

Estimating the Impact of a Provider Tax on Oregon Hospital Net Income: Detailed Analysis on Sacred Heart Medical Center

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Modeling by John McConnell, PhD

Estimating the Impact of a Proposed Provider Tax on Oregon Hospitals Executive Summary

Background

Provider taxes and the matching funds they secure from the federal government are essential to the financing of the Oregon Health Plan (OHP). Oregon's 25 largest hospitals and Medicaid managed care organizations (MMCOs) have been paying these taxes since 2004 to provide coverage for adults with incomes below 100% of the federal poverty level (\$10,400 for an individual). However, under state law, both the hospital tax and the MMCO tax expire on October 1, 2009. On that same date, the federal government will enforce new rules that will deny matching funds for certain provider taxes, such as the tax paid here exclusively by Medicaid managed care organizations. As a result, Oregon's provider taxes must be renewed and restructured to continue to secure the federal matching funds that are fundamental to providing coverage to Oregon's children and very low-income adults.

House Bill 2009 proposes to renew and increase the provider tax paid by hospitals and to restructure the provider tax paid by Medicaid MCOs to apply to all managed care organizations in the state. The hospital provider tax will be increased to an amount sufficient to fully fund an expansion of OHP Standard by about 75,000 people, to a total of 103,000 by the end of the 2009-2011 biennium. The tax on managed care organizations will be established at a rate sufficient to cover 80,000 children.

Providing this coverage depends on the state's ability to obtain federal Medicaid matching dollars: for every \$1 of provider tax revenue, the federal government matches with \$1.66. Expanding these provider taxes provides the opportunity to secure a total of more than \$1 billion dollars in federal matching funds. This additional \$1 billion dollars offers the flexibility to consider policy options unavailable to the state otherwise.

The healthcare coverage made possible by a provider tax results in economic benefits to Oregon communities in several forms, not only by shifting uncompensated care away from the hospitals and physicians, but also through the jobs realized from the stimulus effect of a billion dollars in federal matching funds. This study, conducted by Dr. John McConnell on behalf of the Oregon Health Fund Board, focuses on one part of that equation—the impact of a provider tax on net income for Oregon hospitals, including those being assessed the tax as well as the small rural hospitals that are not assessed but benefit from reduced uncompensated care and increased revenues.¹

The Goal of the Study

In the absence of any changes in revenues, utilization, payer mix or efficiencies, a hospital tax set at 4% would be expected to result in a 4% decrease in net income for the taxed hospitals. However, when provider taxes are used for coverage, as is the case for the proposed Oregon tax, health care dollars move away from uncompensated care and toward new revenues, providing significant offsets to the tax:

¹ Dr. McConnell's study was funded through the generous support of the Robert Wood Johnson Foundation (RWJF) through its State Coverage Initiatives (SCI) program.

- 75,000 uninsured adults below 100% of the federal poverty level (FPL) will now bring a source of payment through the Oregon Health Plan
- 60,000 uninsured children below 200% FPL will bring a source of payment through their enrollment in the Oregon Health Plan
- 20,000 children between 200% and 300% FPL will have access to subsidized commercial health insurance through KidsConnect and bring commercial payment
- Provision of uncompensated care will be significantly reduced.

The goal of this study is to model the combined effect of the tax, increased revenues and reduction in uncompensated care on hospital net income. The model takes into account the potential effect of assumptions regarding how much hospitals can raise rates (the pass through) to commercial health plans in response to the new tax, about the proportion of hospital costs that are variable versus fixed, and the expected utilization hospital services among newly insured individuals.

Dr. McConnell modeled the effects of a four per cent provider tax paid by all hospitals with 50 or more beds, a continuation of the tax exemption for the 32 small, rural hospitals with fewer than 50 beds and increased payments to all hospitals that provide care to OHP patients as proposed in HB 2009.²

The overarching goal of the study is not to solve for a single “answer” but rather to assess different policy options available to the state as it designs specific aspects of the provider tax program. Specifically, three scenarios are tested:

Scenario 1: The Cost of Doing Nothing. Under this scenario, the current provider tax sunsets on September 30, 2009 and is not replaced with a new revenue source. OHP Standard is reduced to zero and children’s coverage is not expanded beyond those currently enrolled.

Reimbursement rates for clients under this scenario are reduced to those outlined in the Governor’s Recommended Budget (GRB). This assumes 72% of Medicare costs for the DRG component of the Medicaid Managed Care rate and anywhere from 47% to 71% of Medicare cost in fee-for-service Medicaid.

The impact on hospital net income of doing nothing is defined as the difference between net income with 2007 reimbursement levels and net income that would result from the “do nothing” scenario.

Scenario 2: 4% Tax with GRB Reimbursement. Under this scenario, the current provider tax is restructured as a 4% tax on DRG hospital net patient revenue. Approximately 75,000 adults are added to OHP Standard, increasing enrollment from 25,000 to 100,000. The number of uninsured children is reduced from 116,000 to 36,000 by enrolling approximately 60,000 children in the Oregon Health Plan (OHP) and another 20,000 children in commercial plans. Reimbursement rates for clients under

² Kaiser Sunnyside Medical Center is part of an integrated delivery system and does not report financial data for hospital operations to the Office for Oregon Health Policy and Research.

this scenario, like Scenario 1, are reduced to those outlined in the Governor’s Recommended Budget (GRB).

The impact on hospital net income of Scenario 1 is defined as the difference between net income under the “do nothing” reimbursement levels and net income that would result from Scenario 2.

Scenario 3: 4% Tax with Reimbursement Increased to 88% of Medicare Cost

Under this scenario, both provider tax structure and coverage assumptions are the same as in Scenario 2. Reimbursement is increased to approximately 88% of Medicare cost across both MCO and FFS Medicaid.

The impact on hospital net income of Scenario 3 is defined as the difference between net income under the “do nothing” reimbursement levels and net income that would result from Scenario 3.

Findings

Briefly, Dr. McConnell’s findings are as follows:

- Hospitals in Oregon would lose an estimated \$60 million in net income if the current provider tax expires and a new revenue source is not found to fund coverage for low-income Oregonians.³
- All of the 32 small and rural hospitals would come out ahead under any provider tax scenario, with net benefits totaling almost \$9 million a year;
- Of the 25 larger hospitals that would pay the tax, eight would get back more than they pay in taxes from increased revenue from new paying patients and reduced uncompensated care;
- The majority of the remaining hospitals would recover more than 70% of the taxes they pay from increased patient revenue.

The attached analysis shows the estimated effects of such a tax on hospitals in Oregon compared to the “do nothing” scenario in which the current tax expires on Sept. 30.

³ These data are preliminary and will be finalized when corrected data from Legacy Health System is submitted.

Impact on Oregon Hospital Net Operating Income: 4% Provider Tax

Sacred Heart Medical Center

Net Operating Income Today: \$60,219,451

Cost of Doing Nothing: (\$3,509,240)	Scenario 1	Scenario 2	Scenario 3
Tax	-	\$18,482,089	\$18,774,158
Operating Revenue	\$470,121,026	\$484,028,026	\$491,329,760
Operating Expense	\$413,410,815	\$420,066,557	\$420,066,557
Net Operating Income	\$56,710,210	\$45,479,380	\$52,489,045
Net Operating Income Change vs. Scenario 1	-	(\$11,230,830)	(\$4,221,165)

All DRG Hospitals

Net Operating Income Today: \$236,736,473

Cost of Doing Nothing: (\$57,772,841)	Scenario 1	Scenario 2	Scenario 3
Tax	-	\$216,957,131	\$221,467,792
Operating Revenue	\$5,518,259,800	\$5,691,200,756	\$5,803,967,279
Operating Expense	\$5,339,296,168	\$5,420,983,087	\$5,420,983,087
Net Operating Income	\$178,963,632	\$53,260,538	\$161,516,400
Net Operating Income Change vs. Scenario 1	-	(\$125,703,094)	(\$17,447,232)

Legend

Scenario 1: Do nothing. Without legislation to renew and restructure, the current provider tax (.63%) sunsets on 9/31/2009, OHP Standard closes, and reimbursement is reduced to rates outlined in the Governor's Recommended Budget (see below).

Scenario 2: 4% tax on net patient revenue with Medicaid reimbursement at rates outlined in the Governor's Recommended Budget (see below).

Scenario 3: 4% tax on net patient revenue with Medicaid reimbursement set at 88% of Medicare cost.

Governor's Recommended Budget: Medicaid reimbursement is 72% of Medicare cost for Medicaid managed care, 47% to 71% of Medicare cost for inpatient fee-for-service Medicaid (varies by hospital), and 59% for outpatient fee-for-service Medicaid.

Type A and B Hospital Reimbursement: Type A and Type B hospitals are small rural hospitals with fewer than 50 beds. Medicaid reimburses all Type A and Type B Hospitals 100% of Medicare cost and this does not change under any scenario.

These data are intended as a resource for legislative decision making and are based on statistical models developed by John McConnell, PhD.

Estimating the Impact of a Provider Tax on Hospital Net Income Data, Methods and Limitations

Data. Primary data sources include the Databank hospital financial data and the public Oregon Hospital Discharge Data. Both data sets are submitted to the Oregon Office for Health Policy and Research (OHPR) by the Oregon Association of Hospitals and Health Systems.

This analysis focuses on 24 DRG hospitals and excludes Kaiser Sunnyside, since detailed financial information about Kaiser are not available in the Databank.

Databank files include information on charges and contractuals by payer, as well as total expenses, bad debt, and charity care. Revenues for each payer are defined as charges minus contractuals. The tax base is defined as total revenues (charges minus contractual for all payers) minus charity care and bad debt evaluated at cost.

Scenarios. There are three scenarios considered in this analysis with the following assumptions:

- **Scenario 1: “Do Nothing”**

Under this scenario, the current provider tax sunsets on September 30, 2009 and is not replaced with a new revenue source. OHP Standard is reduced to zero and children’s coverage is not expanded beyond the currently enrolled 200,000.

- **Scenario 2: 4% Tax with GRB Reimbursement**

Under this scenario, the current provider tax is restructured as a 4% tax on DRG hospital net patient revenue. Approximately 75,000 adults are added to OHP Standard, increasing enrollment from 25,000 to 100,000. The number of uninsured children is reduced from 116,000 to 36,000 by enrolling approximately 60,000 children in the Oregon Health Plan (OHP) and another 20,000 children in commercial plans.

Reimbursement rates for clients under this scenario are reduced to those outlined in the Governor’s Recommended Budget (GRB). This assumes 72% of Medicare costs for the DRG component of the Medicaid Managed Care rate and anywhere from 47% to 71% of Medicare cost in fee-for-service Medicaid.

- **Scenario 3: 4% Tax with Reimbursement Increased to 88% of Medicare Cost**

Under this scenario, both provider tax structure and coverage assumptions are the same as in Scenario 2. Reimbursement is increased to approximately 88% of Medicare cost across both MCO and FFS Medicaid.

Assumptions. Key assumptions necessary to carry out the model are outlined below:

- **Hospitals’ ability to raise reimbursement rates to commercial payers.**

Hospitals may be able to offset the some of the cost of the provider tax by renegotiating rates with commercial health plans. To model these effects, the model assumes that hospitals with greater market power have the ability to increase their rates more, while hospitals with less market power are forced to pay a greater burden of the tax. In this model, market power is determined through the estimation of Herfindahl-Hirschman

Indices (HHI), computed with actual zip-code level patient-flow data to define hospital-system markets (Dranove et al. 2008; Zwanziger, and Melnick 1988). The HHI varies between 0 and 1, with lower levels indicating greater competition. The system HHI is estimated to vary between 0.29 and 0.94 for DRG hospitals, with an average HHI of 0.59.

- **Changes in commercial patients' utilization patterns.**

If hospitals raise their rates, commercial patients may use fewer services for two reasons. First, higher rates may be reflected in higher co-payments or co-insurance for patients, and they may demand fewer services. Second, higher rates will translate into increased premiums, which may lead to individuals and employers to drop coverage. Both of these changes are modeled, including the potential for commercially insured patients to move into the uninsured pool.

- **The cost of services for adults versus services for children.**

The model assumes that the cost of services for children is approximately half of those for adults. Sensitivity analyses are also conducted.

- **The cost of care that can be considered "variable" versus "fixed."**

Suppose that the average operating expenses for a typical DRG hospital was \$250M. Those costs include fixed costs, which are unlikely to change with the volume of patients (utilities, IT, some labor and personnel) and variable costs which would change directly with the volume of patients (food, medical supplies, some labor and personnel). There is no straightforward delineation between variable and fixed costs; in the (very) long run, all fixed costs can be considered variable. In this model the assumption is that 50% of costs are variable. Under this assumption, a 10% increase in patient volume would increase costs by 5%. Sensitivity analyses are conducted to assess the importance of this assumption on the overall findings.

- **The amount of care used by uninsured individuals compared to insured individuals.**

Based on work by Hadley and Holahan (2003) the modeling assumption is that uncompensated care is approximately 30% of care provided to an insured patient. Sensitivity analyses are conducted.

- **Any additional (new) Medicaid/OHP revenues for non-DRG (A&B) hospitals are assumed to be equal to cost.**

Based on these assumptions, the overall approach of this model is to assess the changes in revenues and costs that would occur with a 4% tax, assuming that revenues and costs would change in proportion to changes in adults and children who would be uninsured and who would be enrolled in OHP.

Limitations. There are several limitations in this analysis. Several assumptions are necessary to model the effect of the tax. These assumptions (e.g., variable costs, utilization by the newly insured, the extent to which private rates may be raised) are not directly testable. However, sensitivity analyses have been conducted to assess the effects of these assumptions.

The data are based on Databank data, which are reported on a monthly basis to the Office for Oregon Health Policy and Research (OHPR). These data may differ somewhat from the final

audited year-end financial reports. In particular, four hospitals list Medicaid Charges and Contractuals that suggest estimated Medicaid revenues that are clear outliers. (For example, one hospital lists Medicaid Contractuals that are greater than Medicaid Charges). In this case, Medicaid appears to reimburse at a rate that is much, much lower than cost (less than 40% of total cost) and for these hospitals in particular, OHP expansions result in much lower net incomes, since increases in OHP patients result in higher costs with relatively no new revenues. It may be that these are errors in accounting practices and that the model estimates changes in net income that are more negative than would be likely if more accurate data on Medicaid reimbursements were available.

The Databank data do not have detailed information on the single Kaiser hospital within Oregon, and this hospital has been excluded from this model. Kaiser itself would be likely to be worse off with the tax, since they do not see a large number of uninsured patients and thus would not experience large cost savings from reduced uncompensated care.

The data also do not include information on Disproportionate Share Hospital (DSH) payments or other governmental subsidies. Some hospitals may be worse off than currently estimated if the provider tax led to fewer uninsured and lower DSH payments.

This study does not model crowd-out that could occur if adults who were currently covered by commercial insurance gained coverage through the expanded OHP program. In addition, the model compares a “tax with expanded coverage” scenario to a “no tax and no expanded coverage” scenario using data from 2007 and does not model changes that may occur as the state and hospitals face what is likely to be a substantial economic downturn.

References

Dranove, D., R. C. Lindrooth, W. D. White, and J. Zwanziger. 2008. “Is the impact of managed care on hospital prices decreasing?” *J Health Econ* 27(2): 362-76.

Hadley, J. and J. Holahan. 2003. “How much medical care do the uninsured use, and who pays for it?” *Health Aff (Millwood)* Suppl Web Exclusives: W3-66-81.

Zwanziger, J. and G. A. Melnick. 1988. “The effects of hospital competition and the Medicare PPS program on hospital cost behavior in California.” *J Health Econ* 7: 301-20.