

The Offsetting Financial Impact of Increased Insurance Coverage and Reduced Disproportionate Share Hospital Payments

Medicaid Expansion

Effective 2014, the Patient Protection and Affordable Care Act, combined with the Health Care and Education Reconciliation Act of 2010 require states to expand Medicaid to all non-elderly individuals with incomes up to 133 percent of the Federal Poverty Level (FPL). States may voluntarily expand coverage up to this level beginning April 1, 2010. For most states, the federal government will pay 100 percent of the costs related to these newly eligible individuals for the first three years (2014–2016), 95 percent for 2017, 94 percent for 2018, 93 percent for 2019, and 90 percent for years 2020 and beyond. Special assistance will be provided to “expansion states” that have already expanded coverage to both parents and childless adults with incomes up to 100 percent of FPL.

Subsidized Insurance Exchanges

Each state will also be required to establish an American Health Benefit Exchange by 2014, or participate in a regional exchange. These exchanges will be required to provide four plan levels, covering from 60 percent (bronze) to 90 percent (platinum) of the actuarial value of the plan benefits. And, federal premium tax credits will be provided to “low income,” non-Medicaid eligible individuals (100 to 400 percent of FPL) to help cover the premium cost of plans purchased through the exchange.

These two policy initiatives, in addition to other actions, are anticipated to bring insurance coverage to approximately 94 percent of American residents. Undocumented immigrants will not be eligible to purchase insurance through the new exchanges, nor be covered by the Medicaid expansion in most states.

DSH Payment Reductions

Because the number of uninsured Americans is anticipated to decline so dramatically, special Medicaid and Medicare payments to hospitals previously treating a disproportionate share of uninsured and Medicaid patients will be greatly reduced, as follows:

Disproportionate Share Hospital (DSH) Payment Reductions

	<u>Medicaid</u>	<u>Medicare</u>
2014	-\$500 million	Minus an estimated \$22 billion over 10 years, beginning in 2014. Methodology for reduction to be determined on a state-by-state basis by the Secretary of Health and Human Services, and potentially tied to the reduction in the uninsured.
2015	-\$600 million	
2016	-\$600 million	
2017	-\$1.8 billion	
2018	-\$5.0 billion	
2019	-\$5.6 billion	
2020	-\$4.0 billion	

Disproportionate share hospitals will be impacted disparately by these reductions. In addition, uncertainty remains about what level of cuts will be imposed on each state, as the methodology has yet to be determined by the Secretary of Health and Human Services. Each hospital may be impacted differently based upon one or more of the following factors:

- Its current level of indigent and Medicaid patients served
- The current level of DSH payments received (*note that state Medicaid DSH payment methodologies vary substantially. Some pay two different levels—“big DSH” and “little DSH”—depending on set percentage thresholds of indigent and Medicaid patients served; some devote major portions of their authorized DSH payments to the support of state psychiatric hospitals, etc.*)
- The percentage of current indigent patients who are undocumented immigrants, and therefore not eligible for new coverage

For a DSH hospital in a geographic region with low percentages of undocumented immigrants (such as a major teaching and safety net hospital in Portland, Oregon), a shift of uninsured indigent populations into Medicaid coverage or private insurance obtained through new state insurance exchanges will likely improve its overall payment levels. On the other hand, a DSH hospital in a geographic region with a very high level of undocumented immigrants (such as a major teaching and safety net hospital in Miami, Florida) may be significantly disadvantaged via the loss of DSH payments not offset by increased Medicaid or private insurance coverage.

LarsonAllen recommends that you model the anticipated impact on your hospital, given the specifics of your own situation. Should you need help in that analysis, qualified LarsonAllen staff stand ready to assist you in that endeavor.

Contact: Brad King | Charlotte, Ph: 704-998-5291, bking@larsonallen.com