NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

FUTURE MEDICARE CUTS AND HOSPITAL JOB LOSSES

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At a time when the national economy is still weak and unemployment is especially high, potential federal legislation is jeopardizing jobs in one of the strongest sectors of the economy: hospitals and health care.

JOB LOSS AND THE AFFORDABLE CARE ACT

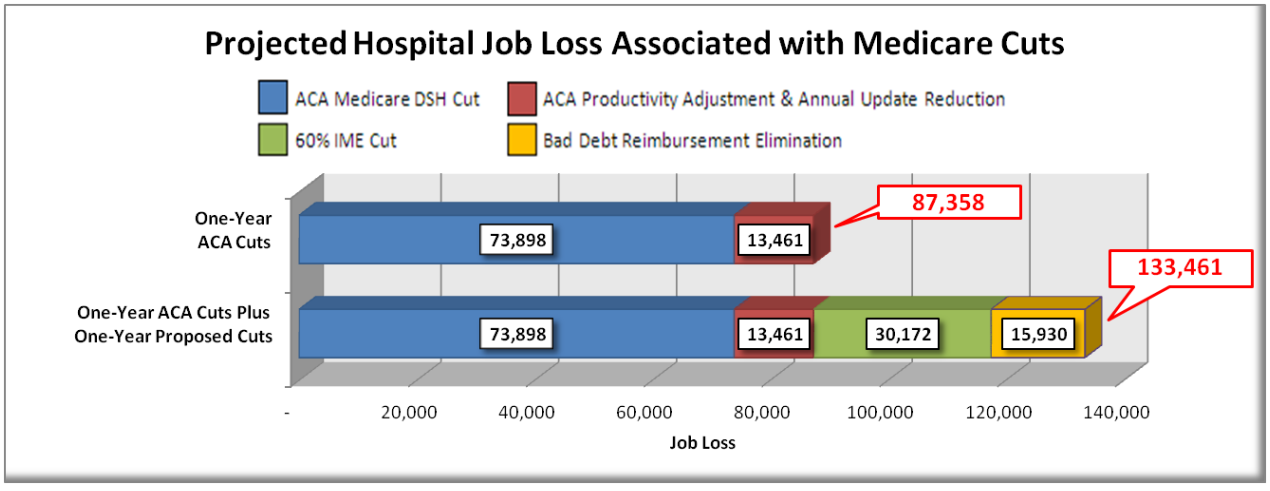
The Affordable Care Act includes $155 billion in payment cuts for hospitals. Much of that reduction consists of a cut of as much as 75 percent in Medicare disproportionate share hospital (DSH) payments – supplemental payments made to selected hospitals that care for especially large numbers of low-income patients. These hospitals suffer considerable financial losses caring for these patients, and the purpose of Medicare DSH payments is to help compensate them for those losses.

A 75 percent cut in Medicare DSH payments could cost hospitals up to 73,898 direct jobs in FY 2014, the first year that cut takes effect.

The Affordable Care Act also calls for reducing hospitals' annual payment updates to a rate less than the increase in the price of goods and services hospitals must purchase to deliver health care and for imposing a "productivity adjustment" that further reduces Medicare payments to hospitals; both changes began in FY 2011 and will continue through FY 2019. In FY 2012 alone, these changes will cost American hospitals as many as 13,461 jobs.

CUTS UNDER CONSIDERATION BY CONGRESS

Through the Joint Select Committee on Deficit Reduction (the "supercommittee"), Congress is now considering additional Medicare and Medicaid spending cuts. The committee's mandate is to recommend at least $1.2 trillion in future federal spending cuts, to be adopted or rejected by Congress by December 23, 2011.



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Reports suggest that this committee is considering an additional $500 billion in Medicare and Medicaid cuts – cuts over and above those in the Affordable Care Act. The committee is thought to be looking closely at the recommendations of 2010's National Commission on Fiscal Responsibility and Reform, so it is useful to consider how such cuts might further affect hospital employment.

The 2010 commission called for the complete elimination of Medicare bad debt reimbursement. Currently, Medicare reimburses hospitals for 70 percent of their Medicare bad debt; most of that bad debt is associated with low-income seniors who cannot afford their Medicare co-pays and deductibles.

The 2010 commission also called for reducing the Medicare indirect medical education (IME) adjustment, currently 5.5 percent of Medicare payments, to just 2.2 percent (a 60 percent cut). These IME payments help underwrite the training of the country's next generation of physicians and a significant portion of the cost of care those physicians provide to low-income and uninsured patients while they are training.

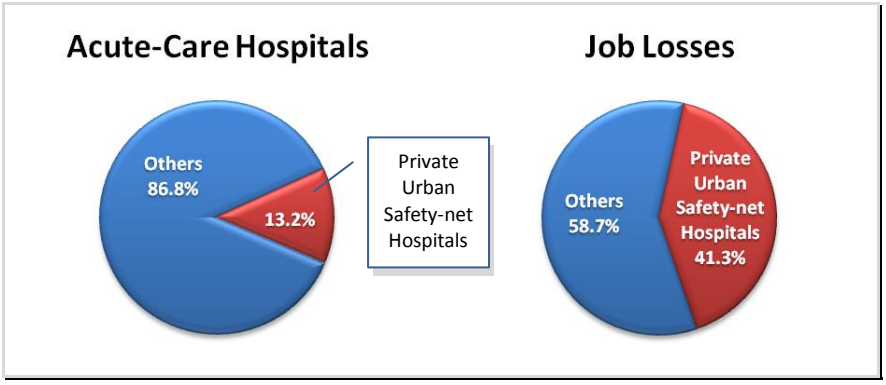
The elimination of Medicare bad debt reimbursement would cost as many as 15,930 direct hospital jobs and the reduction of Medicare IME payments from the current 5.5 percent to 2.2 percent would cost as many as 30,172 hospital jobs.

Even if the supercommittee fails to make these recommendations or if Congress rejects its recommendations, these proposed Medicare cuts may still be considered by Congress as part of a future effort to address the Medicare physician payment problem (often referred to as the "Medicare doc fix," this refers to the sustainable growth rate formula, or SGR, used to determine Medicare payments to physicians).

The graph on page one illustrates the potential job loss associated with the Affordable Care Act cuts and the additional cuts currently under consideration in Congress.

Disproportionate Impact on Urban Safety-Net Hospitals

Currently, 13 percent of American hospitals paid under Medicare's inpatient prospective payment system are urban safety-net hospitals; these are hospitals that are private and non-profit; have at least 200 beds; are located in urban areas; provide at least 15 percent of their services to Medicaid patients; and are paid by Medicare under its inpatient prospective payment system. Private, non-profit urban safety-net hospitals, only 13 percent of all American hospitals, would bear a greatly disproportionate share of these projected job losses: 43 percent of the direct job loss associated with the reduction of Medicare DSH payments; 31 percent of the job loss associated with the reduction of Medicare cost-of-living increases and productivity adjustments; 28 percent of the job loss associated with the elimination of Medicare bad debt reimbursement; and 48 percent of the job loss associated with a major reduction of Medicare IME payments. The graph below illustrates the disproportionate impact of these cuts on urban safety-net hospitals.



CONCLUSION

As these figures illustrate, the Affordable Care Act already will exact a heavy toll on one of the strongest sectors of the economy at a time when the country can ill-afford further job losses. Now, the work of the Joint Select Committee on Deficit Reduction threatens to cause even greater harm to this otherwise vibrant sector of the American economy while also jeopardizing access to care and quality of care in many communities. (Please note that projected job loss data is available for individual states and cities and parts of most congressional districts.)

METHODOLOGY

The National Association of Urban Hospitals (NAUH) modeled the impact of a single year of each of the Medicare cuts described above by assuming that each such cut will be implemented as presented in this paper – based on either the Affordable Care Act or the 2010 deficit commission's proposals – and not implemented to a lesser degree or phased in over a number of years. Even though some of these cuts are expected to take place in future years, they have not been inflated for a specific year. Please note that NAUH performed this modeling and analysis only on acute-care hospitals paid under Medicare's inpatient prospective payment system.

Medicare DSH cuts were estimated using data from the Medicare Impact File that was published with the FY 2012 Medicare inpatient prospective payment system (IPPS) final regulation. NAUH used this same file to model the impact of already-enacted productivity adjustments and the planned withholding of 0.1 percent of future Medicare payment updates (cost-of-living increases). The impact file is available on CMS's web site.

NAUH imported individual hospitals' reported Medicare bad debt and indirect medical education (IME) payments directly from their Medicare cost reports for FY 2009, the most recent year for which data is available; these reports, too, are available on the CMS web site. NAUH estimated the impact of the proposed cuts by applying an equal percentage reduction to every hospital's reported payments.

To estimate the impact of these cuts on jobs, NAUH calculated a hospital-specific average annual salary for every hospital in the data set using the most recent wage data included in the "Three Year MGCRB Reclassification Data for FY 2013 Applications" file, which can be found on CMS's web site. Because not all hospital expenses are wage-related, NAUH reduced its estimates of the total cut amounts by 31.2 percent – the average percentage of expenses that represents costs unrelated to wages at hospitals that participate in Medicare's inpatient prospective payment system; this figure represents the CMS-determined "labor-related share." Finally, NAUH divided the hospital's labor-attributable cuts by the hospital's average annual salary to calculate a conservative estimate of how many jobs are funded with the money the proposed cuts would take away from each hospital.

While the job loss estimates included in this study is national in scope, job loss data for individual states, cities, and most congressional districts is available upon request.

For further information about the projections presented in this document, please contact Ellen Kugler, executive director of the National Association of Urban Hospitals, at 703-444-0989.