The Financial Impact of the American Health Care Act's Medicaid Provisions on Safety-Net Hospitals

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ABSTRACT

ISSUE: Safety-net hospitals play a vital role in our health care system, delivering significant care to Medicaid, uninsured, and other vulnerable patients. The American Health Care Act (AHCA) would make changes to Medicaid that would substantially reduce federal funding, resulting in potential adverse effects on safety-net hospitals and the populations they serve.

GOAL: Examine how the AHCA Medicaid provisions, which the Congressional Budget Office estimates will reduce federal Medicaid spending by $834 billion over 10 years, will affect the financial status of safety-net hospitals.

METHODS: The Dobson | DaVanzo Hospital Finance Simulation Model uses Medicare Hospital Cost Report data for 2015 and assumptions regarding how states will respond to the AHCA Medicaid provisions to estimate the financial impact on safety-net hospitals.

KEY FINDINGS: Beginning in 2020 the financial status of safety-net hospitals will deteriorate as Medicaid coverage is reduced and the per-capita spending limits proposed in the AHCA grow. By 2026 total margins will drop to 0.5 percent compared with estimates under current law of 2.9 percent—representing an 83 percent reduction in net income for safety-net hospitals. Small rural safety-net hospitals and safety-net hospitals treating the largest proportion of low-income patients would be hurt the most.

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BACKGROUND

Safety-net hospitals, which provide care to all patients, regardless of their ability to pay, play an important role in the nation's health care system. These providers deliver a considerable amount of care to Medicaid, uninsured, and other vulnerable patients. Safety-net hospitals include public hospitals that are often providers of last resort in their communities, academic medical centers that combine a teaching function with a mission to serve vulnerable populations, and in some communities, private hospitals that either because of their mission or the absence of public hospitals in the community, serve as the safety-net provider. They often provide services that other hospitals in the community do not, such as trauma care, burn care, neonatal intensive care, and inpatient behavioral health. In addition, these providers offer medical education for future physicians and other health care professionals. Safety-net hospitals are also an important source of care for undocumented individuals who are ineligible for Medicaid or subsidized marketplace coverage.[1]

The Affordable Care Act (ACA) allowed states to expand Medicaid eligibility to nonelderly adults with incomes up to 138 percent of the federal poverty level (about $16,650 for individuals or $33,950 for a family of four in 2017). Thirty-one states and the District of Columbia have expanded Medicaid, while 19 states have not.[2] Several studies have found major reductions in uncompensated care and improved financial status at safety-net institutions in states that expanded Medicaid compared with those in states that have not.[3,4]

The American Health Care Act (AHCA), as proposed, would make several unprecedented changes to Medicaid. First, it would effectively end the ACA's Medicaid expansion, which will result in lost coverage for an estimated 14 million people by 2026. Second, the AHCA would change the longstanding arrangement between states and the federal government by placing caps on the amount that states would receive from the federal government. The most recent Congressional Budget Office (CBO) estimate of the House-passed AHCA indicates that this would reduce federal Medicaid support to states by a total of $834 billion over a 10-year period (2017–26), which would represent a 26 percent reduction in federal Medicaid payments by 2026.[5]

Given the magnitude of these funding reductions, states will likely be forced to make difficult decisions about their continued support for Medicaid programs, ultimately affecting safety-net hospitals. This report examines the impact of the following key provisions of the AHCA on safety-net hospitals:

- eliminating enhanced federal funding for the Medicaid expansion and the individual mandate
- restoring Medicaid disproportionate share hospital (DSH) payments, which are scheduled to be reduced beginning in 2018
- eliminating hospital presumptive eligibility and three-month retroactive eligibility, whereby hospitals can help an uninsured patient apply for Medicaid, and coverage for that individual can date back three months prior to the month the application was filed
- establishing per-capita limits on federal Medicaid funding to states
- providing safety-net funding for states that did not expand Medicaid.

We examine how these AHCA provisions would affect the financial status of safety-net hospitals over the next decade. We use the Dobson | DaVanzo Hospital Finance Simulation Model (HFSM), a hospital-level micro-simulation model that estimates the impact of health reform proposals on hospital revenues, expenses, and net income. The model uses Medicare Hospital Cost Reports as the primary data source and applies assumptions about the impact of the specific health care reform provisions. It then incorporates dynamics of how the assumptions impact hospital utilization, costs, and revenues. The Technical Appendix to this report describes the data used in the model and the methodology for quantifying the impact of health reform provisions on hospitals.

Because the AHCA's proposed federal funding reductions would have varying effects on different states—particularly regarding states that have expanded Medicaid versus other states—it is difficult to predict how each state would respond. Therefore, we performed a set of sensitivity analyses to provide a range of potential financial impacts on safety-net hospitals. The estimates presented correspond to our mid-range assumptions, described below. The final section of this report provides estimates based on a range of different assumptions.

WHAT IS A SAFETY-NET HOSPITAL?

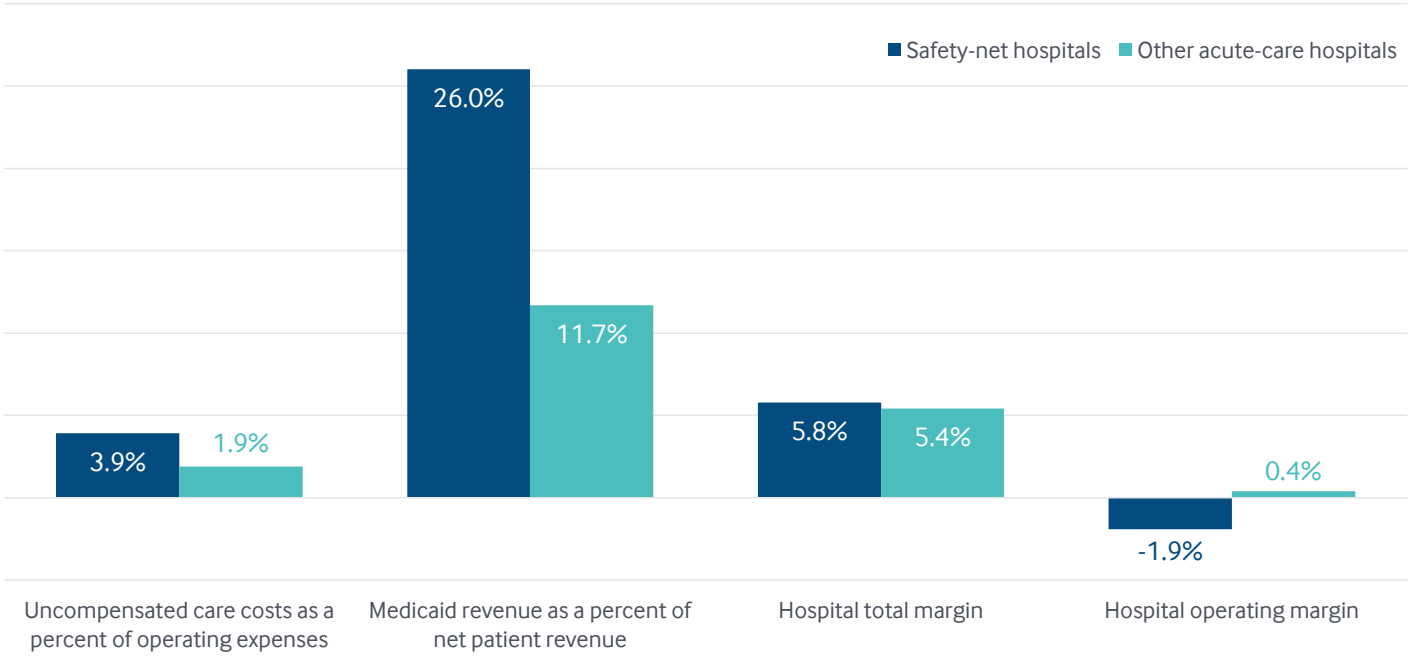
There is no agreement on what should be considered a safety-net hospital. The "deemed DSH hospital" method that we developed for this study (described in this report's Technical Appendix) defines a safety-net hospital as one that is required to receive Medicaid DSH payments because it serves a high share of low-income patients.

Using this method, we identified 660 acute-care hospitals (excluding children's hospitals, rehabilitation hospitals, psychiatric hospitals, and long-term care hospitals) across the United States.

Although the safety-net hospitals identified for this study represented only 15 percent of all U.S. acute-care hospitals, they collectively treated more than 6.2 million patients, provided 33 percent of all inpatient days of care for Medicaid patients, and provided nearly 30 percent of all hospital uncompensated care in 2015.[6]

Safety-net hospitals in Medicaid expansion states had more than twice the level of uncompensated care costs and Medicaid revenue in 2015, compared with other acute-care hospitals (Exhibit 1). Although total margins for safety-net hospitals were similar to those in other acute-care hospitals, operating margins (which includes only revenue from patient care) were substantially lower in safety-net hospitals.

Exhibit 1. Financial Performance of Safety-Net Hospitals Compared with Other Acute-Care Hospitals, Medicaid Expansion States, 2015



Note: All metrics are computed as aggregate ratios or margins, which means that both the numerators and denominators are summed across all hospitals and the ratios are calculated from the summed amounts.

Data: Dobson | DaVanzo analysis of Medicare Hospital Cost Report Data for 2015.

In states that did not expand Medicaid, safety-net hospitals had higher levels of uncompensated care costs and Medicaid revenue compared with other acute-care hospitals in 2015 (Exhibit 2). Both total and operating margins for safety-net hospitals were well below those reported by other acute-care hospitals in nonexpansion states. Operating margins for safety-net hospitals in both expansion and nonexpansion states are near or below zero, which indicates these hospitals must rely on less predictable revenues from sources other than patient care, like investment income and government tax appropriations.

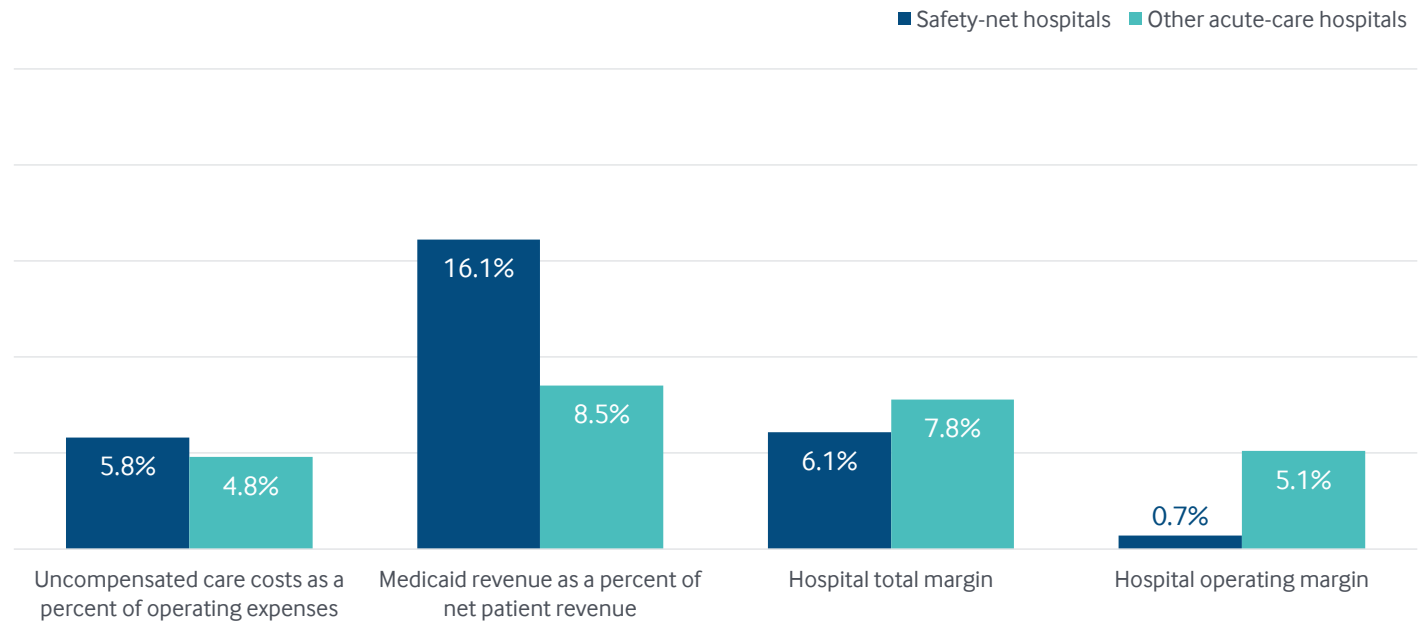
It is important to note that even with the Medicaid expansion, safety-net hospitals in expansion states had lower total and operating margins than safety-net hospitals in nonexpansion states in 2015. These lower margins place these hospitals in jeopardy of financial distress in the event of additional revenue reductions. Between 2012 and 2015, operating margins improved for safety-net hospitals in Medicaid expansion states but declined for safety-net hospitals in nonexpansion states. However, even with the improved financial margins, safety-net hospitals in expansion states still had lower margins than those in nonexpansion states.

On average, safety-net hospitals in nonexpansion states tended to have higher proportions of privately insured patients, higher private insurance payment levels relative to costs, and higher Medicaid payment levels relative to costs than did safety-net hospitals in expansion states. However, these results varied across individual states.

SUMMARY OF DATA AND FINANCIAL METRICS

This analysis uses Medicare Hospital Cost Report Data for the 660 identified safety-net hospitals to obtain baseline revenues and costs by payer category (Medicare, Medicaid, private insurance, and uncompensated care) for fiscal year 2015. It projects hospital revenues and costs for each payer category from 2015 through 2026. A detailed description of the methods is presented separately in the Technical Appendix.

Exhibit 2. Financial Performance of Safety-Net Hospitals Compared with Other Acute-Care Hospitals, Nonexpansion States, 2015



Note: All metrics are computed as aggregate ratios or margins, which means that both the numerators and denominators are summed across all hospitals and the ratios are calculated from the summed amounts.

Data: Dobson | DaVanzo analysis of Medicare Hospital Cost Report Data for 2015.

The key financial metrics used for this study include hospitals' operating margin, total margin, and net income. These measures are defined as follows:

- *Operating margin* measures hospitals' profitability on the income or losses derived from patient care. An operating margin of 5 percent means that each dollar of patient revenues generates 5 cents in profits. Operating margin is often a better measure of a hospital's sustainable profitability than the total margin because it focuses on revenue from patient care as opposed to income from other less dependable sources, such as investment income. This measure is calculated as:

  (net patient revenue – total operating expenses) / net patient revenue

- *Total margin* goes beyond patient care to include all sources of income and expenses. Nonpatient revenue includes income from investment; rental income; sales of drugs and medical supplies to the general public; operations of parking lots, gift and coffee shops, and cafeteria; grants; and governmental appropriations. This measure is calculated as:

  (net patient revenue + nonpatient revenue – total operating expenses – other expenses) / (net patient revenue + nonpatient revenue)

- *Net income* is the difference between a hospital's total revenues and total expenses including patient care and all other sources of income and expenses. Positive net income indicates profits; negative net income indicates losses. This measure is calculated as:

  net patient revenue + nonpatient revenue – total operating expenses – other expenses

These financial metrics show the financial stability of safety-net hospitals. A hospital's ability to maintain positive margins and net income allows it to continue to expand capacity, invest in strategies to improve care, hire new staff, and develop better infrastructure to monitor costs.[7]

IMPACT OF THE AHCA'S MEDICAID PROVISIONS ON SAFETY-NET HOSPITALS

Using our projection of revenues and costs, we estimate that total revenues for safety-net hospitals from 2017 through 2026 under current law would be $2.29 trillion and costs would be $2.22 trillion, which would result in $74 billion in net income over this period (Exhibit 3). We estimate that the Medicaid provisions specified in the AHCA would reduce revenues to safety-net hospitals by $36.5 billion and expenses by $18.3 billion. This would result in an $18.3 billion (24%) loss of net income relative to current law over this 10-year period. The following sections discuss the impact on revenues, expenses, and net income for safety-net hospitals under each of the AHCA's Medicaid provisions.

Eliminating the Individual Mandate and Enhanced Federal Funding for Medicaid Expansion

Currently, 31 states and the District of Columbia have expanded Medicaid to all non–Medicare eligible individuals under age 65 with incomes up to 138 percent of poverty. These states receive enhanced federal funding for newly eligible individuals (that is, people who were not previously eligible for Medicaid based on their state's eligibility criteria in 2010 or who were on waiting lists for a capped program) at 95 percent of spending in 2017, phasing down to 90 percent by 2020. This compares to standard federal matching rates that range across states from 50 percent to 74 percent of Medicaid spending.

Under the AHCA, the federal government would eliminate the enhanced federal matching rate for newly eligible beneficiaries enrolled under the expansion. States that have expanded Medicaid to nonelderly adults as of December 31, 2019, would continue to receive the enhanced federal matching rate for newly eligible beneficiaries enrolled by that time who do not have a break in coverage for more than one month after that date. States may enroll new applicants, but at the state's standard federal matching rate.

Although the individual mandate to buy health coverage is not specific to Medicaid, eliminating the penalties associated with the mandate would have an impact on

Exhibit 3. Change in Revenues and Expenses for Safety-Net Hospitals Because of AHCA Medicaid Provisions, 2017–2026

	Total revenues (millions)	Total expenses (millions)	Net income/ (loss) (millions)
Revenues and expenses under current law	**$2,293,810**	**$2,219,745**	**$74,064**
Eliminating individual mandate and Medicaid expansion	($37,698)	($18,254)	($19,444)
Restoring Medicaid DSH payments	$13,711	$0	$13,711
Eliminating three-month retroactive eligibility	($13,263)	$0	($13,263)
Imposing per-capita spending limits	($3,646)	$0	($3,646)
AHCA funds to hospitals in nonexpansion states	$4,365	$0	$4,365
Total effect of all AHCA Medicaid provisions modeled	**($36,531)**	**($18,254)**	**($18,277)**
Revenues and expenses after the AHCA Medicaid provisions	**$2,257,279**	**$2,201,491**	**$55,787**

Data: Dobson | DaVanzo analysis using Medicare Hospital Cost Report Data.

Medicaid enrollment. The CBO estimates that fewer people would enroll in Medicaid, including some who are not subject to the penalties but think they are. The assumptions developed for modeling these provisions are described in the Technical Appendix.

We estimate that eliminating the individual mandate and the enhanced federal funding for the Medicaid expansion would gradually reduce Medicaid enrollment by about 16 percent by 2026. This would result in a reduction in revenues to safety-net hospitals of $37.7 billion between 2017 and 2026. As individuals lose coverage, we assume they will use less hospital care, resulting in a reduction in hospital costs of $18.3 billion. The difference between changes in revenues and changes in expenses results in a $19.4 billion loss of net income for safety-net hospitals over this period.

Restoring Medicaid DSH Payments

The AHCA would restore some of the Medicaid DSH payments that were reduced under the ACA. The ACA DSH reductions are scheduled to begin in 2018 and end in 2025. The AHCA would entirely restore DSH payments for states that did not expand Medicaid. Medicaid DSH reductions for 2018 and 2019 would be maintained for expansion states, but then would be fully restored beginning in 2020. We estimate that restoring Medicaid DSH payments would result in an increase in revenues to safety-net hospitals of $13.7 billion over 2017 to 2026.

Eliminating Hospital Presumptive and Three-Month Retroactive Eligibility

The AHCA would repeal hospital presumptive eligibility determination beginning in 2020 and eliminates the three-month retroactive coverage requirement beginning in fiscal year 2017. The hospital presumptive eligibility provision under the ACA allows hospitals to enroll low-income people in Medicaid who may be eligible for Medicaid but are not enrolled. The ability to enroll patients at the point of service reduces hospitals' uncompensated care. The retroactive coverage provisions allow hospitals to collect Medicaid payments for services provided to these patients up to three months prior to being enrolled.

Actuarial analyses of Medicaid payments have shown that about 5 percent of Medicaid payments occur during the retrospective eligibility period.[8] In addition, we spoke with officers at a safety-net hospital who estimated that eliminating retroactive eligibility would result in about a

5 percent loss of Medicaid revenue. Based on these results, we assume that eliminating these provisions would result in lost Medicaid revenue of $13.3 billion over 2017 to 2026. However, we assume that the cost of treating these patients would still be incurred by the hospitals, and this provision would therefore result in increased uncompensated care.

Imposing Federal Per-Capita Limits on Medicaid Spending

The AHCA would incorporate per-capita limits on Medicaid spending beginning in 2020. Per-capita limits would be determined by enrollee category—aged adults, people with disabilities, children, expansion adults, or other adults. The caps would exclude Medicaid DSH payments, Medicare copayments, and the cost of care for enrollees in certain eligibility groups. Per-capita limits would be based on 2016 spending per enrollee and trended to future years by the medical component of the consumer price index (plus 1 percent for aged and disabled eligibility groups). If Medicaid spending exceeds the limits, then federal dollars as a percent of total spending would decline over time—leaving states with a larger burden of the cost. To control their spending liability, states would need to incorporate cost-cutting measures such as eligibility limits, reduced provider payments, reduced optional benefits, waiting lists for waiver services, or some combination of the above.

Using projections of Medicaid spending per enrollee from the Center for Medicare and Medicaid Services Office of the Actuary and CBO projections for the medical consumer price index, we estimate that the per-capita limits would gradually reduce federal Medicaid spending by 1.4 percent in 2020 and by 4.6 percent by 2026. It is difficult to determine how states will respond to this reduced level of spending. For this analysis, we assume that states would reduce overall spending to stay within these limits and would not use additional state funding. We also assume one-half of the spending reductions would be achieved by reducing provider payment levels. We present some sensitivity analyses regarding this assumption below.

Based on these assumptions, we estimate that lower Medicaid provider payments would reduce safety-net hospitals' revenues and net income by $3.6 billion over 2017 to 2026.

Providing Safety-Net Funding to Nonexpansion States

The AHCA would provide $2 billion per year from 2018 to 2022 to states that did not adopt the Medicaid expansion to supplement payments to safety-net providers that treat Medicaid patients. The AHCA safety-net funds would be allocated to each nonexpansion state based on the state's proportion of individuals below 138 percent of the federal poverty level. Payments to individual providers would be limited to the costs of treating uninsured patients plus the provider's payment shortfall under Medicaid. The AHCA does not specify how the safety-net funds are to be used, so states would have considerable flexibility in using these funds. Not all the funding would be directed to safety-net hospitals.

For this analysis, we assume that up to one-half of the funds appropriated to each nonexpansion state would be paid to safety-net hospitals. As specified under the legislation, we assume that payments to individual providers would be limited to the costs of treating uninsured patients plus the provider's payment shortfall under Medicaid—the cost of treating Medicaid patients that exceeds Medicaid and DSH payments—in that year. Based on these assumptions, we estimate that these funds would increase revenues to safety-net hospitals by $4.4 billion over 2017 to 2026.

IMPACT OF THE AHCA ON SAFETY-NET HOSPITALS' FINANCIAL MARGINS

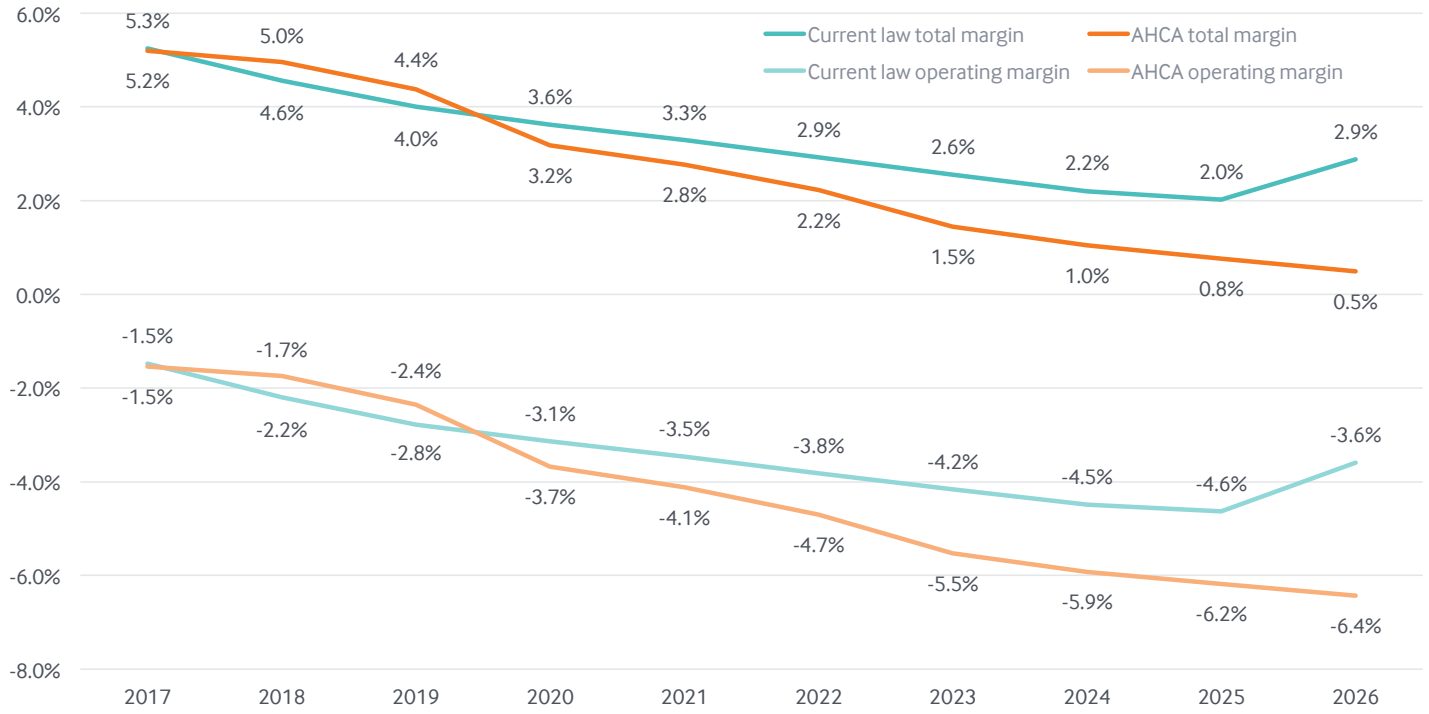
Exhibit 4 presents our projection of operating and total margins under current law compared with margins under the AHCA for safety-net hospitals over the 2017–2026 period. Our projections indicate that total margins for safety-net hospitals under current law would decline from 5.3 percent in 2017 to 2.9 percent in 2026, due to the aging of the population that results in increased proportion of Medicare beneficiaries in their payer mix,

since Medicare pays most hospitals below cost. Since safety-net hospitals rely heavily on Medicaid and DSH payments, the projections show a consistent decline in total margins between 2018 and 2025 due to the scheduled Medicaid DSH reductions under the ACA. However, the ACA Medicaid DSH reductions end in 2026, which results in an increase in total margins from 2 percent in 2025 to 2.9 percent in 2026.

Over the 10-year period from 2017 to 2026, we estimate that the Medicaid provisions of the AHCA would reduce net income for safety-net hospitals by 24 percent. However, the effect of these reductions would increase over time. For example, we estimate that the number of people who lose Medicaid coverage would grow from 5 million in 2020 to 12 million by 2026, which would reduce safety-net hospitals revenues year over year. Similarly, we estimate that the Medicaid per-capita spending limits would have an accumulating effect that would gradually reduce federal Medicaid spending by 1.4 percent in 2020 and up to 4.6 percent by 2026, therefore affecting safety-net providers at an increasing rate. In addition, the benefits to hospitals of providing AHCA safety-net funding and eliminating the Medicaid DSH reductions would only be temporary and would expire in 2022 and 2025, respectively.

As shown in Exhibit 4, total hospital margins for safety-net hospitals under the AHCA would improve relative to current law for 2018 and 2019, primarily due to eliminating DSH reductions and providing AHCA safety-net funding for hospitals in nonexpansion states. However, beginning in 2020, the financial status of safety-net hospitals could deteriorate more and more each year as Medicaid coverage is reduced and the effect of the Medicaid per-capita spending limits grows. Thus by 2026, we estimate that hospital total margins would drop to 0.5 percent, compared with estimates under the current law of 2.9 percent. Exhibit 4 shows a similar trend in operating margins for safety-net hospitals.

Exhibit 4. Projected Total and Operating Margins for Safety-Net Hospitals, 2017–2026



Data: Dobson | DaVanzo analysis of Medicare Hospital Cost Report Data for 2015.

HOW THE AHCA'S IMPACT DIFFERS IN EXPANSION AND NONEXPANSION STATES

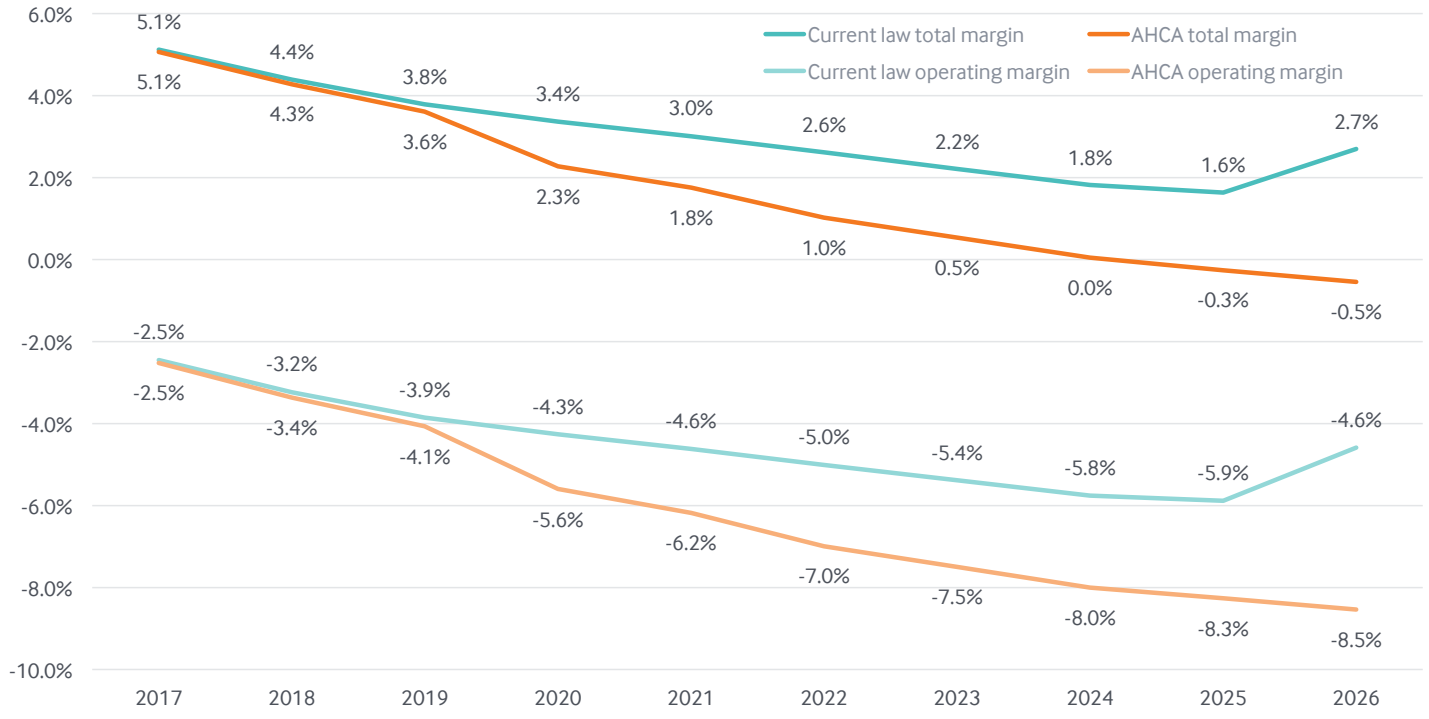
The AHCA would impact safety-net hospitals in Medicaid expansion states differently than in nonexpansion states. The AHCA Medicaid provisions would have an adverse impact on safety-net hospitals in expansion states. We estimate that, beginning in 2020, total margins for safety-net hospitals in expansion states would decline substantially relative to current law and would fall to –0.5 percent by 2026 relative to 2.7 percent under current law (Exhibit 5).

The ACHA provisions that would restore Medicaid DSH payments beginning in 2018 and provide additional safety-net funding to nonexpansion states could improve margins for safety-net hospitals in these states between 2018 and 2022 relative to current law (Exhibit 6). However, we estimate that by 2023 their margins would decline relative to those under current law due to the per-capita spending limits and the elimination of retroactive eligibility. By 2026, we estimate that hospital total margins for safety-net hospitals in nonexpansion states could be more than one percentage point below what margins would be under current law. For these hospitals, a reduction in margin of one percentage point translates into a loss of nearly 33 percent of net income (1.0% ÷ 3.2%).

HOW THE AHCA'S IMPACT DIFFERS BY RURAL/URBAN LOCATION, SIZE, AND SHARE OF LOW-INCOME PATIENTS

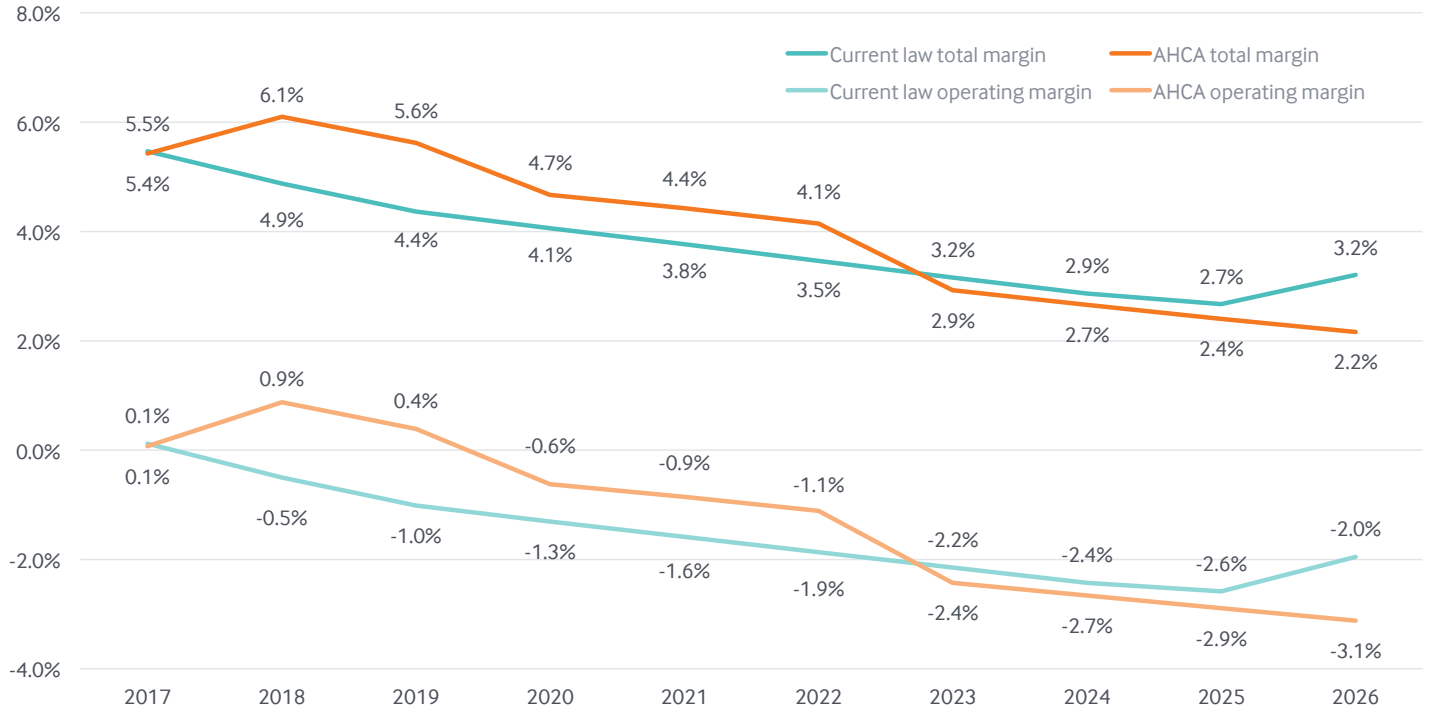
Eliminating the individual mandate, the Medicaid expansion, and retroactive eligibility under the AHCA would have a significant impact on hospitals' uncompensated care costs. By 2026, we estimate that uncompensated care costs for all safety-net hospitals would increase by 65 percent relative to current law (Exhibit 7). Of these, eliminating the Medicaid expansion would have the largest effect on uncompensated care. We estimate that uncompensated care costs would increase by about 16 percent relative to current law for safety-net hospitals in nonexpansion states. Safety-net hospitals in states that expanded Medicaid under the ACA could see uncompensated care costs more than double compared with current law.

Exhibit 5. Projected Total and Operating Margins for Safety-Net Hospitals in Medicaid Expansion States, 2017–2026



Data: Dobson | DaVanzo analysis of Medicare Hospital Cost Report Data for 2015.

Exhibit 6. Projected Total and Operating Margins for Safety-Net Hospitals in Nonexpansion States, 2017–2026



Data: Dobson | DaVanzo analysis of Medicare Hospital Cost Report Data for 2015.

Exhibit 7. Projected Uncompensated Care Costs of Safety-Net Hospitals by Urban/Rural Location, 2026

Hospital characteristics	Number of safety-net hospitals	Uncompensated care costs per safety-net hospital under current law ($1,000s)	Uncompensated care costs per safety-net hospital after AHCA ($1,000s)	Percent change
Safety-net hospitals in Medicaid expansion states				
Total	426	$13,454	$28,232	110%
RURAL	153	$2,636	$5,866	123%
URBAN	273	$19,517	$40,768	109%
Safety-net hospitals in nonexpansion states				
Total	234	$22,508	$26,164	16%
RURAL	99	$3,689	$4,234	15%
URBAN	135	$36,309	$42,246	16%
Total	**660**	**$16,664**	**$27,499**	**65%**

Data: Dobson | DaVanzo analysis using Medicare Hospital Cost Report Data for 2015.

The increase in uncompensated care would be most dramatic in rural safety-net hospitals in Medicaid expansion states that have a high Medicaid payer mix and have therefore benefitted the most from the expansion. Exhibit 7 shows that uncompensated care costs could increase by 123 percent by 2026 for this group of hospitals. Our analysis also showed that rural safety-net hospitals in California, Kentucky, Nevada, Oregon, and Washington could see increases in uncompensated care of more than 200 percent. Hospitals in rural communities have recently been closing at an alarming rate, and an increase in uncompensated care of this level may not be sustainable for these vulnerable hospitals.

The AHCA would have varying impacts on safety-net hospitals of different sizes. Exhibit 8 shows the estimated change in hospital total and operating margins for safety-net hospitals in 2026 relative to current law. As described above, safety-net hospitals in Medicaid expansion states would experience the largest negative impact on margins. Particularly, small rural hospitals as well as small and midsize urban hospitals in expansion states would experience the largest negative impact.

Safety-net hospitals that have the highest commitment to serving low-income and Medicaid patients tend to have the lowest operating and total margins under current law and would be hurt the most by the AHCA, regardless of location in an expansion or nonexpansion state.

Exhibit 8. Projected Total and Operating Margins for Safety-Net Hospitals by Urban/Rural Location and Bed Size, 2026

	Total margin			Operating margin		
Hospital characteristics	Current law	After AHCA	Percentage-point change	Current law	After AHCA	Percentage-point change
Safety-net hospitals in Medicaid expansion states						
Total	2.7%	-0.5%	**-3.2%**	-4.6%	-8.5%	**-3.9%**
RURAL	1.3%	-2.0%	**-3.3%**	-5.9%	-9.9%	**-4.0%**
25 or fewer beds	4.8%	0.2%	**-4.6%**	-2.8%	-8.6%	**-5.8%**
26–99 beds	0.5%	-3.3%	**-3.8%**	-5.2%	-9.6%	**-4.4%**
100+ beds	0.0%	-2.3%	**-2.3%**	-7.9%	-10.7%	**-2.8%**
URBAN	2.8%	-0.4%	**-3.2%**	-4.5%	-8.4%	**-3.9%**
Fewer than 100 beds	3.1%	-0.2%	**-3.3%**	-3.8%	-7.8%	**-4.0%**
100–199 beds	1.6%	-1.7%	**-3.3%**	-6.2%	-10.4%	**-4.2%**
200–299 beds	0.8%	-2.5%	**-3.3%**	-4.8%	-8.6%	**-3.9%**
300–499 beds	2.9%	-0.8%	**-3.7%**	-5.7%	-10.3%	**-4.6%**
500+ beds	4.2%	1.5%	**-2.7%**	-2.4%	-5.6%	**-3.2%**
Safety-net hospitals in nonexpansion states						
Total	3.2%	2.2%	**-1.0%**	-2.0%	-3.1%	**-1.2%**
RURAL	2.3%	1.2%	**-1.1%**	-2.3%	-3.5%	**-1.2%**
25 or fewer beds	3.7%	2.7%	**-1.0%**	-1.6%	-2.7%	**-1.1%**
26–99 beds	0.4%	-0.7%	**-1.1%**	-4.7%	-6.0%	**-1.2%**
100+ beds	5.2%	4.1%	**-1.1%**	2.2%	1.0%	**-1.1%**
URBAN	3.3%	2.2%	**-1.0%**	-1.9%	-3.1%	**-1.2%**
Fewer than 100 beds	7.8%	6.4%	**-1.5%**	7.0%	5.4%	**-1.6%**
100–199 beds	4.5%	3.6%	**-0.9%**	1.6%	0.6%	**-1.0%**
200–299 beds	0.2%	-0.9%	**-1.1%**	-3.1%	-4.3%	**-1.2%**
300–499 beds	4.3%	3.4%	**-0.9%**	-1.5%	-2.5%	**-1.0%**
500+ beds	3.1%	2.0%	**-1.1%**	-2.5%	-3.8%	**-1.2%**
Grand total	**2.9%**	**0.5%**	**-2.4%**	**-3.6%**	**-6.4%**	**-2.8%**

Data: Dobson | DaVanzo analysis using Medicare Hospital Cost Report Data for 2015.

Exhibit 9 shows the estimated change in hospital total and operating margins for safety-net hospitals in 2026 relative to current law by how many low-income patients a hospital serves. Although all safety-net hospitals are by definition committed to serving low-income and Medicaid patients, this metric further sorts safety-net hospitals by their volume of low-income patients.

VARIABLES AFFECTING THIS ANALYSIS

The federal funding reductions from the AHCA's Medicaid provisions would affect states differently, particularly with respect to states that have expanded Medicaid versus states that have not. For this reason, it is difficult to predict how each state would respond to the legislation. Therefore, we performed a set of "sensitivity analyses" to provide a range of potential financial impacts as they relate to safety-net hospitals. Using a range of assumptions (described in the Technical Appendix), we estimate that the Medicaid provisions specified in the AHCA would in total reduce net income to safety-net hospitals between $13.3 billion and $26.9 billion (or an 18% to 36% reduction in net income relative to current law) over the 2017 to 2026 period (Exhibit 10).

Exhibit 9. Projected Total and Operating Margins for Safety-Net Hospitals by Low-Income Utilization Rate (LIUR) Level, 2026

	Total margin			Operating margin		
LIUR level	Current law	After AHCA	Percentage-point change	Current law	After AHCA	Percentage-point change
Safety-net hospitals in Medicaid expansion states						
Total	2.7%	-0.5%	**-3.2%**	-4.6%	-8.5%	**-3.9%**
Lowest tercile	5.5%	3.6%	**-1.9%**	0.7%	-1.6%	**-2.2%**
Middle tercile	0.7%	-3.5%	**-4.1%**	-5.6%	-10.4%	**-4.9%**
Highest tercile	0.0%	-4.7%	**-4.7%**	-12.3%	-18.6%	**-6.3%**
Safety-net hospitals in nonexpansion states						
Total	3.2%	2.2%	**-1.0%**	-2.0%	-3.1%	**-1.2%**
Lowest tercile	5.4%	4.8%	**-0.6%**	1.9%	1.2%	**-0.7%**
Middle tercile	2.3%	1.1%	**-1.1%**	-3.2%	-4.5%	**-1.3%**
Highest tercile	2.0%	0.5%	**-1.5%**	-4.8%	-6.6%	**-1.8%**
Total	**2.9%**	**0.5%**	**-2.4%**	**-3.6%**	**-6.4%**	**-2.8%**

Note: The LIUR is a metric used for determining Medicaid DSH hospitals and consists of a hospital's Medicaid revenue as a percent of total revenue and charity care charges as a percent of total hospital charges.

Data: Dobson | DaVanzo analysis using Medicare Hospital Cost Report Data for 2015.

Exhibit 10. Change in Key Financial Performance Metrics for Safety-Net Hospitals Under Various Assumption Scenarios, 2017–2026

	Total revenues (millions)	Total expenses (millions)	Net income/ (loss) (millions)
Current law	**$2,293,810**	**$2,219,745**	**$74,064**
Low-range estimate	($30,422)	($17,160)	($13,262)
Mid-range estimate (presented above)	($36,531)	($18,254)	($18,277)
High-range estimate	($50,844)	($23,949)	($26,895)

Data: Dobson | DaVanzo analysis using Medicare Hospital Cost Report Data.

DISCUSSION

Under the AHCA, beginning in 2020, the financial status of safety-net hospitals could deteriorate year over year as Medicaid coverage is reduced and the effect of the Medicaid per-capita spending limits grows. By 2026, we estimate that hospital total margins would drop to 0.5 percent, compared with estimates under current law of 2.9 percent—representing an 83 percent reduction in net income for safety-net hospitals.

Safety-net hospitals in Medicaid expansion states would experience the largest losses under the AHCA. Small rural hospitals and small and mid-size urban hospitals would experience the largest negative impact. Safety-net hospitals in states that expanded Medicaid may see uncompensated care costs more than double compared with current law by 2026. This would be most dramatic in rural safety-net hospitals in expansion states that have a high Medicaid payer mix and therefore benefitted the most from the Medicaid expansion. In addition, safety-net hospitals that have the highest commitment to serving low-income and Medicaid patients tend to have the lowest operating and total margins under current law and would be hurt the most by the AHCA, regardless of whether they are in a Medicaid expansion or nonexpansion state. We will be publishing a state-by-state analysis of the impact of the AHCA on hospitals as a follow-up to this report.

The financial margin analysis presented in this report is meant to illustrate the pressures that would be placed on safety-net hospitals due to the reduced Medicaid funding under the AHCA. The negative total margins predicted under the AHCA by 2026 for safety-net hospitals in expansion states indicate that projected revenues from all sources would be less than projected costs. Hospital administrators may need to respond by reducing their costs, meaning eliminating specific services, reducing staff, or possibly closing the hospital.

Our analysis indicates that small rural safety-net hospitals would by hit the hardest by the AHCA's Medicaid provisions. There is already substantial financial pressure on rural hospitals; some 80 rural hospitals have closed or eliminated inpatient services since 2010, and many more are vulnerable to closure.[9] In addition, other rural hospitals are eliminating specific services such as obstetrics care. The impact of the AHCA on these hospitals and the services they provide would not only affect Medicaid patients but also the communities they serve.

Furthermore, since Medicaid helps to absorb the costs of care for so many Americans, cuts of this magnitude could have unintended consequences, including the shift of costs to Medicare and private insurers. Already-low Medicaid provider payments would be at risk for further reductions and, at the same time, uncompensated care costs for hospitals would rise.

NOTES

[1] P. Cunningham and L. Felland, *Environmental Scan to Identify the Major Research Questions and Metrics for Monitoring the Effects of the Affordable Care Act on Safety Net Hospitals* (Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, June 2013).

[2] Expansion states included: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia. The District of Columbia expanded as well. Although Alaska, Indiana, Louisiana, Montana, and Pennsylvania have expanded Medicaid, they are included in our nonexpansion states, since they expanded in 2015 or later, which is the last year of our database. In addition, six states (California, Colorado, Connecticut, Minnesota, New Jersey, and Washington) and the District of Columbia expanded Medicaid prior to 2014. However, we included hospitals in these states in our study as expansion states, because the trend in Medicaid utilization and revenue as well as uncompensated care costs observed for hospitals in these closely resembled the trends observed in other expansion states over the 2012–2015 period.

[3] A. Searing and J. Hoadley, *Beyond the Reduction in Uncompensated Care: Medicaid Expansion Is Having a Positive Impact on Safety Net Hospitals and Clinics* (Georgetown University Health Policy Institute, June 2016).

[4] L. Felland, P. Cunningham, A. Doubleday et al., *Effects of the Affordable Care Act on Safety Net Hospitals*, submitted to the Assistant Secretary for Planning and Evaluation (Mathematica Policy Research, Nov. 2016).

[5] Congressional Budget Office, *Cost Estimate—H.R. 1628, American Health Care Act of 2017, as Passed by the House of Representatives on May 4, 2017* (CBO, May 24, 2017).

[6] Dobson | DaVanzo analysis of Medicare Hospital Cost Reports for federal fiscal year 2015.

[7] L. Felland, P. Cunningham, A. Doubleday et al., Effects of the Affordable Care Act on Safety Net Hospitals, submitted to the Assistant Secretary for Planning and Evaluation (Mathematica Policy Research, Nov. 2016).

[8] Lewin Group, *Assessment of Medicaid Managed Care Expansion Options in Illinois*, prepared for the Commission on Government Forecasting and Accountability (Lewin Group, May 3, 2005).

[9] A. Ellison, *A State-by-State Breakdown of 80 Rural Hospital Closures* (Becker's Hospital CFO Report, Dec. 13, 2016).

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