for this report, it is likely that none is as high as Minnesota's 2.1%.

Competitive Conclusion

- Premium taxes are not competitive. A growing number of out-of-state insurance companies enjoy a competitive advantage relative to Minnesota companies based on lower premium tax rates and MCHA assessments. Though these companies must pay Minnesota's 2% rate on business written in Minnesota, their home state's lower rate can enable them to offer lower-priced products in Minnesota.

- Minnesota-based companies were at a competitive disadvantage in at least 12 states as of the end of 1998, based on lower gross premiums tax rates in those states than our 2%.

- The MCHA assessment roughly doubles the gross premiums tax for insured health plans, further reducing the competitiveness of Minnesota-based insurance companies.

VII. Summary of Evaluations

The following section pulls together all of the evaluations in this report by tax and principle.

Summary of Provider Tax Evaluations

Fairness Conclusion

- According to the latest preliminary estimates, from 1992 to 1996, providers paid roughly $100 million more in provider taxes than they saved in uncompensated care costs. This means that the provider tax has so far failed the benefits-received principle, at least for hospitals and likely for most other providers given their lower rates of uncompensated care.
- The provider tax is not horizontally equitable, because of Medicare, Medicaid, and other exemptions. These exemptions mean that providers with equal revenues may not pay equal taxes.
- The provider tax is not vertically equitable. It falls more heavily on lower-income taxpayers than on those with higher incomes and therefore is regressive. Lower-income taxpayers pay as much as five times more in provider taxes as a percentage of their income than taxpayers with the highest income.

Efficiency Conclusion

- The provider tax is generally allocatively efficient, with the possible exception of discouraging providers from locating in Minnesota.
- The provider tax has no significant administrative efficiency problems compared to all other taxes for most providers, but for providers which also pay the Medical Assistance surcharges (hospitals, HMOs, and nursing homes), the tax is administratively complex, due to tax bases and rates which are different from the surcharges.

Visibility Conclusion

- The provider tax fails the tax principle of visibility because it is not at all visible for most health care services. It is generally not itemized in fees or in insurance reimbursement schedules, leaving many Minnesotans in the dark even as to its existence.

Simplicity Conclusion

- The provider tax is relatively simple.

Adequacy and Stability Conclusion

- The provider tax is stable, raising more revenue as health care expenses rise.
- The provider tax raises more money than needed for the programs it supports.

Competitive Conclusion

- Because competition in the medical industry is based primarily on reputation and not price, the provider tax *generally* does not negatively effect the competitiveness of Minnesota's providers.
- There are competitive issues with providers near other states' borders, especially when the medical assistance surcharges are considered, too.

Summary of Wholesale Drug Distributor Tax Evaluations

(similar to the provider tax above, but with these additional considerations)

Fairness Conclusion

- The wholesale drug distributor tax is not equitable under the benefits-received principle because it does not provide, nor evidently was ever intended to provide, benefits either to consumers or distributors in proportion to the revenue it raises.
- The wholesale drug distributor tax is not horizontally equitable due to the unequal enforcement of the use tax on out-of-state wholesalers, and wholesalers with federal contracts.

Competitive Conclusion

- The wholesale drug distributor tax puts Minnesota wholesalers at a competitive disadvantage.

Summary of Medical Assistance Surcharge Evaluations

(similar to the provider tax above, but with these additional considerations)

Fairness Conclusion

- Medical assistance surcharges are inequitable under the benefits-received principle, even though they were enacted under the premise of equitable benefits. Federal regulations now prohibit providers from receiving benefits in proportion to the tax.

Efficiency Conclusion

- Medical assistance surcharges had no significant administrative efficiency problems compared to all other taxes before the enactment of the provider tax, but are now administratively complex due to tax bases and rates which are different from the provider tax.

Competitive Conclusion

- Medical assistance surcharges raise competitive issues when combined with the provider tax, especially in border communities.

Summary of Health Insurance Premium Taxes and MCHA Assessment Evaluations

Fairness Conclusion

- The insurance premium taxes and MCHA assessments are not horizontally equitable. Health plans with the same amount of tax base pay different amounts of premium tax. The horizontal tax disparities are most extreme between indemnity carriers, who currently pay a total of 4.1% in insurance premium taxes and MCHA assessments, and self-insurers, who pay no premium taxes.
- Because larger employers tend to self-insure, the initial impact of health insurance premium taxes and MCHA assessments tends to fall increasingly on small employers, the self-employed, and individual policyholders.
- Premium taxes are not vertically equitable. All premium taxes are paid by consumers. According to the Minnesota Department of Revenue, the insurance gross premium tax is regressive in that it falls most heavily on lower income families. MCHA assessments, the 1% HMO premium tax, and the 0.6% MA surcharge on HMO premiums are also assumed to be regressive.

Efficiency Conclusion

- Current health insurance premium taxes and MCHA assessments create market distortions, and are therefore not efficient. The distortions are most severe between indemnity insurers and self-insurers.

Visibility Conclusion

- Health insurance taxes are not at all visible to employers and other purchasers. They are not itemized in premiums, and thus like the provider tax, leave many Minnesotans in the dark even as to their existence.

Simplicity Conclusion

- There are no unusual administrative or taxpayer complexities associated with current insurance premium taxes and MCHA assessments.

Stability and Adequacy Conclusion

- Revenues from the 2% gross premiums tax on indemnity carriers, the 1% premium tax, and the 0.6% surcharge on HMOs and non-profit carriers will be fairly stable and predictable. Health insurance premium taxes rise to reflect increases in health care costs, but decline as the growth of self insurance continues to erode the premium tax bases.
- Revenues from the 2% gross premiums tax and the 0.6% surcharge on HMOs are general fund revenues. Because they comprise such a small percentage of the general fund, they cannot be analyzed as to adequacy.
- If the trend to self-insurance continues, revenues from all health insurance premium taxes will fall as a percentage of total tax collections.
- MCHA assessments are neither stable, nor sustainable. Without reforms, rising assessments and diminishing taxable premiums will continue to push the MCHA assessment rate up without limit, causing heavier burdens for many smaller employers who can't self-insure, and others who purchase health insurance in the market.

Competitive Conclusion

- Premium taxes are not competitive. A growing number of out-of-state insurance companies enjoy a competitive advantage relative to Minnesota companies based on lower premium tax rates and MCHA assessments. Though these companies must pay Minnesota's 2% rate on business written in Minnesota, their home state's lower rate can enable them to offer lower-priced products in Minnesota.
- Minnesota-based companies were at a competitive disadvantage in at least 12 states as of the end of 1998, based on lower gross premiums tax rates in those states than our 2%.
- The MCHA assessment roughly doubles the gross premiums tax for insured health plans, further reducing the competitiveness of Minnesota-based insurance companies.

VIII. Options for Reform

Minnesota's system for financing its health care system has some serious flaws. The fact that a major public program is financed nearly invisibly is its most serious shortcoming. Horizontal inequities from taxing competing providers at different rates are also a major concern, especially for those companies subject to the MCHA assessment. Based on the evaluations of the MinnesotaCare and insurance taxes in this report, we provide the following options for reform.

- **Repeal all health care related taxes.** The benefits of the programs funded by these taxes are enjoyed by all Minnesotans, but the funding itself is invisible to most taxpayers. It is not yet possible to measure whether the benefits Minnesotans have enjoyed match the costs of the taxes they are paying. If every Minnesotan benefits from the health care taxes through lowered costs of uncompensated care and increased insurance coverage and preventive care for the newly insured, the tax should be a more direct, broad-based tax rather than the hodge-podge of indirect health care taxes.

  Payments to providers for previously uninsured patients have failed to offset the MinnesotaCare tax burdens on providers, which are now simply increasing the cost of health care. Revisions to federal law have negated many of the key points that encouraged the enactment of the Medical Assistance surcharges. The insurance taxes have created horizontal inequities. The simplest solution would be to repeal all of the taxes. This would require an estimated $362 million per year in total replacement revenues.

- **Repeal all provider taxes, including the wholesale drug distributor tax, and repeal all MA surcharges**. This would reduce revenues to the Health Care Access Fund (HCAF) in FY2001 by approximately $146 million in for the provider taxes, and $128 million in general fund revenue for the surcharges. Revenue replacement options are listed below.

- **Repeal all health insurance premium taxes, including MCHA assessments and the 1% and 0.6% taxes on HMOs and other non-profit plans.** This would solve the most pressing problems with these taxes, which are the horizontal inequity among the various types of insurers and the rapidly rising MCHA assessments relative to the base. It would require replacement revenue of approximately $118 million per year. ($23 million for the 2% gross premium tax, $65 million for MCHA, $16 million for the 1% HMO tax, and $14 million for the 0.6% MA surcharge). As long as ERISA exists in its current form, this is the only way to level the playing field and remove the tax bias to self-insure.

- **Reduce the health insurance portion of the gross premium tax rate on private indemnity companies to equal that paid by HMOs**. The rate for HMOs is 0.6% in 2000 (for the surcharge only) and under current law will be 1.6% starting 1/1/2001. This change would reduce general fund receipts by about $16 million in FY2000 and $5 million in FY2001.

- **Reinstate the tax offset of the MCHA assessment against the gross premiums tax.** There was an offset allowed between 1976 and 1987, when only indemnity insurance carriers paid the MCHA assessment. The fiscal impact of this is likely to be about $65 million per year. This would constitute general fund support for MCHA.

Potential Funding Sources

- **Use HCAF and general fund surpluses**. The HCAF reserves are estimated to be $208.4 million for fiscal year 2001, including the $150 million federal welfare reform contingency reserve that has been shown by events to be unnecessary. That amount provides more than one full year of replacement revenue for the MinnesotaCare program ($194.4 million for FY2001) and almost enough for all uses of the HCAF ($238 million for the same year). The Finance Department in its November 1999 forecast estimates that there will be a $500 million annual structural surplus in the general fund.

- **Use ongoing general fund tobacco settlement money to fund MinnesotaCare.** This would provide an estimated $115 million per year for the 2000-01 biennium, and over $330 million per year in the 2002-03 biennium, under current law.

- **Subject medical services to the general sales tax**. A sales tax rate between 1%-1.5% would raise revenues comparable to the provider tax and Medical Assistance surcharges, and a 2% rate would raise approximately enough revenue to replace all health care taxes. However, no other state in the nation now subjects medical services to the sales tax.

IX. Appendix 1--Description of the Health Care Industry in Minnesota

Minnesota's health care industry can be thought of in terms similar to any other industry, namely, those who produce the product, (in this case health care), and those who buy or consume the product. Using the vocabulary of the industry, the producers of the product are called the providers of health care services, and those who pay for the product are called the payers. The remainder of this brief overview describes types of providers and payers in Minnesota.[38]

Providers

Physicians and Clinics

Providers are the ultimate care givers. As indicated above, payments to hospitals and doctors account for over half of all Minnesota health care spending. In 1996, there were 14,580 physicians licensed in Minnesota.[39] Of these, 10,210 reported Minnesota as their primary place of practice, working in an office or hospital.[40]

A 1996 Minnesota Department of Health survey of physician clinics found that 35% were primary care clinics, 56% were specialty clinics, and 9% were multi-specialty groups. Seventy-three percent of 688 responding clinics were located in urban areas of the state, while 27% were in rural areas.

In 1996, Minnesota physician clinics spent $3.4 billion and collected $3.3 billion in revenue. From 1993 to 1996, clinic spending grew faster than clinic revenue. Spending grew an average of 6.3% per year, while revenues grew 5.9%.

Most clinic revenue (70%) is for direct patient care (professional salaries and benefits, and other costs such as medical equipment and services). Administrative costs such as billings, management, etc. made up 12% of total clinic expenditures.

About 33% of clinic revenue, the biggest share, for both rural and urban clinics comes from commercial insurers and Blue Cross/Blue Shield of Minnesota. In urban areas HMO payments comprise over 20% of revenues, compared to over 10% in rural areas. Rural clinics get a greater percentage of their revenues from public programs like Medicare, Medical Assistance, General Assistance Medical Care, and MinnesotaCare than urban clinics do (31% vs. 16% for 1996). This reflects greater enrollments in Medicare and MinnesotaCare in rural places. Out-of-pocket spending is slightly higher in rural areas due to higher rates of the uninsured and a different mix of insurance coverage.

In 1996, 18% of respondent clinics reported receiving some capitated payments. These contractual payments per health plan member totaled over $203 million, up 21% from the previous year. Capitated revenue continues to be relatively limited. In 1996, 7% of all patient care revenue was in the form of capitated payments. Rural clinics receive only 1.5% of revenue from capitated payments compared to 7.5% in urban clinics. It is not surprising that clinics in urban areas get the biggest share, 31%, of their revenues from capitated payments.

[38] These brief descriptions are summarized from *Minnesota's Health Care Market: Health Care Expenditures and Selected Provider and Health Plan Trends, 1993 to* 1997, written by the staff of the Health Economics Program, and published October 1999.
[39] Medical and osteopathic doctors.
[40] Excludes retired physicians and medical residents

One focus of recent health care reform has been to reduce the amount of uncompensated care in the health care system. Uncompensated care (UC) is defined as care for which the patient or payer was either not billed, or was billed but failed to pay.[41] In 1996, UC provided in Minnesota physician clinics totaled $71.5 million, 2% of clinic revenue, and 90% of which was reported from urban clinics.

Hospitals

Number of Hospitals and Length of Stays

The number of Minnesota hospitals has declined steadily over recent years. From 1985 to 1996, the number of hospitals has fallen from 173 to 145. Of the 145 hospitals in Minnesota in 1996, over one third of them, 52, were in Minnesota's urban areas. The remaining 93 were located in rural areas. Most of the 28 hospital closings since 1985 have been in rural areas.

The trend to managed care, changes in Medicare reimbursement policies, and technological advancements have reduced the average length of hospital stays in Minnesota and the rest of the nation. Minnesota hospital stays are well below the U.S. average, due to the prominence of managed care here and differences in practice patterns and efficiency.

Urban hospitals generally have higher lengths of stays, most likely because they tend to provide greater amounts of tertiary care than rural hospitals. In 1996, urban hospital stays in Minnesota averaged 4.1days, compared to 3.4 days for rural hospitals.

Outpatient and Inpatient Stays

Outpatient visits to hospitals in both Minnesota and the U.S. rose without interruption from the late 1980s to 1996. This is also true of both rural and urban hospitals in Minnesota. Of the 4.8 million outpatient visits in Minnesota in 1996, 27% were emergency room visits, 69% were visits to outpatient departments, and 4% were for surgeries.

In contrast, inpatient visits in both Minnesota and the U.S. fell until 1994 and have been rising since then. Increased use of managed care and changes in payer policies and treatment technologies is credited with precipitating a significant shift from inpatient care to outpatient care. Since 1994, inpatient stays in Minnesota urban hospitals have been on the rise, in part because of most hospital closures have been rural ones.

Revenues and Expenditures

In 1996, 31% of all health care spending in Minnesota was for care provided in hospitals ($4.7 billion). Total hospital revenues, defined as gross revenues less discounts, is estimated to have been about $4.9 billion in 1996.

As expected, hospital revenues over time follow changes in total health care spending. Generally, annual rates of change in Minnesota rural hospital revenues and expenditures has exceeded urban hospital growth rates, though the growth rates for both have fallen from 1990 to 1994. However, since 1993, the growth in rural hospital revenues and expenditures has been higher than that of urban hospitals (3% to 4% vs. 1% to 2%).

[41] Includes charity care for which there is no patient charge and bad debts.

Rural hospitals are more dependent than urban ones on revenues from Medicare, Blue Cross Blue Shield, and commercial carriers. This reflects demographics and the relative dominance of traditional indemnity carriers in rural Minnesota. Urban hospitals get relatively more of their revenues from HMOs and other managed care providers.

Public programs like Medicare, Medicaid, state-operated programs like MinnesotaCare and others provide about 43% of total Minnesota hospital revenues. In 1996, Medicare provided 77% ($1.6 billion) of public hospital revenues in the state, with the remaining 23% ($406 million) coming from Medicaid and state programs. Since 1993, state programs have provided an increasing share of rural hospital revenue, reflecting expanded programs through Medicare and especially MinnesotaCare, for which two-thirds of enrollees are from outside the Twin-Cities seven-county metropolitan area.

Payers

Payers are organizations that pay for or underwrite coverage for health care expenses. They are divided into two main groups: private and public. Private payers do not use government revenues to pay for health care expenses, while public payers do use government revenues.

Private Payers

Private payers include health maintenance organizations (HMOs), indemnity insurance carriers (or commercial insurance companies), Blue Cross/Blue Shield of Minnesota, Community Integrated Service Networks (CISNs), and self-insured plans.

Fully-Insured and Self-Insured

In 1997, the federal government and the state of Minnesota provided primary health insurance to almost 25% of the state's population. The remaining 75% are covered by commercial indemnity insurers (17%), including Blue Cross Blue Shield of Minnesota, and by HMOs (21%). Those covered by these insurers are often referred to as the "fully-insured." For the ten largest private payers in Minnesota by market share, see Table 8 on page 15 in this report.

About one-third of Minnesotans are covered by employer-based self-insured plans. The rest of the state's population, about 6-9% are uninsured.

HMOs

In 1997, about 42% of the state's entire population was enrolled in some type of HMO coverage. Just over two-thirds of those enrolled in an HMO were fully insured, while the remainder were part of companies which were self-insuring. Of total HMO enrollment, the public/private split was about 29% publicly financed to 71% private.

HMO enrollment is not uniform throughout the state. In 1997, nearly 60% of the population in the seven-county metropolitan area was enrolled in an HMO. Elsewhere in the state, the percentages ranged from 16% to 31% of the population. The percentage of the population enrolling in HMOs is increasing in rural areas, however, while it is declining in the metro area. Overall enrollments in HMOs were stable in the last couple of years.

Small Group and Individual Coverage

One area the MinnesotaCare law of 1992 sought to reform was the small group health insurance market. That legislation made it easier for small groups to purchase coverage for their employees. Partly due to these reforms, small group enrollment has increased from 190,000 in 1992 to over 400,000 in 1997, or 9% of the state population. The tight labor market and good economic conditions have also likely played a part in this increase.

A combination of increased premiums for individual coverage and more availability of small group coverage have probably worked to reduce the share of individual insurance coverage from 9.4% in 1990 to about 5% in 1997.

MCHA

The Minnesota Comprehensive Health Association (MCHA) provides coverage for persons not able to purchase health insurance at market rates, or only with restrictive clauses due to pre-existing conditions. Enrollees pay premiums capped at 125% of market rates and annual assessments of fully-insured payers fund the rest. (Legislative appropriations of $15 million per year provided partial funding in 1998 and 1999.)

Enrollment in MCHA peaked in 1993 at nearly 35,000 enrollees, and has declined to under 25,000 enrollees in 1998. Even though enrollment has declined, claims have increased, and assessments to make up the deficits have had to increase. See the MCHA discussion under the evaluation of insurance premium taxes and MCHA assessments beginning on page 40 for more information.

Public Payers

Nearly twenty-five percent of Minnesotans receive health insurance coverage from governmental programs. These insurance programs include Medicare, Medicaid (known in Minnesota as Medical Assistance, or MA), General Assistance Medical Care (GAMC), MinnesotaCare, and the Minnesota Comprehensive Health Association (MCHA).

The federal programs of Medicare and Medicaid were established in 1965 after lengthy national debate. Medicare was established to assist with the medical needs of the elderly, and Medicaid was enacted to address the inadequacies of "welfare medical care" under public assistance.

Medicare was established as a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act. Medicare has two primary components—hospital insurance (HI, or part A), and supplementary medical insurance (SMI, or part B). A newer, part C program called Medicare+Choice program was established in 1997. In 1997, 38 million persons, nationally, were enrolled in one or both of parts A or B of Medicare.

Part A provides protection against the costs of hospital and related care for persons age 65 or over who are entitled to Social Security or Railroad Retirement Board Benefits. Certain deductibles and co-payments apply. Part B covers physician services and other medical services not covered by Part A. Optional Part B benefits are available to almost all resident citizens age 65 or older, even those not entitled to Social Security Benefits, who pay a monthly Part B premium. Medicare+Choice plans are basically risk-based plans that agree to provide certain Medicare

benefits and accept Medicare payments. They are available only to those enrolled in both Part A and Part B of Medicare.

All financial operations of Medicare are handled through two trust funds or special accounts, in the U.S. Treasury, one for Part A and one for Part B. Medicare financed with a mandatory payroll deduction (currently 1.45% of unlimited earnings—paid by both employer and employee and 2.9% for self-employed), and premiums payments. Hospitals receive a predetermined payment for Medicare patients based on the patient diagnoses, irrespective of the actual medical care required during hospital stays, except for extraordinarily costly cases. Physicians are paid the lesser of submitted charges or Medicare fee schedule amounts. Hospitals and care providers who agree to serve Medicare patients must accept Medicare payments as payment in full and cannot accept additional payment from beneficiaries or insurers, beyond the prescribed deductibles and co-payments.

State agencies assist the federal Department of Health and Human Services in identifying, surveying, inspecting, and certifying providers and suppliers who wish to participate in the Medicare program. States also assist providers and coordinate state programs to assure effective, economic care.

Medicaid is a federal-state matching entitlement program that pays for medical assistance for certain vulnerable and needy individuals and families with low incomes and resources. It is the largest source of funding for medical and health-related services for the nation's poorest people.

Within broad guidelines, states establish their own eligibility standards, determine the type, duration, and scope of services, set reimbursement payments for services provided by vendors, and administer their own programs. Hence, a person eligible for Medicaid in one state may not be eligible in another. In a particular state, Medicaid may not provide medical assistance for all poor persons. Though general eligibility can depend on numerous criterion set by individual states, state Medicaid programs must serve categorically needy eligibility groups for which federal matching funds are provided. In addition, states may provide Medicaid coverage to other categorically related groups that share the characteristics of the mandatory groups, but whose eligibility criteria are more liberally defined.

States are required to provide certain basic services, such as inpatient hospital services, vaccines for children, and prenatal care, for example, to all categorically needy populations. They may also receive federal matching funds for providing certain optional services such as clinical services and optometrist services.

Medicaid basically operates as a vendor payment program. States have broad discretion in determining the payment rates and methods. Generally, payments must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within a geographical area. Participating providers must accept Medicaid payment rates as payment in full. Also, states must make additional payments to hospitals that provide inpatient services to a disproportionate number of Medicaid or other low-income or uninsured persons under what is called the "disproportionate share hospital" (DSH) adjustment. Since the mid-1990s DSH payments have become increasingly limited.

Federal participation in financing state Medicaid programs is based on the "Federal Medical Assistance Percentage" or FMAP. This is determined by comparing a state's per capita income to that of the nation as a whole. Higher income states, like Minnesota, are reimbursed a smaller

share of their costs. Except for certain programs, no state is reimbursed less than 50% nor more than 83% of costs. In 1998 the average FMAP was 57%. Ten states received 50%, and the highest share, 77% went to the state of Mississippi. Minnesota's FMAP was approximately 52%.

X. Appendix 2--Health Care Taxes in Other States, Comparison Tables

Appendix Table 1. States with General Provider Taxes on Medical Services As of the Fall of 1999[42]

State or Locale	Base	Rate
Connecticut	• Each hospital's share of actual expenditures made by the Commission on Hospitals and Health Care during each fiscal year • Hospitals' gross earnings • Hospital and medical service corporations' total net subscriber charges	• Not applicable • 6.25% • 2%
District of Columbia	• Hospital's net patient services revenue, excluding net Medicaid revenue • Non-federal nursing home patient days excluding continuing care retirement communities • Intermediate care facilities for the mentally retarded patient days	• 0.45% • $11.88 per day, not to exceed 6% of gross revenues for mental health nursing homes • $15.29 per day, not to exceed 6% of gross revenues
Kentucky	• Gross revenues of hospitals, excluding university, federal, or freestanding psychiatric hospital and excluding outpatient prescription drugs • Non-federal health care providers' gross revenues, including free-standing psychiatric hospitals, and excluding outpatient prescription drugs • Non-federal pharmacy prescriptions • Charitable, federal, and university-run providers are exempt from all three of the above taxes, and governmental reimbursements are exempt.	• 2.5% • 2.0% (physicians' services were exempted beginning July 1, 1999) • 25 cents per prescription
Maryland	Annual assessment on (1) health insurers, nonprofit health service plans, HMOs, (2) third-party administrators, (3) self-insured groups, and (4) practitioners excluding pharmacists	Not to exceed $5 million total per year. Assessed proportional to premiums paid on first 2 classes; set by Health Care Access ad Cost commission for class 3 based on number of enrollees; and included in licensing fee for practitioners
MINNESOTA	• Gross revenues for patient revenues primarily exempting government receipts for health care and previously taxed receipts, home health care and hospice services; and wholesale drug distributors • Gross premiums of HMOs	• 1.5% (2% from 1993-1997 and after 2001) • 1% (from 1993-1997 and after 2000. Currently 0%)
New York	• Fee to support statewide planning and research cooperative system, based on each hospital's proportionate share of the sum of total costs reported by all general hospitals • Gross revenue received for inpatient hospital services, excluding charity and severely financially distressed hospitals from bad debts and charity care	• not to exceed 0.1% of total costs for any one hospital • 1% of gross revenues, to help pay for charity care and bad debts
Rhode Island	• Gross patient service revenue duly licensed on July 1, 1998, excluding psychiatric hospitals	• 2%

[42] Source: Commerce Clearing House, *State Tax Guide, Volume 2*

State or Locale	Base	Rate
	• Gross patient revenue per month for licensed residential facilities for the mentally retarded	• 25%
South Carolina	• Total expenditures of each hospital as a percentage of total hospital expenditures statewide • Patient days of intermediate care facilities for the mentally retarded	• Not given • $8.50 per patient day
West Virginia	• Gross receipts of specified providers, reduced for contractual allowances with third-party payers and for bad debts to the extent they were previously included, for these providers: • ambulatory surgical centers, chiropractic; dental; nursing; opticians'; optometric; podiatry; psychological; and therapists' services • physicians' services • Independent laboratory or x-ray services provided outside hospitals or physicians' offices • intermediate care facilities for the mentally retarded; nursing facilities; and emergency ambulance services • behavioral health or community care services	• 1.75% of gross receipts • 2% • 2.5% • 5.5% • 5%

Appendix Table 2. States with Provider Surcharges on Medical Services, Contingent on Obtaining Matching Federal Funds, Fall of 1999[43]

State or Locale	Base	Rate
Hawaii	Nursing facility income	6% (ended July 1, 1997. This was a provision to get "free" federal money, because it is tied to when "the taxes no longer qualify under Sec. 1903(w) of the federal Social Security Act")
Louisiana	Nursing facilities and intermediate care facilities for the mentally retarded, pharmacies, dispensing physicians, medical transportation providers Medicaid provided services	Fees not to exceed the total cost the state incurs for providing the particular health care service subject to the fee, with these limitations: $10 per occupied bed per day for nursing facilities; $30 per occupied bed per day for mentally retarded facilities; 10 cents per prescription; and $7,50 per medical service trip for transportation providers. Passed to obtain federal matching revenues--fees were automatically repealed when federal law prohibited matching funds for these fees.
Maine	• Hospital gross revenues • Hospital gross patient service revenues for hospitals subject to regulation by the Health Care Finance Commission	• 5.27%, passed to obtain federal matching revenue. Repealed in 1995 legislation, phased out over 3 years, and no longer collected after 6/30/98. • 0.15%, repealed, as above.
MINNESOTA	• Hospital net patient revenues, excluding Medicare • Hennepin County Medical Center and Univ. of MN Hospital net patient revenues • HMOs and Integrated Service Networks • Licensed nursing homes • County nursing homes	• 1.56% • Additional 1.8%, plus $1.5 mil. and $500K per month respectively • 0.6% of total premium revenues • $625 per bed • $5,723 per bed
Nevada	• Tax on hospitals. No other information available	• Probably a federal matching funds tax
Tennessee	• Nursing home beds • Gross receipts of intermediate care facilities for the mentally retarded	• $2,600 per bed • 6% of gross receipts. • Both of these were temporary to get federal matching funds and are no longer in effect
Texas	• Hospital non-Medicaid gross inpatient revenues for the cost-reporting period ending in 1989 for all hospitals more than	• 1.25% of gross revenues

[43] Source: Commerce Clearing House, *State Tax Guide, Volume 2*

State or Locale	Base	Rate
	one standard deviation above the mean number of state fiscal year 1989 Medicaid inpatient days and greater than 12% of all statewide patient days	Assessed for federal matching funds. No longer in effect
Vermont	• Hospital gross inpatient revenues • Nursing home beds • Total annual direct and indirect expenses for the most recently settled audit of intermediate care facilities for the mentally retarded	• 4.02% • $1,000 per bed • 6% Ended July 1, 1997, to obtain federal matching funds
Washington	Hospital state Medicaid receipts	20%, used only to obtain federal matching funds, automatically expired

XI. Appendix 3--Glossary[44]

Capitation (or capitated payments): a stipulated dollar amount established to cover the cost of health care delivered to a person. The term often refers to a negotiated per capita rate to be pre-paid, usually monthly, to a health care provider.

Carrier: an entity that may underwrite, administer, or sell a range of health benefit programs. May refer to an insurer or a managed health plan.

Commercial Health Insurance: A commercial (private), indemnity health insurance plan licensed and regulated by the Minnesota Department of Commerce.

Community Integrated Service Network (CISN): networks of providers and payers which provide care and compete with other systems for enrollees in their community. Systems can include hospitals, primary care physicians, specialty care physicians, and other providers and sites that can offer a full range of preventive and treatment services.

Employee contribution: the amount an employee must contribute toward the premium costs of a health plan contract.

Employer contribution: the amount an employee must contribute toward the premium costs of a health plan contract.

Enrollee: an individual who is enrolled for coverage under a health plan contract and who is eligible on his/her own behalf (not as an eligible dependent).

Enrollment: the total number of enrollees or covered persons in a health plan.

ERISA: The Employee Retirement Income Security Act, passed in 1974 to provide a standard set of federal regulations for pension and insurance benefit plans. It preempts state regulation of self-fund health benefit plans.

Health Care Access Fund: a special fund created by legislation in 1992 in which are deposited all receipts from the 1.5% provider tax and 1% HMO premium tax. Money from this fund is spent primarily on the MinnesotaCare program, but also on other programs as the legislature directs. See Figure 4 on page 34 for how the Health Care Access Fund revenues are spent.

Health Care Financing Administration (HCFA): the federal agency responsible for administering Medicare and overseeing states' administration of Medicaid.

Health coverage: the payment of benefits for covered sickness or injury.

HMO: A health maintenance organization licensed and regulated by the Minnesota Department of Health. HMOs provide, offer, or arrange for coverage of designated health services needed by plan members for a fixed, prepaid premium. There are four basic models of HMOs: group model, individual practice association, network model, and staff model. HealthPartners is the only staff model HMO in Minnesota.

[44] Many of the glossary terms and definitions were taken from *The Language of Managed Health Care*, produced and published (in 1998) by UnitedHealth Group Corporation, and are used by permission.

HMO premium tax: a 1% tax on premiums received by HMOs and nonprofit health service plan corporations for additional revenue to fund MinnesotaCare, effective 1/1/96. Such plans meeting cost containment goals for 1996 and 1997 were exempted by legislation passed in 1997,

Health care spending: Defined by the Minnesota Department of Health's Health Economics Program as funds paid out for health care claims. These are basically payments from insurance entities, including government and self-insurers, plus out-of-pocket payments.

Health plan or health coverage plan: Refers broadly to any type of health coverage, whether provided through an employer, purchased individually or obtained through a government program. Includes the state-regulated health plans such as commercial health insurance, HMO, Blue Cross and Blue Shield, plus the self-insured health plans which are not subject to state regulation (see ERISA above). While the term "health insurance" is commonly used to refer to all type of health coverage plans, the technical meaning of the term is commercial health insurance plans, as opposed to HMOs and nonprofit health service plans such as Blue Cross and Blue Shield.

Indemnity: a plan of insurance that reimburses members, physicians, hospitals, or other facilities based on billed charges.

Managed care: a system of health care delivery that influences utilization, quality of care, cost of services, and measures performance.

MCHA: the non-profit Minnesota Comprehensive Health Association, created in 1977 by enabling legislation in 1976 to provide health insurance coverage for individuals difficult to insure or who are denied insurance by at least one carrier for pre-existing conditions or certain diseases. Premiums are set from 101% to 125% of market value. Any deficit in the costs of the programs not covered by enrollee premiums is assessed against premiums of state-regulated insurance plans.

Medicaid: a federal program administered and operated individually by participating state governments which provides medical benefits to eligible low income persons. The costs are shared by the state and federal governments. In Minnesota, Medicaid is referred to as Medical Assistance.

Medical Assistance surcharges: also known as health care provider surcharges, enacted in 1991 as a way to leverage more federal money for Medicaid reimbursements. The rates are 1.56% of net patient revenues for hospitals, 0.6% of total premium revenues for HMOs, and $625 per licensed bed for nursing homes, with special additional charges for certain government-run hospitals and nursing homes.

Medicare: a nationwide, federally-administered health insurance program that covers the costs of hospitalization, medical care, and some related services for eligible persons. Medicare has two parts: Part A covers inpatient costs. Part B covers outpatient costs.

MinnesotaCare program: a health insurance program enacted in 1992 for low income persons, designed not to erode private coverage (by using strict eligibility standards, benefit limitations, a sliding scale premium payment requirement, and an asset test). The program is funded by a combination of premiums from enrollees and (primarily) revenues from the MinnesotaCare taxes enacted for that purpose. In December of 1998 there were about 105,000 people enrolled in the

program, or about 2.1% of the population. 53% of those were children. 72% had family incomes below 150% of poverty.

MinnesotaCare taxes: a group of taxes enacted in 1992, all commonly referred to as provider taxes, for the purpose of funding the MinnesotaCare insurance program for low income persons. The group includes the hospital and surgical center tax, other health care provider tax, and the wholesale drug distributor tax. The rate for all three is currently at 1.5% of gross revenues for patient services (or the price of the drug), with certain exemptions. See provider tax for more on exemptions.

Nonprofit Health Service Plan: Blue Cross and Blue Shield of Minnesota and other similar nonprofit health plans authorized and incorporated under state law.

Out-of-pocket costs/expenses: the portion of payment for health services required to be paid by the enrollee, including copayments, coinsurance and deductibles.

Outpatient: a person who receives health care services at a hospital or free-standing surgical center without being admitted to a hospital.

Premium: the amount paid to a carrier for providing coverage under a contract.

Prescription drug: a drug which has been approved by the federal Food and Drug Administration and which can, under federal or state law, be dispensed only with a prescription order from a licensed physician.

Provider: a physician, hospital, group practice, nursing home, pharmacy or any individual or group of individuals that provides a health care service. See Table 4 on page 9 for a more detailed list of types of health care providers.

Provider tax: a commonly used name for a group of taxes assessed on the gross receipts of health care providers, minus Medicare and Medicaid revenues and certain other exemptions (see Table 5 on page 10 for a longer list of exemptions). The term provider tax usually is considered to include the hospital and surgical center tax, health care provider tax, and wholesale drug distributor tax. The rate was 2% when the tax was enacted in 1992, but for 1998 through 2001, the tax has been lowered to 1.5%. Revenues from this tax are dedicated to the Health Care Access Fund. See also MinnesotaCare taxes.

State-regulated Health Plan: A health plan that is not self-insured and therefore not exempt from state regulations and taxes under the federal ERISA law. Includes commercial health insurance plans, insured HMO plans and insured health plans offered by Blue Cross and Blue Shield.

Self-insured Health Plan: A health plan offered by an employer or labor union under which the employer or union retains the insurance risk for the costs of the health plan (self-insures). Under these plans, employers fund benefit plans from their own resources without purchasing insurance. Self-insured health plans are exempt from state regulation and taxes under the federal ERISA law. Self-insured health plans may contract with a health insurance company, HMO, Blue Cross and Blue Shield, or other entity to administer their health plan. They may be self-administered, or the employer may contract with an outside administrator for administrative services. Employers who self-fund can limit their liability via stop-loss insurance on an aggregate and/or individual basis.

Staff model HMO: a health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs. HealthPartners is the only staff model HMO in Minnesota.

Third-party administrator: an independent person or corporate entity (third party) that administers group benefits, claims and administration for a self-insured company/group. A TPA does not underwrite the risk.

Third-party payer: a public or private organization that pays for or underwrites coverage for health care expenses or another entity, usually an employer (examples: Blue Cross/Blue Shield of Minnesota; Medicare; Medicaid; commercial insurers).

Underwriting: a review of prospective and renewing cases for appropriate pricing, risk assessment and administrative feasibility.

Utilization: the extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time.

Utilization review: a formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.

Wholesale drug distributor tax: part of the MinnesotaCare tax package enacted in 1992. It adds 1.5% to the price of wholesale drugs sold in Minnesota. A use tax was also enacted to add the same percentage to drugs bought from outside the state.