



FINANCIAL MANAGEMENT OF HEALTH CARE ORGANIZATIONS

An Introduction to Fundamental Tools,
Concepts and Applications

FIFTH EDITION

WILLIAM N. ZELMAN | MICHAEL J. McCUE | NOAH D. GLICK | MARCI S. THOMAS

JOSSEY-BASS™
A Wiley Brand

FINANCIAL MANAGEMENT OF HEALTH CARE ORGANIZATIONS

FINANCIAL MANAGEMENT OF HEALTH CARE ORGANIZATIONS

**AN INTRODUCTION TO FUNDAMENTAL
TOOLS, CONCEPTS, AND APPLICATIONS**

Fifth Edition

**William N. Zelman, Michael J. McCue,
Noah D. Glick, and Marci S. Thomas**

JB JOSSEY-BASS™
A Wiley Brand

This edition first published 2020
© 2020 John Wiley & Sons, Inc.

Edition History

Blackwell Publishing Ltd (1e, 1998 and 2e, 2003); John Wiley & Sons, Inc. (3e, 2009 and 4e, 2014)

Published by Jossey-Bass A Wiley Brand

535 Mission Street, 14th Floor, San Francisco, CA 94105—www.josseybass.com

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, except as permitted by law. Advice on how to obtain permission to reuse material from this title is available at <http://www.wiley.com/go/permissions>.

The right of William N. Zelman, Michael J. McCue, Noah D. Glick, and Marci S. Thomas to be identified as the authors of this work has been asserted in accordance with law.

Registered Offices

John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, USA

Editorial Office

90 Eglinton Ave. E., Suite 300, Toronto, Ontario, M4P 2Y3, Canada

For details of our global editorial offices, customer services, and more information about Wiley products visit us at www.wiley.com.

Wiley also publishes its books in a variety of electronic formats and by print-on-demand. Some content that appears in standard print versions of this book may not be available in other formats.

Limit of Liability/Disclaimer of Warranty

While the publisher and authors have used their best efforts in preparing this work, they make no representations or warranties with respect to the accuracy or completeness of the contents of this work and specifically disclaim all warranties, including without limitation any implied warranties of merchantability or fitness for a particular purpose. No warranty may be created or extended by sales representatives, written sales materials or promotional statements for this work. The fact that an organization, website, or product is referred to in this work as a citation and/or potential source of further information does not mean that the publisher and authors endorse the information or services the organization, website, or product may provide or recommendations it may make. This work is sold with the understanding that the publisher is not engaged in rendering professional services. The advice and strategies contained herein may not be suitable for your situation. You should consult with a specialist where appropriate. Further, readers should be aware that websites listed in this work may have changed or disappeared between when this work was written and when it is read. Neither the publisher nor authors shall be liable for any loss of profit or any other commercial damages, including but not limited to special, incidental, consequential, or other damages.

Library of Congress Cataloging-in-Publication Data

Names: Zelman, William N., author. | McCue, Michael J., author. | Glick, Noah D., author. | Thomas, Marci S., 1953– author.

Title: Financial management of health care organizations : an introduction to fundamental tools, concepts and applications / William N. Zelman, Michael J. McCue, Noah D. Glick, and Marci S. Thomas.

Description: Fifth edition. | San Francisco, CA : Jossey-Bass, 2020. | Includes bibliographical references and index.

Identifiers: LCCN 2019053507 (print) | LCCN 2019053508 (ebook) | ISBN 9781119553847 (hardback) | ISBN 9781119553908 (adobe pdf) | ISBN 9781119553861 (epub)

Subjects: LCSH: Health facilities—Finance. | Health facilities—Accounting.

Classification: LCC RA971.3 .Z45 2020 (print) | LCC RA971.3 (ebook) | DDC 362.1068/1—dc23

LC record available at <https://lcn.loc.gov/2019053507>

LC ebook record available at <https://lcn.loc.gov/2019053508>

Cover image: Wiley

Cover design: © mathagraphics/Shutterstock

Set in 10.5/14pt Warnock by SPi Global, Pondicherry, India

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

To our families, for their love and patience.

**To our students and colleagues, for their invaluable
insights and feedback.**

CONTENTS

Preface	xiii
Acknowledgments	xix
The Authors	xxi
Chapter 1 The Context of Health Care Financial Management	1
Changing Methods of Health Care Financing and Delivery.	3
Addressing the High Cost of Care	9
Value-Based Payment Mechanisms	19
Summary	22
Key Terms.	23
Review Questions	23
Notes	24
Chapter 2 Health Care Financial Statements	25
The Balance Sheet	27
The Statement of Operations	49
The Statement of Changes in Net Assets	64
The Statement of Cash Flows	66
Summary	71
Key Terms.	73
Key Equations	73
Review Questions and Problems	74
Appendix A: Financial Statements for Sample Not-for-Profit and For-Profit Hospitals, and Notes to Financial Statements	84
Note	99
Chapter 3 Principles and Practices of Health Care Accounting	101
The Books.	101
An Example of the Effects of Cash Flows on Profit Reporting under Cash and Accrual Accounting	106
Recording Transactions	108
Developing the Financial Statements	118
Summary	125

Key Terms	126
Review Questions and Problems	126
Chapter 4 Financial Statement Analysis	137
Horizontal Analysis	138
Trend Analysis	144
Vertical (Common-Size) Analysis	144
Ratio Analysis	146
Liquidity Ratios	152
Revenue, Expense, and Profitability Ratios	161
Activity Ratios	169
Capital Structure Ratios	175
Summary	183
Key Equations	186
Key Terms	187
Review Questions and Problems	187
Chapter 5 Working Capital Management	209
Working Capital Cycle	209
Working Capital Management Strategies	211
Cash Management	215
Sources of Temporary Cash	216
Revenue Cycle Management	221
Collecting Cash Payments	225
Investing Cash on a Short-Term Basis	228
Forecasting Cash Surpluses and Deficits: The Cash Budget	230
Accounts Receivable Management	233
Methods to Monitor Revenue Cycle Performance	237
Fraud and Abuse	239
Summary	243
Key Terms	246
Key Equations	246
Review Questions and Problems	246
Notes	257
Chapter 6 The Time Value of Money	259
Future Value of a Dollar Invested Today	260
Present Value of an Amount to Be Received in the Future	267
Future and Present Values of Annuities	270
Future and Present Value Calculations and Excel Functions for Special Situations	276
Summary	284

Key Terms	285
Key Equations	286
Review Questions and Problems	287
Appendix B: Future and Present Value Tables	292
Note	301
Chapter 7 The Investment Decision	303
Objectives of Capital Investment Analysis	304
Analytical Methods	307
Using an NPV Analysis for a Replacement Decision.	321
Summary	326
Key Terms.	328
Key Equation	328
Review Questions and Problems	328
Appendix C: Technical Concerns in Calculating Net Present Value	336
Appendix D: Adjustments for Net Working Capital	342
Appendix E: Tax Implications for For-Profit Entities in a Capital Budgeting Decision and the Adjustment for Interest Expense	345
Appendix F: Comprehensive Capital Budgeting Replacement Cost Example.	349
Chapter 8 Capital Financing for Health Care Providers	361
Equity Financing	364
Debt Financing.	365
Bond Issuance Process	377
Lease Financing	389
Summary	396
Key Terms.	397
Key Equations	398
Review Questions and Problems	398
Appendix G: Bond Valuation, Loan Amortization, and Debt Borrowing Capacity	402
Notes	411
Chapter 9 Using Cost Information to Make Special Decisions.	413
Break-Even Analysis	414
Product Margin	437
Applying the Product Margin Paradigm to Making Special Decisions	441
Summary	448

Key Terms	449
Key Equations	450
Review Questions and Problems	450
Appendix H: Break-Even Analysis for Practice Acquisition.	461
Chapter 10 Budgeting.	467
The Planning-and-Control Cycle	467
Organizational Approaches to Budgeting	472
Types of Budgets	483
Monitoring Variances to Budget	490
Group Purchasing Organizations.	492
Summary	494
Key Terms.	496
Key Equation	497
Review Questions and Problems	497
Appendix I: An Extended Example of How to Develop a Budget	499
Chapter 11 Responsibility Accounting	523
Decentralization	523
Types of Responsibility Centers	526
Measuring the Performance of Responsibility Centers.	531
Budget Variances	533
Summary	545
Key Terms.	547
Key Equations	548
Review Questions and Problems	548
Chapter 12 Provider Cost-Finding Methods	553
Cost-to-Charge Ratio	553
Step-Down Method.	554
Activity-Based Costing	561
Summary	573
Key Terms.	573
Review Questions and Problems	574
Chapter 13 Provider Payment Systems.	579
Evolution of the Payment System	583
Risk Sharing and the Principles of Insurance	607
Evolving Issues.	612
Technology	614
Summary	616

Key Terms	616
Review Questions and Problems	617
Appendix J: Cost-Based Payment Systems	619
Notes	624
Glossary.	627
Useful Websites	653
Index	657

PREFACE

This book offers an introduction to the most used tools and techniques of health care financial management. It contains numerous examples from a variety of providers, including health maintenance organizations, hospitals, physician practices, home health agencies, nursing units, surgical centers, and integrated health care systems. The book avoids complicated formulas and uses numerous spreadsheet examples so that these examples can be adapted to problems in the workplace. For those desiring to go beyond the fundamentals, many chapters offer additional information in appendices. Each chapter begins with a detailed outline and concludes with a detailed summary, followed by a set of questions and problems. Answers to the questions and problems are available for download to instructors at www.josseybass.com/go/zelman5e. Finally, a number of perspectives are included in every chapter. Perspectives—examples from the real world—are intended to provide additional insight into a topic. In some cases these are abstracted from professional journals and in other cases they are statements from practitioners—in their own words.

The book begins with an overview in Chapter 1 of some of the key factors affecting the financial management of health care organizations in today's environment. Chapters 2, 3, and 4 focus on the financial statements of health care organizations. Chapter 2 presents an introduction to these financial statements. Financial statements are (perhaps along with the budget) the most important financial documents of a health care organization, and the bulk of this chapter is designed to help readers understand these statements, how they are created, and how they link together.

Chapter 3 provides an introduction to health care financial accounting. This chapter focuses on the relationship between the actions of health care providers and administrators and the financial condition of the organization, examining how the numbers on the financial statements are derived, and the distinction between cash and accrual bases of accounting. By the time students have completed Chapters 2 and 3, they will have been introduced to a large portion of the terms used in health care financial management.

Building on Chapters 2 and 3, Chapter 4 focuses on interpreting the financial statements of health care organizations. Three approaches to analyzing statements are presented: horizontal, vertical, and ratio analysis. Great care has been taken to show how the ratios are computed and how to summarize the results.

Chapter 5 focuses on the management of working capital: current assets and current liabilities. This chapter emphasizes the importance of cash management and provides many practical techniques for managing the inflows and outflows of funds through an organization, including managing the billing and collections cycle and paying off short-term liabilities.

Chapter 6 introduces one of the most important concepts in long-term decision making: the time value of money. Chapter 7 builds on this concept, incorporating it into the investment decision by presenting several techniques for analyzing investment decisions: the payback method, net present value, and internal rate of return. Examples are given for both not-for-profit and for-profit organizations.

Once an investment has been decided on, it is important to determine how this asset will be financed, and this is the focus of Chapter 8. Whereas Chapter 5 deals with issues of short-term financing, Chapter 8 focuses on long-term financing, with a particular emphasis on issuing bonds.

Chapters 9–12 introduce topics typically covered in a managerial accounting course. Chapter 9 focuses on the concept of cost and on using cost information—including fixed cost, variable cost, and break-even analysis—for short-term decision-making. In addition to covering the key concepts, this chapter offers a set of rules to guide decision-makers in making financial decisions. Chapter 10 explores budget models and the budgeting process. Several budget models are introduced, including program, performance, and zero-based budgeting. The chapter ends with an example of how to prepare each of the five main budgets: statistics budget, revenue budget, expense budget, cash budget, and capital budget. It also includes examples for various types of payors, including those with flat fee and capitation plans.

Chapter 11 deals with responsibility accounting. It discusses the different types of responsibility centers and focuses on performance measurement in general and budget variance analysis in particular. Chapter 12 discusses methods used by health care providers to determine their costs, primarily focusing on the step-down method and activity-based costing. This book concludes with Chapter 13, “Provider Payment Systems.” This chapter, parts of which were combined with Chapter 12 in the first edition, describes the evolution of the payment system in the United States, especially under health reform, as well as the specifics of various approaches to managing care and paying providers.

Major Changes in the Fifth Edition

As noted below, the major changes from the fourth edition involve:

- New sections to reflect changes in accounting reporting and the health care environment.
- Updated data used in examples.
- Updated data used in problems.
- New problems.
- New perspectives.

Chapter 1: The Context of Health Care Financial Management

Changes to Chapter 1, the introductory chapter, provide an updated and current view of today's health care setting. Much has evolved in the industry with the advent of value-based payment systems, population-based approaches to care, the Patient Protection and Affordable Care Act (ACA), and recent changes in health policy. Updated sections are on patient-centered medical homes, accountable care organizations (ACOs), and overall changes within the hospital industry.

Enhancements include updated statistics in the chapter text and all the pertinent exhibits. All perspectives have been replaced to focus on more recent events.

Chapter 2: Health Care Financial Statements

Chapter 2 has been updated to include recent presentation changes issued by the Financial Accounting Standards Board (FASB). These changes address new presentation standards in the balance sheet with respect to the number of net asset classes, reducing them from three (unrestricted, temporarily restricted, and permanently restricted) to two ("with donor restrictions" and "without donor restrictions"). Another update is the new disclosure requirement related to the hospital's management of liquid resources or assets. The purpose of this change is to improve an organization's transparency in reporting what financial assets are available to meet its cash needs within one year. In addition, entities are required to disclose their liquidity management plans. The final major change relates to the new five-step principles-based approach to recognizing revenue. The new approach places the provision for bad debts back in the operating expense section of the statement of operations. All perspectives and problems have been updated. There are also new key terms.

Chapter 3: Principles and Practices of Health Care Accounting

In Chapter 3, the chapter addresses the previously mentioned accounting statement changes as noted in Chapter 2. The perspectives have been replaced and problems have been changed and updated.

Chapter 4: Financial Statement Analysis

Chapter 4 has been updated to include the latest hospital benchmark ratios from the 2018 Almanac of Hospital Financial and Operating Indicators (a reference work from Optum Inc.).

Chapter perspectives have been replaced, and problems have been updated as well to provide a better picture of what each ratio analyzed means, beyond its being above or below the relevant benchmark.

Chapter 5: Working Capital Management

Chapter 5 has new sections on improving the revenue cycle management process and on fraud and abuse. All perspectives and problems have been revised and updated.

Chapter 6: The Time Value of Money

Chapter 6 includes perspectives illustrating time value of money concepts in use, and all the problem sets have been updated.

Chapter 7: The Investment Decision

Chapter 7 now offers an expanded discussion of tax law changes in the hospital industry. In addition, all perspectives have been updated, and problems have been changed and updated.

Chapter 8: Capital Financing for Health Care Providers

Chapter 8 now includes new accounting reporting for lease financing, which provides greater transparency about a hospital's leasing activities, as well as tax law changes on debt financing. All the problems on lease financing and bond valuation have been revised and updated.

Chapter 9: Using Cost Information to Make Special Decisions

In Chapter 9, the conceptual diagram and the related explanation for understanding break even have been substantially revised, and all perspectives have been replaced with updated versions. Most problems have updated figures.

Chapter 10: Budgeting

Though the organization of Chapter 10 remains essentially the same, the basic model on which this chapter is based has been almost totally revised. The updated model focuses on a hospitalist practice that has only two services. The discussion of supply chain operations and maximizing savings from the evaluation of group purchasing organization discounts have been retained in the appendices, but the supplies budget has been dropped. All perspectives have been replaced with updated versions. The problems have been revised to reflect the new content, though the general format is the same.

Chapter 11: Responsibility Accounting

The discussion of cost centers in Chapter 11 has been modified slightly to recognize both service- and product-producing activities, and all perspectives and problem sets have been updated.

Chapter 12: Provider Cost-Finding Methods

Chapter 12's perspectives and problems have been updated.

Chapter 13: Provider Payment Systems

Chapter 13 has been updated to provide a discussion of evolving issues in provider payment. The new payment methodologies address value-based payment models for Medicare and commercial payments and the Medicare Access and CHIP Reauthorization Act (MACRA). The new MACRA regulation repealed the Sustainable Growth Rate formula that computed Medicare payments for physician services, and in addition the law discusses how hospitals are reimbursed based upon the quality and effectiveness of care given. All perspectives have been replaced with updated versions. There are new key terms.

Glossary

The glossary has been completely updated, and includes each term defined in a chapter sidebar and each key term.

Web Pages and Additional Materials

The website for this book, including the instructor's manual and Excel spreadsheets, is located at www.wiley.com/go/zelman5e.

Comments about this book are invited and may be sent to publichealth@wiley.com.

ACKNOWLEDGMENTS

We attempt throughout this book to challenge and enlighten. Quantitative as well as qualitative issues are presented in an effort to help the reader better understand the wide range of issues considered under the topic of *health care financial management*. We would like to thank the many students who over the past several years have pointed out errors, offered suggestions and improvements, and provided new ways to solve problems.

Our particular thanks go to Jennifer Palazzolo, PhD candidate, and Enrique Figueroa for their review of various chapters and problem sets.

Most of all, we would like to thank our families for their encouragement and support and for their understanding during the countless hours we were not available to them.

The authors apologize for any errors or omissions in the above list and would be grateful for notifications to Michael McCue, at mccue@vcu.edu, of any corrections that should be incorporated in the next edition or reprint of this book and posted on the book's web page. William N. Zelman is no longer involved in the development of changes within this fifth edition.

The authors and the publisher gratefully acknowledge the copyright holders for permission to reproduce material in the perspectives throughout the book.

THE AUTHORS

William N. Zelman is a retired professor emeritus from the Department of Health Policy and Management, Gillings School of Public Health, University of North Carolina at Chapel Hill. He was the lead author for the first three editions of this textbook, but was not involved in the changes and updates to this fifth edition. **As a disclaimer, Dr. Zelman requests that all concerns and issues regarding the book be addressed by emailing Michael McCue (mccue@vcu.edu).**

Michael J. McCue is the R. Timothy Stack Professor of Health Care Administration in the Department of Health Administration at Virginia Commonwealth University in Richmond, Virginia. His research interests relate to corporate finance in the health care industry and the performance of hospitals, multihospital systems, and health plans. His previous research examines the determinants of hospital capital structure, the factors influencing hospitals' cash flow and cash on hand, and the evaluation of hospital bond ratings. His current research examines the effects of health reform on the financial performance of commercial health plans.

Noah D. Glick is currently an independent health care consultant in physician practice operations. He has prior consulting experience at two national consulting firms in the areas of physician practice reform and academic strategy. Prior to his consulting work, he was the administrative director for two hospitalist groups outside of Boston, and an information analyst for a small start-up predictive modeling company.

Marci S. Thomas is a clinical assistant professor in the Department of Health Policy and Management at the University of North Carolina at Chapel Hill, where she teaches health care financial and managerial accounting. She consults with health care organizations, educational institutions, and other not-for-profit organizations and their boards on internal control, vulnerability to risk and fraud, strategic planning, and governance issues. She is a nationally

recognized speaker on accounting issues in health care and related not-for-profit entities and on auditing these organizations. Thomas is a coeditor of and contributor to *Essentials of Physician Practice Management* (Jossey-Bass). Her book *Best of Boards: Sound Governance and Leadership for Nonprofit Organizations* was published by the American Institute of CPAs (AICPA) in 2017. She is a certified public accountant and a chartered global management accountant (CGMA).

THE CONTEXT OF HEALTH CARE FINANCIAL MANAGEMENT

Never before have health care professionals faced such complex issues and practical difficulties trying to keep their organizations competitive and financially viable. With disruptive changes taking place in health care legislation and in payment, delivery, and social systems, health care professionals must meet their organizations' health-related missions in an environment of uncertainty and extreme cost pressures. Indeed, financial viability supports an organization's mission of being able to provide quality patient care. These circumstances are stimulating high-performing provider organizations to focus on innovation to help lower costs and find creative ways to deliver services to a population whose members, while aging, are more informed and more demanding of a voice in their care and value for dollars spent than ever before.

The Patient Protection and Affordable Care Act (ACA) was the largest effort toward reform of the health care system since the advent of government entitlement programs in the 1960s. The goal of the ACA was to provide mechanisms to expand access to care, improve quality, and control costs.

But even before the enactment of the ACA in 2010, the Centers for Medicare and Medicaid Services (CMS) had articulated a vision for health care quality: "the right care for every person every time." CMS's stated objective is to promote safe, effective, timely, patient-centered, efficient, and equitable care.

CMS also needs to control the rising cost of care, which has become unsustainable. To accomplish its objectives CMS has been working to replace its old financing system, which basically rewarded the quantity of care, with value-based purchasing (VBP), a system that improves the linkage between payment and

LEARNING OBJECTIVES

- Identify key elements that are driving changes in health care delivery.
- Identify key approaches to controlling health care costs and resulting ethical issues.
- Identify key changes in reimbursement mechanisms to providers.

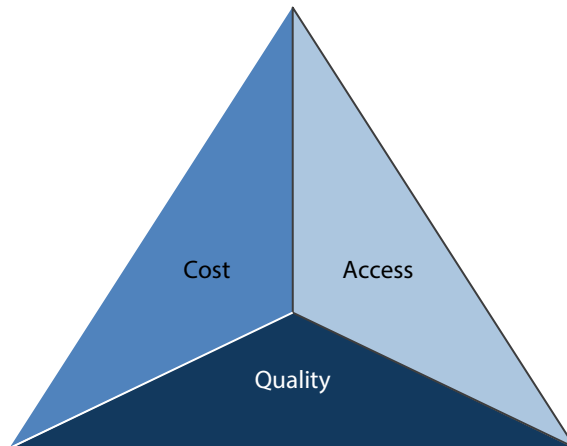
the quality of care. The Deficit Reduction Act of 2005 authorized CMS to develop a plan for VBP for Medicare hospital services beginning in fiscal year 2009. The ACA, which passed in 2010, provided the implementation plan.

CMS implemented four value-based programs from 2012 to 2015 that focus on hospital-based and physician-based care, with the intent to pay providers based upon quality rather than quantity of services. CMS has since implemented several additional value-based programs to monitor care for end-stage renal disease (ESRD) requiring dialysis, skilled nursing facilities (SNFs), and home health care.

Many of these changes were and continue to be the source of controversy and lawsuits. State governments as well as many providers have faced uncertainty about whether the ACA provisions, even though found to be constitutional in 2012, would be repealed. In the early years of the Trump administration, after narrowly failing to overturn the Act altogether, the President set out to scale back numerous provisions in the ACA, including erecting barriers toward new enrollment. While some states have embraced the Act, other states have hesitated to move forward with implementation plans or have tried to block the effort to move forward altogether.

Regardless of whether all parties agree about the legislative outcome, the goal of the U.S. health care system remains to finance and deliver the highest possible quality to the most people at the lowest cost (Exhibit 1.1). Responses to today's challenges have resulted in a new business model that providers are embracing by controlling costs, developing new service offerings, and implementing new information technology, thereby creating added value (see Perspective 1.1 and Exhibit 1.2).

EXHIBIT 1.1 HEALTH SYSTEM GOALS REMAIN UNCHANGED



PERSPECTIVE 1.1 HEALTH CARE TRANSFORMATION

As providers and governmental agencies face mounting pressure to contain rising health care costs, they are resorting to alternative measures but still need to stay focused on providing personalized, preventive care. Changing demographics, including an aging population and sicker patients with more complex health care needs, have created an increasingly challenging environment. While effectively coordinating care, providers still have to document appropriately, abide by compliance regulations, adjust to a more well-informed and demanding patient population, and provide timely and efficient services, all within financial restrictions.

Under CMS's lead, private insurers also have adopted new approaches that have shifted the focus of care from fee-for-service to value-based reimbursement. However, in its infancy, much uncertainty remains in this area regarding proper measurements to use to ensure that value-based care is being applied effectively and appropriately, and how best to empower patients to help to drive the effort.

Source: "Healthcare Transformation," (n.d.). Duke University's Margolis Center for Health Policy. <https://healthpolicy.duke.edu/work/delivery>.

To establish a context for the topics covered in this text, this chapter highlights key issues affecting health care organizations. It is organized into three sections: (1) changing methods of health care financing and delivery, (2) addressing the high cost of care, and (3) establishing value-based payment mechanisms. Without question the health care industry is undergoing rapid change (Exhibit 1.3). The providers who are open-minded and informed, embrace change, and look for effective solutions will be the ones who thrive in this uncertain environment.

Changing Methods of Health Care Financing and Delivery

The push toward health care reform began back in the early 1990s during the Clinton administration. However, it did not make significant inroads until the ACA was signed into law in 2010, though it was complex with numerous provisions. Those that are expected to have the most significant impact on the delivery and financing of care are noted below and discussed in the remainder of this chapter.¹

- *Requirement that almost all individuals have insurance coverage.* This individual mandate lies at the heart of the legislation, though enforcement has since been weakened by the Trump administration via a slower, more voluntary approach which has eliminated large-scale mandatory programs. The ACA initially required all individuals without health

EXHIBIT 1.2 HEALTHCARE TRENDS AND IMPLICATIONS

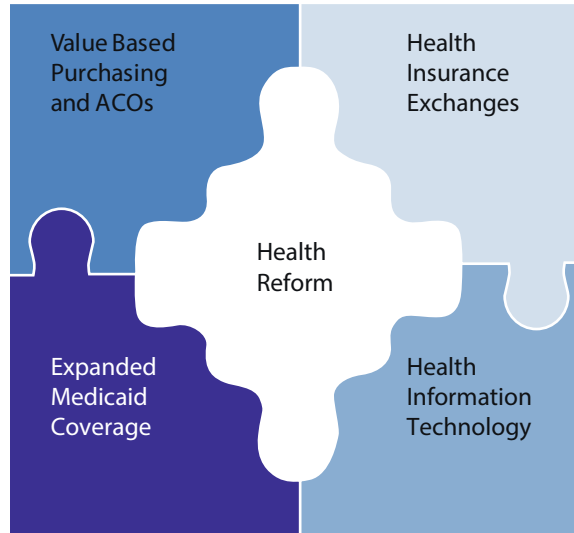
	2010s	2020s
Hospital/Health System Integration	Limited organizational consolidations	Increased organizational consolidations
Next Generation Payment Reform	Volume-based payments	Value-based care and population health management
Applications for Big Data in Health Care	Cloud-based applications and storage	Enhanced medical decision-making
Evolution of the Health Care CEO	Organizational administrator	Population health administrator
Transformation of the Health Care Workforce	Increasing diversity awareness	Four generations of a highly diversified workforce
Physician Leadership and Engagement Strategies	Administration-led changes	Physician-led changes
Advances in Virtual Health Care	Telemedicine for remote areas	Telemedicine for immediate access
Innovations in Health Care	3D printing, robotic surgery, and patient wearables	Artificial intelligence, genomics, enhanced robotics, and home-based patient monitoring

Source: Kaufman, Hall, & Associates, published in Futurescan 2017: Healthcare Trends and Implications, 2017–2022, Society for Healthcare Strategy and Market Development of the American Hospital Association and the American College of Healthcare Executives.

coverage either to join an insurance pool or eventually face a supplemental federal tax, but the ensuing Tax Cuts and Jobs Act (2017) eliminated the tax and offered healthy individuals the option to buy cheaper plans with limited coverage, or to go without any coverage at all. This “cherry-picking” approach effectively left the larger pools with a sicker population and the consequent prospect of rising premiums, while it steered healthy people into suboptimal coverage vulnerable to unforeseen events.

- *Requirement that states create insurance exchanges* where individuals and small businesses can obtain coverage. The ACA contained requirements for an essential benefits package and provided for changes to the tax law that included penalties for individuals who chose not to have insurance. However, some state counties offered few if any options to residents, which fueled opposition to the mandate and intensified efforts to repeal it, and the penalty has since been removed, as noted above. State response was driven by political opposition to the ACA, a fear that state Medicaid costs would rise and deplete state coffers, and/or the inability to provide good options.

EXHIBIT 1.3 SELECTED FACTORS CONTRIBUTING TO UNCERTAINTY IN THE HEALTH CARE INDUSTRY



Note: ACO, accountable care organizations.

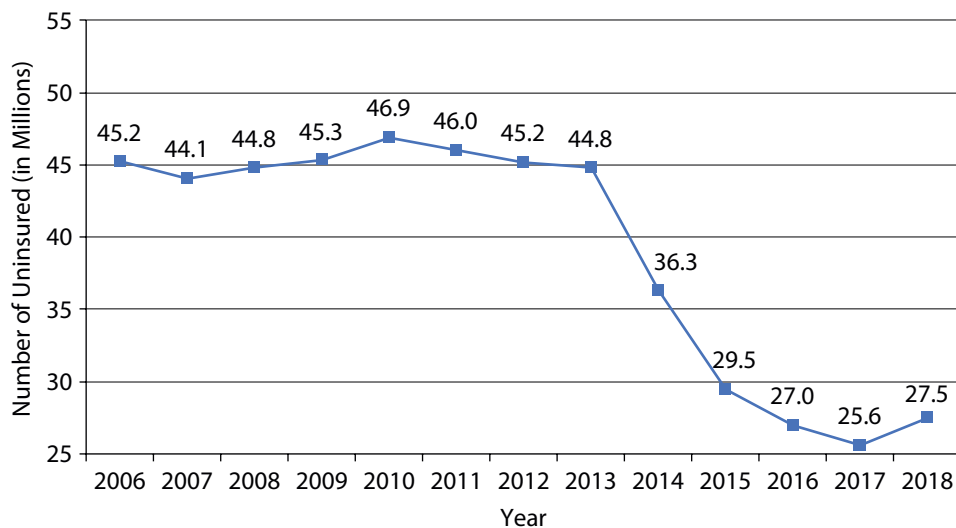
- *Provisions for expansion of Medicaid coverage to all eligible individuals under age 65.* Since adults represented only 25 percent of those covered by Medicaid, this was a significant expansion to include entire families. Federal funds were made available for the expansion at a decreasing rate, down to 90 percent in 2020. This expansion is a state option and remains controversial, as states realized that they would need to shoulder increasing expense as the federal subsidies decrease. The Trump administration also stated that payments to health insurance companies to subsidize out-of-pocket costs for low-income enrollees would be terminated.
- *Provisions for medical loss ratio and premium rate reviews for health plans.* Rebates would be paid to health plan enrollees by health plans that do not meet a required minimum level of spending on medical care.
- *Establishment of payment mechanisms for bundled payments and a value-based purchasing system* along with the restructuring of certain aspects of the Medicare payment system.
- *Provisions for providers organized as accountable care organizations (ACOs)* to share in cost savings that they achieve for the Medicare program.

Health Insurance Exchanges

Though the number of uninsured individuals had risen to 47 million by 2010, enactment of the ACA brought that number steadily down to 26 million by 2017, after which point it started to creep back up again following curtailment of ACA provisions (Exhibit 1.4). At the same time, though having risen again by 2017, the uncompensated care cost had remained below its 2012–2014 levels (Exhibit 1.5). While these have been favorable trends, individuals continue to be uninsured for a variety of reasons, including (1) health insurance and out-of-pocket costs still being too costly for many individuals, even when they are working; (2) employers either scaling back employees' benefits, raising the employee premiums, or eliminating benefits altogether by hiring part-time workers; (3) state governments tightening Medicaid eligibility criteria; and (4) individuals voluntarily deciding not to purchase insurance for a variety of financial and nonfinancial reasons, including the assumption that they will not need care or that they will be taken care of by the “system” anyway. As a result, uncompensated care costs still place a tremendous burden on health care facilities, especially community hospitals.

The ACA authorized a competitive insurance marketplace at the state level and provided for two types of exchanges, an individual exchange and a small business exchange. The individual exchange provides a mechanism for offering health plans for those who either do not have access to health

EXHIBIT 1.4 NUMBER OF UNINSURED, 2006–2018



Source: U.S. Census Bureau, Current Population Survey, 2018 Annual Social and Economic Supplement Bridge File and 2019 Annual Social and Economic Supplement.