Evaluation of Uncompensated Care Provision of the Proposed Affordable Health Care Bill (LSB 1043XS 8.3)

University of Iowa, Public Policy Center

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Background

Division X (*Health Care Provider Access*) of the proposed Affordable Health Care for Small Businesses and Families Bill (LSB 1043XS 8.3) proposes to allow health care providers to deduct from their state taxes: a) the difference between their normal charges and the reimbursement from the Medicaid, Medicare and ***hawk-i*** programs, and b) the actual cost of uncompensated care; if the health care provider can document their gross income was reduced by at least 10%. Access could be improved by recruiting or retaining providers in these programs and by increasing the financial viability of providers in difficult areas such as some remote, rural areas.

Cost implications for care related to the Iowa Medicaid program

Iowa administrative data for Calendar Year 2004 (CY 2004), the most recent year for which full data were available, was used to estimate the potential cost implications for a tax deduction for uncompensated care. The total amount that the Medicaid program reimbursed for five types of care in CY 2004 was compared to the total amount submitted by providers as the "charges" for this care. This proportion of potentially "under compensated" care was then applied to the expenditures for each category of service in Fiscal Year 2006 according to data provided by the Iowa Department of Human Services. http://www.dhs.state.ia.us/dhs2005/dhs_homepage/reports_pubs/medicaid_b1/medicaid_b1.html.

	Inpatient Hospital	Outpatient Hospital	Physician	Dental	Pharmacy
Proportion of submitted charges paid by Medicaid in CY 2004	42%	49%	58%	63%	78%
Medicaid expenditures in FY 2006	$283 million	$167 million	$179 million	$43 million	$340 million
Estimated Medicaid care in FY 2006	$673 million	$341 million	$308 million	$68 million	$436 million
Under compensated care in FY 2006	$390 million	$174 million	$129 million	$25 million	$96 million

Note: total cost implications would have to include estimates for Medicare, ***hawk-i*** and uncompensated care that were not available for this analysis

Limitations of this analysis

While this is a reasonable approach to estimating the cost implications of the Medicaid portion of this bill, these estimate are rough and assume the following: a) the proportion of charges to reimbursement in CY 2004 were similar to those in FY 2006 (reasonable), b) that submitted charges represent actual charges of the provider (questionable).

University of Iowa, Public Policy Center
David J. Forkenbrock, PhD
Director

227 South Quadrangle
Iowa City, IA 52242

PHONE:
319.335.6800

FAX:
319.335.6801

FOR MORE INFORMATION ON THIS TOPIC CONTACT:

Peter C. Damiano, DDS, MPH
Director, Health Policy Research Program
peter-damiano@uiowa.edu

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Tax deduction vs. increasing reimbursement rates

When considering ways to improve access to care and increase the financial viability of rural and other under compensated providers from a financial perspective, directly increasing reimbursement rates is another approach to be considered. Both tax deductions and reimbursement rate increases have costs to the state, however, increased reimbursement rates:

1. Would be matched by federal Medicaid matching funds
2. Would compensate providers regardless of the tax status of the provider (e.g., incorporated, no state taxes owed or less than 10% of gross income)
3. May be more effective in encouraging an increased level of participation by being directly tied to services provided. This is an important consideration when considering improvements in access to care.

Other considerations

There are a number of other implications of this proposal to the state that should be considered:

1. Identifying actual charges is extremely difficult because so much care is provided at rates that are negotiated with health plans. In many cases, the uninsured are the only ones paying full charges. This does not seem to be the rate you would want to use in these calculations.
2. OBRA 1989 federal regulations indicate that Medicaid must reimburse providers at a rate that allows Medicaid enrollees to have the same access to care as enrollees of other private plans in the area. Thus you might want Medicaid and other public programs to pay at a “competitive” market rate, not necessarily the provider’s charges.
3. Through the tax deduction, the state would be subsidizing care provided through a strictly federal program (Medicare)
4. The tax deduction could interfere with the current provision for paying rural critical access hospitals based on their costs by Medicaid
5. Improving other state programs, may be more effective than using tax deductions, with similar costs to the state, for either improving access to providers (e.g., loan repayment programs for underserved areas) or supporting providers in remote areas (e.g., economic development benefits of keeping providers in these areas)

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