

# Financial Forecast for Virginia Hospitals and Its Implication for Certificate of Public Need

*Issue Brief*

Dobson | DaVanzo

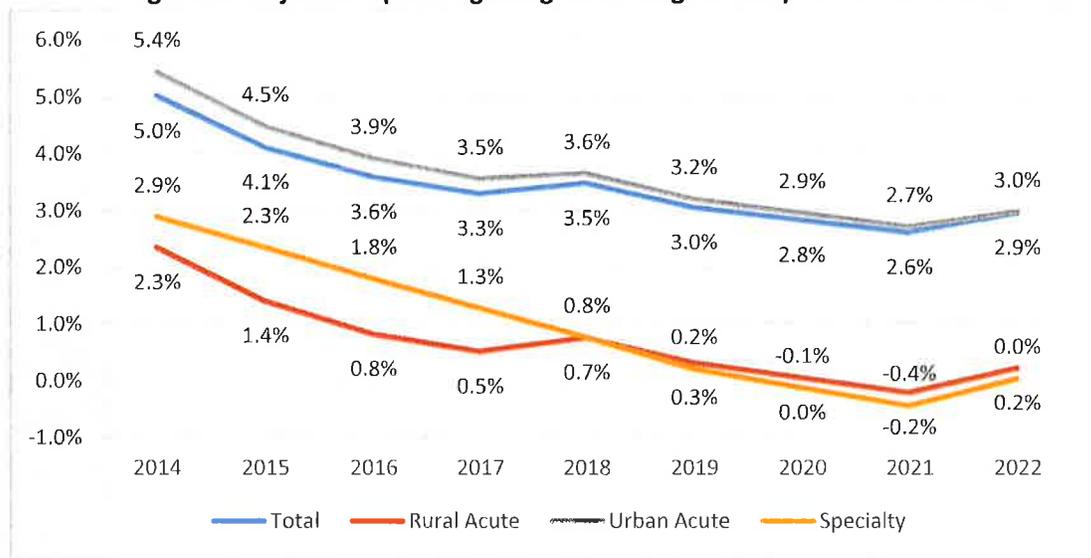
## Financial Forecast for Virginia Hospitals and Its Implication for Certificate of Public Need

This issue brief discusses the potential impact of deregulating the Virginia Certificate of Public Need (COPN) program on hospitals in the state and, in particular, the state’s 37 acute care rural hospitals. The paper examines the current and projected financial status of hospitals in the state, discusses potential implications of deregulating COPN on access to hospital services and quality of care, and discusses the implications of deregulating COPN specifically for rural hospitals in the state.

### Financial Outlook for Virginia Hospitals

Using hospital financial data from Virginia Healthcare Information (VHI), we estimate that operating margins for all Virginia hospitals will be 5.0% in 2014 (**Figure 1**) based on assumptions of the impacts of expanded private coverage in the state under the Affordable Care Act (ACA) and the scheduled Medicare and Medicaid payment reductions, but does not include a Medicaid coverage expansion for low-income adults. Although operating margins are slightly higher for urban acute care hospitals (5.4%), operating margins for rural hospitals and specialty hospitals are well below the average at 2.9% and 2.3% respectively.

**Figure 1: Projected Operating Margins for Virginia Hospitals 2014-2022**



Source: Dobson | DaVanzo estimates using Virginia Healthcare Information hospital financial data.

Hospitals face a number of financial pressures in the near term that will likely have a negative impact on future financial performance. We estimate that operating margins could fall to 2.9% by 2022 on average across all hospitals in the state and fall to zero for rural hospitals. This trend is consistent with investor reports that predict slowed revenue growth and reduced operating margins for not-for-profit hospitals in the near future, which would result in downgraded bond ratings and reduced access to capital.<sup>1 2</sup>

These pressures include:

<sup>1</sup> Moody’s Investor Service, “2014 Outlook – U.S. Not-for-Profit Hospitals”, November 2013.

<sup>2</sup> Standard & Poor’s Rating Services, “The Outlook for U.S. Not-for-Profit Health Care Providers is Negative from Increasing Pressures”, December 2013

- **Medicare and Medicaid payment reductions** – scheduled reductions in Medicare payments to hospitals and federal Medicaid disproportionate share hospital (DSH) allotments will decrease Virginia hospital revenues by an estimated \$6.5 billion over the 2014 to 2022 period (\$6.2 billion in Medicare cuts and \$263 million in Medicaid DSH reductions), which will more than offset the benefits of reduced hospital uncompensated care resulting from the coverage expansions.<sup>3</sup>
- **Shifting payer mix** – the elderly population in the state are projected to grow at 2.7% per year compared to only 0.5% growth in the under 65 population and the Medicaid program has shown similar annual growth of about 2.6%.<sup>4</sup> Thus, hospitals will be seeing a larger share of patients from these programs that have historically paid well below the cost of treating these patients.
- **ACA coverage expansions** – in 2014, approximately 216,000 Virginians enrolled in the Health Insurance Marketplace and we assume that number will grow to nearly 480,000 by 2022.<sup>5</sup> Because not all of the Marketplace enrollees were previously uninsured, we estimate that these expansions in coverage will reduce hospital uncompensated care by about \$2.8 billion over the 2014 to 2022 period (16% of total bad debt and charity care costs). Clearly the impact on uncompensated care would be far greater if the Commonwealth decides to expand coverage to low-income working adults. The Marketplace coordinates with the Medicaid program (applicants for coverage in the Marketplace who are eligible are enrolled in Medicaid) along with the publicity of the ACA, the Medicaid program experienced increased enrollment of about 15,000 new members in 2014 and we estimate this will increase in the future as well. This “woodwork” effect has been substantially lower than originally forecast and will likely remain so as long as the Commonwealth chooses not to expand coverage.
- **Increase in bad debt associated with high deductible health plans (HDHPs)** – hospitals have been experiencing an increase in bad debt from patients with HDHPs. In addition to the increased enrollment of families into HDHPs through employer plans, about 85% of people enrolling in Marketplace plans are selecting “Silver” or “Bronze” plans with an average deductible of \$2,900 and \$5,200 respectively in 2014.<sup>6,7</sup> Therefore, we assume this trend will continue to increase hospital bad debt in the near future.

The private coverage expansions under the ACA, exclusive of the Medicaid expansion, would have a positive impact on hospital operating margins. However, the severity of the Medicare and Medicaid payment reductions eliminates these potential benefits to the point that hospital operating margins during the 2014 to 2022 period would be lower that they would have been in the absence of the ACA.

### Issues Regarding Virginia’s Certificate of Public Need (COPN)

The Virginia COPN program was established in 1973 and was designed to control health care costs, improve quality of care, and maintain access to care by requiring state approval for developing or

<sup>3</sup> Estimates provided by the Hospital Association of New York State for Virginia hospitals.

<sup>4</sup> Population projections from the Demographics Research Group, Weldon Cooper Center, University of Virginia; Medicaid enrollment trends from Kaiser State Health Facts monthly Medicaid enrollment December 2009-2013.

<sup>5</sup> Marketplace enrollment from Kaiser State Health Facts in 2014, we assume increased participation to 468,000 by 2018 using Society of Actuary’s, “Cost of the Future Newly Insured under the Affordable Care Act”, Feb 2013.

<sup>6</sup> ASPE Issue Brief, “Health Insurance Marketplace: Summary Enrollment Report For The Initial Annual Open Enrollment Period”, May 2014

<sup>7</sup> [www.healthpocket.com/individual-health-insurance](http://www.healthpocket.com/individual-health-insurance)

expanding health care facilities or services. Numerous studies and evaluations have been done across the country to determine the effectiveness of COPN programs. Although results of these studies have been mixed as to the effectiveness of COPN in controlling overall health care spending, arguments can be made for potential adverse effects in the short run if COPN is deregulated.

Several studies suggest that specialty providers, such as specialty hospitals, imaging centers, and ambulatory surgical centers frequently arise in the absence of COPN with consequences for safety-net hospitals and hospitals in rural communities.<sup>8 9</sup> These specialty providers usually develop in areas with a large privately insured population and specialize in profitable service lines such as imaging, cardiology and orthopedics. These specialty providers have the potential to drain safety-net and rural hospitals' financial resources because profits made by these hospitals on privately insured patients and profitable service lines help support unprofitable services that are often essential to the community, such as emergency care and labor/delivery services, and support their ability to provide uncompensated care.

The lack of COPN could also result in a migration of services from existing hospitals that could leave inner cities and rural communities without essential hospital services as hospitals shift to more lucrative suburban locations. Thus, COPN may be beneficial because it protects safety-net and rural providers and the essential services they provide, which are often unprofitable, by impeding market entry into better paying market areas. In addition COPN programs help distribute care to disadvantaged populations or geographic areas that may be left unserved, especially in the short term, by new and existing providers.<sup>10</sup>

COPN laws are also intended to ensure that providers maintain high procedure volume which is associated with better outcomes because quality of care is strongly related to volume, and COPN requires applicants to demonstrate that their facilities will have a high volume of patients. Abandoning COPN could lead to expansion of programs with lower average volumes, which has the potential to reduce the quality of care.<sup>11 12 13</sup>

### **Implication for Virginia's Rural Hospitals**

Rural hospitals in the state may be particularly affected if COPN is deregulated. Our analysis shows that operating margins for rural hospitals in the state are substantially lower than their urban counterparts and could decline to nearly zero by 2022. In fact, operating margins for small rural Critical Access Hospitals (CAHs) were negative in 2013 and had been negative in the prior three years (2011 – 2013).

<sup>8</sup> US General Accounting Office, Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served, April 2003.

<sup>9</sup> Jean Mitchell, Effectiveness of Physician-Owned Limited-Service Hospitals: Evidence from Arizona, Health Affairs, 2005.

<sup>10</sup> Yee, et al., Health Care Certificate-of-Need Laws: Policy or politics, National Institute for Health Care Reform, May 2011.

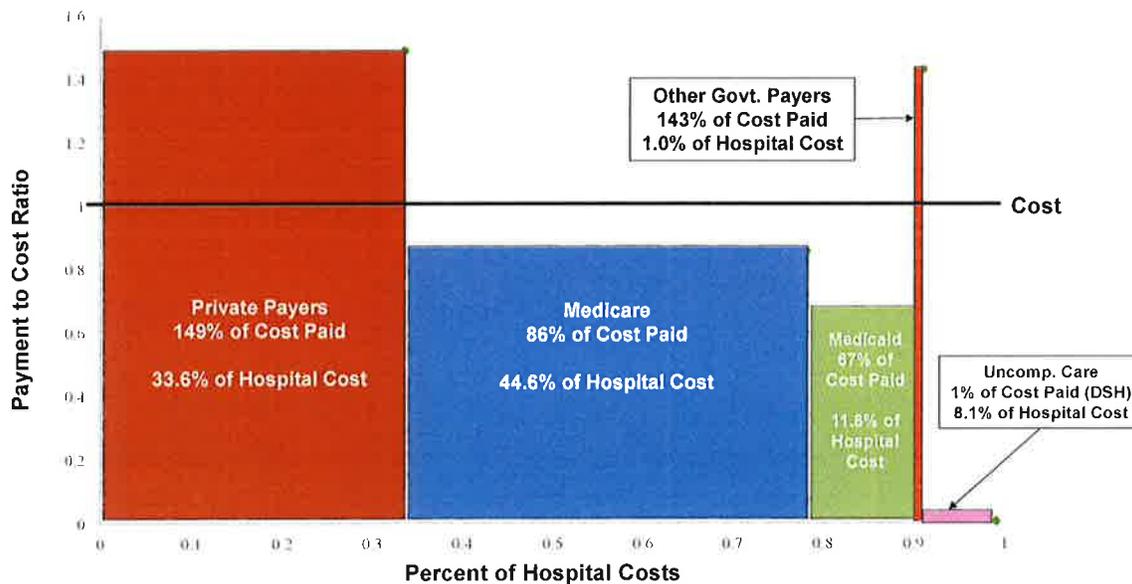
<sup>11</sup> Ho, et al., Trends in Hospitals and Surgeon Volume and Operative Mortality for Cancer Surgery, *Annals of Surgical Oncology*, 2006

<sup>12</sup> Schrag, et al., Surgeon Volume Compared to Hospital Volume as a Predictor of Outcome Following Primary Colon Cancer Resection, *Journal of Surgical Oncology*, 2003.

<sup>13</sup> Birkmeyer, et al., Surgeon Volume and Operative Mortality in the United States, *New England Journal of Medicine*, 2003.

Virginia’s rural hospitals already treat a disproportionately older population that will significantly increase in the future. Thus, the current below cost Medicare payment amounts and scheduled future payment reductions will have a significant impact on these providers. Also, rural hospitals provide a significant amount of uncompensated care that is similar to urban hospitals on a percentage of total operating cost basis. As shown in **Figure 2**, we estimate that by 2022 more than 65% of patient care in Virginia’s rural hospitals will be reimbursed below the cost of treating those patients. Thus, rural hospitals are highly dependent on profits from privately insured patients (which account for only 34% of patient care) to provide uncompensated care, undercompensated care for Medicare and Medicaid patients, and provide essential services in their communities.

**Figure 2: Analysis of Payments and Costs by Payer for Virginia Rural Hospitals in 2022**



Source: Dobson | DaVanzo estimates using Virginia Healthcare Information hospital financial data.

The potential impacts of deregulating COPN in Virginia, described above could have a significant impact on rural hospitals’ financial viability and their ability to provide essential services to their communities. If new specialty providers and existing hospitals expanded services into areas that would move privately insured patients and profitable service lines away from rural hospitals, this would effectively reduce the profits that rural hospitals rely on to cross-subsidize public program and self-pay patients and the ability to provide essential services.

Since we estimate that operating margins for rural hospitals will be near zero by 2022, any additional reductions in net income could cause some hospitals to close or reduce their costs. Reducing costs would often mean eliminating the unprofitable service lines, which are essential to their communities. If Virginia decides to deregulate COPN, it should carefully monitor the financial impact on hospitals, in particular rural hospitals and safety-net providers, in the state and patient access to the essential community services they provide and may need to determine how to otherwise assure that access essential hospital services is continued.

