

Mining Audited Financial Statements to Better Assess Health System Financial Strength and Inform Policy Decisions

By: [Robert A. Berenson, M.D.](#)

The lead story in the [October 5, 2021](#) issue of the Washington Post regarding hospital finances during the coronavirus pandemic highlighted an American Hospital Association spokesperson's recent assertion that "the delta variant has wreaked havoc on hospitals and health systems." The article explained that staff shortages were raising staff salaries substantially, leading to "excess labor costs," which, in combination with a new round of deferred elective procedures during the most recent surge of the delta variant, has reduced hospital profit margins and cash flow.

Current approaches that journalists, researchers, and policy makers use to assess hospital financial strength focus inordinately on revenue trends and profit margins while ignoring the underlying wealth of health systems. This focus on profitability is similar to federal tax policy that taxes income but not the cumulative wealth of the taxpayer. Standard and routinely produced accounting metrics such as the entity's liquidity, solvency and debt capacity, and adequacy of capital investment are often more relevant to a policy issue under consideration – or at least as important – as short-term profitability as measured by the entity's operating and total profit margins.

My purpose here is not to minimize the short-term, profitability challenge that hospitals and health systems now face in the COVID-19 pandemic. Rather, the purpose is to show that a comprehensive accounting for hospital finances provides a different and more accurate financial picture of hospital systems. A comprehensive analysis based on audited financial statements (AFSs) demonstrates that many hospitals, sometimes referred to as “have nots,” face immediate financial stress because they lack negotiating clout with commercial insurers over prices, but that the “have” health systems, typically enjoying strong market power, possess substantial wealth that can readily cover temporary, pandemic-induced shortfalls.

AFSs are the gold standard of health system financial data. They include detailed information about system finances and are certified by outside auditors because the health systems are legally accountable for the accuracy of the information provided. AFSs are available for nearly all hospitals and health systems that participate in the municipal bond market.[\[1\]](#) While policy makers seem oblivious to the readily available AFSs, institutional investors routinely use them to assess the ability of health systems to repay debt.

To illustrate the value and feasibility of using AFSs for policy-related financial analysis, a team of Urban Institute and Harvard-affiliated policy researchers [conducted a study](#) that standardized the AFSs of 50 general hospitals and health systems, representing different ownership categories (for-profit, government-owned, and nonprofit – the largest cohort) and sizes. The sample comprised about one quarter of national admissions adjusted for outpatient activity for 2017-2019.[\[2\]](#) The study showed:

- Medium and large-sized, private, nonprofit health systems typically maintained enough cash on hand to fund operations, assuming no additional revenue, for an average of more than seven months, with some exceeding one year, far more than rating agencies deem necessary

for liquidity purposes.

- On average, and particularly for large nonprofit health systems with substantial liquidity, investment income and market value appreciation contributed as much or more to total margins as did revenues from patient care services; total profit margins were about double operating margins, although with substantial variation across the sample.
- There is a massive financial gap between the haves (mostly nonprofit health systems) and the have-nots (often government-owned hospitals serving low-income populations), not only in profitability, but also in liquidity, solvency, and capital spending metrics. In our sample of 14 government health systems, eight had days cash on hand of less than 100 days, whereas the nine large health systems all had days cash on hand of between about 150 and 400 days. Size by itself, however, was only a weak predictor of underlying financial position; the hospital in our sample with the most days cash on hand was a small, private, non-profit in Kansas with only a small share of their revenues coming from Medicaid.

The study also detailed the absolute level of cash and investments that health systems maintained – a standard metric provided in AFSs. The nine large health systems in our sample had cash and investments worth between \$5 billion and \$19 billion. It is important to understand that by itself, the level of cash and investments can be misleading, because health systems can have substantial long-term debt, as detailed in the paper. It also should be noted, as a point of comparison that publicly traded, for-profit companies do not maintain substantial cash and investments because they generally distribute surpluses as shareholder dividends or buy back their own stock. Other metrics are used to assess for-profit health systems' financial strength.

C-Suite executives of nonprofit health systems commonly justify their demands for ever higher negotiated insurer payment rates and, sometimes, aggressive efforts to collect debt from even uninsured patients with the aphorism, “No money, no mission.” But at some point, maintaining substantial amounts of cash on hand is correctly seen as avaricious behavior, especially when have-not safety net and rural hospitals struggle to survive. The behavior should draw attention to whether their tax-exempt status continues to be sound public policy.

The level of retained cash and investments, recognizing the need to consider debt obligations, demonstrates an order of magnitude of health system wealth that can surely inform policy. For example, this information can apply to enforcement of the recently promulgated price transparency regulations, which require hospitals to post their chargemaster prices as well as the rates they negotiate with individual insurance companies.[\[3\]](#) Under the initial regulations that took effect January 1, 2021, hospitals that do not comply can face a penalty of up to \$300 a day. In a recently released [proposed regulation](#), the Centers for Medicare & Medicaid Services (CMS) has proposed increasing the penalty on a sliding scale based on hospital size. If implemented as proposed, under a full year of non-compliance, the minimum total penalty amount would be \$109,500, and the maximum total penalty would be \$2,007,500 per hospital. However, as mentioned earlier, size does not necessarily predict liquidity. A more logical approach to enforcement of the price transparency rule would be to base fine levels on days cash on hand and other metrics found in AFSs.

The proposal to raise the fines for non-compliance may get the attention of hospital CFOs and Boards of Directors, but, as a hospital consultant opined in a recent [Modern Healthcare article](#), “Some operators are saying, ‘It is a whole lot cheaper for me to write a check for \$2 million.’” While the

size-based penalty would be a non-trivial \$20 million for a system with, say, 10 hospitals, that amount still represents merely a rounding error for many health systems with AFSs that show more than \$5 billion sitting mostly in marketable securities. It's no surprise, then, that most hospitals and health systems have chosen not to comply with the price transparency rule.

In addition to price transparency compliance, here are just a few of the many policy issues for which a comprehensive and standardized, AFS data base would permit more informed decisions:

- AFSs would have informed distribution of Provider Relief Funds under the CARES Act so that bailout funds could be directed more to hospitals with need rather than wealthy hospitals with no problem weathering temporary shortfalls. [\[4\]](#)
- The substantial days of cash on hand, solid profits, and low levels of uncompensated care of many nonprofit systems raise questions about the purpose and validity of favorable tax treatment of this class of hospitals. [\[5\]](#)
- High liquidity, profitability, and solvency as reflected in AFSs lend support to growing interest in placing limits on negotiated rates and/or rate increases that health systems with market power are able to achieve. [\[6\]](#)

[Twelve states](#), including California and Florida, currently require some form of financial reporting using AFSs, without imposing unreasonable reporting burdens. A comprehensive, national database of standardized AFSs, focusing attention on variations across health systems, would provide a greatly enhanced picture of health system finances, with many potential policy applications.

Research and investigative journalism have documented that private, nonprofit hospitals and health systems pay relatively

high salaries, especially to their C-suite executives, have high staffing ratios, and are readily able to replace and upgrade their physical plants. The reality that many nonprofit health systems also maintain substantial stock portfolios that often produce annual income and stock appreciation that exceeds the total revenues from their operations may be surprising to many. Nationally, some health systems use their powerful financial positions increasingly to dominate health care delivery by buying up competing hospitals, physician practices and post-acute care facilities, directly employing formerly independent health professionals, and creating their own health insurance products, among other initiatives, all contributing to sluggish and nonresponsive health care markets.^[7] Overdue action, including more aggressive antitrust enforcement, direct price regulation, and even removing the tax-exempt status of offensively rich health systems should be on the policy table.

^[1] The Municipal Securities Regulation Board makes them available online shortly after their filing on a website called EMMA, available at <https://emma.msrb.org/TradeData/MostActivelyTraded>.

^[2] The paper presents some of the data cited as a three-year average.

^[3] See Dan Diamond, *Nearly all hospitals flout federal requirement to post prices, report finds*, Washington Post (July 16, 2021); Sarah Kliff, *Hospitals and Insurers Didn't Want You to See These Prices. Here's Why*, New York Times (August 22, 2021).

^[4] Jesse Drucker, Jessica Silver-Greenberg and Sarah Kliff, *Wealthiest hospitals get billions in bailout for struggling health providers*, New York Times (May 25, 2020).

[\[5\]](#) Ge Bai and Gerard F. Anderson, *A More Detailed Understanding Of Factors Associated With Hospital Profitability*, Health Affairs (May 2016).

[\[6\]](#) Michael E. Chernew, Leemore Dafny, and Maximilian Pany, *A proposal to cap provider prices and price growth in the commercial health-care market*, The Brookings Institution (March 10, 2020).

[\[7\]](#) Martin Gaynor, *What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work*, The Hamilton Project (March 10, 2020).

About the Author:

[Robert A. Berenson, M.D.](#), is an Institute Fellow at the Urban Institute, performing policy analysis on provider payment reform, health care market consolidation, and performance measurement. He was a member of the Medicare Payment Advisory Commission (MedPAC), serving two years as Vice-Chair. In the Clinton Administration Dr. Berenson directed Medicare payment policy and private health plan contracting in the Centers for Medicare and Medicaid Services. He is a graduate of Brandeis University and the Mount Sinai School of Medicine. He practiced internal medicine in a small group practice in Washington DC.

Submit your guest blog entry to be published on The Source Blog [here](#)!