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Charting the Road to Coverage

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The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States

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Since implementation of the Affordable Care Act (ACA), more than 10 million people in 30 states (including the District of Columbia) that expanded Medicaid have gained Medicaid or CHIP coverage, and the collective rate of uninsured individuals in expansion states has fallen from 18 percent to less than 11 percent.[1,2]

This report is the third in a series prepared by the Robert Wood Johnson Foundation's *State Health Reform Assistance Network* exploring the fiscal implications of expansion. The first two reports explored state budget savings and revenue gains associated with expansion.[3] This paper examines early data on expansion-related decreases in uncompensated care costs and related state budget implications, including impending reductions in federal support for Medicaid Disproportionate Share (DSH) payments and waiver pools made available to support hospital uncompensated care costs prior to the Medicaid expansion authorized and funded under the ACA.

Expansion-related decreases in uncompensated care

Uncompensated care costs are generated in situations where hospitals and other providers deliver services to patients for which they are not fully compensated, primarily because patients are uninsured or underinsured and unable to pay out of pocket for their services.[4] The financial consequences of uncompensated care impact all health care stakeholders: providers shift these costs to insured patients, and as a result private insurance companies increase premiums for consumers and small businesses. Federal, state and local governments also devote significant funding to offset uncompensated care costs for essential providers: as of 2013, state and local governments provided approximately 37 percent of uncompensated care funding, totaling $19.8 billion through a variety of sources.[5]

While there is no standard definition of—or mechanism for—measuring uncompensated care costs, new information is emerging about the impact on uncompensated care costs of ACA insurance affordability programs—including Medicaid, CHIP and advance premium tax credits and cost-sharing reductions.[6] Since implementation of the ACA, states have experienced decreases in hospital uncompensated care costs related to previously uninsured residents gaining health coverage. Decreases in uncompensated care costs have been substantially greater in states that have expanded Medicaid. According to projections by the Assistant Secretary for Planning and Evaluation, uncompensated care costs in expansion states would decline by $5 billion in 2014, more than double the $2.4 billion

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State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org.*

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reduction in non-expansion states.[7] This translates into a 26 percent reduction in uncompensated care costs in expansion states, as compared to a 16 percent reduction in non-expansion states.[8]

Hospitals are tracking and reporting reductions in their uncompensated care costs, which will ultimately translate into savings for states as well as other payers in the health care system. While the methods for measuring uncompensated care vary across systems and states, hospital systems consistently report very different trends in uncompensated care depending on a state's expansion status. While facilities in both expansion and non-expansion states have generally experienced decreases in the volume of admissions or discharges by uninsured patients, expansion states have had substantially greater declines (see Table 1). For example, from the second quarter of 2013 through the second quarter of 2014, admissions by uninsured patients at HCA hospitals in expansion states plummeted by 48 percent as compared to a two percent decline at HCA hospitals in non-expansion states.[9]

Table 1
Percentage Change in Admissions/Discharges by Uninsured Patients and Uncompensated Care Costs in Hospital Systems With Facilities in Both Expansion and Non-Expansion States

Hospital System	Baseline Period	Comparison Period	Percentage Change in Admissions/ Discharges by Uninsured Patients		Percentage Change in Uncompensated Care Costs	
			Expansion States	Non-Expansion States	Expansion States	Non-Expansion States
Ascension[10]	Q2-Q4 2013	Q1-Q3 2014	-32%	-4%	-40%	6%
Community Health Systems[11]	Q2 2013	Q2 2014	-72%	0%	NA	NA
HCA[12]	Q2 2013	Q2 2014	-48%	-2%	NA	NA
LifePoint[13]	Q2 2013	Q2 2014	-67%	-14%	NA	NA
Tenet[14]	Q2 2013	Q2 2014	-54%	-8%	NA	NA

NA = not available

A number of hospital associations and hospital systems in expansion states have also published statewide data showing decreases in admissions or discharges by uninsured patients and corresponding hospital savings. Again, the methods and definitions vary, but the trends are consistent. Early data from hospital associations have shown up to a 46.5 percent decrease in admissions by uninsured patients and up to a 59.7 percent decrease in hospital uncompensated care costs since ACA implementation.[15] Across states, there have been the following examples of reductions in uncompensated care:

- **Arkansas**: During the first six months of the Private Option, Arkansas's alternative approach to Medicaid expansion, there was a 46.5 percent decrease in the number of uninsured admissions and a 35.5 percent decrease in the number of emergency department visits, as compared to a year earlier, according to a study by the Arkansas Hospital Association and the Arkansas Chapter of the Healthcare Financial Management Association. These declines translated into a 56.4 percent drop in uncompensated care losses, or a net gain to hospitals of $69.2 million over the six-month period.[16]
- **California**: Sutter Health, which operates facilities across Northern California, reported that its uncompensated care costs were 45 percent lower in 2014 than in 2013, a decrease from $166 million to $91 million.[17]
- **Colorado**: Data from the Colorado Hospital Association shows that the average uncompensated care costs decreased by 36 percent in the first quarter of 2014 when compared to the same period a year earlier.[18]
- **Iowa**: The Iowa Hospital Association reported that during the first half of 2014, the number of uncompensated cases declined by 18.5 percent, estimated to save hospitals approximately $32.5 million.[19]
- **Kentucky**: From January through September 2014, Kentucky hospitals had approximately 59.7 percent lower uncompensated care charges than the same period a year earlier—a drop from $1.9 billion to $766 million.[20]
- **Michigan**: At Detroit-area hospitals owned by Tenet Healthcare Corp., uncompensated care cases fell by 85 percent from the second quarter of 2013 to the second quarter of 2014.[21] Michigan's expansion took effect in April 2014.
- **New Hampshire**: New Hampshire's expansion was not in effect for most of 2014; it was implemented in August 2014. Nonetheless, according to the New Hampshire Hospital Association, for 2014, New Hampshire hospitals had a 17 percent decrease in emergency department visits, a 16 percent decrease in uninsured inpatient admissions, and an 8 percent decrease in uninsured outpatient services, as compared to the year prior.[22]

- **New Jersey**: Governor Chris Christie announced that New Jersey hospitals have experienced a 43 percent decrease in uncompensated care cases.[23]
- **Ohio**: The Cleveland Clinic reported a 40 percent decrease in its charity care spending from 2013 to 2014, and a 27 percent decrease in its uncompensated care costs during the same period.[24] In the Columbus area, the Ohio State University Wexner Medical Center (Wexner) and OhioHealth saw their percentage of uninsured patients decrease by more than 50 percent from fiscal year (FY) 2013 to FY 2015. At Wexner, hospital uncompensated care costs decreased from approximately $60 million to almost $30 million from FY 2014 to FY 2015, and at OhioHealth, uncompensated care costs decreased from about $120 million to less than $50 million from FY 2013 to FY 2015.[25]

State budget implications

While it is too early to do a comprehensive assessment of how hospital uncompensated care savings translate into state budget savings or enable investment in additional state priorities, some early information is emerging from states:

- **Arkansas**: Reductions in uncompensated care have resulted in $17,200,000 in state general fund savings in 2015.[26]
- **California**: Due to expansion, the state is estimated to save approximately $1.4 billion in general funds for FY 2014-2015 and FY 2015-2016 related to reductions in indigent care funding to counties.[27]
- **Kentucky**: Decreases in uncompensated care have allowed the Commonwealth, the Louisville Metro Government and the University of Louisville to reduce their planned contributions to the University of Louisville Hospital Quality Care Charity Trust Fund by more than $13.5 million in 2015—nearing a 46 percent decrease from 2013 funding levels.[28]
- **New Jersey**: Governor Christie's FY 2016 budget reflects the decline in uncompensated care costs by proposing a $74 million cut in state-funded hospital charity care grants. These funds will instead be used towards a combined state and federally-funded $45 million increase in Medicaid physician reimbursement and a $27 million increase in graduate medical education funding.[29]

Additional factors influencing uncompensated care funding to states

Since the 2012 Supreme Court ruling, which made Medicaid expansion voluntary for states, states have been deliberating a complex set of policy, fiscal and political considerations related to expansion—including the decline in uncompensated care and related fiscal implications. Among the uncompensated care related considerations for states and providers are the impending cuts in federal Medicaid DSH and the Centers for Medicare & Medicaid Services' (CMS) recently articulated policy regarding ongoing federal funding for uncompensated care pools established under Section 1115 waivers.

Medicaid DSH Cuts. With the passage of the ACA, Congress initiated a coverage model intended to ensure access to affordable insurance coverage for most Americans. Anticipating that near universal coverage would significantly reduce the need for uncompensated care funding, Congress made cuts to federal Medicaid DSH allotments to states.[30] The DSH cuts have been delayed, and are now slated to go into effect federal FY 2018 (that is, beginning October 1, 2017). From federal FY 2018 to 2025, federal funding for Medicaid DSH payments is slated to decrease by a total of $43 billion, starting with $2 billion in cuts in FY 2018 and eventually increasing to $8 billion in cuts per year by FYs 2024 and 2025.[31]

The statutory DSH cuts present a significant challenge in states that choose not to expand their Medicaid programs. While non-expansion states have seen decreases in their uncompensated care costs since ACA implementation, those reductions have been substantially smaller than those in expansion states. When the DSH reductions occur, hospitals in the non-expansion states will receive less funding for uncompensated care provided to uninsured individuals, most notably, those with incomes below 100 percent of the federal poverty level (FPL) who are ineligible for both Medicaid and advance premium tax credits and cost-sharing reductions. Conversely, expansion states have an opportunity to reallocate state DSH funds that are freed up as a result of uncompensated care reductions for other state priorities. States could follow New Jersey's lead and re-appropriate state funds they would have used for Medicaid DSH to increase Medicaid provider rates and increase support for graduate medical education.[32] To the extent states use re-allocated funds for the costs of services provided to expansion adults, they will draw down more federal funding through the enhanced federal matching for expansion adults. That is, state DSH costs are matched at a state's standard matching rates, while state costs for services provided to expansion adults are matched at an enhanced rate (100 percent through 2016 and phasing down and leveling off at 90 percent in 2020).

Uncompensated Care Pools. At the same time that states are preparing for a reduction in federal funding for Medicaid DSH, CMS is rethinking its policies on discretionary uncompensated care pools that have been established in some states through section 1115 waivers to help cover the cost of uncompensated care. In a letter to Florida's Medicaid director, CMS articulated a clear policy preference for using federal Medicaid funds to pay for coverage and access rather than uncompensated care.[33] Nine states have received such a waiver, including four states that have not expanded their Medicaid programs; CMS is in discussions with these states regarding the future of their pools.[34] These pools vary in size, but can provide a large amount of funding to hospitals; for example, Florida's Low Income Pool is worth $2.16 billion—including $1.3 billion of federal matching funds.[35] Thus states with uncompensated care pools that have not taken steps to reduce uncompensated care by covering people who could be eligible for Medicaid under the ACA expansion face the prospect of both the loss of Medicaid DSH funds, and restructuring or reduction of their uncompensated care pools, which substantially raises the fiscal stakes associated with the decision not to expand.

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[2] Montana is included in the 30 states that have expanded Medicaid; however, its expansion will not take effect until the State receives approval from the Centers for Medicare and Medicaid Services to implement a waiver consistent with state legislation.

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[6] Depending on the provider type and the purpose for which uncompensated care costs are being measured, the definition could include, in addition to the costs of services provided to uninsured patients, the costs of services provided to underinsured patients, bad debt (related to either or both insured or uninsured patients) and under-reimbursement by Medicaid. It should also be noted that while there is no standard definition of "uncompensated care," there is also no standard definition of "costs."

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[12] Ibid.

[13] Ibid.

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