

THE POTENTIAL IMPACT OF A MEDICARE PUBLIC OPTION ON U.S. RURAL HOSPITALS AND COMMUNITIES: A SCENARIO ANALYSIS

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August 2019

EXECUTIVE SUMMARY

A new analysis of U.S. rural hospitals has found that offering a government insurance program reimbursing at Medicare rates as a public option on the health insurance exchanges created by the Affordable Care Act (ACA) could place as many as 55% of rural hospitals, or 1,037 hospitals across 46 states, at high risk of closure. The rural hospitals at high risk represent more than 63,000 staffed beds and 420,000 employees, according to the analysis by Navigant Consulting, Inc. Even those rural hospitals not at high risk of closure and the communities they serve face an increased threat. The availability of a public option could negatively impact access to and quality of care through rural hospitals' potential elimination of services and reduction of clinical and administrative staff, as well as damage the economic foundation of the communities these hospitals serve.

The analysis incorporated three scenarios in which the availability of a Medicare public insurance option would induce a shift of patients from higher-paying commercial plans, driving down rural hospital net revenue and negatively impacting the communities they serve. Key results and implications from the study include:

1. Revenue loss to rural hospitals is projected to be 2.3% under a Medicare public option if only the uninsured and current individual market participants shift to the public option, placing an estimated 28% of rural hospitals at high risk of closure (Scenario 1).
2. If employers shift between 25% and 50% of their covered workers from commercial coverage to a Medicare public option, hospital revenues are projected to drop between 8% and 14% and cause an estimated 51% to 55% of rural hospitals to face high risk of closure, with an additional 39% to 41% facing moderate risk (Scenarios 2 & 3).
3. To keep hospitals whole from the financial consequences of any of these scenarios, Medicare would have to increase hospital payment levels for a public option between 40% and 60% above present Medicare rates, costing between \$4 billion and \$25 billion annually (depending on the severity of the employer shift).

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BACKGROUND

Rural hospitals are essential to the health and economic well-being of communities across the U.S., often representing a community's largest employer. As rural populations have declined, 108 rural hospitals have closed across 29 states since 2010.¹ Nine states had at least five rural hospital closures, including 17 in Texas and 12 in Tennessee. In a February 2019 study, Navigant found 21% of U.S. rural hospitals remain at high risk of closing unless their financial situations improve.² One factor driving the overall negative financial performance of rural hospitals is the losses they incur on government-covered business. Excluding critical access hospitals, rural hospitals have an approximately negative 8.2% operating margin on Medicare patients,³ creating a dependence on commercial patients and employers to make up the difference.

Rural hospital closures have a pervasive impact on their communities. Approximately half of rural counties already lack obstetric services,⁴ and rural Americans are nearly five times as likely to live in a county with a primary care physician shortage compared to other citizens.⁵ Rural hospitals are usually the only financial support for primary care physicians in small communities, and when a rural hospital closes, physicians and nurses leave the community. Moreover, when a rural community loses its hospital, per capita income falls 4% and the unemployment rate rises 1.6%.⁶

There is much discussion during this political cycle about various options for expanding the Medicare program as a way of addressing gaps in health insurance coverage. The most ambitious of these — Medicare for All — would replace present commercial insurance and Medicaid with Medicare, paying providers current Medicare rates.

Several less-sweeping alternatives to Medicare for All are being considered in Congress and discussed on the 2020 election campaign trail. One alternative is enabling people over the age of 55 to voluntarily buy in to Medicare, subsidizing the premium cost for those unable to afford it. There are other proposals that would enable a public option (paying providers at Medicare rates) on the ACA health exchanges. Because Medicare pays hospitals significantly less than commercial insurance and caps rates paid for care provided out of network, the cost of covering additional enrollees would be lower than if those individuals enrolled in existing private insurance exchange offerings while presenting other trade-offs.

In March 2019, Navigant examined the financial impact of all three of these expansion scenarios — Medicare for All, Medicare buy-in over age 55, and a public option reimbursing at Medicare rates — on a hypothetical, \$1.2 billion regional multihospital system.⁷ The study found significant financial harm to the hypothetical system from the Medicare public option, moving it from a positive 2.3% operating margin to operating losses ranging from 3.9% to 8.4% of revenues. Rural hospitals are much smaller than our hypothetical system and significantly more vulnerable to any reduction in revenues since they already have low volumes, little or no financial reserves, and negligible commercially insured patients.

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1. University of North Carolina Cecil G. Sheps Center for Health Services Research, "108 Rural Hospital Closures: January 2010 – Present," <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.
 2. David Mosley and Daniel DeBehnke, MD, "Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents," Navigant, February 2019, www.navigant.com/-/media/www/site/insights/healthcare/2019/navigant-rural-hospital-analysis-22019.pdf.
 3. Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2019, http://medpac.gov/docs/default-source/reports/mari19_medpac_entirereport_sec.pdf?sfvrsn=0.
 4. P. Hung et al., "Access To Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004-14," Health Affairs, September 2017, <https://www.ncbi.nlm.nih.gov/pubmed/28874496>.
 5. "Addressing the Nation's Primary Care Shortage," UnitedHealth Group, September 2018, <https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2018/UHG-Primary-Care-Report-2018.pdf>.
 6. George M. Holmes et al., "The Effect of Rural Hospital Closures on Community Economic Health," Health Services Research, April 2006, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702512/>.
 7. Jeff Goldsmith, Jeff Leibach, and Kurt Eicher, "Medicare Expansion: A Preliminary Analysis of Hospital Financial Impacts," Navigant, March 2019, <https://www.navigant.com/-/media/www/site/insights/healthcare/2019/medicare-expansion.pdf>.

ANALYSIS METHODOLOGY

Navigant was engaged by the Partnership for America's Health Care Future to quantify the potential financial impact of various public option scenarios on 1,898 rural critical access hospital and short-term acute care rural hospital revenues. We focused our analysis on rural hospitals since they are thinly capitalized and have the smallest margin for error in their cash flows of any hospitals, and since their communities are heavily dependent on them.

SCENARIOS AND ASSUMPTIONS

Navigant tested the following three options for extending access to Medicare through public health exchanges:

- Scenario No. 1: "Individual Market Only, Leakproof Employer Market" — Eighty-five percent of individually-covered commercial lives move from commercial exchange plans to the public option. Zero lives covered under employer-sponsored health plans move to the public option, and 10% of uncompensated care costs are recouped as reduced bad debt write-offs from high-deductible health plans (HDHPs).
- Scenario No. 2: "Minor Employer Shift to Public Option" — In addition to the individual market shift in Scenario 1, 25% of lives covered under employer-sponsored health plans move to the public option, and 15% of uncompensated care costs are recouped as bad debt write-offs from HDHPs.
- Scenario No. 3: "Major Employer Shift to the Public Option" — Fifty percent of lives covered under employer-sponsored health plans move to the public option, and 20% of uncompensated care costs are recouped as bad debt write-offs from HDHPs. Given the larger shift to the public option in this scenario, we increased the assumption for reduced uncompensated care costs since a larger group will be moving off HDHPs. Furthermore, 85% of individual lives move from commercial insurance to the public option.

In addition, each of these scenarios included calculated assumptions for the following variables:

1. The distribution of hospitals' commercial revenue between employer-sponsored and individual plans was assumed to be 86% and 14%, respectively.⁸
2. The degree to which hospitals' uncompensated care costs from commercially covered self-pay would be reduced for patients newly covered by the public option with more generous deductibles.
3. Twenty-two percent of uninsured patients were estimated to select the public option, reducing charity care write-offs by the same measure. This assumption is based on a study concluding that approximately 5.9 million uninsured lives (out of 26.8 million uninsured eligible) would select a new public option.⁹

These scenarios were then used to extend Navigant's February 2019 rural hospital analysis to examine how they would affect hospital closure risk. Based on Navigant's experience, hospitals need 4% operating margins for long-term viability. For the purposes of our new analysis, we assumed that a hospital at medium risk of closure that experienced a 4% or greater expected revenue loss would move into the high-risk category. Similarly, a 10% or greater revenue loss would move a previously categorized low-risk facility to the high-risk pool. These broad ranges reflect the high level of uncertainty that exists in financial viability for rural hospitals. A more than 10% revenue reduction would be difficult for most hospitals to recover from without massive reduction in their scope of services or merger with a larger system.

8. 2018 U.S. census data from CPS Table Creator, Navigant Analysis.

9. Lane Koenig et al., KNG Health Consulting LLC, "The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals," March 12, 2019, <https://impact.americashealthcarefuture.org/wp-content/uploads/2019/03/KNG-Health-The-Impact-of-Medicare-X-Choice-Final-Report-03122019.pdf>.

ANALYSIS RESULTS

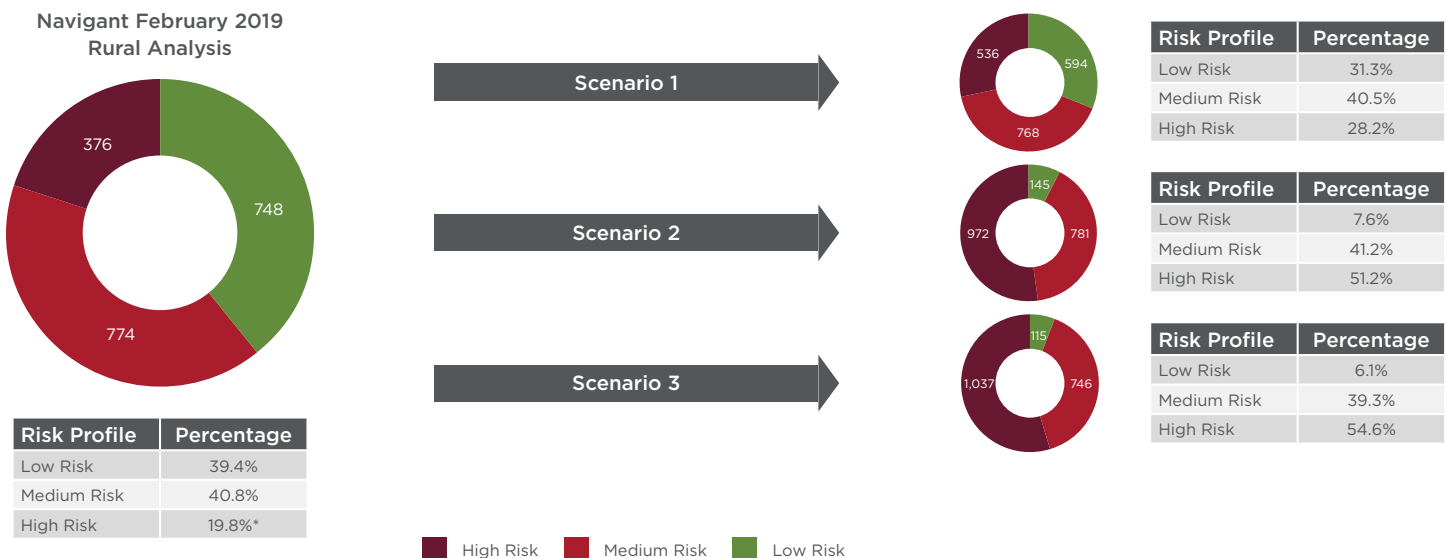
The analysis estimates that financial harm (Figure 1) to rural hospitals would range from \$4.2 billion nationally in Scenario 1 (a 2.3% revenue reduction) to a \$25.6 billion revenue loss under Scenario 3 (a 14% revenue reduction). The difference between the scenarios is primarily driven by the large shift in covered lives from the employer market to the public option. While these were the aggregate results, the impacts were not uniform across hospitals, and we further explore those dynamics below.

Figure 1: Financial Impact on Rural Hospitals by Hospital Type

Hospital Type	Number of Hospitals	Scenario 1 — 0% Leakage		Scenario 2 — 25% Leakage		Scenario 3 — 50% Leakage	
		Net Impact — Dollars	Net Impact — % of Revenue	Net Impact — Dollars	Net Impact — % of Revenue	Net Impact — Dollars	Net Impact — % of Revenue
Critical Access Hospital	1,043	-\$909,118,317	-3.1%	-\$3,082,656,271	-10.6%	-\$5,256,194,224	-18.1%
Short-Term Acute Care Hospital	855	-\$3,317,186,027	-2.1%	-\$11,849,840,759	-7.5%	-\$20,382,495,490	-12.9%
Total Impact	1,898	-\$4,226,304,344	-2.3%	-\$14,932,497,030	-8.1%	-\$25,638,689,714	-13.9%

Using the risk classifications described in the methodology section, and leveraging the initial classifications from the February Navigant study, we project that as many as 55% of rural hospitals — or 1,037 hospitals across 46 states — could be at high risk of closure under Scenario 3 (Figures 2 & 3). These hospitals represent 63,425 staffed beds, 420,000 employees, and \$51.4 billion in total commercial revenue before considering the impacts of the introduction of public option policy. Even under Scenario 1, where revenue impact is more limited, more than 28% of rural hospitals will be at a high risk of closure.

Figure 2: Revenue Impacts Shift Majority of Rural Hospitals to High Risk



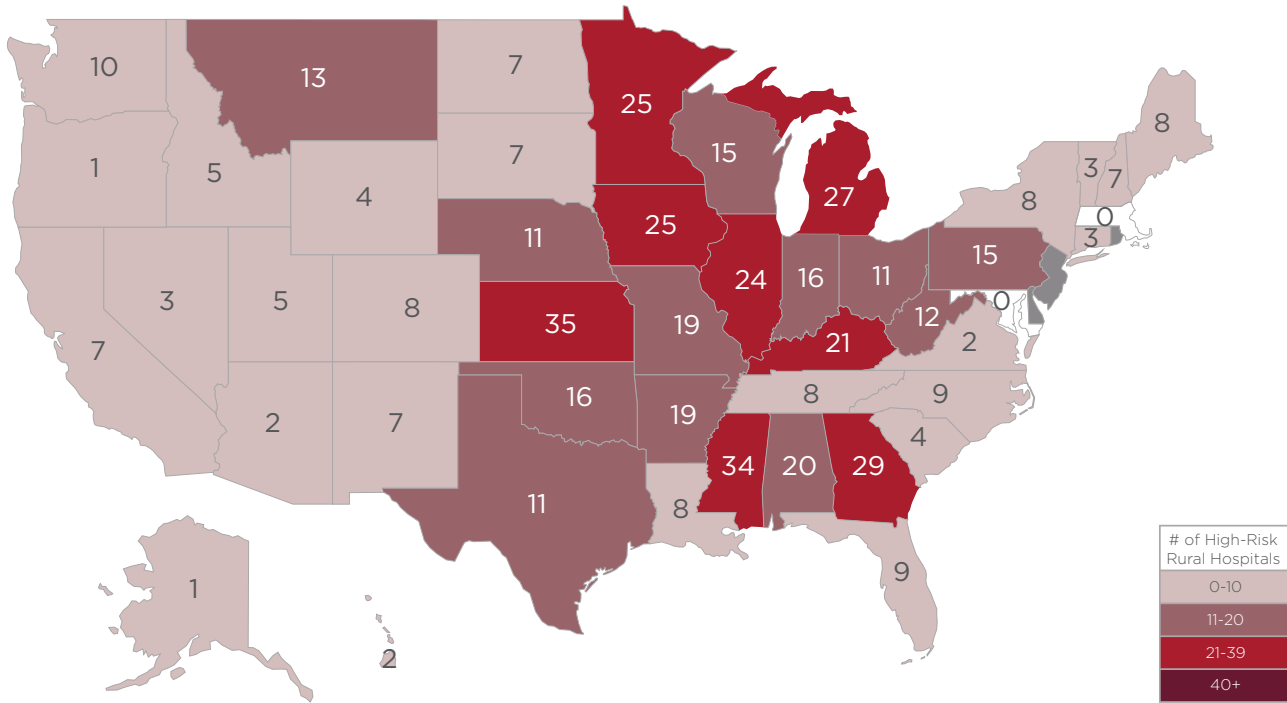
*Criteria applied in the current analysis resulted in some hospitals from Navigant's February 2019 rural analysis being excluded. This led to a lower proportion of high-risk rural hospitals (19.8% vs. 21%) as a percentage of hospitals analyzed.

The following figures show the number of hospitals that fall into the high-risk category by state for each of the three scenarios that Navigant modeled. For a more detailed breakdown of the revenue and facility impacts by state, see Appendix at the end of this document.

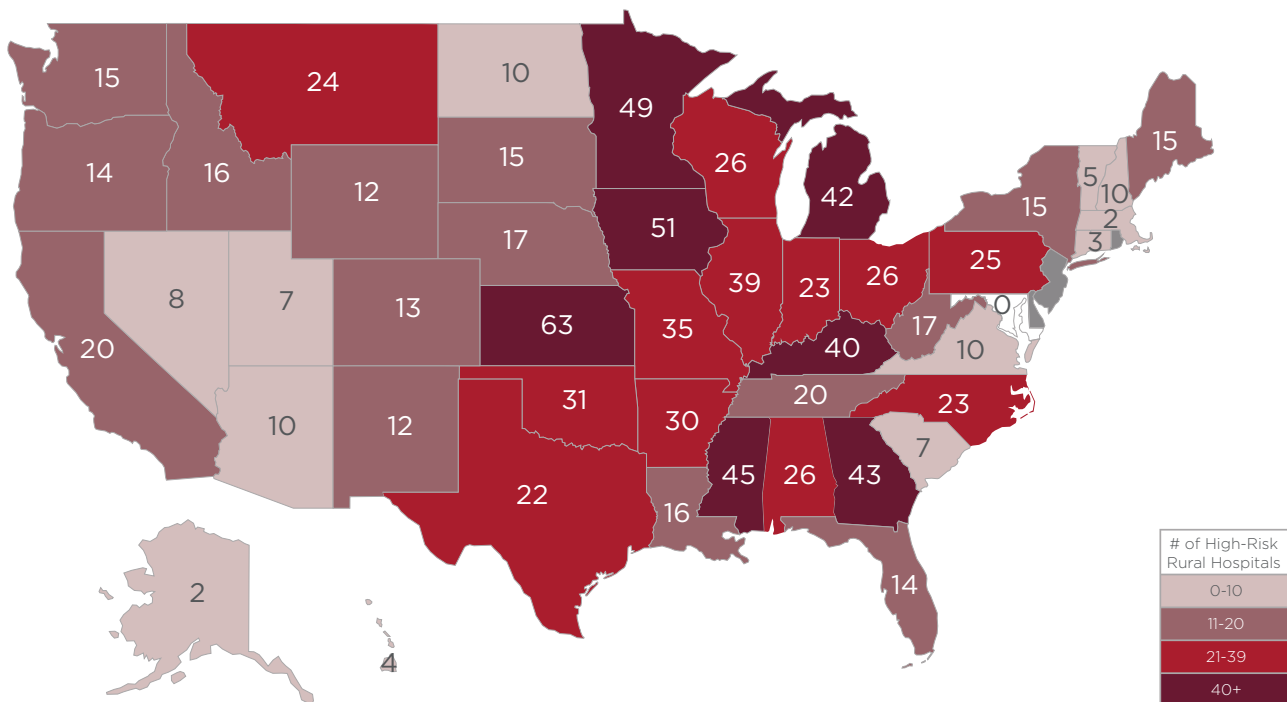
Figure 3: High-Risk Rural Hospitals by State, Scenarios 1-3*

*DE, NJ, and RI have no qualifying rural hospitals.

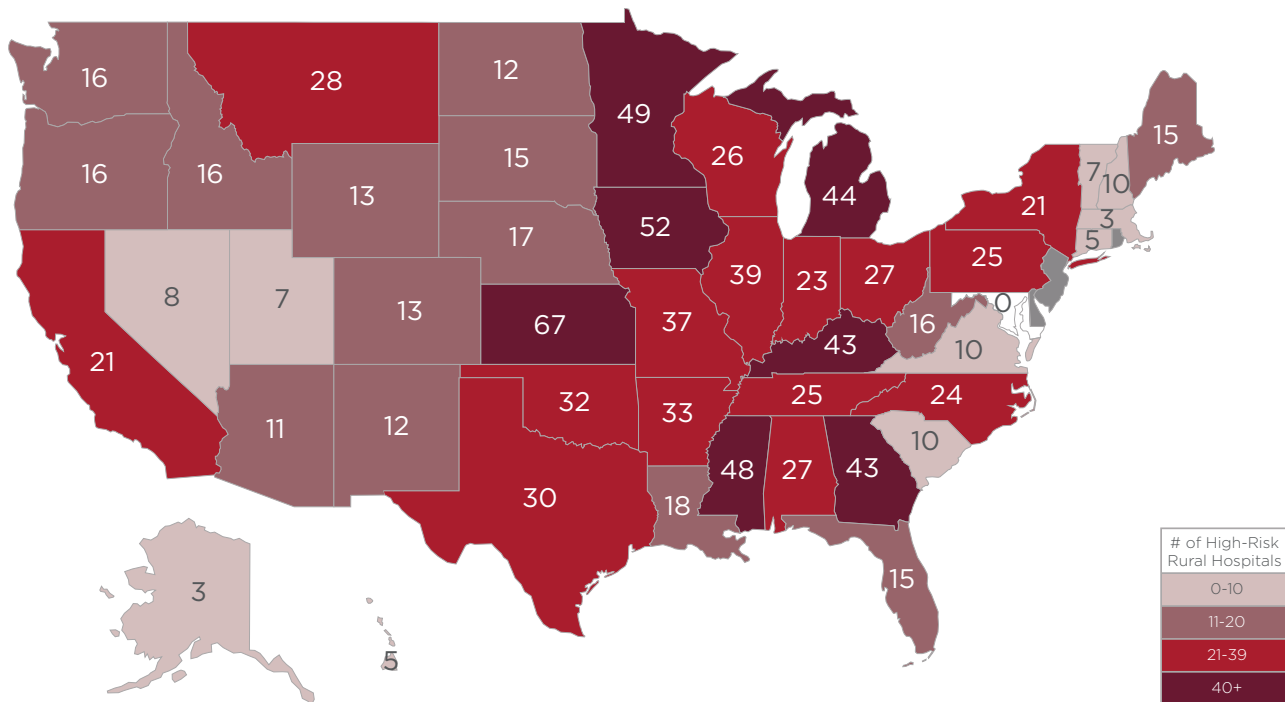
Scenario 1



Scenario 2



Scenario 3



IMPLICATIONS FOR RURAL HOSPITALS AND COMMUNITIES

1. Rural hospitals at high financial risk of closure would likely be compelled to take steps to mitigate the impact, including actions that would reduce access to and quality of care. These actions might include closure of services and satellite facilities, downgrading of emergency services, and termination of clinical and administrative staff. Given the increasing number of rural hospitals at high financial risk, as shown by our analysis, more rural communities throughout the country will likely be impacted by these decisions.
2. While the magnitude of the adverse impact on rural hospitals of the Medicare public option is directly related to the magnitude of the shift of employer-covered lives to Medicare, financial harm to rural hospitals exists in all scenarios, even in the scenario in which only the uninsured and individual market participants select the Medicare public option (Scenario 1).
3. As employer-covered lives shift to the public option (Scenarios 2 and 3), care for a much larger group of formerly commercially insured patients would be paid for at Medicare rates. This results in estimated double-digit revenue reductions with commensurate significant harm to rural hospitals.
4. Current proposals for a 25% rate premium over Medicare rates for rural hospital payments on the public option fall short of covering the revenue reductions from reduced commercial patient volume. According to this analysis, Medicare rates would have to increase 40% in Scenario 1, 56% in Scenario 2, and 60% in Scenario 3 above present levels to hold rural hospitals harmless from the loss of commercial volume. This could increase the cost of the proposed Medicare public option by up to \$25 billion per year.
5. If rural hospitals were not “held harmless,” the number of high-risk hospitals would increase from the 21% level reported in Navigant’s February 2019 study to between 28% and 55% across the three scenarios, increasing the risk of closures and disruption of care for rural patients. In Scenarios 2 and 3, only 7.6% and 6.1% of rural hospitals, respectively, would not be at some elevated risk of closure.

The least harmful scenario for rural hospitals and communities remains the leakproof scenario that prevents employers from pushing their workers into the public option. The most efficient way to do this would be a robust employer mandate or significant restrictions on eligibility for the public option. Without these types of restrictions, we inevitably end up with financial outcomes closer to Scenarios 2 and 3. Overall, it is reasonable to expect some degree of employer shift, regardless of policy-based attempts to reduce this impact.

CONCLUSION

The implementation of a Medicare public option on health exchanges presents significant risks to rural hospitals and communities nationwide. Our modeling indicates negative revenue impacts for all three scenarios. Financial harm to rural hospitals escalates rapidly as the proportion of lives that move from employer-sponsored coverage to the public option increases. Potential capture of revenues presently lost to charity care to the uninsured and uncompensated care from those in high-deductible plans are negligible compared to the loss of commercial revenue.

Even with a conservative estimate of the shift in commercial lives, the Medicare public option would exacerbate the already significant financial risks rural hospitals face. If a substantial percentage of the commercial population were to shift to reimburse at Medicare rates, a large proportion of high-risk hospitals would see a grave threat to their viability, and hundreds of rural hospitals presently at lower levels of risk would move to the high-risk category.

These results have serious implications not only for individual hospitals themselves but for access to care for rural residents, as well as the economic base of communities, where the hospital is often the largest employer.

APPENDIX: RURAL HOSPITAL SCENARIO IMPACTS BY STATE

Rural Hospital Revenue Impact by State — Scenario 1

STATE	RURAL HOSPITALS	NET IMPACT	IMPACT %
CA	45	-\$480.9M	-3.9%
PA	43	-\$456.0M	-3.6%
WI	73	-\$308.2M	-3.7%
NY	48	-\$264.8M	-1.6%
IL	78	-\$222.8M	-1.9%
MN	86	-\$189.2M	-3.5%
OH	64	-\$184.5M	-2.1%
MI	74	-\$175.5M	-1.3%
NC	45	-\$159.1M	-2.0%
KY	66	-\$126.9M	-2.6%
AZ	28	-\$125.2M	-1.7%
MO	60	-\$111.9M	-2.5%
WA	37	-\$94.9M	-3.3%
IN	39	-\$94.9M	-3.9%
CO	38	-\$87.6M	-4.1%
NE	45	-\$79.5M	-4.2%
KS	84	-\$78.6M	-3.2%
IA	90	-\$77.7M	-2.3%
GA	63	-\$75.9M	-2.3%
NH	17	-\$70.5M	-2.9%
ND	24	-\$63.8M	-3.2%
MT	47	-\$63.1M	-2.6%
OR	27	-\$58.5M	-2.3%
SD	36	-\$58.0M	-3.6%

STATE	RURAL HOSPITALS	NET IMPACT	IMPACT %
ME	20	-\$50.4M	-2.5%
MS	61	-\$50.2M	-1.4%
VA	20	-\$46.5M	-2.2%
NM	22	-\$45.4M	-1.9%
WV	26	-\$40.8M	-2.5%
SC	17	-\$40.8M	-1.6%
ID	25	-\$36.5M	-2.8%
CT	6	-\$31.8M	-0.7%
WY	19	-\$29.6M	-3.1%
AR	48	-\$29.6M	-1.4%
UT	14	-\$24.7M	-4.2%
MA	5	-\$23.6M	-2.8%
OK	50	-\$23.0M	-0.8%
FL	21	-\$22.3M	-1.6%
VT	12	-\$22.2M	-2.0%
NV	13	-\$18.1M	-4.8%
TN	37	-\$17.5M	-0.6%
HI	10	-\$10.2M	-1.7%
AK	8	-\$8.1M	-1.6%
AL	40	-\$6.9M	-0.5%
LA	45	-\$6.9M	-0.5%
MD	5	\$7.6M	0.8%
TX	117	\$59.3M	1.0%
Grand Total	1,898	-\$4.2B	-2.3%

High-Risk Rural Hospitals by State — Scenario 1

STATE	HIGH-RISK RURAL HOSPITALS	% OF HIGH-RISK RURAL HOSPITALS
KS	35	41.7%
MS	34	55.7%
GA	29	46.0%
MI	27	36.5%
MN	25	29.1%
IA	25	27.8%
IL	24	30.8%
KY	21	31.8%
AL	20	50.0%
AR	19	39.6%
MO	19	31.7%
IN	16	41.0%
OK	16	32.0%
PA	15	34.9%
WI	15	20.5%
MT	13	27.7%
WV	12	46.2%
NE	11	24.4%
OH	11	17.2%
TX	11	9.4%
WA	10	27.0%
FL	9	42.9%
NC	9	20.0%
ME	8	40.0%

STATE	HIGH-RISK RURAL HOSPITALS	% OF HIGH-RISK RURAL HOSPITALS
TN	8	21.6%
CO	8	21.1%
LA	8	17.8%
NY	8	16.7%
NH	7	41.2%
NM	7	31.8%
ND	7	29.2%
SD	7	19.4%
CA	7	15.6%
UT	5	35.7%
ID	5	20.0%
SC	4	23.5%
WY	4	21.1%
CT	3	50.0%
VT	3	25.0%
NV	3	23.1%
HI	2	20.0%
VA	2	10.0%
AZ	2	7.1%
AK	1	12.5%
OR	1	3.7%
MA	0	0.0%
MD	0	0.0%
Grand Total	536	28.2%

Rural Hospital Revenue Impact by State — Scenario 2

STATE	RURAL HOSPITALS	NET IMPACT	IMPACT %
CA	45	-\$1467.1M	-11.9%
PA	43	-\$1427.1M	-11.4%
WI	73	-\$951.4M	-11.3%
NY	48	-\$936.5M	-5.7%
IL	78	-\$780.7M	-6.6%
OH	64	-\$703.6M	-7.9%
NC	45	-\$626.7M	-7.9%
MI	74	-\$595.5M	-4.5%
MN	86	-\$584.1M	-10.7%
AZ	28	-\$452.6M	-6.3%
MO	60	-\$414.6M	-9.2%
KY	66	-\$403.0M	-8.3%
IN	39	-\$312.1M	-12.7%
GA	63	-\$311.1M	-9.2%
WA	37	-\$307.1M	-10.6%
IA	90	-\$276.9M	-8.3%
CO	38	-\$269.8M	-12.7%
KS	84	-\$253.9M	-10.3%
NE	45	-\$249.6M	-13.2%
NH	17	-\$227.3M	-9.5%
CT	6	-\$226.6M	-5.0%
MS	61	-\$223.3M	-6.2%
OR	27	-\$205.8M	-8.2%
ND	24	-\$202.2M	-10.2%

STATE	RURAL HOSPITALS	NET IMPACT	IMPACT %
MT	47	-\$202.1M	-8.3%
SD	36	-\$187.0M	-11.5%
VA	20	-\$183.5M	-8.7%
SC	17	-\$173.6M	-6.7%
ME	20	-\$170.2M	-8.6%
OK	50	-\$157.3M	-5.6%
NM	22	-\$154.5M	-6.5%
WV	26	-\$139.5M	-8.5%
TX	117	-\$133.9M	-2.3%
TN	37	-\$131.3M	-4.2%
ID	25	-\$126.8M	-9.9%
AR	48	-\$117.3M	-5.7%
FL	21	-\$111.4M	-8.1%
WY	19	-\$99.6M	-10.6%
VT	12	-\$78.8M	-7.1%
UT	14	-\$76.4M	-12.9%
MA	5	-\$73.9M	-8.8%
NV	13	-\$57.9M	-15.2%
LA	45	-\$52.4M	-3.5%
AL	40	-\$46.1M	-3.6%
HI	10	-\$34.7M	-5.7%
AK	8	-\$29.4M	-5.6%
MD	5	\$13.4M	1.5%
Grand Total	1,898	-\$14.9B	-8.1%

High-Risk Rural Hospitals by State — Scenario 2

STATE	HIGH-RISK RURAL HOSPITALS	% OF HIGH-RISK RURAL HOSPITALS
KS	63	75.0%
IA	51	56.7%
MN	49	57.0%
MS	45	73.8%
GA	43	68.3%
MI	42	56.8%
KY	40	60.6%
IL	39	50.0%
MO	35	58.3%
OK	31	62.0%
AR	30	62.5%
AL	26	65.0%
OH	26	40.6%
WI	26	35.6%
PA	25	58.1%
MT	24	51.1%
IN	23	59.0%
NC	23	51.1%
TX	22	18.8%
TN	20	54.1%
CA	20	44.4%
WV	17	65.4%
NE	17	37.8%
ID	16	64.0%

STATE	HIGH-RISK RURAL HOSPITALS	% OF HIGH-RISK RURAL HOSPITALS
LA	16	35.6%
ME	15	75.0%
SD	15	41.7%
WA	15	40.5%
NY	15	31.3%
FL	14	66.7%
OR	14	51.9%
CO	13	34.2%
WY	12	63.2%
NM	12	54.5%
NH	10	58.8%
VA	10	50.0%
ND	10	41.7%
AZ	10	35.7%
NV	8	61.5%
UT	7	50.0%
SC	7	41.2%
VT	5	41.7%
HI	4	40.0%
CT	3	50.0%
MA	2	40.0%
AK	2	25.0%
MD	0	0.0%
Grand Total	972	51.2%

Rural Hospital Revenue Impact by State — Scenario 3

STATE	RURAL HOSPITALS	NET IMPACT	IMPACT %
CA	45	-\$2453.2M	-19.9%
PA	43	-\$2398.1M	-19.1%
NY	48	-\$1608.1M	-9.7%
WI	73	-\$1594.6M	-19.0%
IL	78	-\$1338.5M	-11.3%
OH	64	-\$1222.8M	-13.7%
NC	45	-\$1094.3M	-13.8%
MI	74	-\$1015.4M	-7.6%
MN	86	-\$978.9M	-17.9%
AZ	28	-\$779.9M	-10.8%
MO	60	-\$717.2M	-16.0%
KY	66	-\$679.0M	-14.0%
GA	63	-\$546.3M	-16.2%
IN	39	-\$529.4M	-21.6%
WA	37	-\$519.4M	-17.9%
IA	90	-\$476.1M	-14.3%
CO	38	-\$452.1M	-21.2%
KS	84	-\$429.1M	-17.5%
CT	6	-\$421.5M	-9.3%
NE	45	-\$419.6M	-22.1%
MS	61	-\$396.4M	-10.9%
NH	17	-\$384.0M	-16.0%
OR	27	-\$353.0M	-14.1%
MT	47	-\$341.0M	-14.0%

STATE	RURAL HOSPITALS	NET IMPACT	IMPACT %
ND	24	-\$340.6M	-17.1%
TX	117	-\$327.0M	-5.6%
VA	20	-\$320.5M	-15.2%
SD	36	-\$315.9M	-19.4%
SC	17	-\$306.3M	-11.7%
OK	50	-\$291.7M	-10.4%
ME	20	-\$290.1M	-14.6%
NM	22	-\$263.7M	-11.0%
TN	37	-\$245.1M	-7.8%
WV	26	-\$238.2M	-14.6%
ID	25	-\$217.1M	-16.9%
AR	48	-\$205.1M	-9.9%
FL	21	-\$200.6M	-14.5%
WY	19	-\$169.5M	-18.0%
VT	12	-\$135.4M	-12.3%
UT	14	-\$128.2M	-21.6%
MA	5	-\$124.1M	-14.7%
LA	45	-\$98.0M	-6.6%
NV	13	-\$97.7M	-25.7%
AL	40	-\$85.2M	-6.6%
HI	10	-\$59.3M	-9.6%
AK	8	-\$50.7M	-9.7%
MD	5	\$19.3M	2.1%
Grand Total	1,898	-\$25.6B	-13.9%

High-Risk Rural Hospitals by State — Scenario 3

STATE	HIGH-RISK RURAL HOSPITALS	% OF HIGH-RISK RURAL HOSPITALS
KS	67	79.8%
IA	52	57.8%
MN	49	57.0%
MS	48	78.7%
MI	44	59.5%
GA	43	68.3%
KY	43	65.2%
IL	39	50.0%
MO	37	61.7%
AR	33	68.8%
OK	32	64.0%
TX	30	25.6%
MT	28	59.6%
AL	27	67.5%
OH	27	42.2%
WI	26	35.6%
TN	25	67.6%
PA	25	58.1%
NC	24	53.3%
IN	23	59.0%
CA	21	46.7%
NY	21	43.8%
LA	18	40.0%
NE	17	37.8%

STATE	HIGH-RISK RURAL HOSPITALS	% OF HIGH-RISK RURAL HOSPITALS
ID	16	64.0%
WV	16	61.5%
OR	16	59.3%
WA	16	43.2%
ME	15	75.0%
FL	15	71.4%
SD	15	41.7%
WY	13	68.4%
CO	13	34.2%
NM	12	54.5%
ND	12	50.0%
AZ	11	39.3%
NH	10	58.8%
SC	10	58.8%
VA	10	50.0%
NV	8	61.5%
VT	7	58.3%
UT	7	50.0%
CT	5	83.3%
HI	5	50.0%
MA	3	60.0%
AK	3	37.5%
MD	0	0.0%
Grand Total	1,037	54.6%

Acknowledgments: This work was supported by the Partnership for America's Health Care Future.

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