- *Intermediate care facility, home health,* and nursing services
- Services of managed care organizations
- Lab and x-ray services
- *Emergency ambulance services*
- *Prescription* and non-prescription medications
- Prescription and non-prescription medical devices

We generally think of health care as exempt from taxes, but in fact all the categories above in *green italics* are already subject to something like a sales tax in Vermont via the provider tax. Further, all health care services listed above which are covered by private insurance are taxed. Every time an insurance company receives a premium payment from a Vermonter, the insurance company pays a 2% tax on that revenue, and every time a Vermonter submits a valid claim, the insurance company pays a claims assessment of 0.999% on that claim. These two taxes on insurance companies get factored into the premiums that Vermonters pay.

Commented [NL1]: Vermonters (beneficiaries) themselves do not submit the claims. Providers submit the claims for the services provided to their patients.

The provider tax is imposed on most categories as a net patient revenue tax, which is a gross receipts tax minus contractual discounts/refunds that providers give to payers; charity care; and bad debt. This makes provider taxes functionally similar to a gross receipts tax, which outside of health care is the functional equivalent of a sales tax, as a gross receipts tax on a business gets passed on to consumers via higher prices.

The Effect of Applying the Sales Tax to Health Care on Low-Income Vermonters

Currently, low-income Vermonters are insulated from many of the cost of health care in a number of ways. For those living below 138% of the federal poverty level, the Medicaid program provides access to health care with very little in the way of out-of-pocket costs. For those between 138% and 400% of the federal poverty level who do not receive health insurance through their employer, the Affordable Care Act ("ACA") provides meaningful subsidies for insurance premiums and caps on out-of-pocket spending. For those between 200% and 300% of the FPL, Vermont provides assistance as well. The state also supports low-income Vermonters with Dr. Dynasaur (kids and pregnant women), long-term care assistance, and prescription drug assistance (Department of Vermont Health Access, n.d.).

Commented [NL2]: Advocates might take exception with anything that alludes to low-income VT'ers being completely "insulated" from all health care costs – for instance they may actually avoid services that have limited coverage through Medicaid (such as Dental, etc.).

One complication in health care is that Medicaid patients typically have no or very low co-pays. However, Medicaid and other programs for low-income Vermonters often have fixed payment levels for particular services, and if a provider adds a sales tax to a bill that's already at the maximum reimbursement rate, payment of the full sales tax is likely to fall entirely onto the patient, potentially increasing their co-pay by multiples. It is not clear that the prohibition on balance billing would apply to a sales tax for Medicaid patients. As the additional sales tax might present an insurmountable financial barrier to some Vermonters, we cannot recommend a sales tax on health care without finding a mechanism to protect low-income Vermonters from this burden.

Many states do impose a sales tax on some health care transactions. Of the 45 states with a sales tax, plus the District of Columbia:

- Four states (Delaware, Hawai'i, New Mexico, and Washington State) currently apply a sales tax or a gross receipts tax to physicians' and dentists' work[11].
- Thirty-seven states impose the sales tax on non-prescription drugs (See Appendix 7-1).
- One state (Illinois) currently applies a (1%) sales tax to prescription drugs.
- Thirty-two states apply the sales tax to non-prescription medical devices (Dumler, n.d.).
- Nine states apply the sales tax to medical devices regardless of whether they are prescription or non-prescription (Dumler, n.d.).

We examined the possibility of creating a mechanism by which charges for Medicaid would be exempt from the sales tax. While the states cited above apply a sales tax to some health care expenditures, as we worked through the practical implications of trying to apply a uniform sales tax across all patient-level health care expenditures, it became clear that a system to exempt Medicaid charges from the sales tax rapidly becomes unreasonably complicated and burdensome. Vermont's dual drives toward universal primary care and paying providers based on outcomes add further dimensions of complexity to this question.

We believe that the importance of keeping access to health care as free from barriers as possible, combined with the complexity of how health care for low-income Vermonters is paid for, means that it is not practical to apply the sales tax to health care, either in place of the provider tax or only on those categories of health care that are not subject to the provider tax.

Health care makes up about 18.8% of Vermont's total economic activity (Perry, 2020), and about a third of Vermont's consumer activity, so although health care is not amenable to the sales tax, any analysis of consumption taxes in Vermont that ignores health care is incomplete. We therefore include the provider taxes in our analysis of consumption taxes, and note that every state except Alaska imposes provider taxes.

The provider tax has a unique feature in that Vermont and other states use revenue from the provider tax to help pay for Medicaid, and those provider tax dollars spent on Medicaid trigger the release of matching (at various rates) federal Medicaid dollars to the state. "Beyond Medicaid, states have the policy option to tax most types of providers and services and to designate or earmark the revenue for any state purpose" (National Conference of State Legislatures, 2017).

As noted above, outside of health care, a gross receipts tax gets passed on to consumers via higher prices. In health care, however, there are a variety of ways that providers support the expense of the tax: some providers can charge patients more and some cannot; some providers can charge insurance companies more, and some cannot. The options available to hospitals are different from those available to independent practitioners.

We note also that as it now stands, the provider tax in Vermont is not levied at all on some categories of health care, and it is levied at different rates (between 3.3% and 6%) on the

[11] Delaware and Washington by way of a gross receipts tax. See Federation of Tax Administrators 2017 State Sales Tax Survey data in Appendix 7-1.

various categories on which it is levied. On prescriptions, it is not levied at a rate at all, but at a fixed dollar amount of ten cents per prescription, which on average ends up being about 0.15%. All of this inconsistency adds complexity. It probably also reduces fairness, although again, health care pricing and net revenue are affected by so many factors that the underlying "sales" numbers are inconsistent to begin with. Further, the partial application of the provider tax to health care reduces stability of the tax revenue and increases rates compared to a system in which the provider tax was applied equally to all health care providers.

As noted above, there are four possible reasons that part of health care is exempt from the tax in Vermont: to protect low-income Vermonters; to promote health care; because it's seen as too complicated; and because it's always been exempt. We will now examine the first three of those reasons as they apply to expanding the provider tax.

Do the Current Categorical Exemptions from the Provider Tax Increase Vermonters', and Particularly Low-Income Vermonters' Access to Health Care?

As far as maintaining the partial provider tax exemption to expand access to health care as a public good, RAND analysis of the available data suggests that the price elasticity of demand for health care is -.17 (Ringel, Hosek, Vollaard, & Mahnovski, 2005), which is to say, demand is very inelastic. This is even more true for low-income households who receive health care through federal and state programs, since Medicaid, state programs, and the ACA provide them with lower levels of cost-sharing, and "studies consistently find lower levels of demand elasticity at lower levels of cost-sharing" (Ringel, Hosek, Vollaard, & Mahnovski, 2005). This is in addition to health care's particular distortions of the "purchase" decision, described above.

This means that a 3.6% provider tax on those categories of health care goods and services that are currently exempt, even if it were passed on entirely to the consumer, would result in a reduction of health care utilization in those categories of less than seven tenths of one percent. If you harmonize the provider tax rates across all provider classes, the increase in the tax in half the health care areas will be partially offset by decreases in the tax in some of the other areas.

Are there Undue Complexities in Extending the Provider Tax to All Provider Categories?

One of the main complexities in the United States' health care system is just how many parties are involved in paying for Vermonters' health care:

- The federal government through Medicaid, Medicare, TRICARE, subsidies provided by the ACA, and the federal government's portion of federal employees' health care expenses.
- Individuals and families with private insurance, through premiums, deductibles, co-pays, co-insurance, and payments for non-covered medical expenses.

- Employers that provide health insurance to their employees and their employees' families, through premiums and contributions to HSA-like mechanisms for reimbursing employee out-of-pocket expenses, or through direct payments of claims
- Private insurance companies, through their portion of patient expenses.
- The state government through the state portion of Medicaid; state programs to assist low-income Vermonters with health care costs; and the state's portion of state employees' health care expenses.
- Local governments, including local school systems through the local governments' part of insurance premiums and out-of-pocket health care costs for town employees and teachers and other school system employees.
- Hospitals, which pay for all or part of the care for several groups of patients: emergency care patients, regardless of ability to pay; Medicaid patients, for which they are reimbursed only part of the cost of care; and patients who simply don't pay their bills. To offset the costs of that portion of services for which the hospital doesn't get paid, hospitals are forced to increase charges to private insurance companies. To cover those increases, private insurance companies do two things: increase the premiums that organizations and individuals pay; and reduce coverage by increasing patients' out-of-pocket expenses.

Vermont health care providers and legislators have done a great deal of work over the years on expanding the provider tax, including investigations into including some of the categories that are currently outside the provider tax system. We have studied the Vermont Health Care-related Tax Study Report (Pacific Health Policy Group, 2012). We acknowledge the barriers that exist now or existed in the past, including reporting and administrative barriers and resistance from particular provider categories. We note the fact that many providers, like dental practices, do not routinely produce annual financial statements, and that there would be some cost to each practice to begin to track the inputs to the Net Patient Revenue calculation. This issue also affects independent physician practices, chiropractors, and other practitioners whose finances are not currently regulated by the State. It is also true that to administer, monitor, and collect provider taxes from these health care sectors will require resources and potentially new regulatory authority for some State entity. We do not see any of the concerns, costs, or hurdles as outweighing the benefits to fairness, sustainability, and simplicity that expanding the provider tax to all categories of providers will create.

We are sensitive to the concerns that imposing a provider tax on physicians' practices and on dental practices may make it harder to attract young physicians and dentists to Vermont, and the consequent concern that fewer doctors and dentists practicing in the state will in fact be a significant barrier to access.

However, we note that there is a decline in primary care physicians and dentists now, and since they are currently not included in the provider tax, there are clearly other causes of this decline. We recommend that the legislature identify those causes and address them. We also note that the imposition of the provider tax has not led to a decrease in providers in those categories in which it has been imposed.

7. Consumption Tax Reform

Another factor is the relative number of Medicaid patients that each category of provider treats. Those with higher Medicaid patient populations generally get higher reimbursement rates when the provider tax is imposed on them, while those with lower Medicaid patient populations pay the provider tax, but see a smaller offset from increased Medicaid reimbursement rates.

The recent cases of dentists and emergency ambulance service providers gives us an illustrative contrast. The legislature studied the prospect of extending the provider tax to dental practices. That effort foundered on three snags: first, dental practices don't typically produce audited financial statements, so calculating and monitoring Net Patient Revenue would be difficult; second, many dental practices have few or no Medicaid patients, so increased Medicaid reimbursement rates are of limited value to them; and finally, dentists can support well-organized and well-funded lobbying campaigns.

On the other hand, the effort to extend the provider tax to emergency ambulance services was successful, and indeed had the support of emergency ambulance service providers. Like the dentists, the ambulance services did not typically produce audited financials. Unlike the dentists, the ambulance services all serve a meaningful number of Medicaid patients. By applying a provider tax to emergency ambulance services, the State was able to increase the Medicaid reimbursement rate, and the ambulance services ended up with more revenue.

As increasing Medicaid reimbursements is not a great benefit to those providers who don't treat Medicaid patients, a different approach to securing provider support may be 1) to decide at the outset that all provider classes will be included, so there is no in-or-out decision to be made, and no reason for a provider class to lobby to be in the "out" group; 2) to provide hard numbers in terms of what the inclusion of all provider classes means for how low the provider tax rate will be, and indeed how much lower the state sales tax will be.

As the example of the emergency ambulance service providers shows, implementing adequate financial record-keeping and reporting is not particularly difficult or expensive.

Hawai'i's excise tax on health care services applies to doctors and dentists and includes amounts received from patients and health insurance companies, and Michigan specifically taxes medical services when provided by Medicaid managed care organizations (Dumler, n.d.).

Since we believe the provider tax can be extended to the provider categories that are presently exempt without harming low-income Vermonters, and without limiting Vermonters' access to health care, and without undue complexity, and since we see meaningful benefits for Vermonters in terms of a lower sales tax rate and a consistent provider tax rate, and a simpler and more fair tax system, and since we see benefits to the state government in terms of a more stable and sustainable revenue stream and a simpler tax code, we recommend replacing Vermont's partial and inconsistent provider tax with a consistent provider tax on all providers of consumer health care, and using the revenue from the expanded provider tax to harmonize provider tax rates with each other and with the sales tax rate.

Commented [NL3]: The Medicaid rate is not based on the size of a provider's Medicaid population so those with more Medicaid patients do not get higher rates. Those with a higher Medicaid population/payer mix receive more revenue from Medicaid because they have a higher number of Medicaid beneficiaries getting services in their payer mix and therefore bill Medicaid more frequently.

Commented [NL4]: A rate of 3.7% across the board would actually be a decrease in revenues and would need to be offset elsewhere through cuts or increased revenues elsewhere.

Commented [NL5]: Again, expanding the tax rate to all providers at a blanket rate of 3.7% will not generate more revenue to offset/reduce other taxes but rather less provider tax revenues (mostly from lowering the rates for hospitals). A very back of the envelopes shows that it would likely have to be closer to 4.5% just to break even – more analysis would have to be done to come up with a more firm number.

As a 2012 report prepared for the Department of Vermont Health Access noted: "the actual calculation methodology is different for each of the existing assessments, reflecting the State's long-standing value of working collaboratively with the relevant provider classes to implement the assessments in a manner that is acceptable and transparent for the providers, while also being administratively streamlined for both providers and the State" (Pacific Health Policy Group, 2012, p. 32).

We hope that spirit of cooperation between the providers and the State can continue.

That 2012 study also notes (pp 6 & 7) that when extending the provider tax to new categories of provider, there are several important implementation tasks, including:

- Policy development – defining the classes, conferring with CMS, etc
- Potential impact on Section 1115 Waivers
- Administration – updating taxpayer lists, collecting data, collecting the tax
- Staffing – there must be sufficient resources at the responsible State entity to administer the program.

We expect that Vermont will continue to use the provider tax to fund the portion of Medicaid currently funded with the provider tax, and that will trigger the release of the same federal dollars to Vermont. We rely on the current mechanisms for protecting low-income Vermonters from unaffordable health care costs to continue to do so with the categories of health care that will be newly subject to the provider tax. We also refer back to our primary recommendation in Chapter 5 regarding low-income Vermonters and the tax code.

Therefore, although our preference would be to eliminate the provider tax and apply the sales tax uniformly to all consumer-level transactions, for reasons of fairness, simplicity, and sustainability, we recommend expanding the provider tax to include those categories of providers not already covered. We further recommend harmonizing the provider tax rates across all categories of providers, and to match the provider tax rate to the sales tax rate (2B).

We estimate that about $2,395,322,000 of Vermont health care expenditures are not currently subject to the provider tax (Perry, 2020). Extending a 3.6% provider tax to this activity would generate about $88 million, of which about $8 million would come from low-income Vermonters.[12]

Commented [NL6]: See my earlier notes. I don't think expanding the provider tax (at a rate of 3.7%) to the untaxed providers will raise this much money. Further some of the new revenues would be offset by the lowering of provider taxes for the other already taxed provider classes (particularly hospitals). As such I am very uncomfortable with the assertion that it will raise this much new money.

Per best practice, we recommend consultation with CMS before any changes to taxation and assessments on health care.

We also note that any large-scale reforms to health care, up to and including moving to a single-payer system, have the potential the drastically change any current or future health care taxes.

[12] Calculation based on data from *2018 Consumer Expenditure Survey* (U.S. Bureau of Labor Statistics, 2020) and "State Health Facts - Distribution of Total Population By Federal Poverty Level" (KFF, 2019)

7. Consumption Tax Reform

There is one more topic on the subject of taxing health care in Vermont. Vermont imposes an Insurance Premium Tax of 2%, paid by the insurance companies on the premiums they collect, and a claims assessment of 0.999% on every claim that is submitted to a private insurance company.

Hospitals build their budgets based on all their expected expenses and all their expected sources of revenue. They set the rates they charge commercial insurers based on the expenses the hospital hopes to cover with commercial insurance revenue. This typically does not include the provider tax, which the hospital usually plans to cover with Medicaid reimbursements from the state and federal governments. Insurance companies set their premiums so as to cover the bills from the hospital, and the claims assessment, and the Insurance Premium Tax. This means those taxes get paid by a number of payers:

- For consumers with individual insurance:
  - For consumers who qualify for the ACA's federal and state premium tax credits, the consumer pays for part of those taxes through their premiums, and the federal and state taxpayers pay for the rest through their taxes.
  - For consumers who do not qualify for those tax credits, the consumer pays for the Premium Tax and the claims assessment through their premiums.
- For consumers who get their insurance through their employer, the consumer and the employer together pay the Premium Tax and the claims assessment through their premiums.
- The employees of self-ensured companies don't pay the Premium Tax, but they do pay the claims assessment.

Commented [NL7]: This sentence doesn't make sense to me. The hospitals pay the provider taxes regardless of where the revenues come from. They do not pay the provider taxes with Medicaid revenues only.

There is a small problem here with paying taxes on taxes – since the premium includes money for the claims assessment, taxing the premium in effect is taxing both the money the insurance company collects for its operations and profit, and the money it collects to pass on to the state in claims assessments. This could be solved by allowing insurance companies to deduct the amount they pay in claims assessments from the amount they collect in premiums before they calculate their Insurance Premium Tax.

Further Considerations on Expanding the Sales Tax Base

> *Meaningful [sales tax] base broadening [is] a worthwhile endeavor, as base expansion allows for greater tax neutrality and revenue stability, and can be paired with more targeted relief for low-income households. (Kaeding, 2017)*

We conclude that there are no good reasons to exempt any categories of goods and services from the sales tax, with the single exception of health care, for which we recommend broader provider taxes. We further note that there are some affirmative reasons to include as many categories as possible.

Historically, the sales tax has been applied mostly to goods purchased in person, and as the economy evolves toward more services and more online transactions, it is important to the goals of fairness and sustainability that the tax structure shift with it.

By some measures, Vermont has a fairly narrow sales tax base. If you look just at the number of services Vermont taxes, you see that Vermont is on the lower end of the spectrum.