TSG Task Force Update

To: Arkansas Health Reform Task Force

Re: Context for Considering the Removal of the Private Option

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PREPARED BY:

THE STEPHEN GROUP
814 Elm Street, Suite 309
Manchester, NH, 03102
Main: (603)419-9592
www.stephengroupinc.com

Context for Considering the Removal of the Private Option

The potential re-authorization of the Private Option should be considered in the context of both predictable impacts and other relevant factors. Among the predictable impacts of removing the private option are a negative impact to the general fund and an increase in hospital uncompensated care. Among the other relevant factors to consider when contemplating the removal of the PO are the other impacts of the ACA on the Arkansas health care sector, which will remain whether the PO is re-authorized or not.

Estimate of Impact of Private Option on State Funds

The following table was included in the March 7, 2016 TSG report and shows the estimated impact of the Private Option (PO) on state funds. These estimates are based on data projections provided by DHS. Based on these projections, the 5-year projected impact on the general fund of the PO is $757 million, meaning that general fund amounts available will be $757 million greater with the PO than without it.

It is important to consider that these projection assume that with the removal of Private Option, the State will restore eligibility for traditional Medicaid and uncompensated care payments back to the scenario prior to the implementation of PO.

Projected Aggregate Private Option Impact (SFY 2017-2021)							
(all figures millions $ unless otherwise indicated)							
		2017	2018	2019	2020	2021	2017-2021
Private option expenditures		1,630	1,712	1,797	1,887	1,982	9,009
Impact on State Funds							
Impact on state expenditures	**State match on Private Option**	41	92	114	157	193	598
	State fund savings from optional Medicaid waiver programs discontinued after the establishment of the PO	(21)	(22)	(23)	(25)	(26)	(117)
	State fund savings from cost-shifting from traditional Medicaid to PO	(91)	(96)	(101)	(106)	(111)	(504)
	Administrative costs	3	3	3	3	3	14
	Reductions in state fund outlays for uncompensated care	(37)	(39)	(41)	(43)	(45)	(203)
	Total impact on expenditures	**(106)**	**(62)**	**(47)**	**(13)**	**15**	**(213)**
Impact on state revenues	**Increase in premium tax revenue**	37	39	41	44	46	208
	Increase in collections from economically-sensitive taxes (4%)	64	65	67	69	72	336
	Total impact on revenues	**101**	**104**	**109**	**113**	**118**	**544**
Net impact on state funds		**206**	**166**	**156**	**126**	**103**	**757**

Hospital Uncompensated Care

As in every state, hospitals in Arkansas provide care for which they are not reimbursed. This uncompensated care is the result of incurring costs for providing services to individuals who are not able to pay for the costs of their care.

EMTALA

One of the key factors creating uncompensated care for hospitals is Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals to screen and stabilize any patients that they see, regardless of the patients' abilities to pay. One practical effect of EMTALA is effectively to require hospitals to provide care to anyone who arrives in their emergency rooms, regardless of their ability to pay.

Hospital Uncompensated Care Estimates

The table below appeared in Volume I of the TSG final report from the first phase of the project in October 2015 and includes the projected impact of the PO on hospital uncompensated care. It is projected that, with the PO, hospitals will provide about $1.1 billion less in uncompensated care over the five years 2017-2021. Providers often suggest that they offset uncompensated care with higher rates to other payers, so lower levels of uncompensated care could potentially lead to lower health insurance rates in the commercial market than might otherwise have been the case.

Impact on Hospital Uncompensated Care[1]						
	2017	**2018**	**2019**	**2020**	**2021**	**2017-2021**
With PO	135	141	148	156	164	744
Without PO	329	345	362	380	400	1,816
Difference	194	204	214	225	236	1,072

It is important to note that the hospital-reported data underlying these estimates are based on costs, not charges. In addition, these uncompensated care estimates do not represent funds that would likely be compensated by the state. State funds have not historically been used to reimburse hospitals for their uncompensated care costs. This does not, however, mean that allowing hospital uncompensated care costs to rise again will be without impact. Since all hospitals – public, private, and nonprofit – must operate within their revenues, decreasing hospital revenues by increasing hospital uncompensated care could require hospitals to increase the rates that they charge to other payers (i.e., shift costs to other payers in the system), or to take losses, which could ultimately lead to closure.

[1] TSG calculations based on Arkansas Hospital Association survey data

Other ACA Financial Impacts on Arkansas Health Care Sector

In addition to the Affordable Care Act (ACA) authorizing significant federal funding for the expansion of Medicaid eligibility within each state, there were several other key provisions that were enacted that will have a significant fiscal impact on the Arkansas health care industry whether the PO is retained or not. Most significant among these additional ACA changes were the subsidies for individuals and small businesses for individuals between 138% and 400% of FPL. However, if Private Option were removed, the subsidies would then become eligible for those between 100-138% FPL.

These subsidies will account for an estimated $4.9 billion in additional federal funds coming into the state of Arkansas between 2017 and 2011. On the other side of the ledger, there will be a decrease in federal funds due to a medical device tax and decreased hospital payments through Medicare rate adjustments and the phase-out of the Medicare and Medicaid Disproportional Share Hospital (DSH) programs. These reductions in federal funding will result in a loss of approximately $10 billion of federal funds to the state of Arkansas between 2017 and 2021.

Impacts of other ACA Changes on Arkansas Health Care Providers[2]						
	2017	**2018**	**2019**	**2020**	**2021**	**2017-2021**
Increase in other federal funds flowing into AR due to ACA (exchange subsidies)	846	939	995	1,032	1,097	4,911
Decrease in federal funds flowing into AR due to ACA (taxes and rate effects)	(1,386)	(1,730)	(2,055)	(2,279)	(2,539)	(9,989)

[2] TSG calculations based on CBO estimates.

Congressional Budget Office, letter to House Speaker John Boehner providing an estimate for H.R. 6079, repeal of Obamacare, July 24, 2012. As of December 21, 2012: http://www.cbo.gov/publication/43471

Net impact of other ACA changes	(539)	(791)	(1,060)	(1,246)	(1,442)	(5,078)

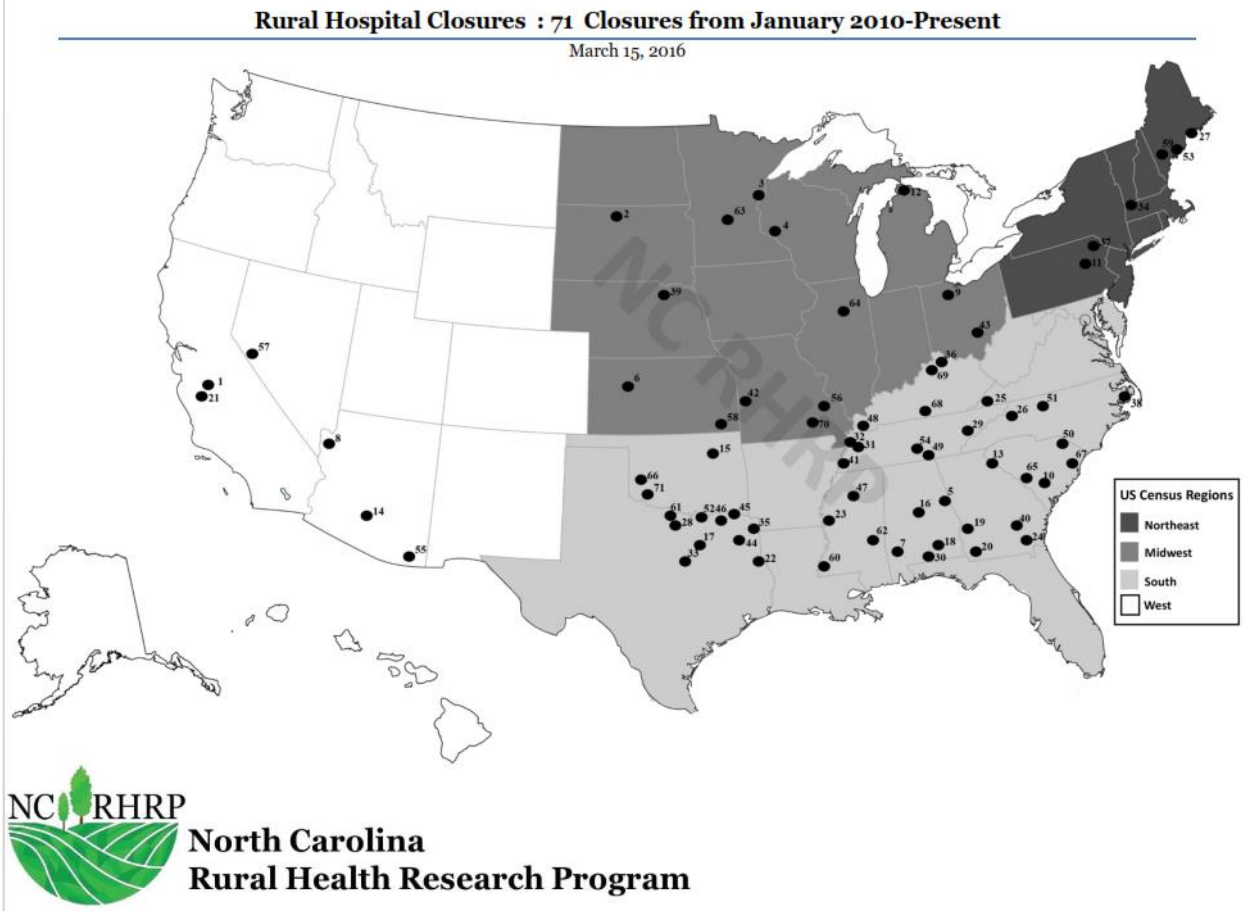
Hospital Financial Stability

Implicit within the previous discussion is the fact that hospital uncompensated care affects overall hospital financial stability. Higher levels of uncompensated care could lead to hospital financial instability and potentially hospital closure. "According to the hospital financial vulnerability developed by iVantage Health Analytics, of the 673 financially vulnerable hospitals in the U.S., 19 are in Arkansas." See http://www.ivantageindex.com/

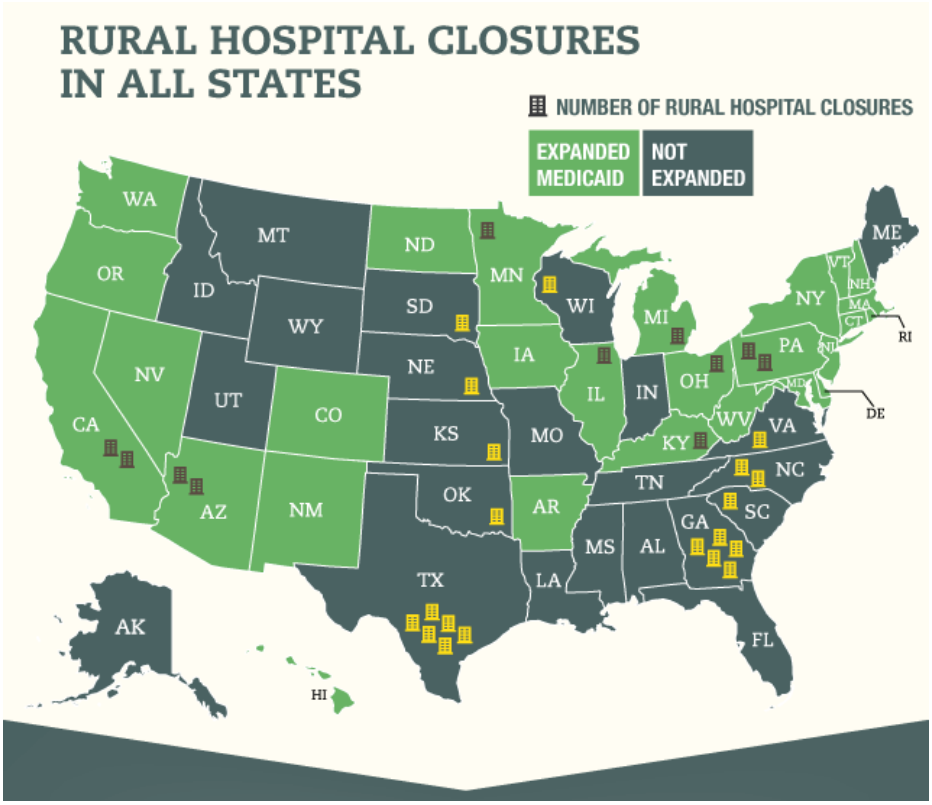
Moody's Investors Service recently revised the outlook for the U.S. non-profit and public health care sector from negative to stable for the first time since 2008, citing reductions in bad debt as one of the primary drivers.[3] In addition, Moody's noted that this improved financial outlook is even better in states that have expanded Medicaid eligibility.

The following graphic is from the North Carolina Rural Health Research Program and shows rural hospital closures from January 2010 through March 15, 2016. Of the 71 rural hospitals that closed during that period, 52 were in states that have expanded Medicaid and 19 were in states that did not expand Medicaid.

[3] Moody's Investor Service. "Moody's revises US not-for-profit healthcare outlook to stable from negative as cash flows increase" https://www.moodys.com/research/Moodys-revises-US-not-for-profit-healthcare-outlook-to-stable--PR_333323


Rural Hospital Closures : 71 Closures from January 2010-Present
March 15, 2016
US Census Regions
Northeast
Midwest
South
West
NC RHRP
North Carolina
Rural Health Research Program

The following graphic from Families USA shows recent rural hospital closures and Medicaid expansion.[4]



[4] Families USA. "Medicaid Expansion and Rural Hospital Closures." http://familiesusa.org/product/medicaid-expansion-and-rural-hospital-closures