National Association of Public Hospitals and Health Systems

Need for a Sustainable Solution: Restoring the Balance In Safety Net Financing

Summary

Hospitals and health systems that provide the bulk of care for society's most vulnerable people, such as the uninsured and Medicaid recipients, face a daunting challenge: steep cuts to federal support for uncompensated care and millions more uninsured patients than first projected under health care reform. Recent reports have focused largely on these two data points, but a third – uncompensated care costs – also deserves attention. **Using data from various nationally recognized sources, the National Association of Public Hospitals and Health Systems (NAPH) projects hospitals will see $53.3 billion more uncompensated care costs by 2019 than originally estimated when lawmakers approved the Affordable Care Act (ACA).** The following analysis describes the problem in detail and discusses policy implications.

Background and Analysis

Safety net providers ensure core public health needs are met and carry out critical health care functions including delivering essential community services, such as trauma and burn care, training tomorrow's health care workforce, and providing uncompensated care to uninsured and underinsured patients. With nearly one-third of the U.S. population covered by Medicaid or uninsured, the need for safety net providers – hospitals and health systems, physicians, and others – is growing.

NAPH represents about 200 hospitals and health systems across the country that are leading providers to Medicaid and uninsured patients. NAPH members serve communities in which, on average, 8 percent of the workforce is unemployed, 14.9 percent of the population is uninsured, and 32.5 percent of the population relies on government-sponsored health care coverage programs. NAPH members often are the only providers available to these vulnerable populations and remain committed to caring for the poor, uninsured, and underinsured, even if they bear a disproportionate share of uncompensated care costs.

However, the sustainability of America's health care safety net is nearing a crisis point. Many states already pay providers far below the cost of providing care to Medicaid patients, and current sources of safety net funding at the federal, state, and local government levels are varied, unpredictable, and dwindling. At this critical juncture, with the federal deficit weighing heavily on the country's future, support for the safety net is unraveling. Safety net health systems face myriad changes riddled with uncertainty: cuts to existing hospital payments, ever-changing regulatory requirements, an unclear outlook for major coverage expansion initiatives, and austere entitlement reform proposals that would further erode safety net funding.

Amid this uncertainty, safety net hospitals will see reductions in Medicaid disproportionate share hospital (DSH) payments starting in fiscal year (FY) 2014. These payments – a key source of support for hospitals shouldering uncompensated care costs generated by Medicaid and uninsured patients – will be reduced by significant amounts according to current law. By FY 2019, the federal government will cut its support of this critical program by about half.

The DSH cuts arose during ACA negotiations as a part of broader hospital payment reductions that lawmakers, at the time, believed would be offset by significant increases in insured patients. But that careful balance was upset by the June 2012 U.S. Supreme Court ruling that effectively rendered Medicaid expansion voluntary for states. Now, the cuts to DSH – unchanged by the court's decision – will come against a backdrop of great uncertainty regarding expanded coverage and the potential for significant shortfalls in federal support for safety net hospitals.

The Congressional Budget Office (CBO) estimates the court's decision will result in 6 million to 10 million more uninsured individuals than estimated when lawmakers passed the ACA in March 2010, bringing the total number of uninsured individuals to 29 million by FY 2019.[1,2]

This imbalance will have disastrous consequences on the nation's vulnerable populations, who rely on the safety net for their health care needs. Studies have shown the clear benefits of health coverage. For example, a recent *New England Journal of Medicine* article found that Medicaid coverage can decrease mortality rates, improve access to health care services, and improve general well-being.[3] The Institute of Medicine (IOM) found that a lack of coverage leads to adults forgoing critical preventive services that can reduce illness and premature death, an increased likelihood of being diagnosed with end-stage cancers, and higher mortality rates among those hospitalized for trauma or other serious conditions. IOM also found that uninsured adults who suffer from chronic conditions are more likely to suffer poorer outcomes, greater limitations in quality of life, and premature death.[4]

In addition to directly threatening patients' access to medically necessary health care services, the significant decrease in DSH payments, coupled with continued high levels of uncompensated care, will strain state and local budgets. This financial burden could lead to reductions in the availability of lifesaving services for vulnerable patients.

To better understand the potential impact of the unexpected higher levels of uninsured, especially in the context of dramatically reduced federal support for the cost of uncompensated care, NAPH conducted an analysis to quantify the financial impact of the Supreme Court's decision. Using data from CBO, the U.S. Bureau of Labor Statistics, the U.S. Census Bureau, and the American Hospital Association's annual survey, NAPH applied a per-capita uncompensated care dollar figure to the increased number of uninsured (as a result of the court's decision) to estimate total uncompensated care costs nationally.

Based on the CBO estimates of the number of additional uninsured individuals from FY 2014 to FY 2019,[5] uncompensated care costs nationally could be $53.3 billion higher than was estimated when Congress passed the ACA.

This unexpected new level of cost to hospitals and health systems dramatically amplifies the impact of the Medicaid DSH cuts, which will total $14.1 billion over the same period. The combined effect will jeopardize access to important health care services for vulnerable people and shift additional and burdensome uncompensated care costs onto state and local governments, providers, and taxpayers.

While the aggregate amount of Medicaid DSH cuts is hardwired into current law, the secretary of the U.S. Department of Health and Human Services has discretion in the distribution of cuts across states. Given this discretion, it is crucial for regulatory decisions to address the uncertainties created by the imbalance between anticipated uncompensated care needs and the level of federal support to hospitals that shoulder the majority of this work.

It is important to understand that DSH is the only Medicaid funding stream through which states are explicitly allowed to reimburse providers for care of the uninsured. But DSH doesn't cover all

uncompensated care costs, which include Medicaid payment shortfalls, and has failed to keep pace with the growth in the number of uninsured and the cost of caring for them. In 2010, 87 surveyed NAPH hospitals collectively incurred more than $8.4 billion in uncompensated care costs but received only $4 billion in Medicaid DSH payments.

The threat of an even greater imbalance created by voluntary Medicaid expansion and guaranteed DSH cuts cannot be justified. If allowed to move forward, this imbalance will have disastrous consequences for safety net hospital patients. The significant decrease in safety net hospital funding and continued high levels of uncompensated care will limit patients' access to lifesaving services.

We ask Congress to revisit the Medicaid DSH cuts included in the ACA. Specifically, we believe DSH funding cut by the ACA should be restored. NAPH is ready to work with lawmakers to devise a safety net funding policy that ensures access to care for all who need it.

---

[1]Congressional Budget Office. (March 2010). Letter to the Speaker of the House of Representatives Nancy Pelosi on cost estimate of H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation). Retrieved from http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

[2]Congressional Budget Office. (July 2012). Estimates for the insurance coverage provisions of the Affordable Care Act updated for the recent Supreme Court decision. Retrieved from http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[3]Sommers, B. D., Baicker, K., and Epstein, A. M. (2012). Mortality and access to care among adults after state Medicaid expansions. *New England Journal of Medicine,* 367(11), 1025-1034. doi: 10.1056/NEJMsa1202099.

[4]Institute of Medicine. (February 2009). America's uninsured crisis: Consequences for health and health care. Retrieved from http://www.iom.edu/~/media/Files/Report Files/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care/Americas Uninsured Crisis 2009 Report Brief.pdf.

[5]Congressional Budget Office. (March 2010). Letter to the Speaker of the House of Representatives Nancy Pelosi on cost estimate of H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation). Retrieved from http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf; Congressional Budget Office. (July 2012). Estimates for the insurance coverage provisions of the Affordable Care Act updated for the recent Supreme Court decision. Retrieved from http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.