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Medicaid Expansion Opt-Outs and Uncompensated Care

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Although most attention leading up to the U.S. Supreme Court decision on the Affordable Care Act (ACA) focused on the individual health insurance mandate, the ruling opened an unexpected new front in the health care reform debate. By a seven-to-two margin, the justices found unduly coercive the government's plan to withhold all federal Medicaid funds from states that don't expand their Medicaid programs. Staking out a middle ground, the Court ruled that the ACA's Medicaid expansion could go forward as an option for states. Already, eight governors have announced their intention to forgo expansion; more may join them in the coming months.[1]

The Court ruling is significant because the ACA's coverage reforms were designed as a package to bring the country closer to universal coverage: the Medicaid expansion will cover uninsured people with incomes below 138% of the poverty level, and a new federal tax-credit and subsidy program is available to taxpayers with incomes between 100 and 400% of the poverty level who purchase coverage through their state's insurance exchange. Combined with the individual mandate and insurance-market regulations guaranteeing access to coverage, these reforms are projected to result in coverage of up to 33 million uninsured people by 2022.[2]

With the number of uninsured people projected to drop by half, policymakers anticipated a substantial decrease in the uncompensated care provided at acute care hospitals. Consequently, beginning in 2014 the ACA initiates a series of payment reductions under the Medicare and Medicaid Disproportionate Share Hospital (DSH) programs. These programs, which pay out about $22 billion annually, partially reimburse nearly three quarters of U.S. hospitals for otherwise uncompensated care provided to low-income patients.[2,3]

Scheduled reductions through Medicaid DSH total $18.1 billion between 2014 and 2020, though details on how these cuts will be distributed among states are still forthcoming. Changes under the Medicare DSH program will be determined under a new formula that begins with a 75% decrease from current levels and then adds back funds on the basis of the percentage decreases in each state's uninsured rate.[4] Under this formula, a hospital in a state that reduces its uninsured rate by half could see a 38% decrease in its Medicare DSH payments.

Without further changes, these DSH reductions could create a substantial financial shortfall for hospitals in states that forgo Medicaid expansion. According to

Simulated Changes in Disproportionate Share Hospital (DSH) Funding per Patient-Day, 2014–2020.*

State	Average DSH Payment per Patient-Day under Current Formulas	Simulated Change under ACA		State	Average DSH Payment per Patient-Day under Current Formulas	Simulated Change under ACA	
		Full Medicaid Expansion	No Medicaid Expansion			Full Medicaid Expansion	No Medicaid Expansion
		dollars				*dollars*	
United States	**194**	**–56**	**–32**	Missouri	293	–79	–55
Alabama	219	–62	–39	Montana	126	–32	–15
Alaska	243	–51	–29	Nebraska	136	–35	–15
Arizona	133	–40	–20	Nevada	120	–35	–19
Arkansas	140	–40	–15	New Hampshire	629	–151	–139
California	263	–79	–40	New Jersey	307	–80	–61
Colorado	128	–36	–22	New Mexico	132	–38	–15
Connecticut	211	–56	–41	New York	260	–72	–47
Delaware	111	–32	–13	North Carolina	183	–55	–28
District of Columbia	249	–70	–42	North Dakota	94	–25	–11
Florida	122	–39	–16	Ohio	156	–44	–27
Georgia	169	–51	–26	Oklahoma	129	–39	–14
Hawaii	119	–38	–16	Oregon	102	–26	–11
Idaho	120	–32	–13	Pennsylvania	154	–41	–29
Illinois	162	–50	–23	Rhode Island	195	–51	–38
Indiana	164	–47	–27	South Carolina	249	–69	–45
Iowa	142	–37	–16	South Dakota	118	–32	–13
Kansas	115	–34	–18	Tennessee	187	–54	–31
Kentucky	178	–55	–25	Texas	200	–58	–32
Louisiana	400	–104	–79	Utah	76	–20	–9
Maine	308	–81	–60	Vermont	243	–65	–44
Maryland	190	–59	–26	Virginia	105	–32	–15
Massachusetts	216	–60	–38	Washington	201	–58	–33
Michigan	162	–49	–25	West Virginia	158	–47	–25
Minnesota	128	–31	–15	Wisconsin	147	–37	–16
Mississippi	219	–66	–33	Wyoming	45	–14	–6

* Dollar values are per–patient-day averages for all inpatients in acute care hospitals in each state. DSH payments under both Medicare and Medicaid are included. ACA denotes Affordable Care Act. Data are from Kaiser State Health Facts, 2009 Medicare Cost Report Data, and the 2009 American Community Survey.

the 2009 American Community Survey, 45% of the nonelderly uninsured population had income above the Medicaid expansion threshold (see Supplementary Appendix, available with the full text of this article at NEJM.org). Therefore, a state that was not expanding its Medicaid program could reduce its uninsured rate and trigger DSH cuts simply by covering people though its insurance exchange. Moreover, since subsidies for coverage through exchanges are available only to taxpayers with incomes above 100% of the poverty level, without an expanded Medicaid program there is no subsidized coverage option for low-income adults who aren't already eligible for Medicaid.[5] Without an affordable coverage option, these people would be exempted from the individual mandate — and so would remain uninsured and the primary beneficiaries of uncompensated hospital care. Hospitals in nonexpansion states, in other words, could face substantial erosion of DSH funds despite seeing little or no change in the amount of uncompensated care they provide.

To further investigate the implications of Medicaid expansion

opt-outs for U.S. hospitals, I simulated state-level DSH changes under the ACA. I did so by combining coverage and income data from the American Community Survey with state data on Medicaid DSH allotments and Medicare cost reports submitted by all acute care hospitals. The analysis considered effects of two scenarios: total DSH reductions if a state fully expands Medicaid and DSH changes if the state forgoes expansion.

Since the new Medicare formula incorporates changes in states' uninsured rates, the analysis required assumptions about the effects of the ACA's coverage expansions. For example, some currently uninsured people who are already eligible for Medicaid are expected to enroll, and nonexpansion states could conduct minimal outreach regarding their exchange, effectively limiting new insurance enrollments. I therefore assumed that a state could cover 60% of its uninsured population with incomes below 138% of the poverty level if it implemented the Medicaid expansion and just 10% if it did not. Similarly, I assumed that 40% of the uninsured population that was eligible for the exchange would be covered if the state fully implemented the ACA, and only 25% would be covered if it did not. These assumptions are in line with published take-up rates for public programs and with Congressional Budget Office estimates regarding the ACA. (Additional methodologic details and sensitivity analyses under alternative assumptions are provided in the Supplementary Appendix.)

The table summarizes the findings. If current funding policies were not changed, hospitals would receive an average of $194 in DSH funds per patient-day across all inpatient admissions. State-specific simulations show wide geographic variation in baseline funding estimates: Wyoming hospitals would receive $45 in DSH funds per patient-day, whereas those in Louisiana and New Hampshire would receive substantially more ($400 and $629, respectively).

Total DSH funding would decrease by about a third ($56 per patient-day) if scheduled DSH-program changes were implemented and if every state expanded its Medicaid program. That would amount to a cumulative reduction of about $51 billion between 2014 and 2020 (see the Supplementary Appendix). Again, there is considerable variation among states. California, which announced its intention to implement the expansion, would see its hospitals' DSH funds decreased by $79 per patient-day on average. Similarly, Illinois hospitals would incur reductions of about $50 per patient-day if the state moves forward with expansion.

Ideally, decreases in DSH funding would occur as more uninsured low-income people became insured, reducing hospitals' uncompensated-care demands. However, the simulation showed nontrivial reductions in DSH funding in nearly every state even under the nonexpansion scenario. If South Carolina continues with its plan to forgo expansion, for example, its hospitals would lose about $45 per patient-day. Critically, these cuts would occur even if few low-income uninsured South Carolinians obtained coverage.

The implications of these findings extend well beyond the millions of low-income uninsured people who would lose access to insurance if a state opts out of Medicaid expansion. Faced with substantial DSH-payment reductions, hospitals could seek to recoup losses through more limited provision of uncompensated care or, most likely, by passing nontrivial costs on to the privately insured. The state-by-state results presented here provide an initial estimate of the extent of costs that would need to be shifted to all inpatients to make up for losses in DSH funds.

To date, the Medicaid-expansion debate has focused on the potential savings for states concerned about financing 10% of the costs after 2019. But without either federal changes to DSH formulas or a full expansion of affordable coverage to the uninsured with incomes below the poverty line, states forgoing the Medicaid expansion are likely to leave a substantial uncompensated-care burden on hospitals. Decisions about expanding Medicaid are therefore difficult — but should be made after a full accounting of the fiscal implications for the state, its citizens, and its health care providers.

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2. Updated projections for the insurance coverage provisions of the Affordable Care Act. Washington, DC: Congressional Budget Office, March 12, 2012.

3. Medicare Payment Advisory Committee. June 2012 data book: health care spending and the Medicare program (http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf).

4. Patient Protection and Affordable Care Act, Title III, Subtitle B, Part III, Section 3133.

5. Kaiser Commission on Medicaid and the Uninsured. Where are states today? Medicaid and CHIP eligibility levels for children and nondisabled adults. Updated July 2012 (http://www.kff.org/medicaid/upload/7993-02.pdf).

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