Design Considerations – Health Services Transaction Tax
For Discussion Only - Updated: 04/15/2008

Overall Proposed Value Proposition	A health services transaction tax is a broad-based, stable source of financing. It would grow at the same rate as health care spending and could be used as a mechanism to help capture some of the cost-shift resulting from coverage of the uninsured. The revenue from the payroll tax could be used to extend coverage to those who are not covered by their employer, and revenue from the health services transaction tax could be used to increase access to care for those in public programs through coverage expansions and increased provider reimbursement. Under this scenario, providers would pay the tax directly, but they would receive higher payments for their Medicaid patients and would have fewer uninsured patients overall. Exempting Medicare and Medicaid revenues from the tax base ensures that providers are not paying more tax based on their decision to see more of these patients.

Design Elements	Options	Policy Considerations Pros	Cons	Straw Proposal
General Tax Payers	Tax would be paid by providers, and the additional amount would be at least partially passed on to: • Patients through coinsurance/deductibles • Health insurers • Employers and employees that – to the extent they contribute to health premiums	Financing source stays in line with health care spending; can "recapture" reduced cost-shift due to coverage of uninsured; fair share payments towards state matching funds for OHP payment rate increases; Distributes cost across entire population of insured population (particularly if no health rating + individual mandate)	Adds to cost of health care; If their benefit plans require coinsurance or deductibles, cost of tax may be passed on to those with high health care needs and services more.	All acute care providers, including hospitals and surgical centers; wholesale drug distributors
Tax Base	1) All health care providers and services 2) All services by specific providers (e.g., all hospital services) 3) All providers of specific services (i.e., MRIs in any setting)	1) Uniform; minimizes federal concerns, may be seen as more equitable; 2) Provides ability to target particular provider groups; reduce administrative cost to implement tax 3) Permits taxation to be coupled with policy goals (i.e., taxing low-evidenced based or over prescribed services)	1) More difficult to administer/enforce due to high # of providers, may be difficult for provider to pass on 2) Less broad based and equitable 3) More difficult to administer	Gross receipts for all health care services provided to commercially insured patients
Exemptions/ Credits	1) Exempt publicly insured (Medicaid, Medicare, FEHBP, etc.) 2) Exempting professional	1) Minnesota has exempted these payers; can not explicitly pass cost on to Medicare and other federal payers due to formula and negotiated rates; Provides incentive to provide care to Medicaid and Medicare	1) Reduces tax base. 2) Not as broad-based. 3) Reduces tax base	Exempt receipts from public programs (state and federal) Exempt county

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	services 3) Exempt long term care and mental health providers 4) Make credits available to assist certain providers who may have to absorb costs of tax?	patients. 2) May make it easier for practitioners who may not be able to pass on to payers. 3) Focuses financing on acute care sector. 4) Could provide mechanism to recognize that some providers may have to absorb cost of tax due to the remaining uninsured or for services not covered by a health plan; Could offer incentive for providers to care for uninsured and Medicaid patients.	4) Potential significant federal Medicaid concerns (likely no-go); creates another administrative process.	programs designed to provide care for indigent Exempt mental health and long-term care facilities, community based services; and retail pharmacies Include professional services No credit available
Tax rate	1) Same % of receipts tax across all providers and services 2) Differential % of cost tax across certain provider groups or types of services 3) Set amount per service or transaction	1) Minimizes federal concerns; Easier to explain and administer 2) Potentially allows you to couple policy and taxation (e.g., higher % on over prescribed services) 3) Easy for providers to calculate; doesn't penalize payers of high cost services	1) May not take into account different provider groups ability to pay 2) More difficult to administer; need to be more careful re: compliance with federal rules 3) More difficult to ensure compliance with federal rules	Same % of receipts tax across all providers and services
Administration	Provider files new type of tax return with state (much like current provider taxes) 1) Requirement that tax passed onto insurers/payers. 2) No requirement to pass through to insurers/payers	1) Clarifies that providers (particularly those without bargaining power) can pass tax onto payers; more transparent? 2) Lets the market act as it will	1) Uninsured/Payers pay full tax 2) Less transparent	No requirement to put fee on bill and not required as a pass through to payers