

The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal

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ABSTRACT

ISSUE: By increasing health insurance coverage, the Affordable Care Act's Medicaid eligibility expansion was also expected to lessen the uncompensated care burden on hospitals. The expansion currently faces an uncertain future.

GOAL: To compare the change in hospitals' uncompensated care burden in the 31 states (plus the District of Columbia) that chose to expand Medicaid to the changes in states that did not, and to estimate how these expenses would be affected by repeal or further expansion.

METHODS: Analysis of uncompensated care data from Medicare Hospital Cost Reports from 2011 to 2015.

FINDINGS AND CONCLUSIONS: Uncompensated care burdens fell sharply in expansion states between 2013 and 2015, from 3.9 percent to 2.3 percent of operating costs. Estimated savings across all hospitals in Medicaid expansion states totaled \$6.2 billion. The largest reductions in uncompensated care were found for hospitals in expansion states that care for the highest proportion of low-income and uninsured patients. Legislation that scales back or eliminates Medicaid expansion is likely to expose these safety-net hospitals to large cost increases. Conversely, if the 19 states that chose not to expand Medicaid were to adopt expansion, their uncompensated care costs also would decrease by an estimated \$6.2 billion.

KEY TAKEAWAYS

- ▶ The Affordable Care Act's Medicaid expansion has significantly reduced hospitals' uncompensated care costs.
- ▶ Safety-net hospitals with high total uncompensated care costs have seen the greatest financial benefits.
- ▶ If all nonexpansion states were to expand Medicaid, total uncompensated care costs would fall by an estimated \$6.2 billion.



BACKGROUND

Prior to the Affordable Care Act (ACA), childless, nondisabled adults were ineligible for Medicaid in most states. The ACA allowed states to expand eligibility to nonelderly adults with incomes up to 138 percent of the federal poverty level (roughly \$16,400 for an individual and \$33,600 for a family of four in 2017). As of March 2017, 31 states and the District of Columbia had expanded Medicaid, while 19 states had not.¹

One intended benefit of the Medicaid expansion was to reduce uncompensated care burdens that hospitals face. Uncompensated care is any treatment or service not paid for by an insurer or patient. We define uncompensated care costs as the sum of a hospital's losses on both charity care (when hospitals forgo or reduce the cost of care) and bad debt (when hospitals bill for services but cannot collect payment).

Our previous research, detailed in a 2016 [Health Affairs article](#), found that hospitals in Medicaid-expansion states experienced a sizeable reduction in their uncompensated care costs between 2013 and 2014, from 4.1 percentage points to 3.1 percentage points of operating costs.² To see if this uncompensated care decrease has continued, we extended our analysis to 2015 and explored which hospitals saw the greatest decreases in uncompensated care costs.

This issue brief is intended to guide decisions around a possible ACA repeal and further state Medicaid expansions, as well as inform policies aimed at alleviating hospitals' uncompensated care burden. In 2015, U.S. hospitals provided a total of \$35.7 billion in uncompensated care, according to the American Hospital Association.³ However, this burden is unevenly distributed. Safety-net hospitals care for a larger-than-typical share of low-income and uninsured patients. In the past, Medicare and Medicaid disproportionate share hospital (DSH) payments provided significant financial relief to safety-net hospitals. But the ACA mandates a sizeable reduction in DSH payments.

FINDINGS

Uncompensated Care Declines in Expansion States Are Substantial Relative to Profit Margins

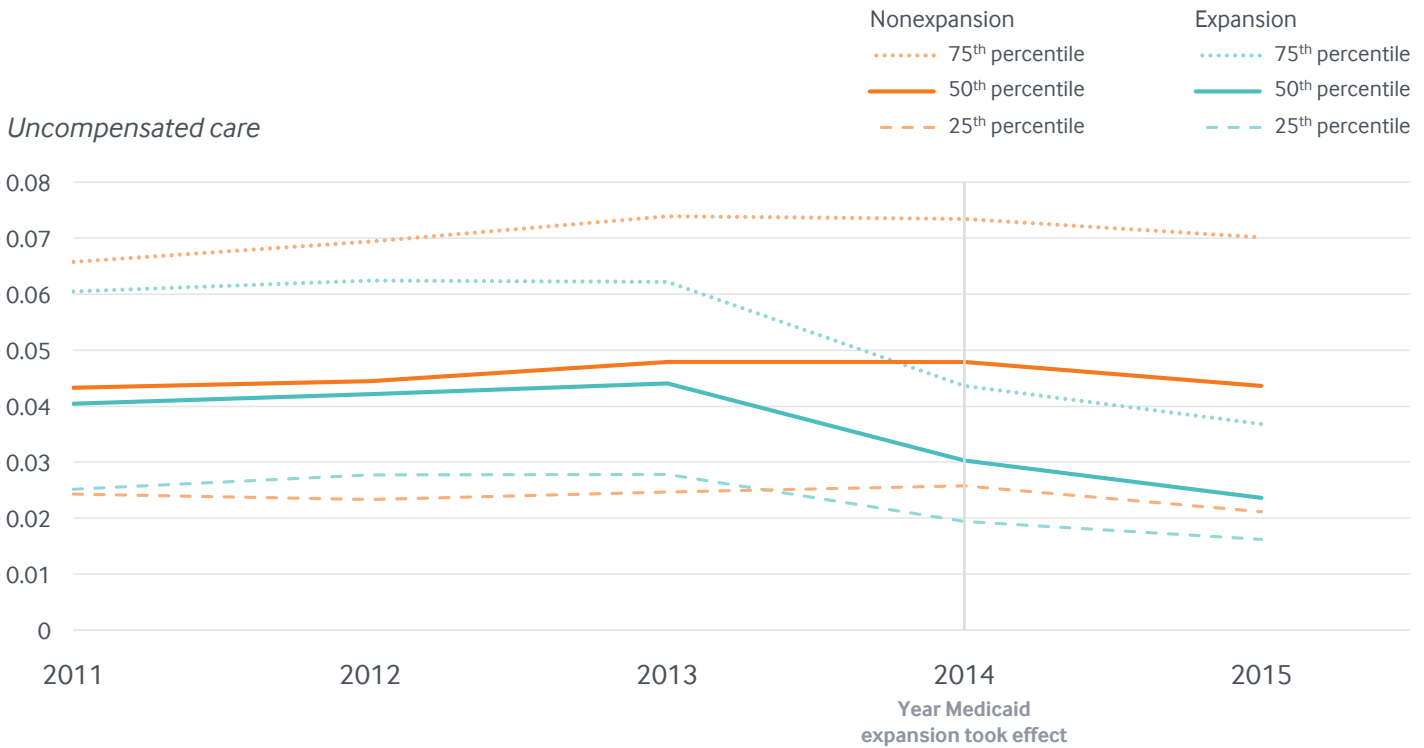
To identify trends in uncompensated care burdens for hospitals in expansion and nonexpansion states, we used data from Medicare Hospital Cost Reports to create a sample of 1,154 hospitals that report financial data for the calendar year. Focusing on hospitals within the 75th percentile, 50th percentile, and 25th percentile of the uncompensated care cost distribution, we found that between 2013 and 2014, these costs markedly declined in expansion states, and this downward trend continued into 2015 (Exhibit 1). The trajectories of uncompensated care costs were similar for hospitals across the three percentiles. In contrast, we found no similar break from historical trend in nonexpansion states.

The decline in uncompensated care costs in expansion states is economically meaningful. For example, the share of uncompensated care costs between 2013 and 2015 fell from just over 6.2 percent to just under 3.7 percent of operating costs among hospitals with high burdens. Overall, this is a cumulative decrease of roughly 40 percent. The decreases among hospitals with medium and low uncompensated care burdens were smaller but also meaningful: 2 percentage points and 1.2 percentage points of operating costs, respectively.

These results suggest that all hospitals benefited from the expansion and that the hospitals that had the highest levels of uncompensated care prior to 2014 benefited the most. Pooling the hospitals in expansion states together, we found that uncompensated care costs decreased between 2013 and 2015 from 3.9 percentage points to 2.3 percentage points of operating costs, a decline of 1.6 percentage points of operating costs.

These reductions in uncompensated care costs are substantial relative to hospital profit margins. Roughly 40 percent of hospitals in our sample had operating margins less than 1.6 percentage points of operating costs in 2011.

Exhibit 1. Uncompensated Care by Medicaid Expansion Status, Year, and Percentile of Uncompensated Care



Note: Uncompensated care is presented as a share of operating costs.
 Data: 2011–2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

For Every Dollar of Uncompensated Care Costs Hospitals in Expansion States Had in 2013, the ACA Erased 41 Cents by 2015

While hospitals in nonexpansion states did not experience dramatic declines in uncompensated care costs between 2013 and 2015, they did see small declines in these costs of 0.3–0.4 percentage points. To identify how much hospitals saved in uncompensated care costs from the Medicaid expansion versus other market changes, we conducted a trend analysis, computing the average change in uncompensated care costs from 2013 to 2015 (Exhibit 2).

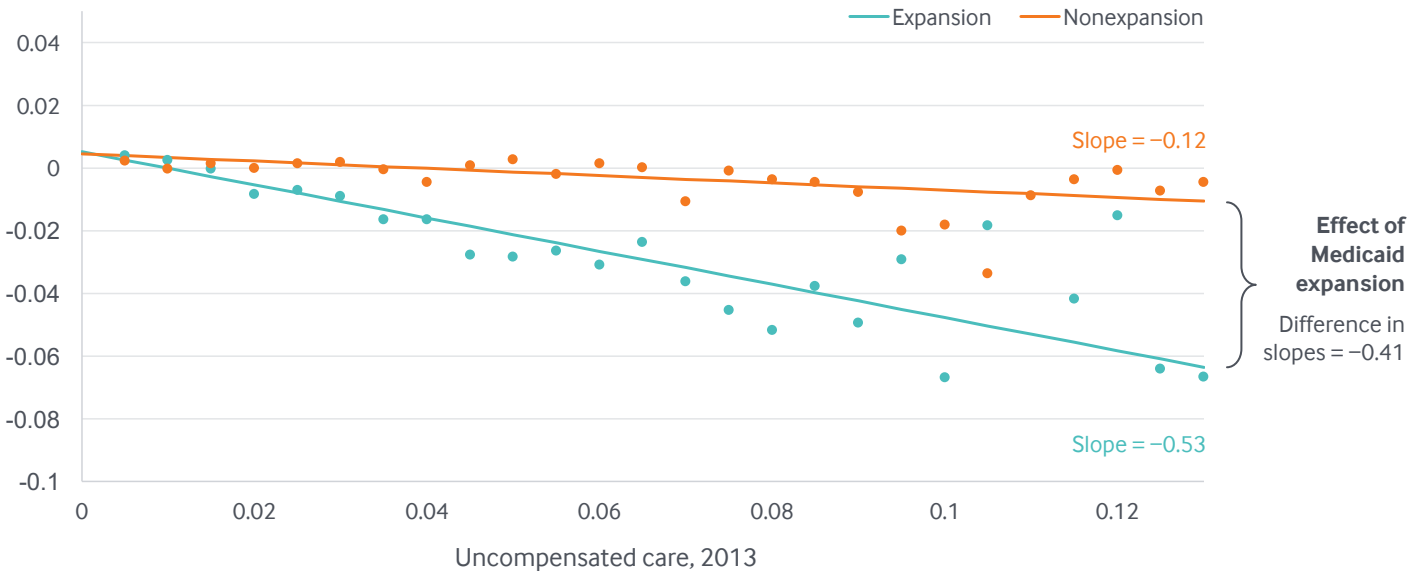
Hospitals in Medicaid expansion states saw their uncompensated care costs decline by 0.53 percentage points between 2013 and 2015 for each additional percentage point of uncompensated care costs in 2013. In comparison, hospitals in nonexpansion states saw their uncompensated costs fall by only 0.12 percentage points for each additional percentage point of uncompensated costs.

Overall, these estimates suggest that Medicaid expansion cut every dollar that a hospital spent on uncompensated care by 41 cents between 2013 and 2015.⁴ Scaling these numbers to all hospitals in the 31 states (plus the District of Columbia) that expanded eligibility suggests that offering Medicaid to nonelderly adults reduced uncompensated care costs in these states by nearly \$6.2 billion.⁵

If the 19 nonexpansion states were to expand Medicaid, uncompensated care in those states would fall from 6.1 percent of operating costs to an estimated 3.6 percent. This would reduce uncompensated care by \$6.2 billion, the same amount as in the 31 states (plus D.C.) that expanded Medicaid. That is because prior to the ACA taking effect, hospitals in both groups of states had the same amount, dollarwise, of uncompensated care. Despite being much smaller in population than the expansion states, the nonexpansion states tend to have higher uncompensated care burdens.

Exhibit 2. Change in Uncompensated Care Costs, 2013–2015

Change in uncompensated care, 2013–2015



Notes: Uncompensated care is presented as a share of operating costs. Hospitals are placed into bins based on their 2013 uncompensated care costs. For each bin, we calculated the average change in uncompensated care costs from 2013 to 2015. Bins for expansion states are presented as teal dots, bins for nonexpansion states are presented as orange dots. The orange line is a regression line through the nonexpansion hospitals, and the teal line is a regression line through the expansion hospitals. For computing the least squares lines, uncompensated care values above or below the 2.5 percentile or the 97.5 percentile are replaced with values at those respective percentiles. For creating the bins, we replace all hospitals above 13 percentage points of operating costs with 13 percentage points of operating costs.

Data: 2011–2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

Medicaid Expansion Reduced Uncompensated Care Burdens for Safety-Net Hospitals Not “Made Whole” by Medicaid DSH Payments

We also explored how the Medicaid expansion specifically impacted uncompensated care costs in safety-net hospitals compared to other hospitals. First we divided hospitals by their share of patients on Medicaid, which is one common measure of whether a hospital is a safety-net provider (Exhibit 3).

In expansion states, hospitals with the highest Medicaid shares in 2013 had slightly larger decreases in uncompensated care costs than hospitals with the lowest shares (0.020% vs. 0.011% of operating costs). While statistically significant, the relationship is weak.

This finding does not suggest that “safety net” hospitals are not benefiting from the Medicaid expansion. Instead, it indicates that looking only at Medicaid share is inadequate for identifying safety-net hospitals. To illustrate this point, we categorized hospitals by their total uncompensated

and undercompensated care burden (Exhibit 4).⁶ This analysis considered shortfalls from all low-income patients, including the uninsured as well as those covered under Medicaid and the Children’s Health Insurance Program. We also included safety-net compensation that is tied to serving these patients, such as Medicaid DSH payments, to determine whether these supplemental payments provide adequate financial assistance.

This analysis provides strong evidence that hospitals with higher overall uncompensated and undercompensated care burdens in 2013 benefited more from the Medicaid expansion than hospitals without large low-income populations. For example, among hospitals with the highest burdens, those in expansion states saw uncompensated care costs decrease by 2.6 percentage points more than hospitals in nonexpansion states. By contrast, among hospitals with the lowest safety-net burdens, those in expansion states saw uncompensated care costs decrease by only 0.7 points more than hospitals in nonexpansion states.

Exhibit 3. Uncompensated Care Costs by Medicaid Share, 2013–2015

	2013	2015	Change, 2013–2015
High 2013 hospital Medicaid share (>11%)			
Expansion states	0.049	0.029	-0.020
Nonexpansion states	0.061	0.057	-0.004
Difference	-0.012	-0.028	-0.016
Medium 2013 hospital Medicaid share (3.9%–11%)			
Expansion states	0.039	0.023	-0.016
Nonexpansion states	0.053	0.055	0.002
Difference	-0.014	-0.031	-0.017
Low 2013 hospital Medicaid share (<3.9%)			
Expansion states	0.030	0.019	-0.011
Nonexpansion states	0.033	0.032	-0.001
Difference	-0.003	-0.013	-0.010

Notes: Uncompensated care is presented as a share of operating costs. Uncompensated care values above or below the 2.5 percentile or the 97.5 percentile are replaced with values at those respective percentiles.

Data: 2011–2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

Exhibit 4. Uncompensated Care Costs by Total Uncompensated Care Burden, 2013–2015

	2013	2015	Change, 2013–2015
High 2013 burden (>7.9% of operating costs)			
Expansion states	0.071	0.038	-0.033
Nonexpansion states	0.093	0.086	-0.007
Difference	-0.022	-0.048	-0.026
Medium 2013 burden (4.7%–7.9% of operating costs)			
Expansion states	0.042	0.025	-0.017
Nonexpansion states	0.053	0.052	-0.001
Difference	-0.011	-0.027	-0.016
Low 2013 burden (<4.7% of operating costs)			
Expansion states	0.021	0.016	-0.006
Nonexpansion states	0.029	0.030	0.001
Difference	-0.008	-0.015	-0.007

Notes: Uncompensated care is presented as a share of operating costs. Uncompensated care values above or below the 2.5 percentile or the 97.5 percentile are replaced with values at those respective percentiles.

Data: 2011–2015 Medicare Hospital Cost Reports, for a balanced sample of 1,154 hospitals.

Hospitals that have benefited from the Medicaid expansion are hospitals that faced substantial shortfalls from serving low-income and uninsured populations. Existing federal funding mechanisms like DSH payments were not designed to mitigate shortfalls of this size. This analysis suggests that eliminating the Medicaid expansions and restoring Medicaid DSH as the primary mechanism for supplementary reimbursement to safety-net hospitals will reintroduce systematic disparities in hospital uncompensated care burdens. It also suggests that, if the Medicaid expansions are eliminated, policymakers will want to consider changing the way DSH payments are targeted so as to include a broader set of metrics.

CONCLUSION

Our analysis suggests that the Medicaid expansion has met the ACA goal of reducing uncompensated care burdens for hospitals. For each additional dollar spent on hospital services for Medicaid patients in expansion states, hospitals enjoyed an approximate 41-cent reduction in uncompensated care costs. When all hospitals in expansion states are considered, this translates into a \$6.2 billion reduction in uncompensated care costs. If the 19 nonexpansion states were to expand Medicaid, uncompensated care costs in those states would, coincidentally, also fall by \$6.2 billion.

There have been noticeable, but much smaller, decreases (0.3–0.4 percentage points) in uncompensated care costs in nonexpansion states. An important question beyond the scope of this brief is whether these decreases have been driven by other features or consequences of the ACA (for example, the individual mandate, the health insurance marketplaces, or outreach efforts to increase coverage) or whether other economic or hospital behavior factors are at play.

Further, our analysis suggests that reductions in uncompensated care costs were concentrated among hospitals that had large budget shortfalls from providing care to low-income and uninsured patients prior to the Medicaid expansions. This suggests that the expansions complemented other programs, such as Medicaid DSH payments, that offer help to safety-net hospitals.

The future of the Medicaid expansions remains uncertain. There is a chance that more of the 19 states that have not yet expanded Medicaid will do so in the future. It is also possible that these expansions will be scaled back or eliminated by future legislation. For example, the American Health Care Act, if it had become law, would have ended the ACA Medicaid expansion by 2020 and likely decreased the number of people gaining insurance through the marketplaces. Our results demonstrate the close relationship between the Medicaid program and hospital finances, suggesting there would be large decreases in uncompensated care costs from further expansion and large increases in those costs if the expansions are rolled back.

HOW THIS STUDY WAS CONDUCTED

This issue brief updates our 2016 [Health Affairs article](#), in which we examined the evolution of uncompensated care costs from 2011 to 2014. We extend the analysis to include 2015 and see how these effects have evolved over time. For methodological details, we refer readers to our previous article.⁷

In this update, we rely on data from the 2011–2015 Medicare Hospital Cost Reports. Our sample is restricted to 1,154 hospitals that report financial data on the calendar year. We created a sample of states that increased Medicaid eligibility for childless adults in 2014 and a sample of states that did not. Six states that made other substantive changes to their Medicaid programs between 2011 and 2015 were excluded.⁸ We dropped hospitals that were not present in all years or had missing or inconsistent data.

We measure a hospital's uncompensated care costs to be the sum of losses from charity care and bad debt, computed as a percentage of total operating costs. To make numbers that are comparable across hospitals of different sizes, we divided each hospital's uncompensated care costs by that hospital's 2011 operating costs. We examine how uncompensated care costs change after the 2014 Medicaid expansions for hospitals in expansion states compared to hospitals in nonexpansion states.⁹ We also examine whether safety-net hospitals (defined using a number of possible criteria) disproportionately benefited from the Medicaid expansion.

NOTES

- ¹ Under the ACA, individuals who earn less than 100 percent of the federal poverty level are not eligible for subsidized coverage in the individual health insurance marketplaces.
- ² D. Dranove, C. Garthwaite, and C. Ody, “[Uncompensated Care Decreased at Hospitals in Medicaid Expansion States but Not at Hospitals in Nonexpansion States](#),” *Health Affairs*, Aug. 2016 35(8):1471–79.
- ³ American Hospital Association, [Uncompensated Hospital Care Cost Fact Sheet](#) (AHA, Dec. 2016).
- ⁴ This is calculated as the differences in slopes between expansion and nonexpansion states: $0.53 - 0.12 = 0.41$.
- ⁵ The \$6.2 billion figure is based on acute-care and critical-access hospitals filing a cost report and excludes Arizona, California, Massachusetts, and Minnesota. It extrapolates our estimates to all hospitals that had expanded Medicaid as of March of 2017. This includes five states that did not expand in 2014 but have since expanded: Pennsylvania, Indiana, Alaska, Michigan, and Louisiana.
- ⁶ This is based on row 31 of schedule S-10 of the Medicare cost reports and is titled “Total unreimbursed and uncompensated care cost.”
- ⁷ See note 2.
- ⁸ We continue the decision in our prior research to discard hospitals in Arizona, California, Massachusetts, and Minnesota. We also exclude Indiana and Pennsylvania because they expanded in 2015.
- ⁹ In our [Health Affairs article](#), we provide further confirmation that the changes in uncompensated care were, in fact, driven by the Medicaid expansion by illustrating that the decreases were largest for hospitals with populations in their catchment areas with incomes less than 138 percent of the federal poverty level—the new eligibility limit for childless adults.

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