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The influence of the Individual Mandate provision of the Affordable Care Act on Uninsured Patients and Nonprofit Hospitals in Southern Illinois

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THE INFLUENCE OF THE INDIVIDUAL MANDATE PROVISION OF THE
AFFORDABLE CARE ACT ON UNINSURED PATIENTS AND NONPROFIT
HOSPITALS IN SOUTHERN ILLINOIS

by

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A Research Paper
Submitted in Partial Fulfillments of the Requirements for
Mast of Public Administration

Department of Political Science
in the Graduate School
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MPA RESEARCH PAPER APPROVAL

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CHAPTER 1

INTRODUCTION

The federal government estimated that in 2011 approximately 48.6 million Americans remained uninsured in the United States (U.S. Census, 2012). Most of the uninsured individuals are in working families yet they do not have access to employer based coverage or cannot afford insurance that is offered by their employer. The high rate of uninsured Americans along with the increasing cost of healthcare has caused healthcare reform to be a hot button issue for many years.

In 2010, the Affordable Care Act (ACA) was passed intending to reduce the number of uninsured Americans by about half. The ACA includes a significant expansion of the Medicaid program, substantial insurance reforms, subsidies for low- and moderate-income individuals and small businesses, an employer mandate, and the individual mandate (Parmet, 2011).

One of the most scrutinized provisions of the Affordable Care Act of 2010 is the individual mandate, which requires all too either obtain health insurance or to pay a penalty tax. It is expected that once the law has been fully implemented, the uninsured rate would decline by 47.1%. Nationally the law is expected to still leave 24 million people uninsured because some people will still not meet the poverty rate for Medicaid, refuse to purchase health insurance, and illegal immigrants will be unable to purchase healthcare or qualify for Medicaid. (Woolhandler & Himmelstein, 2011).

In addition to reducing the number of uninsured, the rising cost of healthcare in the United States is another reason for many to desire healthcare reform. Healthcare in this country has become big business for nearly all of the players that are involved, including insurance companies, medical supply companies, and even nonprofit hospitals. Local nonprofit hospitals are viewed as charities but they typically have tens of millions of dollars a year in net revenues.

Nonprofit hospitals typically have higher revenue margins than for-profit hospitals. Due to growing concerns regarding the actual amount of uncompensated or charitable care non-profit hospitals provide, the Internal Revenue Service has started to require them to document their community contributions in full. These recent changes by the IRS toward non-profit hospitals as well as the provisions within the ACA are expected to influence the amount of uncompensated care that nonprofit hospitals supply (Principe et al, 2012).

This research paper examines how the large number of uninsured patients has affected nonprofit hospitals in Southern Illinois and what influence the individual mandate will have on their future operations. Illinois currently has an uninsured rate of 16.7%, which is well above the national average of 11%. This puts Illinois in the 90th percentile for uninsured Americans (Becker, 2012).

The majority of Southern Illinois is considered to be rural. This places limits on available accesses to care. There are only 10 nonprofit hospitals in 20 counties of Southern Illinois to treat to the uninsured (USA Hospitals, 2010). This research surveyed those hospitals to learn how the large number of uninsured patients and their hospitals will be affected by the individual mandate provision of the ACA. The following literature examines current publication on this topic.

CHAPTER TWO

LITERATURE REVIEW

The United States spent 17.6% of the Gross Domestic Product on healthcare, while most other developed countries spend about half of that amount. The US spending on healthcare is one and half times more than any other country (Kane, 2012). According to a study conducted by McKinsey & Co., the United States spends more on healthcare than the next 10 biggest spending countries combined. (Please see Appendix C for table.) Every other developed nation has universal healthcare through a form of national health insurance, and they all spend less per dollar equivalent on health care than the United States (Woolhandler & Himmelstein, 2011).

Estimates are that Americans will spend \$2.8 trillion on health care in 2013 alone. The federal government will pay for about \$800 billion through Medicare which cover insurance for the disabled and those individuals 65 and over, and Medicaid, which provides care for the poor. The other \$2 trillion will be paid for by private insurance companies and those individuals with no insurance (Brill, 2013).

The Uninsured

The large number of individuals without health insurance has been a cause for concern for many years due to the rising cost of healthcare. The federal government estimates that in 2011 there were approximately 48.6 million Americans uninsured in the United States (U.S. Census, 2012). That is a decrease of 1.3 million from 2010, but it was the first decrease since 2007, where the number grew by more than 4.5 million (The Kaiser Family Foundation, 2012).

There are many causes for the high rate of uninsured Americans. Insurance coverage varies by state depending on the portion of families with low incomes, the rate of employment in

the state, and the extent of Medicaid within the state. Insurance coverage options and the availability of jobs also influence the amount of individuals who are insured. For example, due to health reform legislation passed in 2006, Massachusetts now has near universal coverage and has an uninsured rate of 5%. Other states have uninsured rates that are much higher, such as Nevada, Florida, and Texas which are 24% or higher. Illinois has an uninsured rate of 16.7%, which is about 1.9 million individuals (The Kaiser Family Foundation, 2012 & U.S. Census, 2012).

Most of the uninsured individuals are in working families but do not have access to employer based insurance or cannot afford the insurance that is offered by their employer. The majority of the uninsured have very low income, making it difficult for them to afford coverage on their own. Adults account for a large portion of the uninsured population because they are less likely than children to be eligible for Medicaid benefits (The Kaiser Family Foundation, 2012).

Emergency Room Care

When the uninsured lack primary care options, they rely on emergency rooms to treat their health care needs. In 1986 Congress passed the Emergency Medical Transport and Labor Act (EMTLA) which requires all nonprofit hospitals to treat any individual who comes to the emergency department seeking medical care. Although hospitals do not always receive proper reimbursements from the uninsured, they are still required to provide them medical treatment. The hospital must either stabilize the medical condition or transfer the person to another medical facility in accordance with the law's transfer requirements. A hospital's failure to meet one or more of these constitutes is a violation of the statute. The law also prevents a hospital from delaying examining a patient in order to question a patient about payment or insurance coverage.

Before the passage of EMTLA, “patient dumping” posed a serious threat to the health of patients. Uninsured patients and those with government funded insurance were being transferred from one hospital to another due to economic reasons, despite the risk it caused (Dame, 1998).

Hospital Costs

An unintended consequence of EMTLA is that hospital emergency departments have become health care clinics for uninsured patients. The nation’s nearly 4,000 emergency department’s act as the primary entrance for uninsured patients admitted to U.S. hospitals. Studies have found that providing uninsured patients with free or low-cost primary care will reduce the use of hospital emergency departments (Zahradnik, 2008). Hospitals and physicians assume the financial weight for the uninsured by acquiring billions of dollars in bad debt or unpaid services each year. Fifty-five percent of emergency care goes unpaid, according to the Centers for Medicare & Medicaid Services. Healthcare costs for the uninsured have been estimated to total \$176 billion dollars per year (American College of Emergency Physicians, 2012). The weight of uncompensated care differs across providers. Hospitals endure 60% of the cost of uncompensated care even though physicians and clinics see more uninsured patients. Most government funding of uncompensated care is paid to hospitals based indirectly on the share of uncompensated care they provide (The Kaiser Family Foundation, 2012).

When the uninsured use emergency rooms for their primary care it causes the hospitals money and reduces available access to those facilities for other sick patients. Billions of dollars of uncompensated care has resulted in the closure of hundreds of emergency departments in America, which is reducing capacity and threatening people’s access to lifesaving care. The ACA is expected to increase primary medical care, since this is typically a patient’s first introduction to the health care system (Hofer, Abraham, and Moscovice, 2011). The expanded

coverage is predicted to increase the national number of annual primary care visits between 15.07 million and 24.26 million by 2019. The ACA's health insurance expansion is expected to significantly increase the use of primary care facilities and clinics, which focuses primarily on preventative care (Hofer et al, 2011).

Illegal Immigrants

Also, most illegal immigrants are uninsured, contributing to uncompensated care. It has been estimated that 11 million people currently living illegally in the United States will not be covered under the Affordable Care Act. Even if they were eligible for coverage, most could not afford it, nor could they afford to visit a private physician's office. They are not eligible for Medicaid. Census data reveal a strong link between immigration and the rapid growth of the medically uninsured (U.S. Census, 2012). Many hospitals are concerned that the U.S. government will reduce the estimated \$20 billion annually that they currently pay for emergency care for illegal immigrants mostly in poor urban and rural areas, such as Southern Illinois. The health care law will eventually reduce that amount because of the anticipation that fewer people will be uninsured after the individual mandate is implemented (American College of Emergency Physicians, 2012).

High Profit Healthcare

Another issue with the United States healthcare system is the incredibly high profits accrued by insurance companies, hospitals, providers, and medical suppliers. Many nonprofit hospitals that often provide health services to the uninsured have transformed into high-revenue businesses. The Internal Revenue Code exempts nonprofit hospitals from paying federal income taxes. Local nonprofits are viewed as charities but they typically make tens of millions of dollars a year and often pay their administrators six or seven figure salaries. The average profit

margin for all nonprofit hospitals is 11.7%. The profit margin is the hospital's excess of revenue over expenses. There are roughly 2,900 nonprofit hospitals in the United States which average higher operating profit margins than the 1,000 for-profit hospitals after the for-profit hospital's tax deductions. While the current average profit margin for non-profits is high, treating more patients with healthcare coverage is expected to reduce healthcare costs; therefore the profit margins should expect to decrease. In health care, being nonprofit creates more profit. Yet, there are no restrictions under the IRS rules for nonprofits to not make more than they spend. They just cannot allocate the profits to their shareholders, because they do not have shareholders (Brill, 2013). The excess revenue is placed back into the organization to help fulfill the mission.

A cause for concern regarding the high profits of non-profit hospitals is that it has been speculated that nonprofit hospitals do not provide the amount of benefits to their community to justify their tax-exempt status. There are approximately 4,200 nonprofit hospitals in the United States that receive an estimated \$6-8 billion in tax exemptions per year. This is an average of \$1.6 million per hospital. It is assumed that these tax savings will be used by nonprofit hospitals to support activities that will benefit local communities, such as, healthcare for the uninsured, research, and teaching. But it has been determined that nonprofit hospitals do not provide a greater level of uncompensated care than for-profit hospitals (Cram, Bayman, Popescu, Vaughan-Sarrazin, Xueya, & Rosenthal, 2010). Due to these growing concerns, the Internal Revenue Service has started to require them to document their community contributions in full. Starting with the 2009 tax year, nonprofit hospitals must file a redesigned IRS Form 990 that will show the IRS as well the public a more clear view of how tax-exempt organizations perform to fulfill their mission (Principe, Adams, Maynard, & Becker, 2012).

These changes as well as the provisions within the Affordable Care Act are expected to influence the amount of uncompensated care that nonprofit hospitals supply (Principe et al, 2012). There are currently healthcare reform proposals to include legislation that would mandate nonprofit hospitals to provide a clearly defined quantity of charity care or they could lose their tax exempt status. The ACA, specifically the individual mandate, will have an impact on the amount of care nonprofit hospitals provide which they are in turn not compensated for. It is expected the ACA will strengthen the amount of uncompensated care nonprofit hospitals can provide because organizations will be better able to locate subsidies for uncompensated care and increase subsidized services that affect public health (Principe et al, 2012).

Healthcare Reform

Healthcare reform has been a popular topic for many years due to the high number of uninsured Americans and the increasing cost of healthcare. It became a top priority of then presidential candidate Barack Obama during his 2008 election campaign. Healthcare reform had been a longstanding desire of the Democratic Party and would have a heavy impact on the Obama presidency. Studies have been conducted to show that our healthcare system has serious problems that require reform. For example, a study conducted in 2009 showed that 45,000 Americans die annually due to lack of health insurance (Woolhandler & Himmelstein 2011). When the uninsured do seek medical treatment, the related costs that are accrued do not just go unpaid. The medical care of the uninsured is often passed on to those that have insurance through increased health insurance premiums and increased healthcare costs from the hospitals and medical providers. Since people tend to live longer than in past decades, more people will be eligible for Medicare, which leaves the government responsible for paying for a larger portion of the growing healthcare costs.

There are also problems within the United States healthcare system that are not caused by the uninsured, but from insured Americans that are still suffering from massive medical expenses. These individuals are referred to as “the under-insured.” Nearly one-third of Americans are not sufficiently insured, which increases the likelihood that a medical illness will cause them to go bankrupt. A study conducted by Harvard Law School and Ohio State University discovered that one half of the bankruptcies are in part due to medical illness or medical bills. A large majority of these medical bankruptcies were from individuals that were covered by health insurance, or were at least covered at the beginning of their illness. In 2007, 78 percent of the people who filed for bankruptcy due to medical illness costs had health insurance. Most of these individuals held on to their health insurance through their illnesses but were still forced into bankruptcy due to high deductibles, uncovered services, copays, and gaps in coverage (Woolhandler & Himmelstein, 2011).

Once the ACA has been fully implemented, it is expected that the uninsured rate would decline by 47.1% nationally. The uninsured rate in Illinois is expected to decrease by 45.4% after the ACA is fully implemented. Every area in the state is projected to decrease the uninsured rate by greater than 35%, with some areas projected at 50% or over (Kenny, Huntress, Buettgens, Lynch, & Resnick, 2013). Yet, even after the ACA is fully implemented in 2019, there will still be 24 million people uninsured (Woolhandler & Himmelstein, 2011). Different coverage provisions in the ACA will affect the uninsured in different income brackets differently, but they will all be affected by the new rules and regulations on insurance.

Individual Mandate & Health Insurance Reform

One of the most debated provisions of the ACA is known as the individual mandate, which requires most individuals to have qualifying health coverage or be subject to a tax penalty.

The United States Supreme Court has upheld the individual mandate provision as a proper exercise of the United States Constitution's power to tax. Individuals will not be forced to purchase health insurance but will be required to pay a penalty tax to the Internal Revenue Service if health insurance is not purchased (Supreme Court Upholds ACA's Individual Mandate, 2013). The tax in 2014 for adults will be the greater of one percent of income or \$95.13. Over time, the penalty will climb to the greater of \$695.00 or 2.5 percent of income up to the cost of the "average bronze plan premiums." The penalty for children will be one-half of that for adults. The family penalty is capped at 300% of the annual flat dollar amount. However, low-income individuals, religious objectors, prisoners, members of Native American tribes, and individuals who receive a hardship waiver will be exempted from the mandate (Parnet, 2011). Premium tax credits will be available to fund coverage for individuals up to 400% of the federal poverty rate (Supreme Court Upholds ACA's Individual Mandate, 2013).

Due to the ACA's insurance reforms, health insurance companies will be prohibited from denying coverage or charging more due to pre-existing conditions or health status. They are also now forbidden to cancel coverage to individuals that make large claims. Insurance companies must sell insurance to those willing to pay, regardless of their health status. The mandate is intended to prevent individuals from waiting to purchase health insurance until they are in need of health care. It seeks to prevent this by encouraging healthy individuals to purchase insurance before they should become ill, which will decrease the insurance company's risk and therefore lower costs. The individual mandate suggests that everyone with the financial means should accept the costs of joining the health insurance system (Parnet, 2011). The individual mandate is a significant part on the ACA, especially in regards to health policy.

The Health Insurance Exchanges will also be fully implemented in 2014. It is a provision of the ACA designed to ensure a more level competitive environment for insurers and to provide consumers with information on cost and quality to enable them to choose among plans. The law will prevent private insurance companies from denying coverage to people for any reason, including their health status (The Kaiser Family Foundation, 2012).

While some of the provisions still have not been implemented, other provisions have been in effect since shortly after the law was passed. One of the first implemented provisions of the Affordable Care Act allowed individuals up to the age of 26 to act as dependents on their parent's health insurance plan. The share of young adults that were uninsured decreased from 30.0% in 2010 to 27.9% in 2011. The change in coverage for this age group accounted for about 40% of the overall decline in the number of uninsured (The Kaiser Family Foundation, 2012). The ACA provision led to a fast and large increase in the amount of young adults with dependent coverage and a decrease in their uninsured rate in the early months of implementation. The ACA presented a successful effort to reduce the amount of uninsured individuals (Cantor et al, 2012). The largest gains in access to health care coverage have been those people who are unmarried, men, and nonstudents. It has been estimated that three million young adults have gained access to insurance due to this provision (Sommers, Buchmueller, Decker, Carey, & Kronick, 2013). With the increase in insured young adults, it can be assumed that hospitals experienced an increase in revenue for this age group (Cantor et al., 2012).

The Medicaid Expansion

Increasing the healthcare coverage of individuals who are considered low-income is one of the primary focuses of the ACA. Currently Medicaid is the country's largest public health insurance program for low-income Americans. It provides healthcare coverage to more than 62

million low-income children, families, seniors and people with disabilities. To qualify for Medicaid benefits, a person must meet certain financial standards. Federal law requires states to cover school age children up to 100% of the poverty rate. States are required to cover parents below states' 1996 welfare eligibility levels which are often below 50% of the federal poverty level. Medicaid beneficiaries are poorer and in worse health than the insured population. Without Medicaid, most beneficiaries would be uninsured. As the Affordable Care Act goes into effect, Medicaid will be the base for expanding health care coverage to many of the lowest income Americans (The Kaiser Family Foundation, 2012).

Starting in 2014, the ACA provides for the expansion of Medicaid eligibility to adults with incomes up to 138% of the poverty rate, largely with federal funding. Some states may not expand their Medicaid programs under the ACA. If a state does not expand Medicaid, adults in that state with incomes between 100% and 138% of the poverty rate will still be eligible for subsidies to purchase coverage through other new health insurance regulations, while those with incomes below 100% of the poverty rate will not be qualified for the subsidies and will not be covered by the provisions to expand coverage under the ACA (Kaiser Commission on Medicaid and the Uninsured, 2012). It is projected that total Medicaid/CHIP (Children's Health Insurance Program) enrollment under the ACA will rise from 48.3 million to 66.4 million. In Illinois, the Medicaid/CHIP enrollment is expected to increase over 33%, or by about 696,000 new enrollees (Kenny et al, 2013).

In 2012 the Supreme Court voted to uphold the Medicaid expansion within the law, but the Courts decision allows the expansion to be optional within the states. The Supreme Court's decision on the Medicaid expansion provision is expected to reduce the number of currently uninsured individuals who would have been covered in the future. Also, this decision will

reduce the number of newly insured individuals who will have coverage in hospitals and for their prescriptions.

In regards to hospitals, the ACA is unattractive because they were expecting more patients to be covered by Medicaid. While Medicaid payments are typically low, they are better than no payment at all. The ACA also includes large reductions in Medicare payments to hospitals for “disproportionate share” payments, which are payments to hospitals with large portions of Medicare and Medicaid patients. It is estimated that hospital revenue from these payers will continue to remain low due to the ACA (Carpenter, 2012).

CHAPTER THREE

METHODS

The purpose of this research was to determine what effect the individual mandate provision of the Affordable Care Act will have on nonprofit hospitals in Southern Illinois due to the number of uninsured individuals the hospitals treat. With the rising cost of health care and a large portion of Americans being uninsured, the newly implemented act is expected to change many aspects of health care. While this act will most certainly affect nonprofit hospitals in a variety of ways, the change in the operation due to the individual mandate and decrease in uninsured patients has been the concentration for this research. Since nonprofit hospitals are largely based on their ability to provide uncompensated health care, the number of uninsured patients treated will play a large role in the amount of health care services nonprofit hospitals provide. It will also likely influence the current cost of services at these hospitals. The information gained from this research has been compared to the current literature on this topic.

A mix of qualitative and quantitative questions was used for this research project in the form of an online survey to collect applicable and relevant data. The survey consisted of open-ended questions as well questions regarding statistical data of the hospitals. These surveys were given to hospital administrators from different nonprofit hospitals in Southern Illinois. Each hospital was contacted by phone to receive the email address of the appropriate hospital administrator where the survey would be sent. The respondents to the surveys were three Chief Financial Officers and one Executive Director of Qualified Health Plans. Southern Illinois is being defined as the counties located south of Interstate 64. This defined area includes twenty counties and a total of ten nonprofit hospitals (USA Hospitals, 2010). These hospitals were asked to cooperate in the form of an online survey. A qualitative approach was used to determine the views of the hospital administrators about the individual mandate provision of the

ACA. Questions were asked regarding their opinions regarding the ACA on the amount of future uncompensated care that will be provided and plans for treating the uninsured after the ACA is implemented. Quantitative questions asked were related to the insured rate of patients and the current amount of uncompensated care the hospitals provide. Responses were recorded in comparison to the other responses for each question. All responses were kept anonymous so that any negative responses would not damage the reputation of the hospital.

The Affordable Care Act has been met with a great deal of hostility since it passed in 2010. Because of the strong views that have been expressed concerning different elements of the act, I anticipated some reluctance to answer some of questions included in the survey. Also, organizations are not always eager to disclose financial information to individuals with whom they are not familiar. Since the current and future state of these hospitals was critical to the research it is important to retrieve this information. The surveys were provided through the online survey website, SurveyMonkey.com, with the hope that individuals would be able to fill out the survey at their convenience and feel more comfortable relaying the information than in an in person interview. Not all of the counties within the defined area of Southern Illinois have a nonprofit hospital. It was also expected that some hospital administrators would not be willing to participate. Information was gathered from as many of the nonprofit hospitals that were available and willing to participate. All survey questions are located in Appendix A.

CHAPTER FOUR

RESULTS AND DISCUSSION

There were ten non-profit hospitals in Southern Illinois that were asked to participate in the online survey regarding the effect of the ACA. Of those ten hospitals that were sent the survey, there were four responses. In order to keep the responses confidential, they will be referred to as “Hospital A”, “Hospital B”, “Hospital C”, and “Hospital D”. To determine the amount of patients that are treated at each hospital who are uninsured versus having insurance, each hospital was asked to provide the percentages of patients that are seen at their hospitals that have Medicare, Medicaid, private insurance, or are uninsured. For each of the hospitals, the percentage of patients that were treated that were on Medicare was the highest, between 42-51%. Also, the percentage of patients that were treated at the hospital that did not have insurance was the lowest for each of the hospitals, between 6-11%. All of the individual responses are located in Appendix B.

In response to the question, “Due to Illinois’s recent financial struggles, has this hospital suffered financially with payments from the state being late?” all the responses stated that their hospital had struggled to receive payments from the state that they were owed. Also, “Hospital A” and “Hospital B” stressed that the delays in payment from the state costs them money, affecting the amount of uncompensated care that can be provided. Respondents were asked what percentage of hospital revenue is given in uncompensated care and if the hospital expected a change in the amount of uncompensated care that will be provided due to the ACA. The responses to the percentage of hospital revenue that is given in uncompensated care ranged from 1.1-4.5%. Three of the hospitals, “Hospital A”, “Hospital C”, and “Hospital D”, did not expect a change in the amount of uncompensated care that will be provided due to the ACA. Yet, the literature states that ACA will strengthen the amount of uncompensated care nonprofit hospitals

can provide because organizations will be better able to locate subsidies for uncompensated care and increase subsidized services that affect public health (Principe et al, 2012). “Hospital B” does expect there to be a change in the amount of uncompensated care provided, but the amount of change expected was not reported.

The most shocking result of the survey is that none of the hospitals listed any way in which they were preparing to handle uninsured patients after the individual mandate is implemented. “Hospital A” and “Hospital B” stated that they do not expect there to be much of a change in regards to the number of uninsured patients that are treated at their hospital. These responses are surprising because it is expected that once the law has been fully implemented, the uninsured rate would decline by 47.1% nationally and the uninsured rate in Illinois is expected to decrease by 45.4% with every area in the state projected to decrease the uninsured rate by greater than 35% (Kenny, Huntress, Buettgens, Lynch, & Resnick, 2013). Therefore, the hospitals in Southern Illinois that responded to the survey should expect there to be some sort of change in the amount of uninsured patients treated at their hospital. Also, it would be wise for these hospitals to be prepared to handle the individuals that will still be without healthcare coverage once the ACA is fully implemented.

Some of the provisions of the ACA have already been implemented. One question on the survey asked if the hospital had seen any change in the number of patients with health insurance. If the response was yes, did it allow an increase in net revenue? “Hospital B” and “Hospital D” stated that they had seen an increase in the amount of patients with health insurance since the ACA was first implemented, but the amount of the increase was not provided. These hospitals also stated that it had caused an increase in net revenue, but the amount of the increase was also not provided. “Hospital A” and “Hospital C” both responded with a “No” for this particular

question. It can be assumed that hospitals experienced an increase in revenue since there has been an increase in the number of individuals that are insured (Cantor et al., 2012). Since the individual mandate provision of the ACA is expected to drastically change the healthcare system, the administrators were asked if their hospital had considered any policy changes due its implementation. “Hospital A” responded that they have not considered any policy changes. “Hospital B”, “Hospital C” and “Hospital D” all stated that policy changes are being considered but since no changes had been implemented, they did not feel comfortable explaining what would be included in the new policy change.

The implementation of the Affordable Care Act has been met with a great deal controversy since it passed in 2010. This may be the reason that some of the organizations were not offering a great deal of information about their future plans or how the ACA has affected their organization since it was implemented. Some reluctance to answer the questions included in the survey was anticipated. A limitation to the study is that only four of the ten hospitals that were contacted completed the survey. Each hospital was contacted more than once and asked to participate. Again, the lack of participation could be due to the controversy over the ACA. Another reason could be that the organizations are not always eager to divulge financial information. Participation from a greater number of hospitals with more in depth answers could have provided a more accurate portrait of how the ACA is expected to affect the non-profit hospitals in Southern Illinois.

CHAPTER FIVE

Policy Implications

This research paper intended to learn how the large number of uninsured patients has affected nonprofit hospitals in Southern Illinois and what influence the individual mandate will have on their future operations. The literature examined current publications on this topic and provided some information as to what hospitals and the American people can expect once the individual mandate has been implemented.

The survey of non-profit hospitals in Southern Illinois was intended to answer the questions raised during this research paper by asking questions regarding treatment of uninsured patients versus insured patients, recent financial troubles caused by the State of Illinois, the amount of uncompensated care provided, and future plans or changes for the hospital due to the implementation of the ACA. The Southern Illinois location was chosen for this research due to its high rate of uninsured and the limited access to nonprofit hospitals available in the region.

Four of the ten hospitals that were given the survey responded. They did not provide much insight into future operations within the hospital. The surveys did reveal that percentage of patients that were treated at the hospitals that were uninsured was between 6-11%. Once the ACA is fully implemented, the uninsured rate in Illinois is expected to decrease by 45.4%; therefore, the hospitals in Southern Illinois should expect a change in the amount of uninsured patients treated at their hospital. With the increase in the amount of insured patients, it can be assumed that hospitals will expect an increase in net revenue. It is also expected that the ACA will increase the amount of uncompensated care that non-profit hospitals can provide because they will be better able to locate subsidies and because of the increase in subsidized services that affect public health (Principe et al, 2012).

Since the major provisions of the ACA have not been implemented it is difficult to predict the positive and negative effects on nonprofit hospitals and the uninsured. This research could be explored in further detail roughly a year after the individual mandate has been implemented. One year from the implementation date will help determine the actual effect the provisions had on the uninsured and non-profit hospitals in Southern Illinois.

Although it is clear that there are substantial problems within our current healthcare system, the leaders within the healthcare field tend to have different opinions about what should be done to make improvements. One of the main goals of healthcare reform is to increase provider accountability. Some leaders have expressed making changes to provide patients with more information to ensure that providers are being held accountable for the care that they offer. Another goal is to reduce healthcare costs by between \$830 billion and \$1.2 trillion over the next decade (Grube and Kaufman, 2010). There have been discussions among healthcare leaders regarding the increasing costs of healthcare services and the potential for eliminating waste to help reduce these costs. With major provision of the ACA being implemented in a matter of months, healthcare leaders must come together to make healthcare reform successful and beneficial to the American people.

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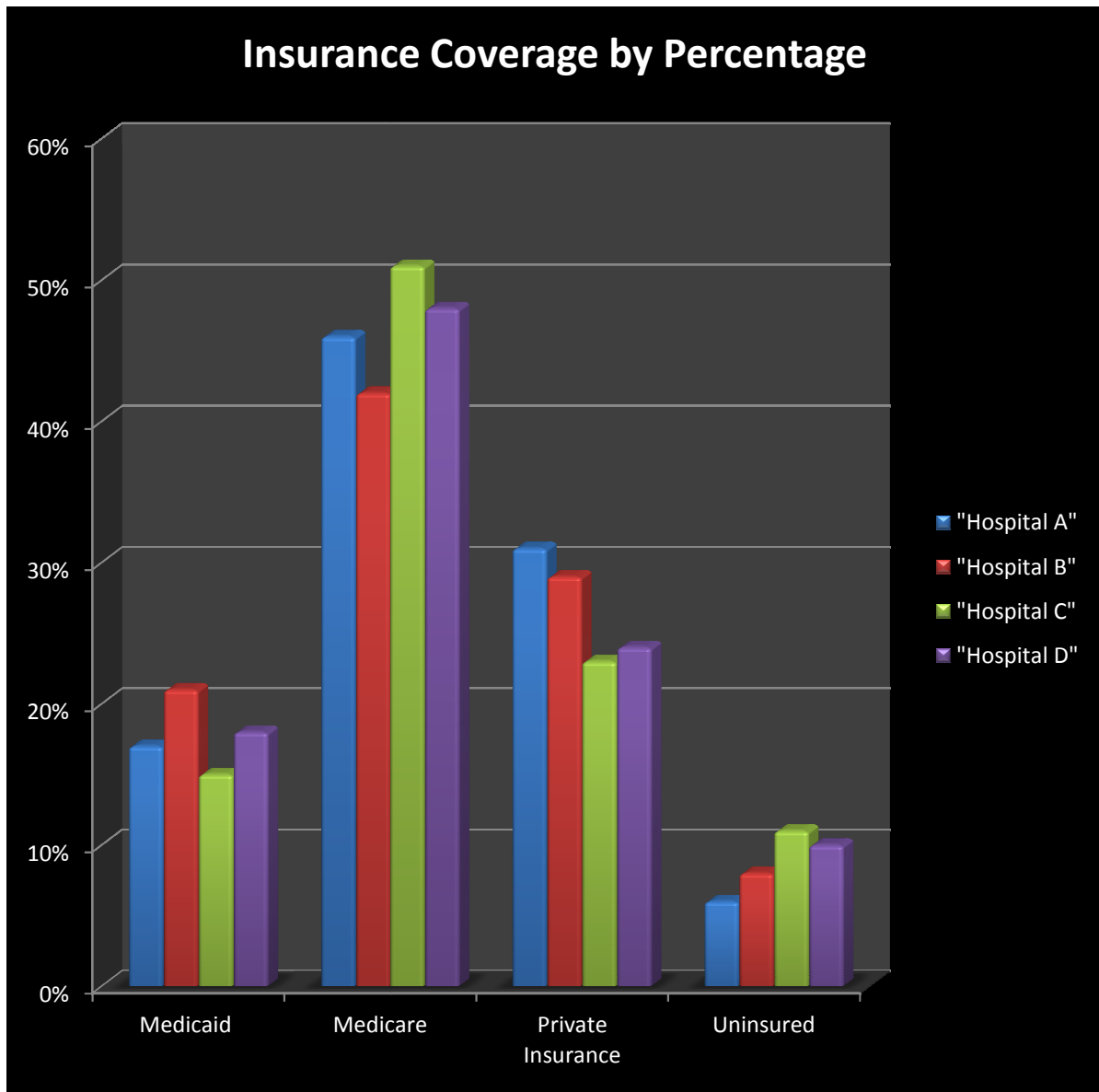
APPENDICES

APPENDIX A

Online Survey

1. Complete name of organization.
2. Position held at organization.
3. What percent of patients that are seen at this hospital do not have health insurance?
4. What percent of patients that are seen at this hospital are on Medicaid?
What percent of patients that are seen at this hospital are on Medicare?
What percent of patients that are seen at this hospital have private insurance?
5. Due to Illinois's recent financial struggles, has this hospital suffered financially with payments from the state being late?
6. What amount of uncompensated care is given annually by this hospital?
7. What percent of this hospital's revenue is given in uncompensated care? Does this hospital expect a change in the amount of uncompensated care that will be provided due to the ACA?
8. It is expected that even after the Affordable Care Act is fully implemented in 2019, there will still be an estimated 24 million people uninsured. What does this hospital expect to see in regards to the number of uninsured patients treated at this hospital after the individual mandate is implemented? How is this hospital prepared to handle uninsured patients even after the individual mandate is implemented?
9. With some of the provisions of the ACA already implemented, has this hospital seen a direct change in the number of patients with health insurance?
If yes, has this allowed an increase in annual net revenue?
10. Has this hospital considered any policy changes due to the implementation of the individual mandate provision?
If yes, please explain.

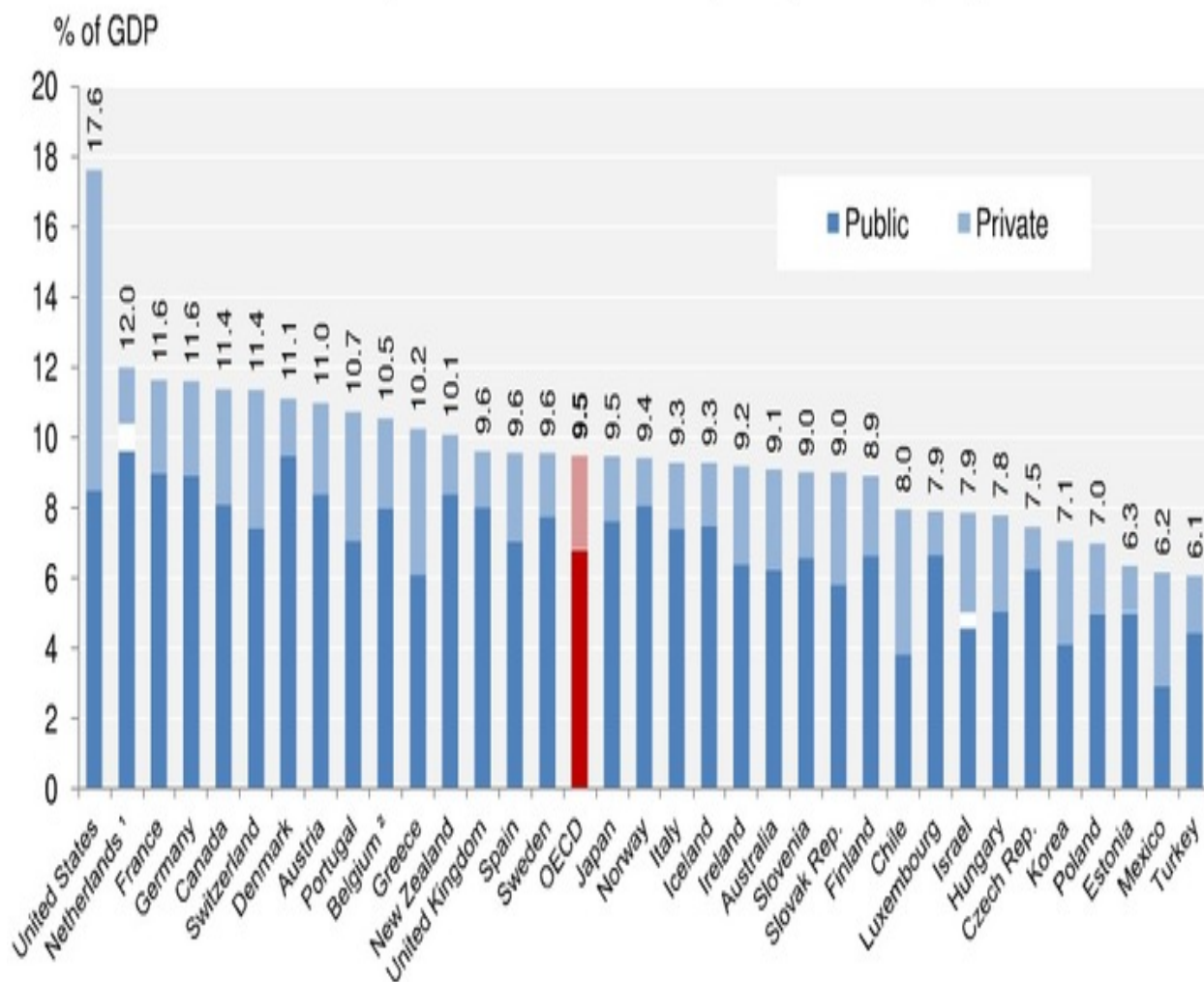
APPENDIX B



Appendix C

At 17.6% of GDP in 2010, US health spending is one and a half as much as any other country, and nearly twice the OECD average

Total health expenditure as a share of GDP, 2010 (or nearest year)



1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.

2. Total expenditure excluding investments.

Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2012.

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Major Professor: Dr. James Grant