How Closing the Coverage Gap Benefits Hospitals

Hospitals have a lot at stake in state decisions to close the coverage gap. Concern about uncompensated care costs, coupled with impending cuts in funding for treating low-resource consumers, have galvanized hospital support for expanded coverage options in many states and helped move the needle forward in these discussions.

This brief explores what we know so far about how state coverage gap decisions have impacted hospitals. Specifically, the brief examines the impact of the coverage gap on:

- Uninsured admissions, uncompensated care costs and the financial stability of hospitals
- Hospital closings, particularly for rural hospitals

Closing the Coverage Gap Reduces Uncompensated Care Costs, Uninsured Admissions, and Improves Hospital Finances

Since 2014, 7.5 million more Americans have gained coverage under Medicaid and CHIP – two critical sources of health and economic security.[1] However, that positive gain is mostly concentrated in states that closed the coverage gap, where the uninsured rate dropped by 38 percent.

By contrast, states that did not close the coverage gap saw only a 9 percent decline in uninsured.[2] The decisions by these states to leave nearly four million Americans without coverage are also hurting their hospitals.[3] Hospitals in coverage gap states:

- **Bear a heavier burden of uncompensated care costs (UCC).** As a result of enrollment in both Medicaid expansion and the Health Insurance Marketplaces, hospitals across the country saved $7.4 billion in UCC in 2014. But hospitals in expansion states reaped the greatest share of UCC savings, at $5 billion.[4]
- **Saw a slower reduction in uninsured patients in 2014.** Between Q2 2013 and Q2 2014, hospitals in expansion states saw a 48-72 percent decline in uninsured admissions. By contrast, hospitals in states still with a coverage gap saw little change in 2014, hovering between a 0-14 percent decline.[5]
- **Will be hardest hit by upcoming DSH payment reductions.** [6] Revenue increases generated by the newly insured Medicaid population were intended to balance out the $22 billion reductions in Medicaid Disproportionate Share Hospital (DSH) funding, which are scheduled to begin in 2017.[7] But in the 22 states that have yet to close the coverage gap, hospitals will face DSH payment reductions *and* will lose out on the cumulative $167.8 billion in Medicaid revenue that would have come from closing the coverage gap in those states from 2013-2022.[8] For state-specific data on how hospitals will be affected by these cuts without Medicaid expansion, see this report.

Hospitals on the ground have already begun reporting about the impact of the coverage gap on their bottom lines. For example, HCA Holdings, the country's largest hospital chain, is reporting better-than-expected revenue growth from health reform – and these benefits are concentrated in expansion states. In HCA's five expansion states, Medicaid admissions increased 32 percent, triggering a 65 percent decline in uninsured admissions by the end of 2014. In non-expansion states, its uninsured volume declined by only 2 percent.[9]

With more people insured, hospitals in states that closed the coverage gap have reported reductions in UCC in 2014 from 2013 levels:

- Arkansas hospitals realized a $69 million decline in UCC.[10]
- Hospitals in Iowa yielded a $32.5 million reduction in UCC.[11]
- Hospitals in Colorado saw a drop of $1.7 million in UCC.[12]
- Kentucky's hospitals experienced a $1.15 billion reduction in UCC.[13]

Some Medicaid expansion opponents have dismissed these benefits to hospitals, because they claim that expansion will shift consumers out of private insurance, which has higher payment rates than Medicaid. These claims are unfounded:

- According to the Urban Institute, each dollar in revenue from private insurance lost to Medicaid expansion creates $2.50 in new Medicaid revenue.[14]
- Only about 10 percent of Medicaid-eligible consumers at 138 percent or below of the Federal Poverty Level (FPL) likely were previously covered through private insurance.[15]
- In states that raised Medicaid income eligibility limits to levels similar to those under the ACA's expansion level, the shares of low-income residents who have private coverage are virtually identical to the shares in states that have not expanded Medicaid coverage.[16]

The Coverage Gap Leaves Rural Hospitals Especially Vulnerable

Medicaid provides critical access to care in rural areas, where 15 percent of adults fall in the coverage gap compared to 9 percent in metropolitan areas.[17] Failing to cover more low-income rural Americans has contributed to the peril of rural hospitals, where about 60 percent of their gross revenue relies on Medicare and Medicaid[18] (compared to 45 percent for urban hospitals).[19]

While hospital closings result from a combination of factors – demographic trends, health care economics and political forces –the coverage gap has exacerbated hospitals' financial stress. As rural hospitals face faltering bottom lines, as well as impending cuts to DSH payments, insuring more vulnerable consumers through Medicaid would provide a critical infusion of revenue to struggling rural hospitals:

- Since 2013, **24 rural hospitals have shut down across the nation** – double the pace from the previous 20 months. Most rural hospital closings are in states that rejected new federal Medicaid dollars (Figure 1).[20]
- **40 percent of rural hospitals nationwide are operating in the red**.[21] These hospitals need an infusion of expanded Medicaid customers to avoid another 20 percent of rural hospitals closing by 2020.[22]

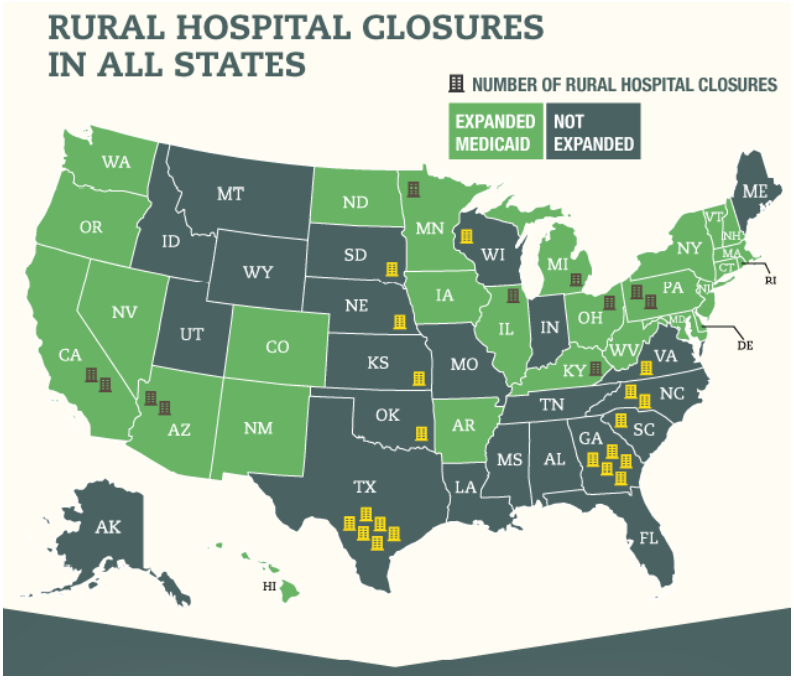

Figure 1. Families USA. (2014) Medicaid Expansion and Rural Hospital Closures.

Closings of hospitals trigger a harmful domino effect on local communities and economies. When a hospital closes, patients often have to travel much farther to seek care. Hospitals in surrounding areas must absorb these displaced patients, straining their resources and capacity to treat larger shares of uninsured.[23] This ultimately impacts *everyone's* access to care, regardless of insurance type. Fortunately, closing the gap can be an immediate remedy for financially stressed rural hospitals. In 2014, rural hospitals in Kentucky received 297 percent more payment from Medicaid expansion than from DSH, and they benefited from almost a $200 million drop in UCC.[24]

Conclusion

Covering more people through Medicaid expansion has infused some hospitals with critical revenue from formerly uninsured patients. Yet, in states that have rejected these expanded coverage opportunities, hospitals are losing out both on reductions in uninsured volume and savings in UCC. The differential benefits realized from closing the gap will only become more salient in light of upcoming DSH payment reductions.

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