New Spending from Filling the Medicaid Coverage Gap Would Outweigh Cuts in Disproportionate Share Hospital Payments

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The current draft of the Build Back Better Act (BBBA) includes provisions to increase health care subsidies and health insurance coverage nationwide and to augment coverage in the 12 states that have not expanded Medicaid under the Affordable Care Act (ACA), hereafter called "nonexpansion states."[1] These provisions are expected to extend health insurance coverage to millions of people and to lower the cost of health care for many families. In this analysis, we compare (1) additional resources from two important provisions of the BBBA intended to help people with incomes below the federal poverty level (FPL) in nonexpansion states (also known as people in the "Medicaid gap") with (2) the 12.5 percent reductions in federal Medicaid disproportionate share hospital (DSH) allotments in nonexpansion states also proposed in the BBBA.[2]

Provisions of the BBBA would extend enhanced Marketplace subsidies to people in the Medicaid gap. If those provisions were implemented, the increased federal subsidies that would flow to nonexpansion states would be significantly larger than the proposed Medicaid DSH cuts while the subsidies are in effect.[3] The increased federal subsidies would stem mainly from the two BBBA provisions modeled here: one that extends American Rescue Plan Act subsidies and a second provision that extends Marketplace eligibility to people in the Medicaid gap.[4] We refer to these two provisions collectively as the "reform." Though only a portion of the total increased federal spending under the reform would flow to hospitals, our estimates conclude that in the years during which additional subsidies would be provided, hospitals overall would be substantially better off than they are under current law, even after a Medicaid DSH cut. Another recent analysis of the effect of filling the Medicaid gap also finds large net benefits to hospital finances in nonexpansion states.[5]

Table 1 shows the number of people in the Medicaid gap who would newly gain coverage in each nonexpansion state under the reform, the increase in federal health spending for those people following the increase in coverage, the increase in that spending that goes to hospitals, and the reduction in Medicaid DSH allotments. Results are presented for 2022. We estimate that hospitals in the 12

[1] The Medicaid DSH policy can be found in the October 28 version of H.R. 5376, the Build Back Better Act, Rules Committee Print 117-17, available at https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-117HR5376RH-RCP117-17.pdf.

[2] This provision would also apply to any state that drops its Medicaid expansion in the future.

[3] We model policies as if in place and fully phased in in 2022.

[4] We model the extension of American Rescue Plan Act subsidies as being permanent; subsidy take-up is uncertain given the subsidies' temporary nature.

[5] Matthew Fiedler, "How Would Filling the Medicaid 'Coverage Gap' Affect Hospital Finances?" (Washington, DC: Brookings Institution, 2021).

nonexpansion states would see more than $6.8 billion in new spending for people in the Medicaid gap as a result of the coverage expansions, which is about 15 times larger than the expected DSH cuts of $444 million. Overall, new federal health subsidies going to these people in nonexpansion states would be $19.6 billion. The effects would vary across states largely because of differences in state populations. Florida hospitals are projected to gain $1.7 billion in new spending because of added coverage and to lose $33 million in DSH allotments, resulting in a net gain of $1.6 billion. Texas hospitals could gain $1.6 billion in new spending and lose $157 million in DSH allotments, gaining almost $1.5 billion. Georgia and North Carolina hospitals would also have substantial increases in spending because of added coverage that would exceed their reduced Medicaid DSH allotments by more than $750 million and almost $900 million. Because Wisconsin already covers adults up to the FPL under Medicaid, it would have a small net loss in payments to hospitals for the Medicaid gap population, but a net gain overall.[6]

TABLE 1

Projected New Coverage, Change in Federal Health Subsidies, and Change in Spending Going to Hospitals for Nonelderly People in the Medicaid Gap and Change in the Medicaid DSH Allotment in Nonexpansion States under the Reform, 2022

	Thousands of people gaining coverage	Increase in federal health subsidies ($million)	Increase in spending going to hospitals ($million)	Reduction in federal Medicaid DSH allotment ($million)
Alabama	166	1,365	476	-51
Florida	692	4,739	1,652	-33
Georgia	370	2,287	797	-44
Kansas	68	431	150	-7
Mississippi	106	820	286	-25
North Carolina	298	2,706	943	-49
South Carolina	155	1,143	398	-54
South Dakota	18	161	56	-2
Tennessee	173	1,156	403	-7
Texas	982	4,642	1,619	-157
Wisconsin	15	29	11	-16
Wyoming	10	153	53	*
Total	**3,052**	**19,631**	**6,846**	**-444**

Sources: Health Insurance Policy Simulation Model and "Federal Medicaid Disproportionate Share Hospital (DSH) Allotments," Kaiser Family Foundation, accessed November 4, 2021, https://www.kff.org/medicaid/state-indicator/federal-dsh-allotments.

[6] We estimate Wisconsin would have a small (less than $5 million) reduction in net payments to hospitals for people in the Medicaid gap. Wisconsin did not adopt Medicaid expansion but did extend Medicaid coverage under traditional rules to people with incomes up to the FPL. Thus, the gain in coverage relative to the state population is relatively small. Wisconsin would gain $29 million in new federal health subsidies overall for people in the Medicaid gap. Hospitals would have $11 million in new spending for this group but would lose $16 million in federal DSH allotments. Overall, the state would be better off under the reform, but it would face a small net loss in payments to hospitals for the Medicaid gap population.

Notes: DSH = disproportionate share hospital. People in the Medicaid gap are those with incomes below the federal poverty level who live in the 12 nonexpansion states. Changes in federal health subsidies are modeled as if they were for a permanent American Rescue Plan Act extension and a Marketplace plan to fill the Medicaid gap; this change does not account for Build Back Better Act provisions to eliminate the employer-sponsored insurance firewall for people with incomes below 138 percent of the federal poverty level. Cuts to Medicaid DSH payments are the 12.5 percent cuts to current-level (2020) payments called for in the Build Back Better Act inflated to 2022. Wisconsin has not expanded Medicaid under the Affordable Care Act but covers adults with incomes up to the federal poverty level under Medicaid.
* Estimate is below $500,000.

We estimate changes in state-specific federal funding; however, we are unable to disaggregate changes by individual hospitals within each state. The benefits of the changes would not necessarily go to the same hospitals that would sustain reductions in DSH allotments. Thus, some hospitals may indeed be worse off with the proposed changes. Hospitals serving a disproportionately high share of undocumented people would see less benefit from reform than other hospitals and could see substantial DSH cuts. At the same time, the overall decline in the number of uninsured people could save spending on uncompensated care for the uninsured. If states and localities save on uncompensated care, the savings could be distributed to hospitals most in need after DSH cuts.

Our analysis looks only at a single year, but the BBBA would provide enhanced subsidies and new Marketplace eligibility to people in the Medicaid gap only for 2022 through 2025 (unless Congress were to extend them), whereas the cuts to DSH payments as proposed would be permanent. Our analysis does not include the BBBA provision that drops, for people with incomes less than 138 percent of FPL, the regular ACA rule that requires people to lack an "affordable" offer of coverage to be eligible for Marketplace coverage. It also does not include the BBBA provision that would increase cost-sharing subsidies for Marketplace enrollees with the lowest incomes. Both provisions would increase the number of people covered by Marketplace plans, the total amount of subsidies paid, and hospital spending for people in the Medicaid gap. Our analysis also looks only at new subsidies for people in the Medicaid gap; additional new coverage, federal subsidies, and hospital spending for higher income people would result from extension of ARPA subsidies.

Other uncertainties about hospital financing exist as well. The BBBA would limit uncompensated care pools established by Medicaid waivers in Florida, Kansas, Tennessee, and Texas. Further, as noted, the bill's increased subsidies are set to end after 2025, whereas the bill's Medicaid DSH cuts would be permanent. More broadly, nationwide Medicaid DSH cuts specified under the ACA have been repeatedly delayed, but they are now due to be implemented in fiscal year 2024; at $8 billion in that year, those cuts are much larger than the DSH cuts specified in the BBBA.[7] Unless Congress intervenes, these ACA-related DSH reductions would be in addition to the DSH cuts in the BBBA for the 12 nonexpansion states. In addition, take-up of nongroup coverage could be affected by the temporary nature of the subsidies; if take-up were lower than we've estimated, hospitals would have to care for more uninsured people with less money than estimated here.

[7] "Disproportionate Share Hospital Payments," Medicaid and CHIP Payment and Access Commission, accessed November 4, 2021, https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/.

We modeled DSH cuts by inflating fiscal year 2020 federal Medicaid DSH allotments to 2022, [8] assuming 4 percent annual growth. We then applied the 12.5 percent DSH cut specified in the BBBA. Additional federal subsidies from coverage expansions for the 12 nonexpansion states were modeled using the Urban Institute's Health Insurance Policy Simulation Model and are consistent with estimates presented in a recent Urban Institute analysis, "The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress." [9] We assume hospital shares of the new subsidies would equal 41 percent of new spending, including Medicaid spending and, after a 15 percent adjustment for administrative load, ACA subsidies.

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[8] Fiscal year 2020 DSH allotments were retrieved from "Federal Medicaid Disproportionate Share Hospital (DSH) Allotments," Kaiser Family Foundation, accessed November 4, 2021, https://www.kff.org/medicaid/state-indicator/federal-dsh-allotments.

[9] Jessica Banthin, Michael Simpson, and Andrew Green, "The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress" (New York: Commonwealth Fund, 2021).

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