

STIFFENING HEADWINDS CHALLENGE HEALTH SYSTEMS TO GROW SMARTER

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EXECUTIVE SUMMARY

In an analysis of a three-year sample of the financial disclosures of 104 prominent health systems operating 47% of U.S. hospitals, Navigant Consulting, Inc. found broad-based and significant deterioration of operating earnings. Two-thirds of the health systems in the sample saw operating income decline from FY 2015 to FY 2017. Moreover, 27% lost money on operations in at least one of the three years, and 11% had negative margins across all three years. The total erosion for systems with operating earnings declines was \$6.8 billion, a 44% reduction. The main cause: hospitals' expenses grew by 3 percentage points faster than their revenues from 2015 to 2017. To reverse this operating performance decline, hospitals must achieve both strategic clarity regarding their growth and transformation investments, and improved operating discipline in a markedly tougher environment.

INTRODUCTION

The past decade has been a roller-coaster ride for U.S. health systems. The recession of 2008 put tremendous pressure on hospital performance, increasing the number of uninsured and triggering changes in private health coverage that exposed them to patient nonpayment of bills. Then, in 2010, Congress approved the Affordable Care Act (ACA), which added more than 21 million people to coverage between 2014 and 2015.

However, in the ensuing three years, health systems experienced softening demand for their core services and reduced revenue growth. At the same time, despite significant expense reductions in many systems, operating expenses grew at an unsustainably higher rate from 2015 to 2017, diminishing operating earnings. This study seeks to understand the magnitude of these impacts, and provide clues to how health systems can improve their performance.

METHODOLOGY

Navigant obtained the audited financial reports for 104 leading health systems from their filings in the Municipal Securities Rulemaking Board Electronic Municipal Market Access (EMMA) database.¹ These systems operate roughly 47% of the nation's community hospitals, or 2,289 hospitals. We extracted from their filings the operating income and operating revenues for fiscal years 2015, 2016, and 2017, and analyzed the trends in operating margins, both for individual systems and for regions of the country. Operating revenue changes reflect both additions to and subtractions from health system holdings due to mergers or divestitures (that is, they are not "same store"). For the specifics of our methodology, please see the Appendix of this report.

1. Municipal Securities Rulemaking Board, EMMA Database, 2018, <https://emma.msrb.org/>.

RESULTS

Health System Financial Performance Deteriorated Sharply Post-ACA

Health system operating margins in our sample dropped by 38.7% from 2015 to 2017, the two full years that followed the ACA coverage expansion (Figure 1). Not-for-profit system margins fell by 34%, while for-profit system margins fell by 39% (Figure 2).

Figure 1: Average Operating Margin by Fiscal Year (2015-2017)

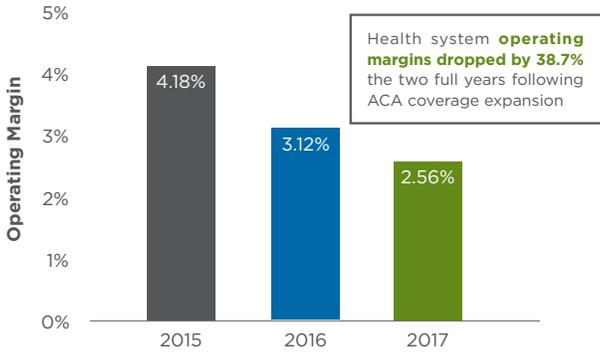
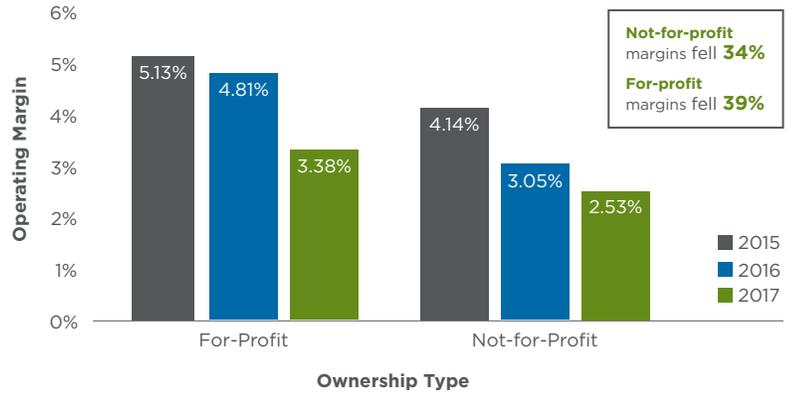


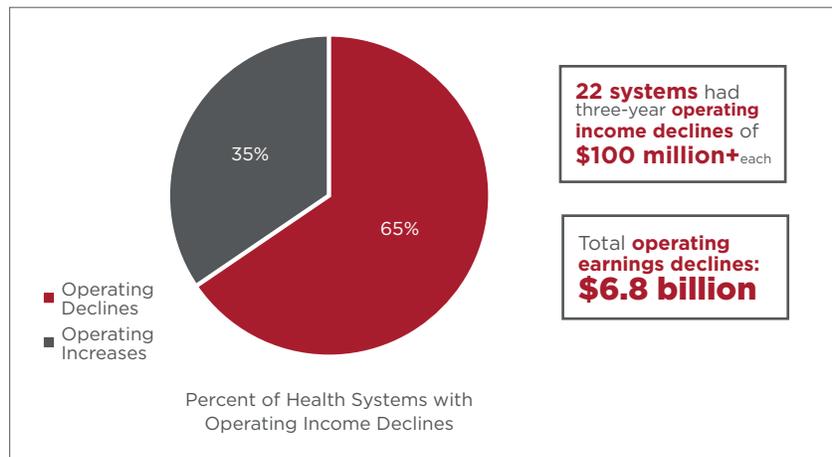
Figure 2: Average Operating Margin by Health System Type (FY 2015-2017)



Source: Navigant

Two-thirds of the health systems in the sample saw operating income decline from FY 2015 to FY 2017. Twenty-two of these health systems had three-year operating income declines of more than \$100 million each. Moreover, 27% lost money on operations in at least one of the three years, and 11% had negative margins across all three years. The total erosion for these systems with operating earnings declines was \$6.8 billion, a 44% reduction from 2015-2017 (Figure 3).

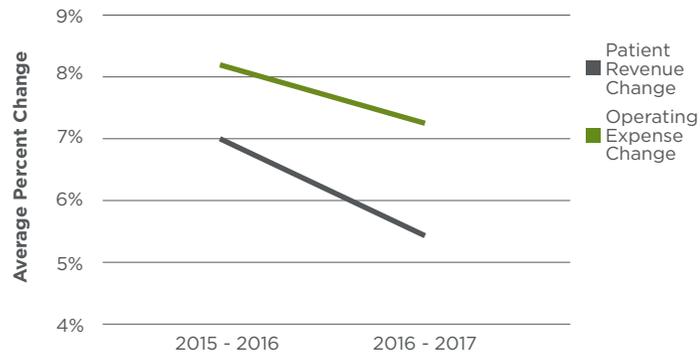
Figure 3: Health System Operating Income Declines (2015-2017)



Source: Navigant

At the root of these declines were multiyear reductions in the rate of revenue growth. Top-line operating revenue growth fell from 7% (2015 to 2016) to only 5.5% from (2016 to 2017) (Figure 4). While many of these systems had major expense reduction initiatives underway, they did not keep pace with revenue declines, as expense growth still exceeded revenue growth by 3 full percentage points over the three-year span.

Figure 4: Net Patient Revenue and Operating Expense Change by FY (2015-2017)



The 2016 data point represents the percent change from FY 2015 to 2016

Source: Navigant

Declines Affecting For- and Not-for-Profits, Large and Small, Market Leaders and Followers Alike

Neither scale nor market dominance immunized health systems against declines in operating earnings. Three of the six largest declines in operating income came from the three largest for-profit systems, the smallest of which had over \$15 billion in 2017 operating revenues.

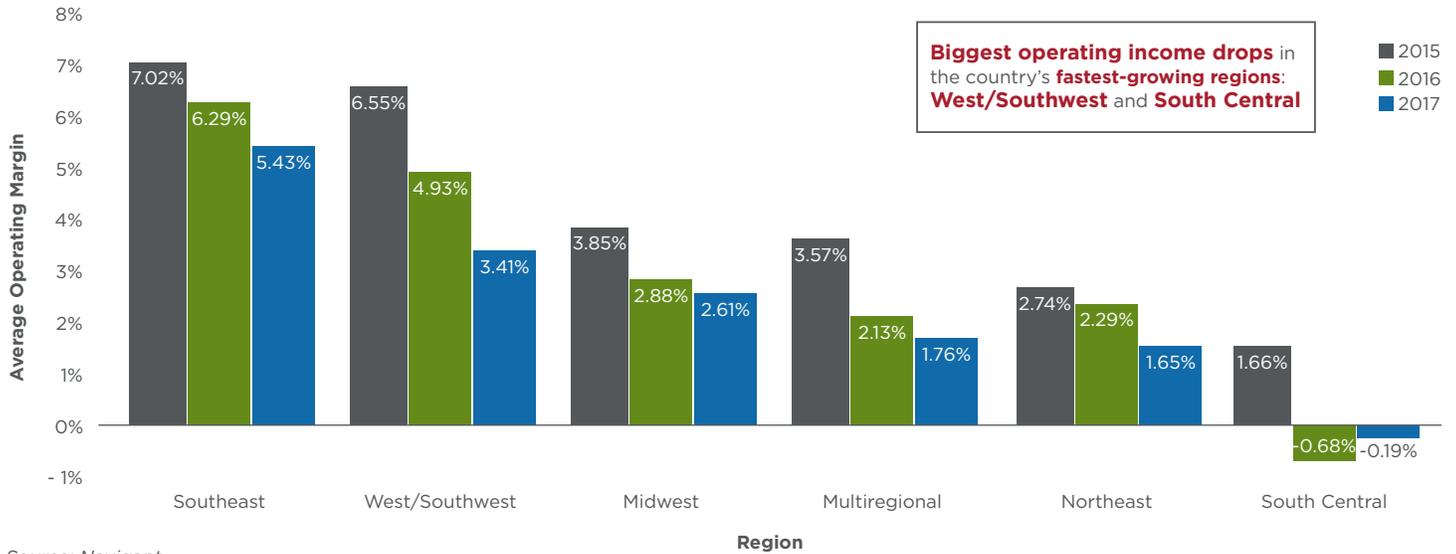
Furthermore, despite a more than thirtyfold difference in operating revenues between the largest and smallest systems, there was no statistical relationship between total operating revenues and operating profit in 2017, or the change in operating profit from 2015 to 2017. This finding flies in the face of the incessant chorus of advocacy for scale and market dominance among prominent strategy firms and their colleagues in investment banking. Scale was of no help in system operating performance during this difficult period.

Significant Regional Differences in Operating Margin Pressures

Though margins were lowest in the South Central (including Texas) and Northeast U.S., the most significant reductions in operating income came in the fastest-growing regions of the country: West/Southwest and the South Central. Most of the states in the South Central chose not to expand their Medicaid programs, as offered by the ACA.

Regional declines were steepest in all regions from 2015 to 2016, the first full year after the ACA expansion, pushing the systems in the South Central into negative operating margins. There was some moderation in the adverse operating trend in 2017, with increased margins in the South Central, and reduced erosion in the rest of the regions (Figure 5).

Figure 5: Operating Margins by Region
(2015-2017)



DISCUSSION

The deterioration in health system operating earnings is striking not only because of its sudden onset in 2016, but also because it is occurring at the top of an economic cycle, with the general economy at or below 4 unemployment. Typically, hospital financial performance deteriorates one to two years *after* a recession. Recessions normally cause Medicare and Medicaid to cut their rates while employers tighten their group plans and shift more of the cost to their workers.

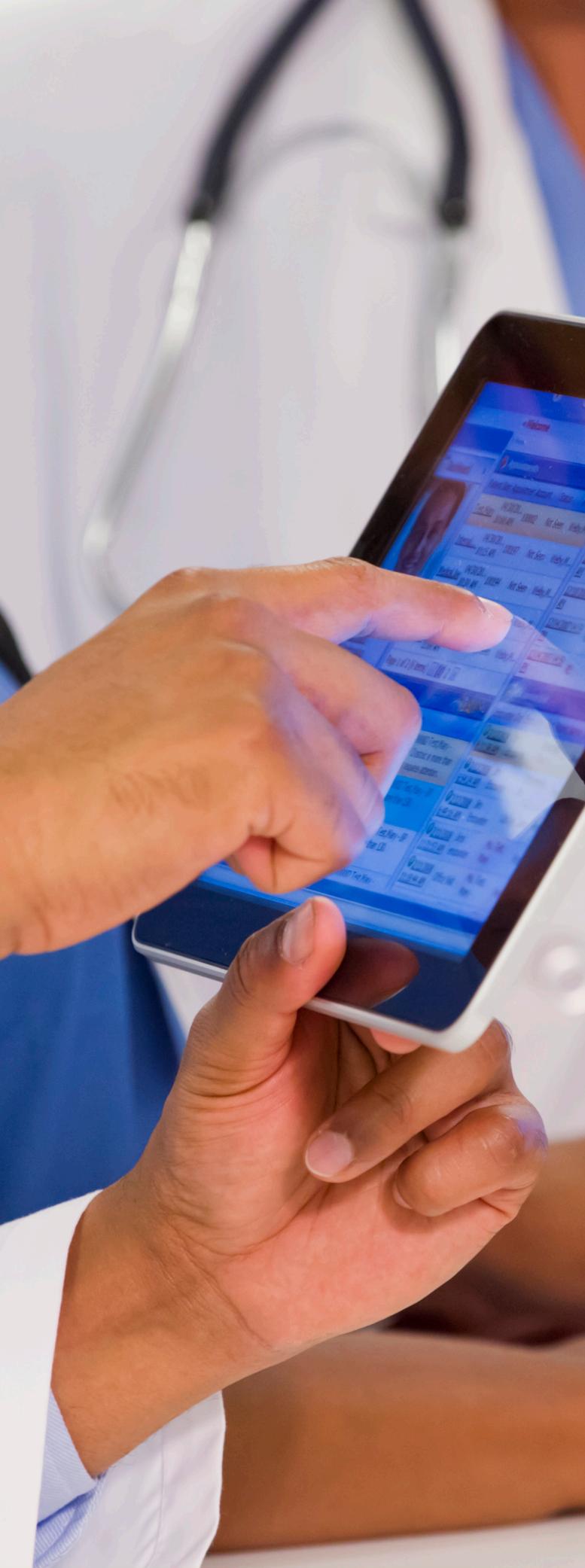
The sharp reduction in operating margin is also anomalous because it comes hard on the heels of the ACA's historic 2014 expansion of health coverage, which added 21 million people to coverage and reduced the uninsured to less than 10% of the U.S. population. Initially, this coverage expansion provided a stiff shot of positive cash flow and reduced bad debts for the nation's hospitals.

The causes of health system operating earnings erosion are twofold: declining topline revenue growth and a failure to contain expenses in line with the topline deterioration. The main drivers of topline weakness appear to be:

1. Weakening demand for core hospital services, particularly surgery and inpatient admissions.
2. Deteriorating collection rates for private accounts in non-ACA expansion states.
3. Reductions in Medicare payment updates due to the ACA and the 2012 federal budget sequester.
4. The failure of "value-based" health insurance contracts to deliver sufficient patient volume to offset steep upfront discounts granted to insurers.

These latter two factors were consequences of the ACA, which was funded in part by permanent, significant cuts in annual updates of Medicare payments to hospitals. It also introduced a new distribution system for private health coverage — the ACA health insurance exchanges. Provider reaction to the uncertainties posed by the emergence of narrow network plans targeted at the ACA's exchanges contributed materially to disinflation in private insurance payment rates.

However, rising losses from the regular Medicare program may have played a disproportionate role in the sharp downturn in operating earnings as well. Because of reductions in Medicare



updates from ACA and the sequester, hospital losses in treating Medicare patients rose from \$20.1 billion in 2010 to \$48.8 billion in 2016, according to American Hospital Association analyses.² The sharp \$7.2 billion deterioration in Medicare margins that occurred from 2015 to 2016³ surely contributed to the reduction in hospital operating margins in the same year of this analysis.

Expenses Driven by EHR, Physician, and Other Population Health Investments

On the expense side, hospitals incurred significant expenses from strategic initiatives catalyzed in major part by the ACA. Though systems do not disclose the extent of these investments in their financial statements, most pursued a consensus strategy driven largely by compliance with ACA mandates surrounding information technology (IT) and payment reform.

Major strategic investments included:

1. Compliance with 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act mandates to install qualifying electronic health records (EHRs), both in hospitals and in affiliated physician practices.
2. Compliance with ACA Medicare payment reform initiatives, including pay-for-performance and accountable care organizations.
3. New value-based health insurance contracts and, in some cases, provider-sponsored health insurance plans for both public and private health exchanges.
4. Formation of captive (e.g., employed) physician groups designed to facilitate achievement of items 2 and 3 above, as well as clinically integrated networks (CINs) designed to enable sole source contracting spanning regional physician markets.

In addition to these strategic investments, other factors drove up routine patient care expenses, including a nursing shortage that increased nursing wages and agency expenses; specialty drug costs, particularly for chemotherapeutic agents; and, for some systems, recalibration of retirement fund costs.

2. American Hospital Association, "TrendWatch Chartbook 2018," 40, May 2018, <https://www.aha.org/guidesreports/2018-05-22-trendwatch-chartbook-2018>.

3. MedPAC, "REPORT TO THE CONGRESS: Medicare Payment Policy," March 2018, http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0.

There is no reason to believe that the forces that have diminished demand for hospital care, particularly rising patient cost exposure due to high-deductible health plans, will abate in the coming years. Moreover, it is unlikely that the reduced Medicare payment updates hardwired into the law will be adjusted upward in future years. This means that the low rate of revenue growth that led to operating earnings problems are likely to be the “new normal.”

Any downturn in the economy will increase pressure to contain Medicare expenses, almost certainly reducing Medicare’s unit payments. It is also likely that the favorable investment climate that produced record investment earnings for health systems in 2017 will not continue indefinitely, exposing organizations that cannot manage their operating performance more effectively to financial harm, including potential ratings downgrades.

STRATEGIC IMPLICATIONS

Health Systems Need Strategic Discipline to Achieve Smarter Growth

For health systems to regain their financial footing, they must achieve strategic discipline and operational excellence — both containing expenses and growing in a market-responsive way.

Systems must be disciplined to invest their growth capital in areas of actual reachable demand; that is, matched to the growth potential in the specific local markets the system serves. For example, creating a Kaiser-like closed panel capitated health offering in markets where there is no employer or health plan interest in buying such a product is a waste of scarce capital and management bandwidth.

Strategic discipline requires judicious pruning of the portfolio of a system’s owned assets, as many systems have begun to do. It also necessitates improving utilization of clinical capacity by enhancing patient throughput. Doing this requires detailed attention to patient scheduling, clinical staffing, consistent adherence to consensus care pathways, and streamlining discharge and care transition processes.

Health systems must then adjust physical capacity (beds, operating suites, ICUs, ambulatory sites) to actual demand, consolidating or eliminating excess capacity to thus improve operating profit. Doing so means confronting duplicative capacity in hospitals with overlapping service areas, and biting the bullet on service line rationalization.

Improving performance also requires smarter contracting strategy. Damage to health systems’ revenues and rate structures by “faith-based” contracting with private insurers was a major contributor to declining revenue growth. Investment in risk strategies (CIN development, IT, and administrative support such as care managers) must not exceed the potential return in new revenue growth. To change this, systems need to carefully re-evaluate narrow network contracts under which front-end discounts were not offset by promised increased enrollment or assumed collection rates from patient cost shares. Contracts must fully price in the value of the health system’s offerings, and not be contingent on volumes or “lives” materializing at the expense of others.

Finally, systems will need to use their managed care tools (CINs, care coordinators, clinical IT infrastructure) not only to improve performance on risk contracts, but also reduce Medicare operating losses by adjusting the cost of “producing” a diagnosis-related group (DRG) to more closely match Medicare’s fixed payments.

This necessitates examining and reducing variation in clinical resource among practicing physicians, regardless of their employment status, and should be done in full realization that payment levels will not reflect inflation-adjusted cost. If care costs do not come down, losses will increase. Alternatively, 100% of every dollar saved by reducing the cost of “producing” a DRG drops through to the bottom line. The savings do not need to be “shared” with the federal government as they do in the Medicare Shared Savings Program.

Growth Around the Edges and Through Better Vertical Alignment

Revenue growth is more likely to occur around the edges of the hospital’s core services — inpatient care, surgery, and imaging — rather than from those services themselves. Creatively repackaging services like care management that is presently imbedded in every aspect of clinical operations, and finding retail demand for services presently bundled as part of the hospital’s traditional service offerings, represent such edge opportunities. (See *Edge Strategy: A New Mindset for Profitable Growth* by Alan Lewis and Dan McKone⁴ for a full explication of this thesis).

4. Alan Lewis and Dan McKone, *Edge Strategy: A New Mindset for Profitable Growth*, December 29, 2015, <https://hbr.org/product/edge-strategy-a-new-mindset-for-profitable-growth/15026-HBK-ENG>.

More reliable system performance of key service lines through “blueprinting” care pathways and improved continuity of care can yield:

- Better Medicare STAR ratings.
- Reduced readmissions and avoidable adverse events.
- Growth in volume through favorable references from satisfied patients and their families.
- Better contracts with health plans.

A markedly improved patient care experience can lead to both higher volumes and better capacity utilization.

More growth should come from improving vertical alignment. For example, “captive” multi-specialty groups that have been created for contracting purposes often leak significant utilization to competing facilities. This leakage should be reduced or eliminated through better scheduling and care coordination, as well as clinical discipline and addressing bottlenecks and quality deficiencies. Referral patterns must better support health systems’ sub-acute and ambulatory services portfolios, or else those service offerings must be scaled more appropriately to actual demand. If improved capture of referrals is not matched by improved service, however, patients will exercise their consumer sovereignty and get their care elsewhere.

Clinical leaders should also target clinical process improvements in populations where they have the greatest actual economic risk. This includes regular Medicare and Medicaid populations, which cost hospitals almost \$70 billion in operating losses in 2016. Hospitals do not need to have risk contracts to be at risk, nor to manage that risk more effectively. More consistent adherence to care pathways will not only help reduce excessive resource consumption that does not lead to improved clinical results, but also help reduce avoidable money-losing admissions and other services that are not fully paid for.

CONCLUSION

The past two years of deteriorating operating performance should compel health system management teams and boards to re-examine their assumptions about the future direction of their markets and organizations. In addition, the present economic expansion will not continue indefinitely. When it is over, those who pay for care will place renewed pressure on the care system by pressuring rates and shifting more of the cost onto consumers, many of whom are unable to pay the patient share.

Furthermore, health systems cannot count on continued strength in their investment portfolios to offset declines in their operating income. The freshening headwinds that produced this broad-based decline in industry operating performance may be the first gust of a full force gale.

To achieve better performance, health system management and boards must take a fresh look at their strategy considering local market realities. They need to look closely at the markets they serve, and size and target their offerings to actual market demand. They must re-examine and rationalize their portfolio of assets and demand marked improvements in efficiency and effectiveness, and measurable value creation for those who pay for care, particularly their patients. Since much of this should have been done five years ago, time is of the essence.

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APPENDIX

Definitions

- Operating Expenses include:
 - Salaries and benefits
 - Supplies and technology
 - Medical claims and premium expenses
 - Other operating expenses
 - Depreciation and amortization
 - Interest or interest expense
- Expenses NOT considered Operating Expenses:
 - Gains or losses on sales of facilities or businesses
 - Gains or losses on extinguishment or retirement of debt
 - Legal claims
 - Impairment charges
 - Fees or charges related to investments
- Operating Revenues include:
 - Net patient revenue less provisions for bad debt
 - Premium or capitation income
 - Research grants
 - Other operating revenues, including sales of services, rent, etc.
- Investment income, gifts, and philanthropic contributions were not considered operating revenue, nor were gains or losses from sale of facilities, net assets released from restrictions, inherent contributions from business combinations, equity in income from unconsolidated organizations, and losses from early extinguishment of debt.
- Net operating income was operating revenues minus operating expenses as defined above.
- Income tax expenses were not included though other taxes, assessments, and fees were.

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