NC RHRP

Findings Brief
NC Rural Health Research Program

June 2016

Does ACA Insurance Coverage Expansion Improve the Financial Performance of Rural Hospitals?

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BACKGROUND

The implementation of the Patient Protection and Affordable Care Act (ACA) is changing hospital reimbursement in important ways.[1] The most significant changes stem from increasing access to health insurance coverage for previously uninsured or under-insured populations. Since rural residents are more likely than urban residents to be uninsured,[2] increased access to health insurance should, in theory, provide a new source of revenue for rural hospitals and, therefore, improve financial performance. However, the ultimate financial impact of the ACA on rural hospital providers is still unknown. To better understand how the ACA's expansion of insurance coverage has affected uncompensated care,[3,4] unreimbursed cost,[5] and financial performance in rural hospitals, we interviewed rural hospital administrators, state hospital associations, and State Offices of Rural Health (SORHs). We asked respondents about their perceptions of changes in payer mix; changes in uncompensated care (bad debt[6] and charity care[7]) and unreimbursed cost (shortfalls between the costs of providing services and payments by public programs); and financial performance in their respective hospitals/state.

KEY FINDINGS

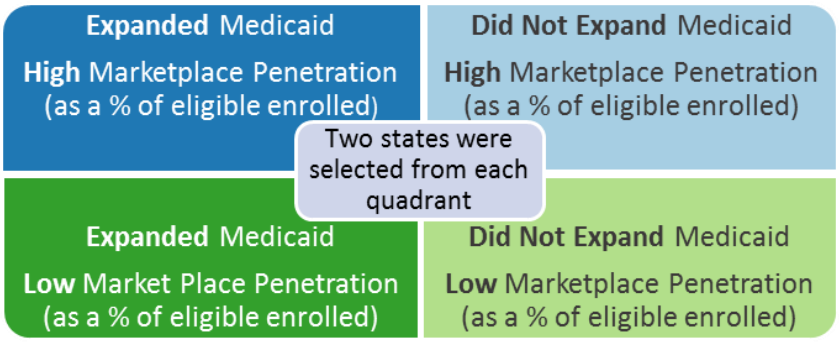
- Results from interviews with hospital administrators and state leaders underscored the importance of local market and economic conditions (and health system changes more generally) in moderating the effects of the ACA.
- While some rural hospitals reported decreases in charity care, few reported a positive net financial impact as a result of the ACA's expanded insurance coverage — primarily because respondents felt that bad debt from high-deductible health plans and shortfalls between payments and costs of care in Medicare and Medicaid were growing.
- Most respondents in states that had not expanded Medicaid reported some growth in the numbers of individuals who gained insurance coverage either through new Medicaid enrollments or enrollments in Marketplace plans; however, respondents in these states viewed the lack of Medicaid expansion as a missed opportunity.
- Respondents believed the expanded insurance coverage as a result of the ACA was the right thing to do for patients, but expressed concerns that the coverage may not be adequate to ensure access to care.
- Downward pressure on reimbursement from Medicare and commercial payers, an increase in high-deductible health plans, below-cost reimbursement for growing numbers of Medicaid enrollees, and anticipated cuts to Medicaid Disproportionate Share Hospital funds all contributed to uncertainty about the long-term financial sustainability of rural hospitals.

METHODS

We used a comparative case study design to examine the perceived effects of increased availability of health insurance through the ACA on rural hospitals' payer mix, levels and mix of uncompensated care and unreimbursed cost, and financial performance. We defined uncompensated care and unreimbursed care consistent with the categories reported on the Medicare Cost Report form S-10.[3] The form defines uncompensated care as bad debt and charity care, and it also collects unreimbursed cost for Medicaid, the State Children's Health Insurance Program (SCHIP) and state and local indigent care programs. We chose to include all of these sources of unpaid costs as they are all included when determining the distribution of Medicaid Disproportionate Share (DSH) funds.[8] We first stratified states into four groups by Medicaid expansion status (yes/no) as of May 2015, and 2015 insurance marketplace enrollment (above/below national median percent of eligible individuals enrolled) as reported by the Kaiser Family Foundation.[9] From each of the four groups, we purposively selected two states based on geographic variation and the number of rural

hospitals in the state (as defined using Rural Urban Commuting Areas). Figure 1 demonstrates the criteria used to select the eight states for the study (based on Medicaid expansion status and marketplace penetration). Within each state, we attempted to interview administrators (Chief Executive Officer or Chief Financial Officer) from two Critical Access Hospitals (CAHs) and one rural Prospective Payment System (PPS) hospital, and a rural representative from the state hospital association and/or the State Office of Rural Health (SORH). Potential state-level respondents were identified via website searches of the state hospital association or SORH and contacted via e-mail. Representatives from all eight states agreed to participate. State-level representatives were asked to recommend potential hospital respondents based on longevity of the executives at the hospitals so that the executives would have the knowledge to comment on changes that happened over time. Between May and September 2015, we conducted a total of 21 thirty-minute semi-structured telephone interviews across the eight states. As shown in Table 1, respondents included nine CAHs, three rural PPS hospitals, and nine hospital association or SORH representatives. Data were coded and analyzed using NVivo qualitative data analysis software.

Figure 1: Criteria Used to Select Participating States



LIMITATIONS

Results of this study should be interpreted cautiously and within the context of the following limitations. First, while we sought to obtain a representative sample, results of this study are based on interviews with only 21 respondents from eight states who voluntarily entered our study, and may not reflect the experiences of rural hospitals or states nationwide. In particular, hospitals' experiences with Medicaid expansion may vary based on states' Medicaid eligibility rules prior to January 1, 2014, and on whether a hospital's costs for providing services to Medicaid patients exceed that state's Medicaid reimbursement rates. Second, rural hospitals are facing a myriad of pressures and uncertainty as the ACA and other policy initiatives unfold. As a result, respondents may not have been able to fully attribute outcomes to the ACA versus other environmental factors. In fact, several respondents reported that certain changes began prior to the implementation of the ACA's coverage provisions. Third, because this was a qualitative study conducted relatively early after implementation of the ACA's coverage expansions, the findings reflect respondents' perceptions of early effects and may not be predictive of future outcomes. Finally, the participation of only three rural PPS hospitals suggests that the findings may be more applicable to CAHs. Still, results of this study provide an early look at how the ACA's coverage provisions may be impacting rural hospitals and suggest areas for monitoring going forward.

Table 1: Type and Number of Respondents

SORH or State Hospital Association	9
Hospital Administrators	12
CAHs (9)	
Rural PPS Hospitals (3)	

RESULTS

For each hospital and state respondent, we categorized interview responses into themes (bold) and subthemes (italics) among the eight states. These themes and subthemes are discussed below. Because the primary purpose of our study was to explore the effects of the ACA's coverage expansions on rural hospitals generally, our findings focus primarily on aggregate responses rather than responses by sampling quadrant. We found some evidence of differences in perspectives between respondents from Medicaid expansion states and non-expansion states, and between respondents from states with high-marketplace enrollment versus low-marketplace enrollment, and where we did, these differences are noted. Because only three rural PPS hospitals participated, we do not report results by hospital type.

Perceptions of Hospital Administrators

Results from interviews with hospital administrators underscored the *importance of local market and economic conditions (and health system changes more generally) in moderating the effects of the ACA*. Hospital administrators' responses regarding the ACA's effect on payer mix, uncompensated care and unreimbursed cost, and financial performance were categorized into six themes: 1) payer mix changes, 2) continued shortfalls, 3) costs of high-deductible plans, 4) reduced reimbursements from commercial payers, 5) limited impact on hospitals' financial performance, and 6) concern over losing Medicaid Disproportionate Share Hospital (DSH) payments.

Effects on hospital payer mix have been limited, with the greatest effects reported by three hospitals in Medicaid expansion states.
When asked about the effects of the ACA on payer mix, only five of the 12 hospital respondents reported a noticeable change in payer mix. Results show *some differences between hospitals in Medicaid expansion versus non-expansion states*. Three of the respondents were from hospitals in two states that expanded Medicaid. All three noted a shift *from self-pay to Medicaid*, while one also noted a shift from commercially insured to Medicaid. In contrast, two respondents from states that had not expanded Medicaid but that had high-marketplace enrollment reported small shifts *from self-pay to commercial insurance*. These shifts were attributed to a combination of the ACA and improving economic conditions that led to increased employment with employer-based insurance coverage. The remaining seven hospital respondents, representing four non-expansion states and one expansion state, reported *no noticeable changes in payer mix*, despite two of the states reporting high-marketplace enrollment. One possible explanation is that the growth in insurance coverage due to the marketplace was concentrated in urban areas and even among high enrollment states the change in rural areas may have been modest.[10]

Even with more people insured, uncompensated care and unreimbursed cost remain an issue for rural hospitals.
Respondents were asked about the effects of the ACA on uncompensated care and unreimbursed cost. Eleven hospital administrators responded. Of the 11 respondents, only one hospital reported a decrease in total uncompensated care and unreimbursed cost as a result of the ACA, and this hospital was located in a state that expanded Medicaid. This respondent noted, "The self-pay uncompensated care has gone down quite a bit because there are fewer uninsured." The remaining 10 either reported an increase or no change in total uncompensated care: five respondents (representing one Medicaid expansion/low-marketplace enrollment state and two non-expansion/high-marketplace enrollment states) reported increases in total uncompensated care and unreimbursed cost; and five, all in non-expansion states (half with high-marketplace enrollment) reported no changes in total uncompensated care and unreimbursed cost. Several reasons were cited for the persistence of uncompensated care and unreimbursed cost including *little or no growth in the number of insured patients seen by the hospital, below-cost Medicaid reimbursement rates, and bad debt or charity care related to high-deductible health plans*.

The following passage includes a variety of responses about this issue from our interviews. One respondent from a non-expansion state with high-marketplace enrollment said,

> "We are seeing an increase in bad debt. We are seeing an increase in charity care without the corresponding increase in the number of insured patients."

The respondent went on to explain that there were no gains in Medicaid because the state did not expand the program, and enrollments in the marketplace seemed to be from patients that already had individual plans, but were going to the marketplace in order to get new plans that were subsidized. This comment suggests that state-level measures of marketplace insurance coverage gains may not reflect the experiences of all hospitals within the state.

Three respondents representing one expansion and one non-expansion state noted growth in unreimbursed costs (i.e., Medicaid reimbursement rates that were less than the cost to the hospital of providing services to Medicaid enrollees). Respondents referred to differences between Medicaid reimbursement rates and the cost of providing services using terms such as "shortfalls", "allowances" or "write-offs" as represented by the following comment.

> "Our bad debt has gone down, but our Medicaid write-off has gone up. Medicaid is the worst payer that we have. We're getting something on the dollar for that, but we were getting something from our self-pay folks as well."

Finally, five respondents (from two Medicaid expansion/low-marketplace enrollment states and two non-expansion/high-marketplace enrollment states) noted growth in uncompensated care related to high-deductible health plans. Representative comments were:

> "While there are more people insured, some of them are insured in high-deductible plans and that's increased some of the bad debt there."

> "Overall I don't think [uncompensated care has changed] because it seems that to the extent people are moving into commercial insurance, they are probably in high-deductible plans and that becomes an uninsured liability as well."

> "If someone goes from no insurance to a high-deductible plan, they are effectively uninsured, and bad debt is likely for that high-deductible piece."

While some hospital respondents reported bad debt related to high-deductible plans, others reported providing charity care to patients that could not afford their deductibles as illustrated by the comments below.

> "We have…seen an increase in charity care that we provide. Bad debts have been relatively stable. But if you look at bad debt and charity care together, it's increasing and increasing significantly – a lot of which we believe is tied to high-deductible plans."

> "We are experiencing greater charity care as well. We are finding charity care not only with those who are uninsured but those with large deductible plans as well. They are going to the exchange, getting subsidized insurance with a large deductible, and then applying for charity care to cover the balance."

Respondents from two states were concerned about employer-based insurance markets increasing use of high-deductible plans and its impact on bad debt.
In addition to noting the emergence of more high-deductible plans in the ACA marketplace, respondents from one Medicaid expansion state and one non-expansion state noted a *growing trend of high-deductible plans in employer-based commercial markets*. These respondents suggested that this shift contributed to increases in bad debt. For example, a hospital administrator from a state expanding Medicaid noted,

> "We've seen many employers – probably most – who have made the jump from a more standard indemnity plan when they were using self-insured or indemnified plans – [to] high-deductible plans."

Similarly, a respondent from a non-expansion state observed,

> "We are seeing commercial plans and employers switching over to more high-deductible plans, [and] that absolutely contributes to our bad debt. And then with the ACA and all those plans being high deductible, [it] absolutely contributes."

Both of these respondents believed the increase started prior to the implementation of the ACA.

Respondents from two states were concerned about commercial payers lowering their reimbursements.
With regard to commercial plans, respondents from both a non-expansion and an expansion state noted increased downward pressure on reimbursement. Some comments included:

> "We are starting to see some pressure from commercial payers to move toward a Medicare-type payment plan. …in the past, commercial payers have been basically where we've been able to make the money to cover the uninsured or the unreimbursed cost from the federal government… So the pressure from insufficient reimbursement is certainly a reality for us."

> "With the push toward how payment policies are being devised and structured, the insurance companies are – at least the ones that we're working with as a small rural hospital – really taking it as kind of a free rein to really buckle down and put the screws on small hospitals that have basically no negotiating power."

Hospital perspectives varied on how and whether the ACA's coverage provisions are affecting financial performance.
When asked to describe the net financial impact of changes in insurance coverage under the ACA, only two of the 12 respondents (both from Medicaid expansion states with low-marketplace enrollment) said they have experienced a positive net financial impact. Respondents noted several reasons for the limited financial impacts including *limited increases in the numbers of newly insured patients* and *other financial pressures, such as declining reimbursement or programs such as Meaningful Use*.[11] For example, one respondent from an expansion state with low-marketplace enrollment commented,

> "[Our state], for the most part, didn't have a lot of uninsured because of other state programs that existed to fill in the federal gaps. So we've seen negative impacts, mostly on the reimbursement side."

Another from a non-expansion state with high-marketplace enrollment offered,

> "The biggest potential impact did not come to fruition for [our state]—Medicaid expansion. That's where we feel like we have missed an opportunity."

Finally, a third respondent from a non-expansion state with high-marketplace enrollment said,

> "As far as the impact of the ACA is concerned, we really have not seen an increase in the number of insured patients compared to previously uninsured patients. In fact, based on the cost that we are incurring for Meaningful Use and everything else, we are probably actually seeing a decline in our financial position…"

Hospitals that currently receive Medicaid DSH payments reported concerns about the loss of those payments.
Six of the 12 responding hospitals (three PPS and three CAHs, representing five different states – two expansion, three non-expansion) reported receiving DSH payments and said losing the payments would have a *significantly negative impact on their hospitals*. One respondent noted, "Losing DSH will hurt a lot. We try to break even. If DSH is cut, then we may have to reduce services. I hope not." A second commented, "The reduction in this is really going to hurt us. Around 15% of our patients are Medicaid patients. And we get about $125,000, which is significant for us." A third indicated, "It will have a significant negative impact, primarily because we have so much Medicaid. It will be a net negative."

Perceptions of State Office of Rural Health or State Hospital Association Leaders

We categorized responses from the nine SORH and hospital association leaders into four primary themes reflecting their views on insurance coverage and payer mix, uncompensated and unreimbursed care, and hospitals' financial performance. Of note, state hospital leaders' perceptions of state-level effects did not always reflect the experiences reported by individual hospitals within their states. As indicated by several of the responses below, state-level respondents acknowledged this fact and noted the importance of local payer mix and market conditions in determining the ultimate impact of the ACA on individual hospitals.

The ACA has increased the number of people with insurance coverage, particularly in states that expanded Medicaid.
Regardless of a state's classification based on Medicaid expansion or marketplace enrollment, all nine respondents reported at least some increase in the number of people with insurance coverage in their state. A respondent from an expansion/low-enrollment state noted,

> "We do know there was a substantial decrease in [our state] of the uninsured."

Likewise, a respondent from a non-expansion/high-enrollment state commented,

> "It has improved. More than half a million people have gained insurance."

While all of the respondents reported an increase in the number of insured individuals, *non-expansion states were more likely to report smaller increases citing lack of Medicaid expansion* as a primary reason why the increase was not more substantial. For example, one respondent from a non-expansion/high-marketplace enrollment state suggested,

> "We've got probably somewhere in the neighborhood of [tens of thousands][12] in the state that would qualify for [Medicaid] under the expanded population. I think about [70 percent][12] of those actually applied for insurance through the Exchange and were denied coverage because they were below eligibility guidelines. We've identified a good number of them but we just haven't been able to get them into any form of coverage."

A respondent from a non-expansion/low-enrollment state said,

> "For the Exchange, [thousands of][12] people have signed up for insurance that did not have insurance before. So the percentage of people with coverage has changed slightly, but not dramatically."

The ACA has increased the proportion of people with Medicaid coverage

Despite the lack of Medicaid expansion in four of the states, two of the non-expansion states and all of the expansion states reported *increases in Medicaid enrollments*. Respondents in two non-expansion states reported fairly large increases in newly enrolled Medicaid beneficiaries (people who had never enrolled before despite being eligible). Respondents in expansion states felt that Medicaid expansion had the largest impact on increasing insurance coverage. Several of the states began these expansions prior to the ACA, and considered the ACA as an iteration of what their state was already doing.

Regardless of the states' expansion status, a majority of respondents felt that increases in coverage were leading to a *shift in the payer mix of rural hospitals—to more Medicaid coverage*. Five of the eight respondents (three expansion and two non-expansion states) attributed changes in rural hospitals' payer mix to increases in Medicaid enrollees. One expansion state respondent commented,

> "**S**o [our data] really show the true movement of an uninsured, self-pay, charity care population into the Medicaid population."

Respondents were less sure about other payer shifts. Two said there were no changes in non-Medicaid payment percentages (one expansion, one non-expansion) and one did not know (non-expansion). A respondent from a non-expansion state commented,

> "**T**here has been an increase in the number of people who are insured, so that's a great thing. But, you know, to what degree I'm not sure. In the rural areas they still struggle with a higher than average self-pay population."

There is uncertainty at the state level about the ACA's effect on uncompensated and unreimbursed care.

Some respondents felt that, on average, uncompensated and unreimbursed care had decreased, some felt it had increased, and some felt it was still too soon to know. Respondents who felt there was little change suggested that *added coverage was not enough to mitigate uncompensated care and unreimbursed cost*. One respondent stated,

> "**E**ven though we have more coverage, there is still an increase in uncompensated care."

Some comments were more specific to Medicaid. Six respondents noted *increases in the shortfall between Medicaid payments and the cost to hospitals of providing care to Medicaid patients* (four expansion and two non-expansion states). One respondent commented,

> "**O**bviously the uncompensated care drop and the self-pay drop is a financial benefit to hospitals, but that is offset by the increased Medicaid volumes that they see and the under-reimbursement of those increased volumes. Add to that the increase in bad debt that is occurring because of the high-deductible plans. Payer mix varies dramatically across hospitals. Depending on payer mix, the impact is going to be very different on hospitals."

Another respondent said,

> "**U**ncompensated care increased overall and is due to shortfalls in Medicaid reimbursement."

There was also some *skepticism among a few respondents who reported general decreases in uncompensated care*. For example, one respondent said there has been a "decline in charity care but we are waiting to see if this shifts to bad debt."

And finally, one respondent described why he or she believes it is *difficult to measure the ACA's impact on uncompensated care* stating,

> "**W**e haven't seen significant changes in the amount of uncompensated care as a whole. What we are seeing is more uncompensated care from insured individuals rather than those who have no insurance. This is the underinsured. We also know hospitals are trying to change how they approach patients with high-deductible plans—to better identify them upfront so that they can provide financial assistance through charity care. There will be shifts with bad debt and charity care as hospitals become more sophisticated in finding people who need financial help at the front door rather than at the back door."

When asked specifically about how expanded coverage had affected bad debt and charity care among their states' hospitals, some respondents reported positive changes and some reported negative changes. Only two respondents said

they believed the changes in uncompensated care were driven solely by the ACA, and two specifically stated that the changes began in their states prior to the implementation of the ACA.

Perspectives varied on the net financial impact of changes in ACA-related insurance coverage.
In contrast to the perceptions of most hospital respondents, three of the nine state-level respondents felt the *net financial impact of the ACA's coverage provisions had been positive* (two expansion, one non-expansion). Four felt there had been *no change* (three non-expansion, one expansion), and two felt the impact has been *mixed depending on the hospital*. The differences in perceptions at the state versus hospital level underscore the importance of monitoring individual hospitals' experiences in addition to average effects at the state and national levels. Similar to the hospitals, state-level respondents noted *factors outside of the ACA that are affecting hospitals' financial performance* (e.g., local economic and demographic drivers, changing payment methodologies). One expansion state respondent commented,

> "I think clearly expanding coverage, having people insured versus not insured, is always going to be better. It is certainly better for patients, but also for the health care provider. I think the overall net financial impact is still going to be positive. I think for individual hospitals in rural areas, their specific organizational financial performance will be far more dependent on patient payer mix in their community. Within that, there is a mix of factors going on outside of the Affordable Care Act."

Finally, most respondents reported *concern about the long-term sustainability of rural hospitals*. Even in expansion states, respondents raised concerns such as,

> "The hospitals are reporting that they are doing better because the increase in visits and coverage and people coming into the office who are covered. They are still worried—even though they may not be seeing it in their finances—about long-term sustainability."

Reflecting on responses at the hospital level, concerns about sustainability seemed to stem from two primary issues: *high-deductible health plans* and *impending changes to Medicaid Disproportionate Share Hospital (DSH) payments.*[13] Most of the respondents believed high-deductible plans were a problem that added to bad debt and thus had a negative overall financial impact on their states' hospitals and the patients' access to care. One stated,

> "The underinsured are an issue because of high-deductibles and co-pays. They still do not have access to care."

Similarly, six of the nine respondents (three expansion and three non-expansion) said that losing DSH payments would have a negative impact on their states' rural hospitals. There was no consensus on whether lost Medicaid DSH payments would be offset by increased revenue from insured patients.

DISCUSSION

Results from interviews with a sample of hospital administrators and state representatives from eight states suggest that the early effects of the increased availability of health insurance coverage under the ACA on rural hospitals' payer mix, uncompensated care and unreimbursed cost, and financial performance are limited, which is not surprising as the markets continue to adjust.

All of the state respondents agreed that the ACA has been successful in increasing the number of people with insurance coverage, with most respondents suggesting gains in Medicaid outpaced private marketplace coverage. Some hospitals concurred; however, there was variation in the extent to which individual hospitals experienced reductions in their uninsured patient populations. The hospitals noting shifts from self-pay to Medicaid were located in states that had expanded Medicaid, and the two hospitals that reported small shifts from self-pay to commercial insurance were located in states with high marketplace enrollment. Some hospitals experienced little to no change in the number of uninsured, despite being located in states with high marketplace enrollment.

All but one hospital reported little to no reduction in total uncompensated care and unreimbursed cost. Even among hospitals that saw gains in insurance coverage in their populations, concerns about uncompensated care and unreimbursed cost remained, primarily because high deductibles and under-payments by Medicaid (and in some cases Medicare) offset the effects of coverage gains.

The reported effects of the ACA's coverage expansions on hospital financial performance were mixed, and most respondents were concerned about the future. State representatives were more positive than hospitals about the overall

financial impacts of the ACA, perhaps reflecting a more aggregated view of net financial improvements. Downward pressure on reimbursement from commercial payers, an increase in high-deductible health plans, below-cost reimbursement for growing numbers of Medicaid enrollees, and anticipated cuts to Medicaid DSH funds all contributed to uncertainty about the long-term sustainability of rural hospitals. Notably, state and hospital respondents agreed that hospitals' local market conditions and payer mix would play a prominent role in determining individual hospital performance under provisions of the ACA.

Our results are consistent with a recent report by the Medicaid and CHIP Payment and Access Commission (MACPAC) that found: "Early reports suggest that unpaid costs of care for the uninsured are declining, particularly in states that have expanded Medicaid, but the shortfall (if any) between Medicaid payments and the costs of providing services to Medicaid patients may be increasing with greater Medicaid enrollment. In addition, it is not yet clear whether all hospitals, including those serving the highest share of low-income patients, are experiencing these changes equally."[8]

As such, the results suggest a need for caution and close monitoring of rural hospitals, not only at the national and state level, but also at the individual level, as the ACA's coverage provisions and other policy initiatives continue to be implemented. While respondents were optimistic about the expanded insurance coverage as a result of the ACA, they were concerned that the growth was not enough to ensure hospitals' long-term sustainability and patients' access to care, especially with additional cuts like DSH on the near horizon.

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This study was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement # U1CRH03714. The information, conclusions and opinions expressed in this brief are those of the authors and no endorsement by FORHP, HRSA, HHS, or The University of North Carolina is intended or should be inferred.