PUBLICATION

Supreme Court's Affordable Care Act Ruling Could Cause Problems for Many DSH Hospitals [Ober|Kaler]

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As we all know by now, on June 28, 2012, the U.S. Supreme Court issued its ruling generally upholding the constitutionality of the Affordable Care Act (ACA). For many hospitals, the ruling will be good news. Apart from the societal benefit of having a greater percentage of the nation's population covered by insurance, the ruling likely will result in a higher percentage of patients treated at our hospitals having the means to pay for that care, either through private insurance or through Medicaid. The picture, however, is not entirely rosy, particularly for hospitals that have a high population of low-income individuals for which they receive Medicaid or Medicare disproportionate share (DSH) payments.

Under the ACA, beginning in 2014, Medicare is to start reducing DSH expenditures by $22 billion dollars over a ten year period. These cuts will eventually reduce each hospital's current Medicare DSH payments by 75%. Similarly, the statute reduces Medicaid DSH payments by $14 billion dollars over ten years beginning in fiscal year 2014. One operating presumption supporting these cuts was that hospitals would see an increase in their number of insured patients – patients insured through the greater availability of insurance and through Medicaid expansion – and that these newly insured individuals would reduce the need for the DSH payments. For certain hospitals in certain regions, however, that presumption may not fit.

Looking at the so-called penalty provision associated with the individual mandate of the ACA, the initial penalty for not having insurance is relatively small compared to the amount that an insurance premium might cost. Hence, anecdotal evidence suggests that significant numbers of the uninsured will remain uninsured, deciding that it is cheaper to pay the penalty than to obtain insurance. While over time this calculus may change because the penalty will increase, at least initially it appears that a fair percentage of the uninsured will likely remain uninsured.

Similarly, and of perhaps greater significance, the Medicaid populations may not grow substantially in certain states. While the Court generally upheld the ACA's constitutionality, it placed limits on the federal government's ability to force states to expand their Medicaid populations. Under the ACA, states were required to expand their Medicaid populations to include all individuals whose incomes were below 133% of the federal poverty level. States that failed to do this risked all of their Medicaid funding. The Supreme Court, however, concluded that this all or nothing proposition was unduly coercive, a ruling that surprised virtually all who were attempting to forecast the Court's ruling. Under its ruling, the Court effectively is allowing states a choice. They may opt to adopt the expanded population requirement and receive federal funding (FFP) associated with that expanded population, or they may decline to expand their Medicaid population and any FPP associated with the expansion, but do so without risk to the FFP related to their existing Medicaid State plans.

A number of governors – particularly those in what might be termed “red” states – have said publicly that they will not implement the ACA's Medicaid expansion, thereby leaving a significant portion of their populations without Medicaid and, in many instances, without the financial means to buy insurance. Hospitals in states in which their elected officials take such a position will likely suffer financial shortfalls. They will receive substantially lower Medicare and Medicaid DSH payments and at the same time, will have an inadequate

number of insured patients to offset those reductions. Absent a change in sentiment in the states or a change in the federal funding mechanism, this could prove most problematic.

Ober|Kaler's Comments

The funding reductions attributable to DSH could place many hospitals in a financially difficult situation, particularly those hospitals with high DSH populations in states whose governors elect not to expand Medicaid. Hospital management, together with their government affairs representatives, should consider reaching out to their elected representatives to see what, if anything, can be done.