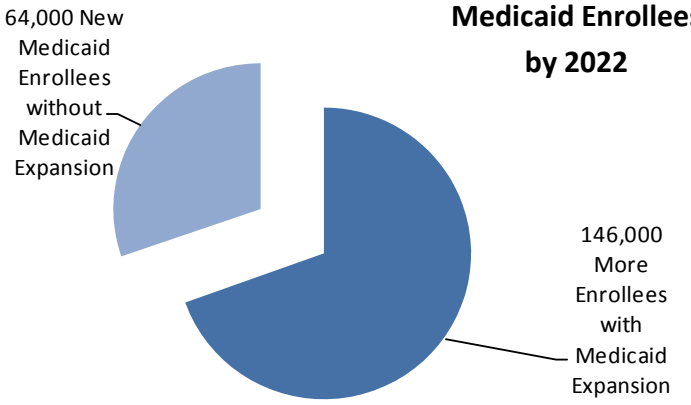
Economic and Fiscal Effects of Expanding Medicaid in Maryland

Brief

It's about **Coverage**…

Last summer's Supreme Court decision, solidifies Maryland's decision to lead the way in implementing the provisions of the Affordable Care Act (ACA). As a result, Maryland's Medicaid program expands to approximately 146,000 residents of Maryland. In addition to these newly eligible residents, it is anticipated that 64,000 people who are currently eligible for Medicaid would enroll by 2022. **A total 210,000 Marylanders will benefit from Medicaid expansion.**

Breakdown of 210,000 New Medicaid Enrollees by 2022



Source: Kaiser Commission on Medicaid & the Uninsured, Nov. 2012

It's about **Jobs and Economic Growth**…

The total amount of expenditures on health care for those covered under an expanded Medicaid program would be hundreds of millions of dollars, but the majority of that money will be put right back into the Maryland economy. That money will result in an **increase of between 9,500 and 10,000 new jobs from 2014 to 2020**. These jobs will not only be in hospitals, clinics, nursing and other health facilities, but also in those industries that support the Maryland health care industry. Various businesses in Maryland will benefit from growth in incomes.

Jobs and Economic Effects of Expansion

Year	New Federal Funds (in millions)	Increase in Gross State Product (in millions)	Increase in Jobs* (Not Cumulative)
2014	$1,003	$731	9,700
2015	$1,068	$770	10,000
2016	$1,137	$794	10,000
2017	$1,151	$770	9,600
2018	$1,226	$783	9,500
2019	$1,306	$798	9,500
2020	$1,391	$815	9,500
Total	**$8,282**	**$5,461**	NA

* Determined by comparing job growth with Medicaid expansion to baseline job growth without Medicaid expansion

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

This information is from a report prepared for the Maryland Hospital Association and funded by the American Hospital Association. All opinions and conclusions in this report are those of the authors and do not represent institutional views of REMI, GW, the American Hospital Association or the Maryland Hospital Association.

REMI

It's about **Savings**…

Through 2016, the Federal Government will cover 100 percent of the cost of newly eligible enrollees. The Federal share of costs will decline to 90 percent by 2020. Maryland shares the expense of providing Medicaid coverage with the federal government. Today, Maryland is responsible for 50 percent of most Medicaid spending in the state, and the federal government covers the remaining percentage. The ACA substantially increased the federal matching rates for persons who are newly eligible through the Medicaid expansions, such as childless adults and adults with incomes between 116 and 138 percent of poverty, which will reduce state costs for this population. The state can achieve offsetting savings through enrollees who can be transitioned into the Medicaid expansion or savings from other state programs for the uninsured. Net savings to the state of Maryland with Medicaid expansion would be $2,090 million from 2014 to 2020.

Maryland Fiscal Impacts

Year	Direct State Medicaid Savings (in millions)	New State Revenues (in millions)	Other State Health Savings (in millions)	Net State Savings (in millions)
2014	$221	$17	$18	$256
2015	$231	$35	$37	$304
2016	$241	$39	$58	$338
2017	$219	$41	$60	$320
2018	$198	$43	$63	$304
2019	$179	$46	$65	$290
2020	$162	$48	$68	$278
Total	**$1,453**	**$270**	**$368**	**$2,090**

The Bottom Line…

Expanding Medicaid to non-elderly adults with family incomes up to 138 percent of the federal poverty level will provide considerable economic benefits to Marylanders. It is important to remember that projections have some uncertainty. Our estimates of the economic and employment impact are based on the level of new federal revenue that are generated by a Medicaid expansion. Both our estimates indicate that there is a net reduction in state fiscal costs from 2014 to 2020 due to a Medicaid expansion. This analysis shows that Medicaid expansion will reduce direct Medicaid costs to the state, and enable the state to draw down billions of dollars in additional federal funding that will support jobs and maintain the state's healthcare infrastructure. The increases in employment and economic activity will occur both within the health care sector as well as in other sectors of the state economy. While there are some new costs associated with the expansion, these costs can be offset by new state revenue and other health savings that the state will be able to achieve. Overall, the state can substantially reduce its state costs through a Medicaid expansion, while providing more than one hundred thousand low-income Marylanders with insurance coverage. In order to achieve long-run health care savings, it will be necessary to bolster effective primary care, using systems such as patient-centered medical homes, and ensure a better transformation to promote a longer-term transformation to an efficient health care system. Maryland should carefully plan how to leverage its opportunities and federal funding to develop the systems needed to sustain both quality improvements and cost efficiencies on a long-run basis.

This brief is a summary of the full report, "Economic and Employment Effects of Expanding Medicaid in Maryland," by Regional Economic Models, Inc. and George Washington University.

Economic and Employment Effects of Expanding Medicaid in Maryland

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Introduction

Under the Patient Protection and Affordable Care Act (ACA), states may decide whether to expand eligibility for their Medicaid programs to non- elderly adults whose family incomes are less than 138 percent of the Federal Poverty Level (FPL) (an annual income of about $32,500 for a family of four in 2013). To avoid creating undue financial burdens for states, the federal government will pay 100 percent of the medical costs of serving the newly eligible from 2014 to 2016, but its share will phase down to 90 percent for 2020 and the years thereafter.[1] The original intent of the ACA was that all states undertake this expansion, but the Supreme Court's decision in *National Federation of Independent Businesses v. Sebelius* established that states effectively had the option of whether to expand Medicaid eligibility. States may decide whether and when to implement an expansion, but, if it is adopted, Medicaid eligibility must rise to the 138 percent level.

The purpose of this report is to offer a balanced and comprehensive view of the economic, employment and budgetary effects of the decision to expand Medicaid in Maryland. Governor Martin O'Malley's administration and the Maryland legislature have been supportive of the ACA and Medicaid expansion.[2] In considering adoption of the Medicaid expansion, a state must consider the budgetary and economic consequences of its decision, as well as the

[1] States that had already expanded Medicaid coverage will have an enhanced matching rate for childless adults, eventually reaching 90 percent by 2020 and beyond.

[2] Governor O'Malley said the Supreme Court "gives considerable momentum to our health care reform efforts here in Maryland," and the state will implement changes. Jun. 28, 2012. http://www.governor.maryland.gov/blog/?p=5876

This is an independent analysis of the economic impact of a Medicaid expansion, conducted by researchers at Regional Economic Models, Inc. (REMI) and the George Washington University (GW). This report was prepared for the Maryland Hospital Association and funded by the American Hospital Association. All opinions and conclusions in this report are those of the authors and do not represent institutional views of REMI, GW, the American Hospital Association or the Maryland Hospital Association.

health consequences. In the normal course of consideration, a state office prepares a budget estimate of the cost to the state of adopting a new policy. While the budget estimates that are usually prepared are important, they often fail to provide a comprehensive view of the effects because they are focused solely on the direct costs that must be borne by the state.

This report offers a more comprehensive view of the total effect of a Medicaid expansion by also looking at the effect on:

- The level of additional federal funds that will be earned in Maryland due to the Medicaid expansion,
- Maryland's economic activity (that is, the gross state product),
- Employment levels in Maryland,
- State tax revenues that would increase due to higher economic activity, and
- Other budgetary savings, such as savings in other health care costs that may occur if Medicaid covers more low-income patients.

It is important to note that this report focuses on the effects of Maryland's decision concerning the Medicaid expansion alone; it does not address the impact of the overall federal health law. Under the Supreme Court decision, other changes required by the ACA, such as the establishment of health insurance exchanges, increases in Medicaid primary care payment rates, or changes in how income is counted in Medicaid, will occur regardless of whether a state expands Medicaid or not. This report examines only the additional consequences of expanding Medicaid and assumes the other changes will take place as specified in the federal law.

Maryland's Medicaid Program

Maryland's current Medicaid program covers adults with dependent children (i.e., parents or guardians) if their family incomes are below 116 percent of the FPL, which varies by family size. This percentage equates to roughly $27,318 in annual income for a family of four in 2013. Limits on assets (e.g., money in savings accounts) also apply. Maryland does not provide full Medicaid benefits to childless adults under age 65 unless they qualify because of a disability. However, Maryland's Primary Adult Care (PAC) program provides a limited array of benefits for childless adults ages 19 and older with incomes below 116 percent of poverty. The PAC covers ambulatory health services, but limits coverage of inpatient stays to the hospital bill for medical emergencies only; it does not pay for other hospital bills. Because of this, the childless adults on PAC are not considered to have complete health insurance and are eligible for 100 percent federal matching from 2014 to 2016.

Maryland shares the expense of providing Medicaid coverage with the federal government. Today, Maryland is responsible for 50 percent of most Medicaid spending in the state, and the federal government covers the remaining amount. The ACA substantially

increased the federal matching rates for persons who are newly eligible through the Medicaid expansions, such as childless adults and adults with incomes between 116 and 138 percent of poverty, which will reduce state costs for this population. From 2014 to 2016, the federal government will fund 100 percent of spending for this population. This enhanced federal match declines to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.

The non-partisan Urban Institute estimates that implementation of the Medicaid expansion will increase the number of newly eligible people in Maryland covered by Medicaid by 146,000 people by 2022.[3] The Urban Institute projects that an additional 64,000 people, who are currently eligible for Medicaid, will enroll in Medicaid because of the ACA, even without the optional expansion for adults. The latter figure includes those already eligible, who are projected to sign up due to the publicity and other coordinated enrollment requirements related to health reform; sometimes people call this a "woodwork" effect (i.e. "to come out of the woodwork" and enroll as a result of these activities). Maryland will have to pay the regular matching rate (currently 50 percent) for any Medicaid-covered services obtained by these individuals.

Economic Impact of Medicaid Expansion

Any expansion of Medicaid will have economic impacts. This section estimates the inputs and results, and describes the cause and effect relationship between them. The results reflect the projected economic growth created by the ACA and its expansion of Medicaid coverage in Maryland. These outputs include an array of economic and demographic indicators including total state employment, gross state product, personal income, and total revenues. All of the following amounts are in nominal (i.e. not inflation adjusted) dollars.

Federal Expenditures for Expansion

We estimate that Maryland's health care providers and pharmacies, with the exception of hospitals, will gain more than $8 billion in federal funds from 2014 to 2020 due to the Medicaid expansion. Under the proposed new revenue caps in Maryland's Medicare waiver application, there is no guarantee that hospitals will see any extra revenue as a result of expansion unless approved by the Centers for Medicare & Medicaid Services.[4] This estimate indicates a net state savings associated with a Medicaid expansion because of the higher federal matching rates for those who are newly eligible in an expansion and for former PAC enrollees. All estimates—others and ours—are approximate since it is impossible to know in advance exactly the condition of the state's economy, how many people will participate or how high medical costs will be in the future. However, our projections provide a general sense of the overall magnitude and

[3] Holahan, J., Buettgens, M., Carroll, C. and Dorn, S. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Kaiser Commission on Medicaid and the Uninsured. Nov. 2012.

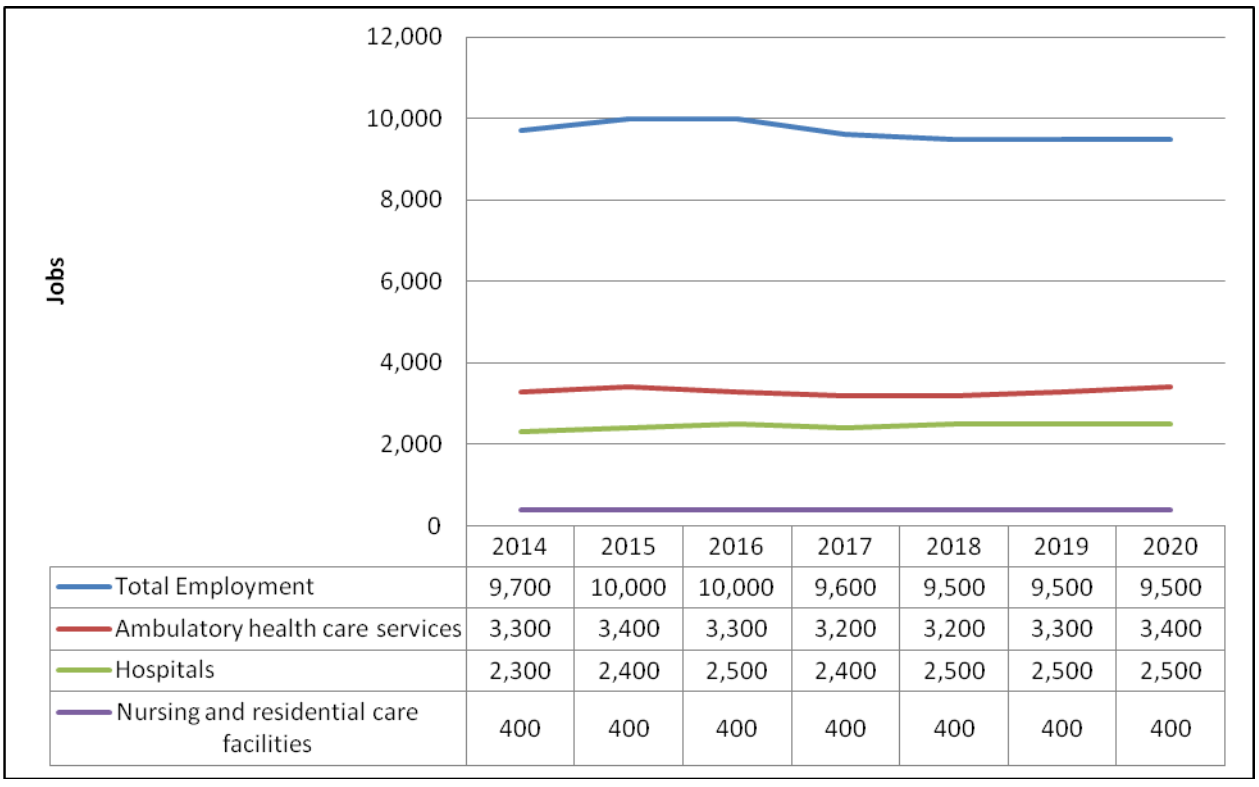
[4] Proposal to Modernize All Payer System, http://dhmh.maryland.gov/docs/Final%20Combined%20Waiver%20Package%20101113.pdf, September 2013.

direction of expected economic and budgetary impacts.

Total Change in Employment and Earnings

One of the most obvious ways that the economy affects people's lives is through creation of new jobs. The additional spending that occurs as a result of expanding Medicaid will lead to millions of dollars of new money going into the health care industries noted above. Most beneficial to Maryland is the commitment of the federal government to cover 100 percent of the cost through 2016. Figure 1 shows the expected change in employment resulting from the increase in demand for health care and the ripple effects of these changes. The net increase in overall state employment will be between 9,500 and 10,000 jobs. While the majority of these jobs will be in the health care sector, a substantial share will occur in other economic sectors, reflecting the broad multiplier effect of the Medicaid expansion on many sectors of the state economy. For example, to the extent that health care facilities need to expand to serve the newly covered patients, there will be real estate and construction costs that will boost employment in those sectors as well.

Figure 1: Changes in Employment Levels Due to Medicaid Expansion, Rounded

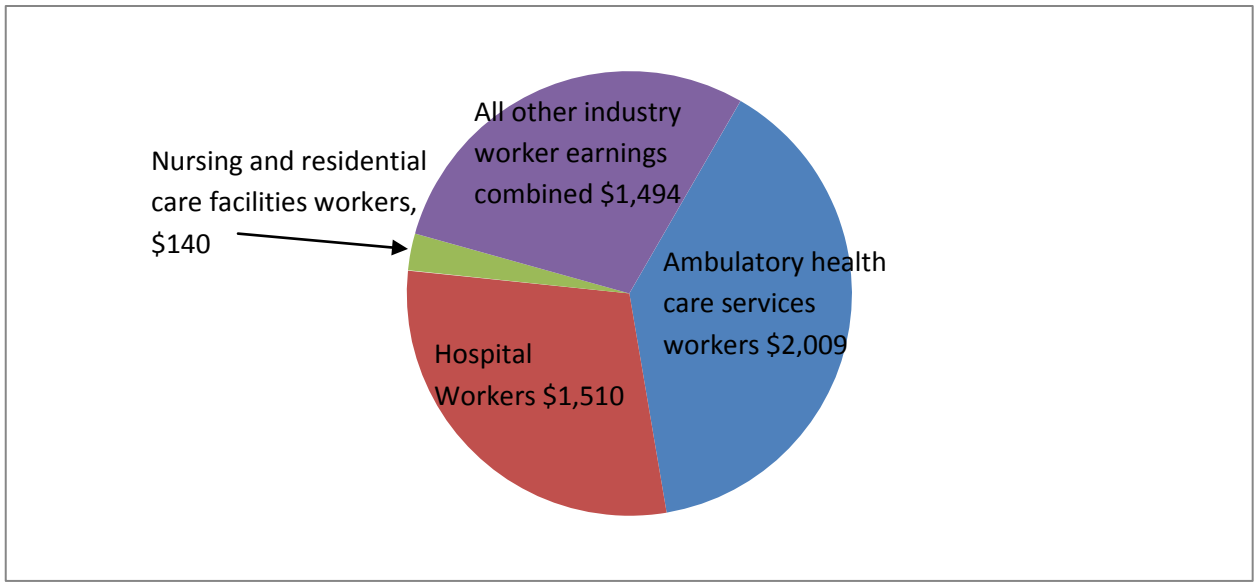


	2014	2015	2016	2017	2018	2019	2020
Total Employment	9,700	10,000	10,000	9,600	9,500	9,500	9,500
Ambulatory health care services	3,300	3,400	3,300	3,200	3,200	3,300	3,400
Hospitals	2,300	2,400	2,500	2,400	2,500	2,500	2,500
Nursing and residential care facilities	400	400	400	400	400	400	400

Each of the jobs shown in Figure 1 will come with a paycheck. Those paychecks together form Total Earnings by Place of Work, which is the sum of wages, benefits, and proprietors'

income paid to employees working in Maryland. These earnings form the basis of Personal Income and increased consumption in the state. As such, they are of primary importance in driving changes in income and sales tax. In 2020, these earnings represent changes of 1.75 percent for Ambulatory Health Care, 2.17 percent for Hospitals, 0.47 percent for Nursing and Residential Care, and 0.29 percent for all other industries.

Figure 2: Cumulative Change in Worker Earnings (2014-2020) (millions of nominal $)



Total Economic Activity

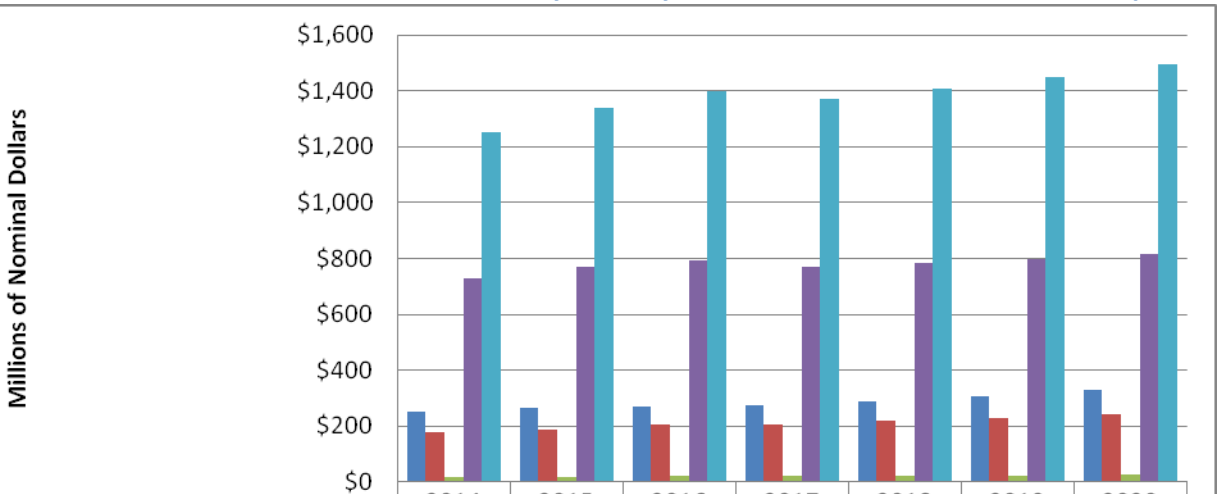
Because some of the federal health care funding will flow out of the state, the input amounts do not equal the direct, *local* impacts. If we do this, we underestimate the effect each dollar of local spending has on the local economy. For example, we estimate that about 23 percent of the inputs in the hospital sector will be received by out-of-state hospitals. Therefore, it is unreasonable to use the full value of spending in the Hospital sector as the increase in revenues going to in-state hospitals. There are two concepts commonly used to quantify economic growth: output and gross state product. Output is the same as revenues so every time a transaction is completed where money is exchanged, output increases whether it is a business-to-business sale or one to the household consumer. As a result of the Medicaid expansion, output in Maryland is expected to increase by an average of $1.39 billion per year for a cumulative increase of $9.71 billion from 2014 through 2020.

Gross State Product (GSP) is a subset of output and is the total new value created within Maryland. GSP can be thought of as all net new economic activity or output minus the goods and services used as inputs to production. Which transactions are counted is the key difference between GSP and output: where output counts every transaction, GSP only counts the final transaction. As a result of the Medicaid expansion, GSP in Maryland is expected to

increase by an average of $780 million per year for a cumulative increase of $5.46 billion from 2014 through 2020.

When choosing between the two concepts output is most appropriate when referring to changes in business activity, as it shows the total amount of new revenues received by all businesses in the state. However, when referring to new growth or value created in the state's economy, GSP is the best measure to use, as illustrated in Figure 3.

Figure 3: Contributions to Gross State Product by Industry and Other Totals Due to Medicaid Expansion



	2014	2015	2016	2017	2018	2019	2020
Ambulatory health care services	$251	$265	$269	$273	$286	$308	$328
Hospitals	$177	$188	$206	$205	$219	$229	$242
Nursing and residential care facilities	$19	$20	$21	$22	$23	$24	$26
Gross State Product	$731	$770	$794	$770	$783	$798	$815
Total Output	$1,254	$1,338	$1,397	$1,371	$1,408	$1,449	$1,495

State Tax Revenue Changes

The economic growth created by expanding Medicaid will create more revenue for the state. A simple way to understand where these revenues come from is to use the output growth shown in Figure 3 as an example. Each of these dollars means greater income for businesses which means more corporate income tax revenue for the state. This example can easily be expanded to understand how economic growth supports greater general tax revenues. Table 1 shows state revenues gained from economic growth.

Table 1: Change in State Revenues (millions of nominal $)

Category	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	Total
Total Revenues	$17	$35	$39	$41	$43	$46	$48	$270

State Savings

Direct

The expansion of Medicaid eligibility has the potential to reduce other state or local expenditures for health care in Maryland. One important area of savings is the transfer of Maryland's Primary Adult Care (PAC) program, which provides a limited array of health benefits (not including inpatient hospitalization), for childless adults with incomes below 116 percent of poverty, to the Medicaid expansion. PAC currently earns a regular 50 percent federal match, while the shift to the Medicaid expansion would provide the higher expansion matching rate of 100 percent from 2014 to 2016. This will save the State $120 million.

Other

Table 2 illustrates some potential additional savings in community mental health costs. The state currently provides funding for community mental health services that may no longer be needed if coverage expands from 116 to 133 percent of poverty (ambulatory mental health services are already covered by Medicaid and PAC).[5] We assume that, when fully implemented, about one-tenth of the expenses could be averted because more low-income people would be covered by the Medicaid expansion. We assume that the full level of savings could not be implemented from the start and would need to gradually ramp up in 2014 and 2015. Such savings may not be possible if there are other needs for these services that are not now being met. For example, it is plausible that there are additional mental health needs that are not now being met by state funds; if a Medicaid expansion reduced the need for some current funding, these funds might instead be used to address other behavioral health needs.

Table 2: Potential Offsetting Health Care Savings Once Medicaid is Expanded (millions of nominal $)

Category	2014	2015	2016	2017	2018	2019	2020	Total
Community Mental Health	$17.8	$37.0	$57.8	$60.1	$62.5	$65.0	$67.6	$367.8

[5] Data for state community mental health funding for years 2005 to 2010 came from the National Association of State Mental Health Directors Research Institute and were projected, assuming growth rates comparable to historical levels. This excludes funding for psychiatric hospitals, prevention, research, training and administration costs. Medicaid can cover the costs of ambulatory mental health services, but not services at inpatient psychiatric hospitals (instiutions of mental disease) for adults.

State Budget Fiscal Impact

Table 3 summarizes the potential fiscal impact on the state budget of Medicaid expansion. These estimates suggest that the combination of direct savings, new state revenues and additional savings related to Medicaid expansion could actually lead to a substantial positive fiscal impact over the 2014-2020 period of more than $2 billion. Again, we note that these savings are the incremental savings associated with expanding Medicaid vs. not expanding Medicaid. The state will have to cover ongoing Medicaid expenditures and other ACA-related changes, including a significant woodwork effect, regardless of the decision to expand Medicaid eligibility or not.

Table 3: Net State Government Savings of a Medicaid Expansion (in millions of nominal $)

Maryland Fiscal Impacts

Year	Direct State Medicaid Savings (in millions)	New State Revenues (in millions)	Other State Health Savings (in millions)	Net State Savings (in millions)
2014	$221	$17	$18	$256
2015	$231	$35	$37	$304
2016	$241	$39	$58	$338
2017	$219	$41	$60	$320
2018	$198	$43	$63	$304
2019	$179	$46	$65	$290
2020	$163	$48	$68	$278
Total	$1,453	$270	$368	$2,090

Methods

The underlying purpose of this report is to illustrate the broad economic and employment consequences of a Medicaid expansion in Maryland. It is fundamental to understand that a Medicaid expansion has very broad economic impact, beyond the state budgetary costs. Since most of the increased costs will be borne by the federal government, there will be a substantial inflow of federal funds to Maryland, although some will also be paid by the state government. These funds will initially be paid to health care providers, such as hospitals, clinics, pharmacies and health insurance plans, as health care payments for Medicaid services. The health care providers then distribute these funds as salaries to health care staff, payments for other goods and services (such as the costs of rent, equipment, medical supplies, and other goods and services), and as state and local tax payments. The third step in the funding flow is into the broader state economy as workers and businesses use their income to pay for general goods and services, such as mortgages or rent, utility bills, food bills, transportation and educational services. In turn, the real estate, grocery and other firms distribute these funds as salaries to their employees and to buy other goods and services. Thus, the Medicaid

funds trickle through the broader state economy and the total economic impact ends up being larger than the initial amount of Medicaid payments, since the money is recycled through many layers of the state economy.

Researchers from the George Washington University (GW) estimated the additional state and federal Medicaid expenditures or savings resulting from Medicaid expansion, based on the non-partisan Urban Institute's Health Insurance Policy Simulation Model and published by the Kaiser Commission on Medicaid and the Uninsured.[6] The GW experts allocated these estimated expenditures among four healthcare sectors used in the fiscal and economic effects model, described below. The allocations rely on information from several sources, including state Medicaid expenditure data from the Centers on Medicare and Medicaid Services, Medicaid spending and enrollment projections from the Congressional Budget Office, and publicly available reports and projections from the Hilltop Institute.[7]

Using these inputs, experts at Regional Economic Models, Inc. (REMI) used a structural macroeconomic model to quantify the impact of the ACA on the broader Maryland economy, with and without the Medicaid expansion. REMI simulated the statewide net fiscal and economic effects of expansion, and assessed the net effect of the changes in healthcare spending along with the direct costs to the state from additional enrollees, while considering the federal contribution both in the short and longer term. REMI's models have been used in thousands of national and regional economic studies, including studies of health care reform and health care issues around the United States.

The model used in this analysis covers the state of Maryland and includes 70 industry sectors, three of which pertain most closely to the health care industry data used in this analysis. The three health care sectors used in the model are outlined below with definitions from the U.S. Census Bureau's North American Industry Classification System along with one consumption category:

Ambulatory Health Care Services: Establishments in this sector provide health care services directly or indirectly to ambulatory patients and do not usually provide inpatient services. Health practitioners in this sector provide outpatient services, with the facilities and equipment not usually being the most significant part of the production process.

Hospitals: This sector provides medical, diagnostic, and treatment services that include physician, nursing, and other health services to inpatients and the specialized accommodation services required by inpatients. Hospitals may also provide outpatient services as a secondary activity. Establishments in the hospitals sector provide inpatient health services, many of which can only be provided using the specialized facilities and equipment that form a

[6] Holahan et al., Nov. 2012

[7] Fakhraei, S. H. "Maryland health care reform simulation model: Detailed analysis and methodology." Baltimore, MD: The Hilltop Institute, University of Maryland at Baltimore County. July 2012.

significant and integral part of the production process.

Nursing and Residential Care Facilities: Industries in the Nursing and Residential Care Facilities subsector provide residential care combined with either nursing, supervisory, or other types of care as required by the residents. In this subsector, the facilities are a significant part of the production process and the care provided is a mix of health and social services with the health services being largely some level of nursing services.

Spending on Pharmaceuticals: Pharmaceutical costs fall into two broad areas: distribution and manufacturing costs. Distribution costs include the retail, wholesale and transportation related costs, which are primarily local in nature. Pharmaceutical manufacturing often occurs in another state. REMI assumes that a portion of manufacturing costs may remain in the state, based on estimates of state manufacturing for pharmaceuticals obtained from other REMI models.

State Government Spending: This analysis does not include the state's share of funding for the Medicaid expansion. Given the balanced budget requirement, any additional dollar spent on Medicaid must come from somewhere else in the state. Revenue can come from economic growth, reallocation from other spending, new revenue sources, and cost savings in other health care programs. The net result of all these spending changes is likely to be negligible and thus it is excluded from this simulation.

Table 4 shows a summary of the estimated annual federal Medicaid expenditures by sector associated with the incremental federal funds received for a Medicaid expansion. These represent the "inputs" to the model.

Table 4: Federal Inputs Rounded (millions of nominal dollars)

Detail	2014	2015	2016	2017	2018	2019	2020
Total Federal	**$1,002.8**	**$1,068.0**	**$1,137.4**	**$1,151.4**	**$1,226.3**	**$1,306.0**	**$1,391.0**
Ambulatory health care services	$421.2	$448.6	$458.7	$471.0	$497.8	$538.3	$576.2
Hospitals	$411.2	$437.9	$485.4	$484.7	$520.0	$545.7	$578.3
Nursing and residential care facilities	$30.0	$32.0	$34.1	$34.5	$36.8	$39.2	$41.8
Pharmaceutical and other medical products	$140.4	$150.0	$159.2	$161.2	$171.7	$182.8	$194.7

The REMI model treats the input data as demand variables for the health care sectors. The demand variable induces increased growth of those industries, which simulates the effect of expanding government spending on health care. We note that only a portion of the health care

expenditures result in increased output by state firms. For example, some patients, particularly those living near state borders, may receive care in an out-of-state facility. Consequently, not all of the new Medicaid spending will be in-state. The regional purchase coefficient shown in Table 5 estimates the amount of demand satisfied locally. In turn, if a bordering state expands Medicaid, Maryland health care providers would have increased revenue as shown in Table 6. But since this report focuses only on Maryland policies we effectively assume that no bordering states expand Medicaid. In this respect, these estimates may be a conservative representation of increased demand by Maryland health care providers.

Table 5: Regional Purchase Coefficients - Averages 2014 - 2020

Category	Average
Ambulatory health care services	83%
Hospitals	77%
Nursing and residential care facilities	83%

Table 6: Estimated Demand for Health Services In-State and Out-of-State, 2014-2020 ($ millions)

Industry	Total Direct Inputs	Imports from Out of State
Ambulatory health care services	$2,819	$593
Hospitals	$2,662	$801
Nursing and residential care facilities	$207	$41

Uncompensated Hospital Care in Maryland

The provision for uncompensated care in hospital rates is one of the unique features of rate regulation in Maryland. Uncompensated care includes bad debt and charity care. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those Marylanders who cannot pay for care. The uncompensated care provision in rates is applied prospectively and is meant to be predictive of actual uncompensated care costs in a given year. Maryland's uncompensated care policy achieves a balance between providing hospitals with funding for uncompensated care and impressing upon hospitals the importance of collecting from individuals who are able to pay for care.

Policy Implications for Hospital Payments

It will be difficult to know in advance exactly how many uninsured individuals and families will participate in the expanded Medicaid program. Until the full impact of expansion is understood, Maryland should refrain from prospectively reducing Uncompensated Care funding. In addition to not knowing the initial uptake by the uninsured population, it is also unknown how many employers will drop coverage and encourage employees to enroll in Medicaid or the Exchange. This scenario, known as "crowd-out", will potentially lead to a short term increase in

the uninsured population. Finally, recent insurance policy trends are forcing insured individuals and families to pay higher deductibles and co-pays. These trends are making out-of-pocket health care costs less affordable and will increase the amount of uncompensated care at hospitals. Understanding the interaction of trends impacting uncompensated care will be critical toward determining when and how to adjust Maryland's Uncompensated Care policy.

The state will need to proceed carefully in making adjustments to the all payor rate setting system to address the anticipated impact of coverage expansion. The Medicaid expansion will lead to an increase in the volume of Medicaid-financed hospital care, and this will be accompanied by reductions in uncompensated care payments. However, it is critical to understand that many other changes are occurring which will affect the finances of Maryland hospitals. For example, the federal sequestration under the Budget Control Act of 2012 reduced Medicare payment rates by 2 percent at Maryland hospitals.[8] In addition, the Affordable Care Act includes other provisions that will reduce Medicare payments to hospitals[9], Maryland hospitals receive similar reductions related to readmissions and quality incentive programs on an all payor basis.

Additionally, a recent analysis found that the finances of Maryland hospitals in 2013 are already weak and financial margins are at their lowest point in more than a decade.[10] While a Medicaid expansion could help Maryland hospitals, policy officials should be careful in determining whether and how rapidly they should assume that uncompensated care costs will decline and how this should be factored into the all payor system.

The Massachusetts Experience

After Massachusetts implemented its health insurance expansion, there was about a one-third reduction in hospital uncompensated care costs, and Massachusetts, like Maryland, had an uncompensated care fund. Thus, hospitals experienced about a one-third reduction in revenue from the uncompensated care system. Massachusetts hospitals experienced particular problems, however, because the subsequent recession led the state to revise its Medicaid hospital payment policies, lowering regular Medicaid reimbursements to many hospitals. These reductions resulted in financial problems for a number of hospitals, including some of the major safety net hospitals, and forced some retrenchment in hospital services as well as leading to two lawsuits filed by hospitals against the state due to the changes in Medicaid reimbursements.[11]

The changes that happened in Massachusetts need not occur in Maryland. Because of its

[8] Walker A. "Md. hospitals say rate vote means jobs cuts," *Baltimore Sun*, May 2, 2013.

[9] See, for example, National Association of Urban Hospitals, "The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals," Nov. 2012.

[10] Gantz, Sarah, Baltimore Business Journal "Maryland Hospitals Post 71% Profit Decline, Operating at Record Low Margins," September 19, 2013

[11] Ku, L., Jones, E., Shin, P., Burke, F., and Long, S.. "The Role of the Safety Net After Health Reform: Lessons from Massachusetts." *Archives of Internal Medicine*, 171(15): 1379-84, August 8, 2011.

all-payor rate setting system, Maryland cannot simply reduce Medicaid hospital payments without affecting other payment policies. But the experience in Massachusetts may provide a cautionary tale for Maryland. Anticipated reductions in uncompensated care costs at hospitals should not precipitate changes to broader hospital payment policies without careful planning and discussion.

Ensuring Access to Care

It will be important for state officials and the Health Services Cost Review Commission (HSCRC) to carefully monitor changes in the use of hospital resources as the insurance expansions progress and how they relate to overall systematic changes in the health care system. For example, some have voiced concerns that insurance expansions should stimulate the demand for primary care services, but the supply of primary care clinicians may be inadequate, particularly in certain areas of the states.[12] [13] If the patients, both newly insured and uninsured, experience problems accessing primary care services, they may instead turn to hospital outpatient and emergency departments to get care, which will increase the utilization of hospital resources.

Some assume that reductions in the number of uninsured will lead to reductions in hospital emergency department visits. But recent evidence suggests that immediate reductions in emergency visits may not materialize; a recent study in Oregon found that emergency room visits were not reduced after a Medicaid expansion.[14] While expanding insurance increases the availability of primary and preventive care services that can lower emergency room use, expanded insurance also decreases financial barriers that may keep some patients from using emergency rooms.

In order to achieve long-run health care savings, it will be necessary to bolster effective primary care, using systems such as patient-centered medical homes, and ensure a better transformation to promote a longer-term transformation to an efficient health care system. Maryland's all payor rate setting System has helped Maryland achieve lower-than-average increases in health care costs.[15] Maryland needs to carefully plan how to leverage the current opportunities and federal funding to develop the systems needed to sustain both quality improvements and cost efficiencies on a long-run basis.

Conclusion

Expanding Medicaid to non-elderly adults with family incomes up to 138 percent of the

[12] Ku, L., Jones, K., Shin, P., Bruen, B. and Hayes, K. "The States' Next Challenge — Securing Enough Primary Care for an Expanded Medicaid Population." *New England Journal of Medicine* 364(6):493-95, Feb. 10, 2011.
[13] Sage Policy Group, A Comparison of Two Maryland Physician Workforce Studies, Report to Maryland Hospital Association, July 2011.
[14] Baicker K, Taubman S, Allen H, et al. "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes." *New England Journal of Medicine.* 368: 1713-22, May 2, 2013.
[15] Cohen, *op cit.*

federal poverty level will provide considerable economic benefits to Marylanders. It is important to remember that projections all have some inherent level of uncertainty. Our estimates of the economic and employment impact are based on the level of new federal revenue that will be generated by a Medicaid expansion. Our estimates indicate that there is a net reduction in state fiscal costs from 2014 to 2020 as a result of Medicaid expansion, although there are additional costs that are related to the implementation of the ACA, regardless of whether Medicaid is expanded.

This analysis shows that Medicaid expansion will reduce direct Medicaid costs to the state, and enable the state to draw down billions of dollars in additional federal funding that will support jobs and maintain the state's health care infrastructure. The increases in employment and economic activity will occur both within the health care sector as well as in other sectors of the state economy. While there are some new costs associated with the expansion, these costs can be offset by new state revenue and other health savings that the state will be able to achieve. However, it will be important for the state to proceed cautiously in considering how to make adjustments in its all payor rate setting system. Overall, the state can substantially reduce its state costs through a Medicaid expansion, while providing more than 100,000 low-income Marylanders with insurance coverage.