Health Economics Program | Issue Brief
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Implementation of the Affordable Care Act in Minnesota – Preliminary Projections of Reductions in Uncompensated Care by 2016

Introduction

The system of health insurance coverage and financing in Minnesota and the U.S. leaves some individuals struggling to meet their share of health care costs, resulting in health care providers bearing significant costs related to uncompensated care. It is the expectation of many health care observers[1] that implementation of the Affordable Care Act (ACA),[2] through its provisions affecting health care market regulation and the development of insurance exchanges, will reduce the need for provider-based uncompensated care. This issue brief estimates the potential reduction in hospital uncompensated care that may occur by 2016 in Minnesota.

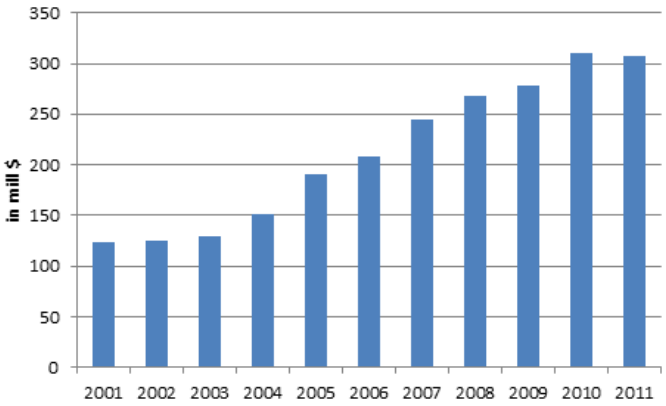
Overview of Hospital Uncompensated Care

As shown in Figure 1, the amount of uncompensated care provided to hospital patients in Minnesota community hospitals is substantial and has been increasing over time. In 2011, hospital uncompensated care amounted to $308 million, almost two and a half times the amount ten years ago ($124 million). During the recent economic downturn, uncompensated care rose particularly steeply, growing at an average annual rate of growth of 6 percent since 2007; uncompensated care fell slightly in 2011.

Overall, uncompensated care appears to be about evenly split between charity care (care provided for free or at a discounted rate to low income patients who are eligible for it), and bad debt (care for patients with a responsibility to pay, who do not meet that obligation). Charity care accounted for 49.3 percent of uncompensated care in 2011, bad debt made up the remaining 50.7 percent.

Figure 1

Uncompensated Care at Minnesota Community Hospitals



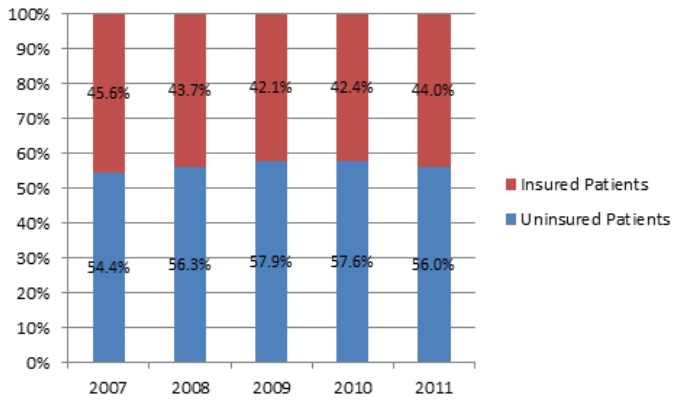
Source: MDH Health Economics Program analysis of Minnesota hospital annual reports

The majority of uncompensated care is incurred on behalf of patients who lack insurance coverage and thereby an independent source of funding for health care. Generally, when uninsured patients in Minnesota present for hospital care, they are evaluated for eligibility for free care (fully charity care) or discounted care (partial charity care) based on eligibility criteria set by the hospital.[3] However, nearly half of uncompensated care (44 percent or $135 million in 2011) is provided by hospitals on behalf of *insured* patients. (See Figure 2). These likely increasingly include patients who have chosen health insurance products with affordable premiums but

that require substantial cost sharing for health care services.[4] Much of the uncompensated care costs for insured patients (41 percent) is for charity care, with the remainder accounted for by bad debt. This indicates that a substantial number of patients with insurance coverage who receive uncompensated care are of lower incomes but not eligible for public programs (generally a requirement for receiving charity care).

Figure 2

Hospital Uncompensated Care by Insurance Status



Source: MDH Health Economics Program analysis of Minnesota hospital annual reports

Projections of Hospital Uncompensated Care with and without the ACA

Without implementation of the ACA, hospital-based uncompensated care is likely to continue to grow because of a number of factors including: (1) projected further growth in health care costs; (2) population growth; (3) likely growth in insurance products that shift a greater share of costs to patients in the form of increased cost sharing; and (4) factors related to ACA requirements that incent hospitals to provide community benefits.[5]

Given the inherent and substantial uncertainties related to making economic and health care related projections, uncompensated care spending with and without the ACA is projected in ranges of spending that form potential "bookends" to what actual uncompensated care spending might be in future years.[6] As shown in Table 1, given the upper and lower bound scenarios, hospital uncompensated care without the ACA in 2016, the year when the health insurance exchange is expected to have reached mature enrollment, is projected to increase to between $319 million and $411 million.

Table 1

Projected Uncompensated Care Cost without ACA

	2011	2016	Change
Upper Bound			
Insured	$135,532,105	$181,166,844	$45,634,739
Uninsured	$172,579,790	$230,688,780	$58,108,989
Total Uncompensated Care	$308,111,896	$411,855,624	$103,743,728
Lower Bound			
Insured	$135,532,105	$141,908,247	$6,376,142
Uninsured	$172,579,790	$177,056,826	$4,477,036
Total Uncompensated Care	$308,111,896	$318,965,073	$10,853,178

Source: Projections by MDH Health Economics Program

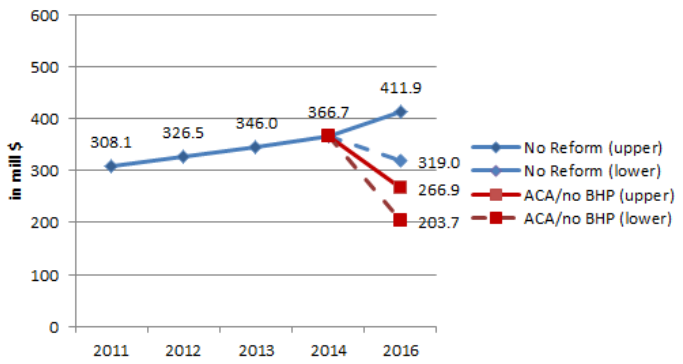
Implementation of the ACA through health care market regulations,[7] the requirement for individuals to carry insurance coverage, and the establishment of health insurance exchanges[8] is predicted to reduce rates of uninsurance and improve the mix of health insurance benefits chosen by enrollees in health insurance products.[9] The combined effect of these dynamics in Minnesota, as shown in Figure 3, is predicted to reduce uncompensated care spending by about 35 percent relative to the base case of projected uncompensated care in the absence of the ACA. This effect reflects potential reductions in uncompensated care of between $115 million (at the lower bound) and $145 million (at the upper bound).

Under this scenario, the number of uninsured is estimated to decline by nearly 60 percent, from 499,000 to about 201,000 Minnesotans; it relies on assumptions made by contractors to the state that include Medicaid expansion to 138 percent as allowed under the ACA.[10] In addition, nearly 100,000 individuals in the individual market and others with public program or small group coverage are likely to see their benefits expand because of requirements for essential benefits and standards for how these benefits are packaged in certain cost (or actuarial value) levels. The

drop in uncompensated care is smaller than the estimated drop in the number of uninsured, because a significant portion of uncompensated care is associated with care provided to people with health insurance coverage. In other words, even after gaining health insurance coverage, some individuals will likely lack the ability to pay their share of health care costs, or cost sharing.

Figure 3

Effect of ACA Implementation without a Basic Health Plan on Minnesota Hospital Uncompensated Care

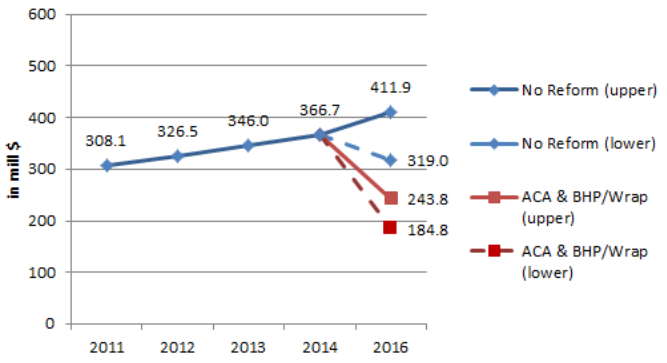


Source: Projections by MDH Health Economics Program

One of the key decisions that Minnesota policymakers will be making in the coming months relates to whether or not Minnesota will adopt a Basic Health Plan (BHP). A BHP under federal health reform is an optional program under which states can use a certain amount of federal funding to subsidize coverage for individuals with incomes between 138 to 200 percent of poverty (as measured by the federal poverty guideline). Economic simulations of the effects of implementing a BHP with expanded (wrap-around) coverage in Minnesota indicate that the number of uninsured in Minnesota would further decline with a BHP (to approximately 160,000 individuals) and that people with incomes between 138 percent and 200 percent of poverty would obtain health insurance benefits with lower cost sharing requirements.[11] Again, taking both effects into consideration, Minnesota is projected to see a reduction in hospital uncompensated care with implementation of a BHP by about 40 percent, reducing uncompensated care by an additional $19 million (at the lower bound) to $23 million (at the upper bound).

Figure 4

Effect of ACA Implementation with a Basic Health Plan on Minnesota Hospital Uncompensated Care



Source: Projections by MDH Health Economics Program

Conclusion

In summary, implementation of the ACA in Minnesota with establishment of a health insurance exchange and a BHP with expanded health benefits could result in reduction of projected hospital uncompensated by between $134 million and $168 million by 2016. This estimate is likely a conservative, low estimate, because it only considers hospital uncompensated care. National research shows that community-based providers and physicians deliver as much as 39 percent of total uncompensated care to patients.[12,13] However, should the state decide not to expand Medicaid coverage up to 138 percent of poverty, projected uncompensated care cost reductions would be lower than estimated in this issue brief.

Limitations

As with all projections, this analysis is subject to significant uncertainties related to trends in demographics, economic performance and policy developments. Further, this analysis relies on high-level, aggregated data from Minnesota health care providers. A more refined analysis would draw on more complete and disaggregated, data and detailed results from actuarial and economic simulations that could identify more precisely the relationship between uncompensated care and type of coverage in a health market with an insurance exchange.

Endnotes

[1] See for instance: Holahan J. and Garrett B, "The Cost of Uncompensated Care with and without Health Reform: Timely Analysis of Immediate Health Policy Issues," Urban Institute, March 2012.

[2] The Patient protection and Affordable Care Act (Pub.L. No. 111-149, 124.Stat 119) amended by the Health Care Education and Reconciliation Act, (Pub.L. No. 111-152, 124.Stat 1029 is referred to in this issue brief as the Affordable Care Act.

[3] In addition, Minnesota hospitals, under an agreement with the Minnesota Attorney General, provide a discount to uninsured patients with incomes below $125,000 and who qualify for charity care that is equal to discounts offered to health insurance plans.

[4] MDH research has shown that the number of individuals in the health insurance market with substantial cost sharing has increased notably over time. For instance, the rate of individual market enrollees who purchased health insurance products that have deductibles of greater than $3,000, increased from 14.6 percent in 2002 to 73 percent in 2011. auto medical insurance

[5] Section 9007 of the ACA established two requirements related to community benefit (of which free and discounted care is one component) for hospitals that seek to maintain their non-profit tax-exempt status: (1) hospital must demonstrate that they understand the community health needs among their patient base and seek ways to address them; and (2) hospitals must implement practices and policies related to financial assistance, billing and collections that protect consumers. See for example: Folkemer D.C., Spicer L.A. et al., "Hospital Community Benefit After the ACA: The Emerging Federal Framework," The Hilltop Institute, January 2011.

[6] Upper bound projections assume uncompensated care cost growth consistent with the average annual rate of growth between 2007 and 2011; lower bound estimates assume uncompensated care spending per insured and uninsured Minnesotan in 2011 (about $58 and $355, respectively) would hold moving forward.

[7] Includes provisions such as the removal of annual limits on benefits paid by insurance coverage, establishment of minimum amounts of premiums spent on health care claims, broadening coverage of young adults as dependents, and removal of health factors in determining insurance premiums.

[8] Includes provisions under which certain eligible lower income individuals will receive financial support for the purchase of insurance coverage and payment of cost sharing obligations.

[9] Gruber J. and Gorman B., "Analysis of Implementation of the Affordable Care Act, Health Insurance Exchange, and Basic Health Plan on Minnesota," Report to the Department of Minnesota Management and Budget, forthcoming.

[10] The Minnesota legislature is currently considering the choice to further expand Medicaid eligibility in Minnesota.

[11] See note number 8.

[12] Hadley J., Holahan J, and T. Caughlin, et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs, 27, no.5 (2008)

[13] Data from community-based providers and office-based physicians is not available in Minnesota to refine these estimates.

The Health Economics Program conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy.

For more information, contact the Health Economics Program at (651) 201-3550. This issue brief, as well as other Health Economics Program publications, can be found on our website at http://www.health.state.mn.us/healtheconomics.

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