THE EFFECTS OF THE ACA ON UNCOMPENSATED CARE, BAD DEBT, AND CHARITY CARE IN IOWA CRITICAL ACCESS HOSPITALS by Leon Sun

This policy brief explores the impact that Iowa's Medicaid expansion had on uncompensated care costs, charity care, and bad debt in Iowa Critical Access and non-Critical Access Hospitals utilizing CMS hospital cost reports.

KEY FINDINGS

- Medicaid expansion decreased uncompensated care, bad debt, and charity care among both Critical Access and non-Critical Access Hospitals.
- Uncompensated care cost as a share of operating expenses in Critical Access Hospitals decreased 34% from 3.5% in 2013 to 2.3% in 2015, as compared to non-Critical Access Hospitals which decreased 32% from 4.6% in 2013 to 3.1% in 2015.
- Within both Critical Access Hospitals and non-Critical Access hospitals, the largest decreases in uncompensated care resulted from bad debt reductions.
- Bad debt accounts for the majority of uncompensated care within Critical Access Hospitals and charity care accounts for the majority of uncompensated care within non-Critical Access Hospitals.

INTRODUCTION

Prior to the passage of the ACA, Medicaid eligibility was denied to nondisabled childless adults. These adults remain ineligible in almost every state that has not expanded Medicaid.1,2,3 The ACA allowed states to expand Medicaid coverage to non-disabled, childless adults up to 138% of the FPL. As of August 2020, Iowa is one of 37 states to expand Medicaid under the ACA.4

An important goal of the ACA was to reduce hospital uncompensated care cost. This is frequently defined as the sum of uncollectable debt (bad debt) and care provided for free or at reduced rates (charity care).1 Increased levels of uncompensated care have been linked to financial instability, causing hospitals to cut services and reduce infrastructure spending leading to declines in care quality.5-8 Additionally, reductions in uncompensated care have been linked to improved hospital performance and patient experience.9 Thus, understanding how ACA-related policy changes impact uncompensated care helps us continue refining policies that improve the financial health of hospitals and the wellbeing of patients.

Our study examines uncompensated care costs of Iowa Critical Access Hospitals (CAHs). The CAH designation was created by the Balanced Budget Act of 1997 as part of an effort to financially support geographically isolated hospitals. Hospitals considered for CAH status must meet a number of criteria, including being located greater than 35 miles from the nearest hospital.10 Due to their importance as a healthcare access point for rural populations as well as their financial vulnerability, it's important to understand the impact of Medicaid eligibility changes on their uncompensated care burden.

The relationship between changes in Medicaid eligibility and uncompensated care cost is well established. Studies using Medicare hospital cost reports found that states that expanded Medicaid either through the ACA or through pre-ACA programs had greater decreases in uncompensated care costs compared to states that didn't expand. 1, 11-15 The effects of Medicaid eligibility expansion on bad debt and charity care specifically is less well understood. Existing studies are limited in scope and yield inconsistent results.16-19

METHODS

Our data source is the CMS Hospital Cost Report Information System (HCRIS), processed through the RAND Hospital Data: Web-Based Tool. All Medicare providers must submit an annual cost report to CMS consisting of worksheets that collect information on hospital operations such as uncompensated care costs, facility characteristics, and financial statement data.20 HCRIS has been utilized in previous studies proving to be a robust tool for studying changes in uncompensated care due to the amount of information and number of hospitals it contains. Uncompensated care, bad debt, and charity care were measured as a share of operating expenses. These measurements were obtained through calculations performed by RAND.21 The ACA went into effect in Iowa on January 1st, 2014. Our analysis will focus on costs from 2011-2017.

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RESULTS

Figure 1. Our data encompassed 116 Iowa hospitals. 82 of the hospitals were designated CAHs and 34 hospitals were not designated CAHs. Iowa expanded Medicaid under the ACA January 1st, 2014, between fiscal year 2013 and 2014. Source: CMS Hospital Cost Report Information System 2011-2017.

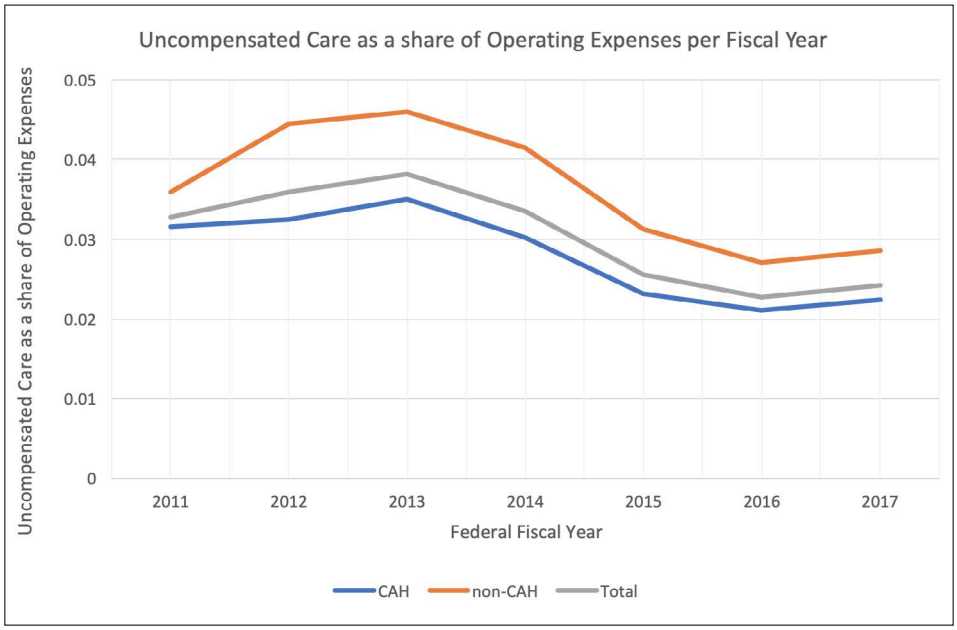


Figure 1 shows that uncompensated care as a share of operating expenses decreased among all hospitals from fiscal year 2013 to 2014 and declined further in 2015. Among all hospitals from 2013 to 2015, costs declined from 3.8% of operating expenses to 2.5%, a decrease of 32%. Costs remained low into 2016 and 2017. The largest reductions in uncompensated care costs occurred in non-CAH hospitals, which previously bore the largest burden of uncompensated care. Costs dropped 32% from 4.6% of operating expenses in 2013 to 3.1% in 2015. CAHs bore both a lower burden of uncompensated care and experienced smaller reductions compared to non-CAHs, dropping 34% from 3.5% in 2013 to 2.3% in 2015.

Figure 2. Our charity care data encompassed 116 total hospitals, 82 of which were designated as CAHs and 34 that were not. Iowa expanded Medicaid under the ACA January 1st, 2014, between fiscal year 2013 and 2014. Source: CMS Hospital Cost Report Information System 2011-2017.

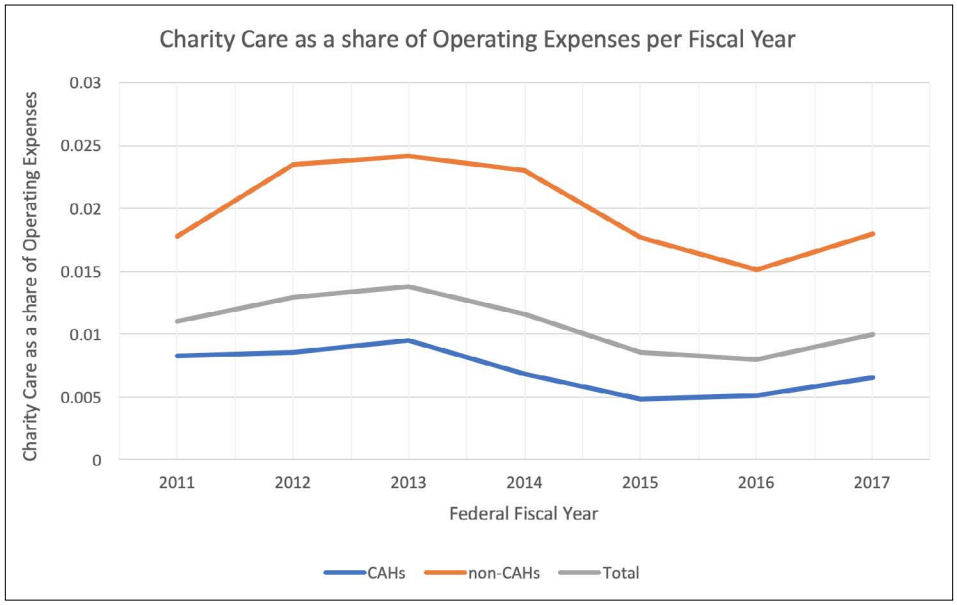
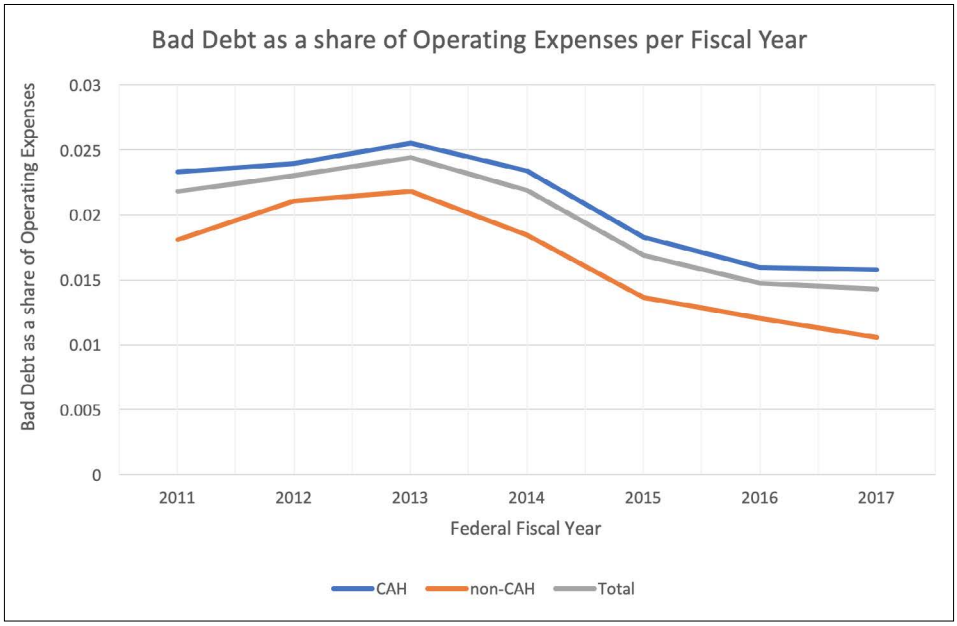


Figure 3: Our bad debt data in the years 2011-2013 and 2017 encompassed 116 total hospitals, 82 of which were designated as CAHs and 34 that were not. Between 2014-2016 our data contained 115 total hospitals and 81 CAHs. Iowa expanded Medicaid under the ACA January 1st, 2014, between fiscal year 2013 and 2014. Source: CMS Hospital Cost Report Information System 2011-2017.



Figures 2 and 3 show that a decrease in cost as a share of operating expenses occurred in both charity care and bad debt across both hospital types. Non-CAHs carried a greater burden of charity care pre-ACA and declined by a greater amount following Medicaid expansion, dropping 25% from 2.4% to 1.8%. In contrast, CAHs carried a higher burden of bad debt. CAH bad debt declined 28% from 2.5% to 1.8% while non-CAHs declined 37% from 2.2% to 1.4%.

Among all hospitals, reductions in bad debt accounted for the majority of the decrease in uncompensated care costs.

LIMITATIONS

Despite the advantages of the HCRIS data set, cost reports are not required to be audited and a close analysis of cost reports reveal issues such as discrepancies in reported profits, item nonresponse, and missing information.[22,23] By focusing our study on one state, we hope to minimize the impact of interhospital discrepancies in reporting practice as well as changes in reporting practices over time.

DISCUSSION

Iowa hospital's uncompensated care costs decreased along with national trends. A small decrease in costs occurred in fiscal year 2014, corresponding with the implementation of the ACA on January 1st, halfway through the fiscal year. Costs continued to fall during fiscal year 2015, corresponding to the first full year of the ACA.

Our results suggest that CAHs are benefiting from Medicaid expansion policies, albeit to a slightly lesser degree than non-CAHs. A potential explanation for this is that CAHs tend to be located in rural areas, which have a lower uninsured rate in individuals who are <138% of the FPL compared to urban areas.24 Thus, urban hospitals may see a larger proportion of patients receiving coverage due to Medicaid expansion, leading to a larger decrease in costs. This explanation is supported by existing data showing that rural hospitals receive smaller decreases in uncompensated care from Medicaid expansion compared to urban hospitals.25

The finding that bad debt accounts for the majority of the decrease in uncompensated care is surprising. Charity care benefits are provided to individuals with limited income who a hospital determines are unable to pay, whereas bad debt is uncollectible debt from individuals that a hospital has determined is capable of paying. It is logical to assume that Medicaid expansion would enable many patients previously eligible for charity care to be covered, leading to a substantial decrease in charity costs. However, our findings suggest that bad debt is the key factor in reducing uncompensated care, raising questions about hospital practices in determining and enrolling charity care eligible patients.

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