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Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect

Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains

By Jessica Schubel and Matt Broaddus

Hospitals' and other providers' uncompensated care costs have fallen significantly since the implementation of the Affordable Care Act's (ACA) major coverage provisions. But approved and proposed Medicaid waivers that would take Medicaid away from people not working or engaged in work activities for a set number of hours each month; lock people out of coverage for not paying premiums or meeting other requirements; and/or delay access to coverage jeopardize the financial gains beneficiaries, hospitals and other providers, and states have made. By making it harder for beneficiaries to obtain and maintain coverage, these proposals will not only impede access to care, they will also increase uncompensated care (services for which neither an insurer nor the patient reimburses providers), especially for hospitals.

Between 2013 and 2015, as the nationwide uninsured rate fell from 14.5 percent to 9.4 percent (a 35 percent decline), uncompensated care costs as a share of hospital operating expenses fell by 30 percent.[1] While such costs fell in all but two states, declines were larger in states where uninsured rates fell more, with a roughly one-to-one relationship between percent declines in uninsured rates and percent declines in uncompensated care costs as a share of hospital operating expenses. States that expanded Medicaid to low-income adults under the ACA saw both larger coverage gains and larger drops in uncompensated care: a 47 percent decrease in uncompensated care costs on average compared to an 11 percent decrease in states that did not expand Medicaid.

Less uncompensated care benefits patients, hospitals, and state budgets. While uncompensated care costs are bills patients don't pay up front, they still give rise to medical debt, which hospitals may seek to collect; become part of patients' credit history, reducing their access to loans; and can sometimes lead people to declare bankruptcy. Meanwhile, uncompensated care costs burden hospitals, making it harder for them to invest in new technologies or equipment, maintain needed capacity to serve patients, or even keep their doors open. Finally, uncompensated care costs burden

[1] Except where otherwise noted, all uncompensated care data come from: Medicaid and CHIP Payment and Access Commission (MACPAC), "Report to Congress on Medicaid and CHIP," March 2018, https://www.macpac.gov/wp-content/uploads/2018/03/Report-to-Congress-on-Medicaid-and-CHIP-March-2018.pdf.

state budgets, because many states cover a portion of these costs, at least for public hospitals and other safety net providers.

Because they would reverse a significant share of the coverage gains achieved under the ACA's Medicaid expansion, approved and pending Medicaid waiver proposals also threaten to reverse a meaningful share of the recent drop in uncompensated care costs. Kentucky, for example, secured a waiver earlier this year that will allow it to impose unprecedented barriers to care. By Kentucky's own estimates, the waiver will ultimately reverse about 15 percent of the Medicaid coverage gains achieved through expansion, potentially reversing a similar share of uncompensated care declines.

Medicaid Expansion Has Helped Drive Down Uncompensated Care Costs

Hospitals saw significant reductions in uncompensated care costs as the ACA's Medicaid expansion to low-income adults, marketplace subsidies, and major insurance market reforms took effect in 2014. From 2013 to 2015, the nationwide uninsured rate fell 35 percent, and nationwide hospital uncompensated care costs fell by about 30 percent as a share of hospital budgets — a $12 billion drop in 2015 dollars. But such costs fell even more precipitously in expansion states, where hospitals' uncompensated care costs fell by roughly half.[2] And in the ten expansion states (Kentucky, West Virginia, Washington, Oregon, Rhode Island, California, Vermont, Minnesota, Michigan, Illinois) where uninsured rates dropped most, uncompensated care costs fell by 57 percent on average.

These large drops in uncompensated care costs were almost certainly the result of the large coverage gains made under the ACA. Nationally, the decline in 2014 was striking compared to the previous couple years.[3] Moreover, as Figure 1 shows, there is a tight, roughly one-to-one relationship between the magnitude of a state's uninsured rate reductions and its drop in uncompensated care: the larger a state's uninsured rate drop, the larger the decline in uncompensated care. (See Appendix Table 1 for state-by-state data.)[4] Declines in uninsured rates and uncompensated care costs were greater in Medicaid expansion states, and the relationship between uninsured rate declines and uncompensated care drops was also stronger in these states, likely because Medicaid serves the most financially vulnerable who are least likely able to pay medical bills when uninsured, thus leading to hospital uncompensated care costs.

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[2] In general, this paper defines uncompensated care as any services for which a provider is not reimbursed. As noted, the hospital uncompensated care data are taken from the March 2018 MACPAC report. The MACPAC estimates are drawn from Medicare hospital cost reports. These reports generally define uncompensated care as the combined cost of charity care (medical service costs which the hospital determines the patient does not have the financial capacity to pay) and bad debt (unpaid medical service costs which the hospital determines the patient does have the financial capacity to pay).

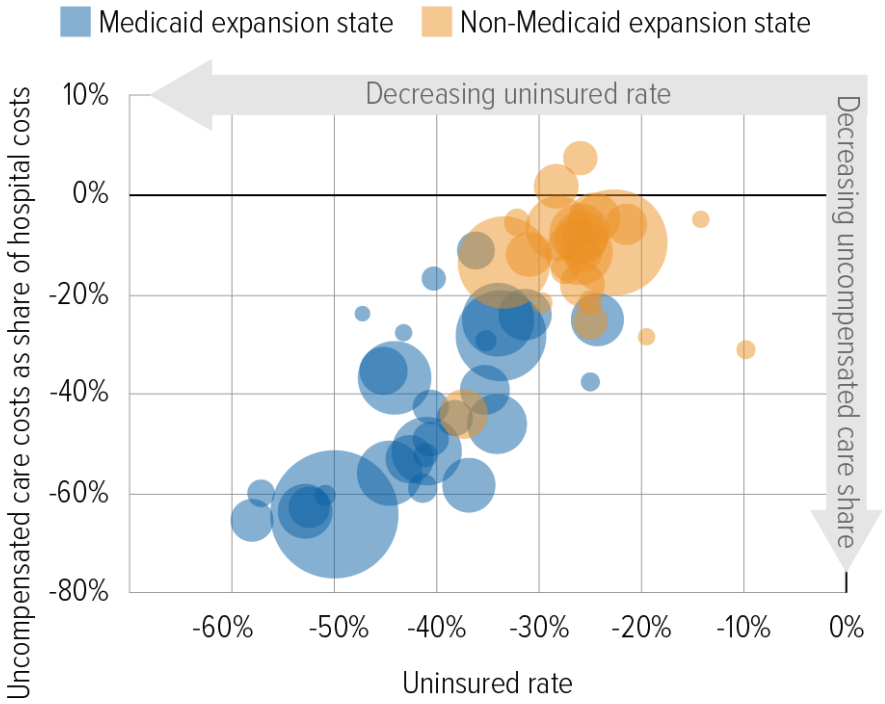
[3] Council of Economic Advisers, "The Economic Record of the Obama Administration: Reforming the Health Care System," December 2016, https://obamawhitehouse.archives.gov/sites/default/files/page/files/20161213_cea_record_healh_care_reform.pdf.

[4] A regression of percent changes in uncompensated care on percent changes in state uninsured rates, weighted by state population size, confirms the roughly one-to-one relationship.

FIGURE 1

Uncompensated Care Costs Decline with Decline in Uninsured Rate

Percent change, 2013 to 2015



Source: CBPP analysis using Medicaid and CHIP Payment and Access Commission data on uncompensated care costs and Census Bureau data on uninsured rates by state.

Note: The Affordable Care Act allows states to expand their Medicaid programs. Each bubble represents a state with the size of the bubble based on state population.

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Uncompensated Care Declines Benefit Patients, Hospitals, and States

The ACA's coverage expansions, and Medicaid expansion in particular, have significantly improved access to care. Nationally, the share of people failing to get needed medical care due to cost fell by about a quarter between 2013 and 2015, with larger declines in states where coverage gains have been larger.[5] Meanwhile, Medicaid expansion resulted in increases in the shares of people with a personal physician, getting check-ups, and getting recommended preventive care such as

[5] https://www.cdc.gov/nchs/data/nhis/earlyrelease/Earlyrelease201705_03.pdf; Council of Economic Advisers, "The Economic Record of the Obama Administration: Reforming the Health Care System," December 2016, https://obamawhitehouse.archives.gov/sites/default/files/page/files/20161213_cea_record_health_care_reform.pdf.

cholesterol and cancer screenings, and decreases in the shares of people delaying care due to costs, skipping medications due to costs, or relying on the emergency room for care, studies have found.[6]

In addition to improving access to care and health outcomes for Medicaid beneficiaries, expanding coverage also has increased financial security by lowering medical debt and reducing the risk of medical bankruptcy. Expanding Medicaid coverage results in fewer and smaller unpaid medical bills as well as having fewer debts sent to third-party collection agencies, studies have found.[7] Another study showed that the share of low-income adults in Arkansas and Kentucky having trouble paying their medical bills dropped substantially, compared to low-income adults in Texas (which did not expand Medicaid).[8] Moreover, with fewer and lower unpaid medical bills, adults who gained coverage through the Medicaid expansion have been found to have better credit, qualifying them for lower-interest mortgage, auto, and credit card loans — leading to estimated savings that average $280 per adult gaining coverage per year on interest payments, and an estimated $520 million across the expansion population.[9]

Meanwhile, Medicaid expansion has substantially improved hospitals' finances, especially for rural hospitals. While Medicaid expansion has improved *all* hospitals' operating margins (i.e., the difference between their revenue from providing services to patients and their total operating expenses) and total margins (the difference between revenue from all sources, including donations, parking fees, vending machines, etc., and total operating expenses), the effect was particularly pronounced in rural areas.[10] From 2013 to 2015, rural hospitals in expansion states increased their operating margins by 4 percentage points more, and their total margins by 2.3 percentage points more, than rural hospitals in non-expansion states.[11] Reducing uncompensated care costs helps

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[6] See Benjamin D. Sommers *et al.*, "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *Journal of the American Medical Association*, October 2016, http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420. For a review of the literature, see Assistant Secretary for Planning and Evaluation, "Medicaid Expansion Impacts on Insurance Coverage and Access to Care," Department of Health and Human Services, updated January 18, 2017, https://aspe.hhs.gov/system/files/pdf/255516/medicaidexpansion.pdf.

[7] Matt Broaddus, "Study: Medicaid Expansion Improves Low-Income Peoples' Financial Health, Too," Center on Budget and Policy Priorities, November 14, 2017, https://www.cbpp.org/blog/study-medicaid-expansion-improves-low-income-peoples-financial-health-too, and Matt Broaddus, "Medicaid Improves Financial Well-Being, Research Finds," Center on Budget and Policy Priorities, April 28, 2016, http://www.cbpp.org/blog/medicaid-improves-financial-well-being-research-finds.

[8] Benjamin Sommers *et al.*, "Three-Year Impacts Of The Affordable Care Act: Improved Medical Care And Health Among Low-Income Adults," *Health Affairs*, May 2017, http://content.healthaffairs.org/content/early/2017/05/15/hlthaff.2017.0293.

[9] Kenneth Brevoort, Daniel Grodzicki, and Martin Hackmann, "Medicaid and Financial Health," National Bureau of Economic Research, November 2017, http://www.nber.org/papers/w24002.pdf.

[10] A hospital's operating margin is a good measure of how much it earns providing care to patients. A hospital's total margin is a good measure of its bottom line.

[11] Matt Broaddus, "Affordable Care Act's Medicaid Expansion Benefits Hospitals, Particularly in Rural America," Center on Budget and Policy Priorities, June 23, 2017, https://www.cbpp.org/research/health/affordable-care-acts-medicaid-expansion-benefits-hospitals-particularly-in-rural.

hospitals by reducing strain on their budgets, enabling them to make investments such as in technology or equipment and increase or maintain capacity and making hospital closures less likely.[12]

State budgets also benefit from more people having coverage and lower uncompensated care costs. Medicaid expansion has produced savings in Arkansas, Louisiana, Kentucky, Michigan, and elsewhere, partly because of reduced uncompensated care, research has found.[13] As more low-income people have gained Medicaid coverage, demand for state-funded health programs that serve this population, including payments to hospitals to cover uncompensated care, has dropped, providing net savings. For example, Louisiana saved $199 million in the first fiscal year of its expansion and is projected to save an additional $350 million in the current fiscal year, in large part because of lower payments to hospitals for uncompensated care.[14] Colorado's Medicaid expansion is expected to produce $134 million in net savings through 2026.[15]

Waiver Proposals Jeopardize Progress in Reducing Uncompensated Care

Medicaid waivers recently approved by the Centers for Medicare & Medicaid Services (CMS) and pending or under discussion in states include provisions that will cause people to lose coverage and/or delay access to coverage even for those who retain access to Medicaid. Because these proposals threaten to roll back a significant share of the coverage gains achieved under Medicaid expansion, they also threaten jeopardize progress in reducing uncompensated care.

Waiver Provisions Likely to Increase Uncompensated Care

Eligibility restrictions likely to increase uncompensated care costs include:

- **Proposals to take Medicaid coverage away from people not meeting work requirements.** In Kentucky, Indiana, Arkansas, and New Hampshire, CMS has approved unprecedented new rules taking Medicaid coverage away from people not working or participating in work activities for a specified number of hours each month. These proposals — and similar state proposals pending with CMS (Arizona, Kansas, Maine, Mississippi, Ohio, Utah, and Wisconsin) — are likely to lead to large coverage losses, including among working

[12] Craig Garthwaite, Tal Gross, and Matthew Notowidigdo, "Hospitals as Insurers of Last Resort," National Bureau of Economic Research, NBER Working Paper No. 21290, June 2015, http://www.nber.org/papers/w21290.pdf.

[13] Jesse Cross-Call, "Medicaid Expansion Producing State Savings and Connecting Vulnerable Groups to Care," Center on Budget and Policy Priorities, June 15, 2016, https://www.cbpp.org/research/health/medicaid-expansion-producing-state-savings-and-connecting-vulnerable-groups-to-care and Jesse Cross-Call and Matt Broaddus, "Medicaid Expansion Would Benefit Main in Far-Reaching Ways, Contrary to Governor's Claims," Center on Budget and Policy Priorities, October 25, 2017, https://www.cbpp.org/research/health/medicaid-expansion-would-benefit-maine-in-far-reaching-ways-contrary-to-governors#.

[14] Louisiana Department of Health, "Medicaid Expansion 2016/2017," http://www.dhh.louisiana.gov/assets/HealthyLa/Resources/MdcdExpnAnnlRprt_2017_WEB.pdf.

[15] The Colorado Health Foundation, "Medicaid Expansion: Examining the Impact on Colorado's Economy," http://www.coloradohealth.org/sites/default/files/documents/2017-01/EXECUTIVE%20SUMMARY%20-%20Medicaid%20Expansion_Examining%20the%20Impact%20on%20Colorado_s%20Economy%202.11.2013.pdf, and John Z. Ayanian *et al.*, "Economic Effects of Medicaid Expansion in Michigan," *The New England Journal of Medicine*, February 2, 2017, http://www.nejm.org/doi/full/10.1056/NEJMp1613981#t=article.

people with unstable jobs and volatile hours and people with disabilities and serious health needs. All states that have released projections for work requirement proposals predict large coverage losses.

- **Eliminating retroactive coverage.** Retroactive coverage, a feature of Medicaid since 1972, lets hospitals and safety net providers get paid by Medicaid for the care they provide to people who incurred medical costs up to three months before enrolling in Medicaid, if they were eligible for the program during that three-month period; the care would otherwise be uncompensated. Some states (Indiana, Kentucky, and New Hampshire) are eliminating retroactive coverage for Medicaid expansion adults and low-income parents, whereas other states have eliminated it (Iowa) or are proposing to eliminate it (Arizona) for the majority of their Medicaid beneficiaries.

  Under waivers that eliminate retroactive coverage, a hospital would no longer get paid for, say, providing an emergency appendectomy or setting a broken bone for adults who are uninsured but Medicaid-eligible at the time of their accident, likely leaving the costs unpaid. For example, data from Indiana showed that, on average, individuals with medical bills incurred before enrolling in Medicaid owed providers $1,561, which Medicaid would pay under standard rules, but not under Indiana's waiver eliminating retroactive coverage.[16] In Arizona, which has a retroactive coverage waiver under review at CMS, the state chapter of the American Academy of Pediatrics expressed concern that "this proposed provision will put patients and families at risk for medical debt as well as increased uncompensated care costs for hospitals … this could put hospitals … at risk for cuts or closure potentially leaving entire communities with limited or no access to health care."[17] In states that eliminate retroactive coverage, increases in uncompensated care are likely to be even larger than one might predict based on coverage losses alone.

- **Eliminating hospitals' ability to conduct presumptive eligibility determinations.** The presumptive eligibility process allows uninsured people to enroll immediately in Medicaid by answering a set of questions at the hospital or other safety net provider. If the individual appears eligible, a hospital can make a "presumptive" eligibility determination, which prevents a delay in care while the state conducts a full eligibility determination. During this temporary coverage period, providers (including hospitals, doctors, and pharmacies) receive full Medicaid reimbursement for services they provide, even if the individual is later found ineligible for Medicaid. Eliminating presumptive eligibility for adults, as Utah and Maine have proposed, could lead to large increases in uncompensated care, particularly if coupled with elimination of retroactive coverage.

- **Requiring people to pay premiums, and delaying coverage until they do.** Some approved waivers (Arizona, Iowa, Indiana, Kentucky, and Montana) require some beneficiaries to pay monthly premiums as a condition of receiving coverage, often delaying the start of coverage until an individual has paid their premium. Research shows that premiums

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[16] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[17] Arizona Chapter of The American Academy of Pediatrics, Letter to Arizona Health Care Cost Containment System, February 12, 2018, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa7.pdf.

reduce coverage for low-income adults by deterring enrollment, increasing disenrollment, and shortening people's period of coverage, with a particularly large impact on people with incomes below the poverty line, who are also likelier to remain uninsured if they lose coverage.[18] Even for those who are still able to enroll in Medicaid, the delay in getting coverage creates a window in which some are likely to incur uncompensated care costs.

- **Locking people out of coverage.** Several waivers have been approved, or propose, to lock people out of coverage for a sundry of reasons (Indiana, Kentucky, Maine, Montana, New Mexico, and Wisconsin). These include not paying monthly premiums on time, not meeting work requirements, failing to turn in Medicaid renewal paperwork on time, or not reporting changes in income, employment, or work-related activities. By forcing longer coverage interruptions, lockouts directly increase the amount of time people go uninsured and are at risk of incurring uncompensated care. In particular, they prevent individuals who lose coverage for failing to comply with new eligibility restrictions — for example, failing to pay premiums — from re-establishing eligibility if they become seriously ill and need hospital care. In addition, by forcing longer interruptions in coverage, lockouts lead to longer interruptions in access to primary and preventive care and care for chronic conditions — for example, medications to control diabetes or hypertension. That can lead to greater need for emergency services, harming patients and further increasing uncompensated care costs.[19]

Potential Impacts on Uncompensated Care

The precise impact of these types of changes on uncompensated care costs is hard to predict, but there is little question that, in states where waivers roll back a significant portion of the coverage gains achieved under Medicaid expansion, they will also roll back a significant portion of the uncompensated care gains. Waiver proposals that include eligibility restrictions such as those described above will cause people to lose coverage, causing the number of uninsured to rise. And as described above, the higher the uninsured rate, the greater the likelihood of uncompensated care.

Kentucky's waiver includes most of the eligibility restrictions described above: an 80-hour-per-month work requirement, premiums and delayed start to coverage, coverage lockouts, and no retroactive coverage. The state projects a 15 percent drop in adult Medicaid enrollment by the waiver's fifth year — that means that about 100,000 people will lose coverage in an average month.[20] Based on the relationship between Medicaid coverage gains and reductions in uncompensated care costs as Medicaid expansion took effect, these coverage losses would be expected to lead to a similar increase in uncompensated care costs for Kentucky hospitals. Other states considering similar waivers should expect cost increases of similar magnitudes, potentially reversing a significant share

[18] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 21, 2017, http://www.kff.org/medicaid/issuebrief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[19] Leighton Ku and Erika Steinmetz, "Bridging the Gap: Continuity and Quality of Coverage in Medicaid," Association for Community Affiliated Plans, September 10, 2013, http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%20%209-10-13.pdf.

[20] Judith Solomon, "Kentucky Waiver Will Harm Medicaid Beneficiaries," Center on Budget and Policy Priorities, January 16, 2018, https://www.cbpp.org/research/health/kentucky-waiver-will-harm-medicaid-beneficiaries.

of the gains they've achieved over the past several years and putting low-income families' financial security and hospitals' financial stability at risk.

APPENDIX TABLE 1

Uncompensated Care Costs Fall as Uninsured Rate Falls

		Uncompensated care costs as share of operating costs				
States	Medicaid expansion state as of March 2015	2013	2015	% change, 2013 to 2015	$ change, 2013 to 2015 (in millions, $2015)**	% change uninsured rate, 2013 to 2015
United States		4.4%	3.1%	-30%	-12,015	-35%
Expansion states	29	3.7%	2.0%	-47%	-10,317	-43%
Non-expansion states	22	5.6%	5.0%	-11%	-2,063	-27%
Alabama		5.6%	4.6%	-18%	-112	-26%
Alaska*		4.2%	3.0%	-29%	-31	-19%
Arizona	y	4.8%	2.0%	-58%	-458	-37%
Arkansas	y	4.7%	2.7%	-43%	-139	-41%
California	y	3.9%	1.4%	-64%	-2,782	-50%
Colorado	y	3.4%	1.6%	-53%	-239	-43%
Connecticut	y	1.8%	1.6%	-11%	-22	-36%
Delaware	y	2.4%	1.7%	-29%	-23	-35%
DC	y	1.8%	1.3%	-28%	-23	-43%
Florida		6.6%	5.7%	-14%	-433	-34%
Georgia		7.0%	6.2%	-11%	-189	-26%
Hawaii	y	1.2%	1.0%	-17%	-7	-40%
Idaho		3.7%	3.5%	-5%	-9	-32%
Illinois	y	4.9%	3.1%	-37%	-675	-44%
Indiana	y	5.0%	3.8%	-24%	-219	-31%
Iowa	y	3.8%	2.1%	-45%	-142	-38%
Kansas		2.7%	2.9%	7%	16	-26%
Kentucky	y	4.6%	1.6%	-65%	-403	-58%
Louisiana*		5.9%	6.0%	2%	13	-28%
Maine*		3.7%	2.9%	-22%	-44	-25%
Maryland	y	5.1%	3.1%	-39%	-321	-35%
Massachusetts	y	2.4%	1.8%	-25%	-168	-24%
Michigan	y	3.4%	1.5%	-56%	-571	-45%
Minnesota	y	1.7%	1.1%	-35%	-111	-45%
Mississippi		5.9%	5.2%	-12%	-56	-26%
Missouri		4.4%	4.2%	-5%	-42	-25%
Montana*		4.6%	3.6%	-22%	-40	-30%
Nebraska		4.0%	3.4%	-15%	-39	-27%

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Uncompensated Care Costs Fall as Uninsured Rate Falls

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		2013	2015	% change, 2013 to 2015	$ change, 2013 to 2015 (in millions, $2015)**	% change uninsured rate, 2013 to 2015
Nevada	y	4.9%	2.5%	-49%	-138	-41%
New Hampshire	y	4.6%	2.2%	-52%	-111	-41%
New Jersey	y	6.3%	3.4%	-46%	-682	-34%
New Mexico	y	6.1%	2.5%	-59%	-202	-41%
New York	y	3.2%	2.3%	-28%	-642	-34%
North Carolina		6.0%	5.6%	-7%	-102	-28%
North Dakota	y	3.2%	2.0%	-38%	-46	-25%
Ohio	y	3.5%	1.7%	-51%	-756	-41%
Oklahoma		5.2%	4.9%	-6%	-32	-21%
Oregon	y	4.3%	1.6%	-63%	-304	-52%
Pennsylvania	y	2.0%	1.5%	-25%	-224	-34%
Rhode Island	y	4.8%	1.9%	-60%	-104	-51%
South Carolina		6.7%	5.9%	-12%	-98	-31%
South Dakota		3.2%	2.2%	-31%	-40	-10%
Tennessee		3.6%	3.3%	-8%	-51	-26%
Texas		7.4%	6.7%	-9%	-467	-23%
Utah		5.1%	3.8%	-25%	-88	-25%
Vermont	y	2.1%	1.6%	-24%	-12	-47%
Virginia		5.2%	4.8%	-8%	-78	-26%
Washington	y	3.3%	1.2%	-64%	-453	-53%
West Virginia	y	5.0%	2.0%	-60%	-180	-57%
Wisconsin		2.5%	1.4%	-44%	-227	-37%
Wyoming		6.0%	5.7%	-5%	-5	-14%

* These states have expanded Medicaid coverage to low-income adults since March 2015. Maine adopted the Medicaid expansion through a ballot initiative in November 2017 that required submission of a state plan amendment within 90 days and implementation of expansion within 180 days. The governor failed to meet the submission deadline.
** For each state, this calculation reflects the 2013 to 2015 percentage point reduction in uncompensated care costs as a share of hospitals' total operating budgets applied to hospitals' 2015 total operating budgets.
Source: CBPP analysis of MACPAC estimates of uncompensated care costs in states, and Census Bureau estimates of uninsured rates in states.