

## Hospital Economics and Healthcare Reform: No Free Lunch (In Fact, I Might Go Hungry)

**While conventional wisdom suggests that U.S. hospitals, on balance, stand to benefit from the Affordable Care Act (ACA), L.E.K. Consulting analysis shows that the net impact of legislative, structural and demographic factors will be materially negative on most hospitals in the country. This article describes each of the major drivers of change to hospital economics, and discusses the strategic implications of these changes – not only for hospitals, but also for the rest of the healthcare value chain.**

Conventional wisdom holds that U.S. hospitals will be net beneficiaries of healthcare reform as the Affordable Care Act (ACA) moves more people into insurance coverage, and patients who previously represented whole-dollar “losses” will be reimbursed at minimum Medicaid rates.

However, this conventional wisdom is contingent upon two assumptions: First, that the proportion of the uninsured, non-paying patient population is sufficiently large to make a positive impact on the hospital’s overall economics. And second, that this uplift will overcome other negative macro forces that will simultaneously affect hospitals in the same time period.

In this paper, we examine healthcare reform and other macro forces that will affect hospitals in sequence, and submit that the future of hospital economics in the wake of healthcare reform is not nearly as rosy as conventional wisdom holds. According to L.E.K. Consulting’s analysis, the net impact of legislative, structural and demographic factors will be materially negative on most hospitals in the country.

### Hospital Economics Today

Hospitals constitute one of the core anchors of the U.S. healthcare value chain. Nearly half of the \$2.7 trillion spent on healthcare are spent in or around the hospital in inpatient and outpatient settings, and for ancillary services associated with hospital services. One of the showcase elements of the Affordable Care Act (ACA) is the concept of the accountable care organization (ACO), and hospitals – with their organizational structures, capitalization and resources – have been a central organizing agent in the formation of these constructs. Outcomes that result in instability or structural imbalance for hospitals will be bad for the whole sector; on the other hand, solutions and strategies that help hospitals attain financial and structural sustainability in light of these headwinds will find a willing and growing market.

We begin our study with a graphic that outlines the component parts of a hospital’s gross margins today, before the impacts of healthcare reform have fully taken hold. It is worth noting here that this analysis is not universally applicable; the analysis is for a typical suburban large hospital, and not for academic medical centers, rural or “super-urban” hospitals for whom the

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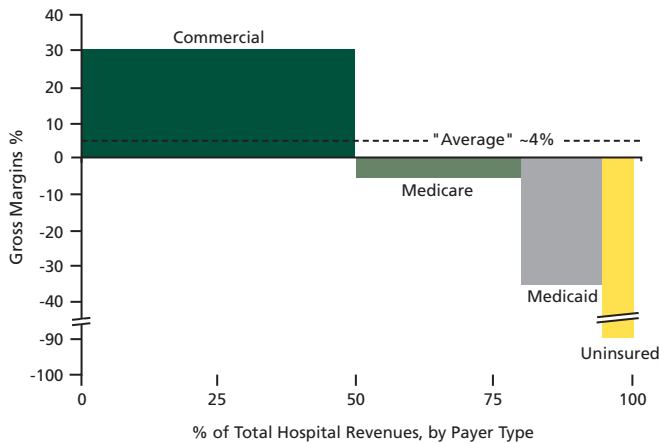
*Hospital Economics and Healthcare Reform: No Free Lunch (In Fact, I Might Go Hungry)* was written by **Tip Kim**, Managing Director in L.E.K.’s Healthcare Services Practice, and **Scott Miller**, Healthcare Services Practice Specialist.

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**Figure 1**

**Example Hospital Gross Margins Today**

Hospital Gross Margins: Typical Suburban Community Hospital



**Indicative and Illustrative:** Each facility in each market achieves unique outcomes and financial results.

Source: L.E.K. Consulting analysis

payer mix of Medicaid and uninsured will be materially different relative to “commercial” reimbursement (i.e. employer-covered or cash-paying under-65-year-old patients). However, it is also worth noting that the macro impacts we outline here will apply to all hospitals, albeit in different proportions.

The above chart shows the payer mix on the x-axis. In this example, patients with commercial insurance coverage constitute about half of the total patient volume. Medicare (fee-for-service Medicare, Medicare Supplement, and Medicare Advantage) constitutes 30% of patient volume. Medicaid constitutes another 15% of volume. Finally the uninsured patient volume constitutes about five percent.

The y-axis, then, shows the gross margins on providing care to the respective populations as a function of their reimbursement (revenues for that population). These profit margins are obviously not “hard” as they are laden with allocations of fixed cost and shared services. Nonetheless, it can be stated that hospitals “make money” with commercial patients. Medicare patients, given their acuity and current levels of reimbursement, are critical for offsetting fixed costs, but the typical hospital cost struc-

ture is not set up to make margin on the Medicare population as a whole. Medicaid, which reimburses typically at 60-70% of Medicare, has larger “losses” still. Finally, aside from self-pay, special considerations from the state, and disproportionate share hospital (DSH) payments,<sup>1</sup> the uninsured represent large “losses” to the hospital.<sup>2</sup> In this hospital example, the weighted average gross margin is approximately four percent.

Clearly, no two hospitals are the same; there are certainly hospitals with a higher share of Medicare and Medicaid, and those with a much larger proportion of uninsured; however, the net impact of a different mix is a different starting point, resulting in a variation in the relative impact of each driver we are about to discuss; all hospitals will face the impacts we are about to discuss to some degree.

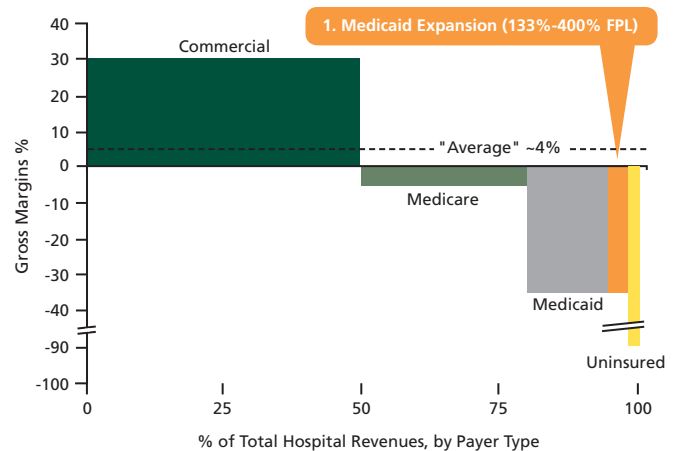
**1. The Impact of Medicaid Expansion**

Let us evolve this starting point and take into account the major elements affecting hospitals. Figure 2 below describes the impact of Medicaid expansion, whereby patients who were previously uninsured (and creating near whole-dollar losses) are now being reimbursed at Medicaid rates.

**Figure 2**

**Impact of Medicaid Expansion**

Hospital Gross Margins: Typical Suburban Community Hospital



**Indicative and Illustrative:** Each facility in each market achieves unique outcomes and financial results.

Source: L.E.K. Consulting analysis

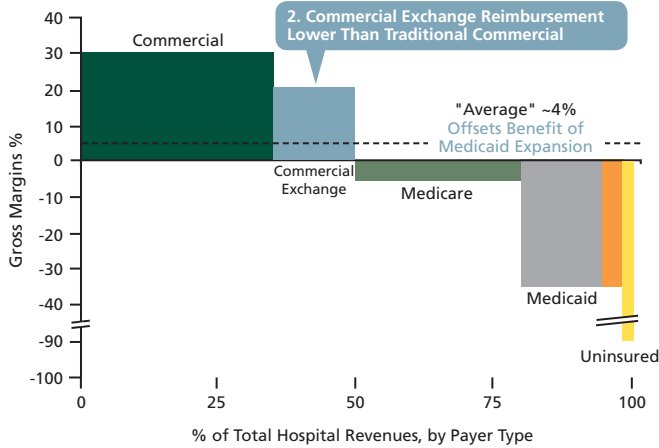
<sup>1</sup> Disproportionate share hospital (DSH) adjustment payments, according to the U.S. Health & Human Services, provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients; eligible hospitals are referred to as DSH hospitals.

<sup>2</sup> We leave aside the fact that these “losses” are by design borne by those who are insured – these costs are a part of the hospital cost base that is used to determine commercial and Medicare reimbursement.

**Figure 3**

**Impact of Exchange Product Reimbursement**

Hospital Gross Margins: Typical Suburban Community Hospital



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Source: L.E.K. Consulting analysis

Comparing Figure 1 with Figure 2, we see that the uninsured patient volume goes down, and those previously uninsured now are reimbursed at Medicaid rates. The net result is a 200 basis point improvement on the overall gross margin. In short, this describes the anticipated “conventional wisdom” uplift.

**2. The Impact of Insurance Exchanges: The Offset**

If the story ended there, this hospital's gross profits would improve by 50 percent. But this effect does not exist in a vacuum. Let us now consider another key impact, which is the advent of public insurance exchanges. Now being pursued across the United States, these exchanges (along with private exchanges) are beginning to take hold. As contracts are being signed for these products between payers and hospitals, L.E.K. research suggests that the “market-clearing” reimbursement levels for these products, while close to traditional commercial rates, are not quite as high as commercial rates.<sup>3</sup> As a result, these patients (who were being reimbursed at commercial rates but now are being reimbursed at the new exchange rates) will create negative pressure on hospital margins. Figure 3 shows this impact for our example hospital.

Various studies place the proportion of the commercial population that will shift eventually to the exchange at 20-30% of the overall traditional commercial population. Should this prediction prove accurate, the gains made as a result of the expansion of Medicaid will be offset by the shift of patient payer mix from commercial to commercial-exchange business.

**3. The Aging of the Population**

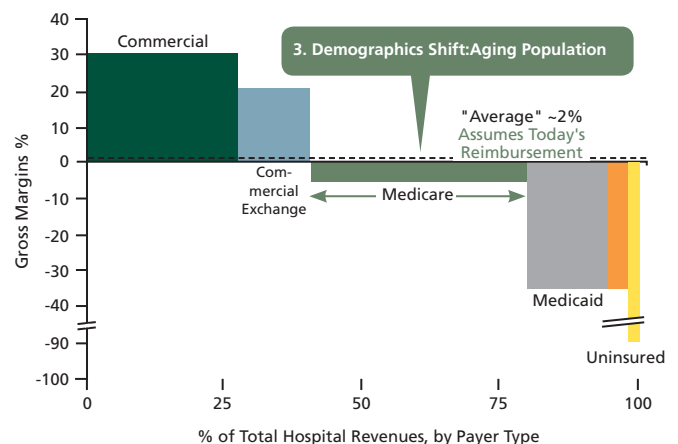
Each day, approximately 10,000 Americans turn 65, and become eligible for Medicare. Even without any consideration of the cuts to Medicare (which will be discussed in the next section), the changing patient mix alone will negatively impact the margins of our typical hospital. Figure 4 below shows this impact on our example hospital.

The example of Figure 4 only attributes a 10 percentage point shift in patient mix to Medicare. If current utilization rates were assumed, the demographic impact would be greater; however, we assume that the increased penetration of managed care in Medicare (via Medicare Advantage) and aligned incentives to control utilization will provide some buffer against this trend.

**Figure 4**

**Impact of Aging of the Population**

Hospital Gross Margins: Typical Suburban Community Hospital



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Source: L.E.K. Consulting analysis

<sup>3</sup> Notably, for-profit hospital chains such as Tenet and HCA have announced to investors that they are achieving commercial rates; however, our research with payers suggests that the market-clearing rates are falling below traditional commercial rates; state regulator limits on payer annual-rate increases are having an impact.

#### 4. Cuts to Medicare: The Other Shoe, and Cascading Impact

The Obama administration plans to take hundreds of billions of dollars from Medicare cumulatively over the next decade, disproportionately from managed care, but in fee-for-service as well. The net impact of this cut (mitigated by changes to standard of care, better utilization management, and improved asset utilization) is shown in Figure 5 for our example hospital.

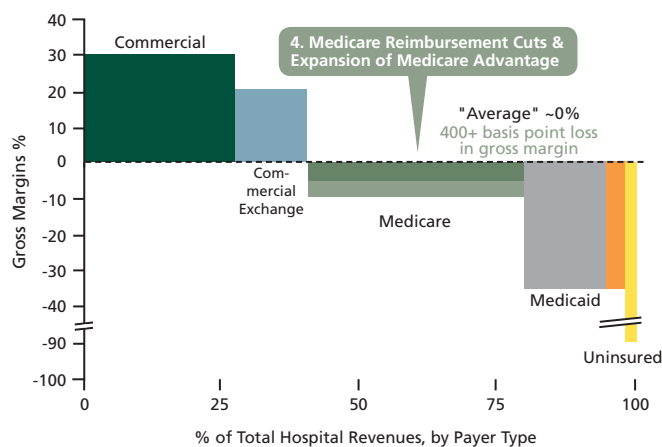
It is worth repeating that the impact of key trends on our example hospital will be felt to varying degrees by hospitals across the U.S., depending on their own patient mix, their underlying cost structure, their ability to react, and other factors. Medicaid funding (federal funding fuels most of the Medicaid expansion) may be particularly susceptible to further cuts in the future.

It is fair to say that the impact of Medicare cuts to our example hospital is understated; Medicare serves as a benchmark to commercial and Medicaid reimbursement schema; it can be expected that the other payers will take cues from Medicare's lead. Even in this muted example, however, our hospital's historical gross margin—four percent—is essentially eliminated. In fact, the one-two punch of expanded Medicare patient mix, and cuts to Medicare will be an impact that may swamp all other impacts.

**Figure 5**

#### Cuts to Medicare

Hospital Gross Margins: Typical Suburban Community Hospital



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Source: L.E.K. Consulting analysis

#### Implications for Hospitals and Other Players along the Value Chain

One would be tempted to despair given the magnitude and the unrelenting nature of these impacts. Even if the ACA were to be repealed, the underlying demographic and structural pressures would not be alleviated. The truth is simple: There is no more money. Even the most ardent opponent of the ACA would have to acknowledge that the law precipitates such insurmountable pain that the entire value chain must innovate and change in order to create new paradigms in order to survive, and thrive.

There is an obvious upside as well: once hospitals do find a way to make money at government reimbursement levels, margins on their commercial business will be even greater. This creates the virtuous cycle whereby more dollars would be available for further innovation, aggressive pricing that attracts even more patient volume through payer steerage, and so on.

To a large extent, leading hospitals are not standing still; having identified these trends, they are developing strategies, organizational structures and capabilities to create the new paradigm. These strategic initiatives include the following:

- **(Re)Evaluation of the Provider-Acquisition Strategy:**

Acquisition of physician practices in order to ensure referral flows and create more vertical integration (which would in turn enable ACO-like structures) has been a trend for about a decade; however, given the economic realities and the operational challenges of effectively managing physician practices ("now that you own it, how do you manage it?"), some hospitals are re-thinking the deployment of physician groups within their network, or developing core capabilities to manage these providers.

- **Evaluating All Cost Centers Within the Hospital for Value Creation:**

Services considered to be de rigueur such as diagnostic facilities, labs, ancillary services, and the like are being reviewed with a keen eye toward ROI, strategic value, and trade-offs versus other solutions. Best-of-breed service providers outside of the hospital who can either directly compete with – or more interestingly

partner with—hospitals have found that they have more options and a broader field of play available to them. Alternative sites (e.g., community clinics, outpatient settings outside of the hospitals, sub-acute and home-based services) are playing a key role in changing the economics and patient flows to meet the new paradigm—as long as their deployment is based on careful analysis of fundamental assumptions about cost, comparative advantage, and patient outcomes.

- **Developing Care Models that Synchronize More**

**Closely with Payers:** One of the key trends emerging from the other core part of the healthcare value chain is that payers are being forced to fundamentally evaluate their provider-network strategy; payers' clients (employers, individuals) have pushed cost sharing to individual beneficiaries as far as they can go. Payers, even in markets where open network access has been a foundational competitive requirement, are considering narrowing their network for some portion of their product offerings, and employers who had not entertained these types of narrow-network products are beginning to seriously consider them. Consequently, payers and providers are becoming more choosy in their "dance partners," and requiring tighter synchronization with operational processes, data exchanges, and work flows.

- **Developing Internal Utilization Management and Case Management Capabilities:**

Innovative hospitals are developing capabilities that were once the domain of payers. While the introduction of diagnosis-related groups (DRGs) spawned innovations by hospitals to manage patient utilization of assets once the patients were admitted, the new reality is requiring the hospital to think beyond its own walls to control patient flows, to direct patients to the appropriate levels of care, and to synchronize care management with external partners.

- **Embracing Government Business:** Not only do government-funded programs (Medicare, Medicaid, Medicare-Medicaid Alignment Initiatives, etc.) have lower reimbursement generally and overall, they also have fairly significant reporting requirements around patient protection, quality, cultural sensitivity and the like. In order for maximum potential for incentive-bonuses to be realized, hospitals with significant patient volume are aligning with these government program requirements. Certain hospital systems are going as far as directly acquiring the actual managed-care government programs, and still others are contemplating entering the Medicare Advantage business, not only as an end in and of itself, but as a means to learn core capabilities of operating in a government-heavy environment.

- **Developing Payer-Like Analytics and Reporting**

**Capabilities:** Whether it's direct reporting to the Center for Medicare and Medicaid Services (CMS) or to the state government, or coordinating with payers more closely, hospitals are seeing a need for the type of reporting and analytics capabilities that are more payer-like (at finer levels of detail), versus more clinical or capacity utilization-oriented metrics. These payer-like analytical capabilities are a natural extension of having to take on the activities of payers in various constructs.

## Summary and Conclusions

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This study has attempted to capture the latest in the evolution of the hospital as the nexus of care in the United States. Innovations that are defining the new paradigm have far-reaching implications for the rest of the value chain. Indeed, it is hard to contemplate a meaningful bend to the healthcare cost curve that does not involve a material contribution from hospitals.

The encouraging news is that leading hospital systems (those with commanding market presence and power, and thus with incentives to preserve the status quo) are among the most active in defining and creating the new paradigm. Periods of chaos and upheaval are opportunities for some to feast, while others starve. Now appears to be one of those times.

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