10 top healthcare finance trends of 2017

The most important developments hospital finance and operations executives should understand heading into 2018.

Tightening budgets, power deals threatening hospitals, Amazon and MACRA - - those are just the start of industry-shaping trends that came about in 2017.

Let's take a look at the ten most important developments this year and why they matter to hospitals and health insurance companies alike.

1. Squeezed tight

Not-for-profit providers are operating on ever-thinning margins, a trend expected to continue to be foremost on finance executives' minds for 2018.

Hospitals' median operating margin fell from 3.4 to 2.7 percent between 2015 and 2016, a Moody's Investors Service report said earlier this year. Cash flows also declined.

What is growing are expenses, by 7.5 percent last year, faster than annual operating revenues of 6.6 percent, the report said.

Everything is more expensive, from labor to prescription drugs. The shift to value-based payment is risky; Medicare, with its flat and lower rates than commercial insurance, is becoming a bigger piece of the reimbursement pie as baby boomers retire; and the amount of uncompensated care is expected to increase as a result of the tax bill ending the individual mandate.

Providers are getting no help from payers, as the insurance industry moves into their territory of basic care.
2. Payer power deals compete with primary care

The most recent direct assault is Anthem's deal to buy HealthSun, a Florida network of primary care practices that will benefit Anthem's Medicare Advantage members.

The acquisition signals Anthem's intent to compete with UnitedHealth's Optum, Forbes' Bruce Japsen said.

UnitedHealth Group has been on its own buying binge for Optum, recently paying $4.9 billion for DaVita Medical Group. Perhaps not surprisingly, Anthem's new CEO Gail Boudreaux, is a former UnitedHealth executive.

3. Payers, pharmacists and Amazon

In December, CVS Health's $69 billion bid to buy Aetna had analysts wondering what companies would be next to integrate prescription drugs and insurers.

The data and analytics of a combined CVS\Aetna population health business redefines the retail healthcare business and what it means to offer high quality care in a lower cost setting.

Hospitals that have extended their reach by building outpatient facilities in the remote reaches of their market may find it hard to compete against a CVS that has mini health hubs in 9,700 pharmacies on city corners in just about every major metropolitan area.

Generating even more buzz and worry is a deal that's still in the speculation stage, that of Amazon potentially getting into the pharmacy business. Cleveland Clinic CEO Toby Cosgrove said at a recent Medical Innovation Summit in Cleveland, "We are concerned about the major forces, Amazon ... coming at us in purchasing."

Some analysts have said the CVS and Aetna deal was spurred by the possibility of an Amazon Pharmacy.

Cleveland Clinic's Toby Cosgrove said, "Without significant consolidation on the part of providers, it's going to put us at a disadvantage."
4. Drugs and the supply chain

During his first public appearance before Congress after taking over as head of the Department of Health and Human Services, Alex Azar, former pharma executive, said prescription drug prices are too high.

Retail prices for 768 prescription drugs commonly used by older adults increased by an average of 6.4 percent in 2015, outpacing the general inflation rate of 0.1 percent, according to an AARP Public Policy Institute report. This is at least the 12th straight year of substantial retail price increases for prescription drugs, the report said.

Cleveland Clinic's Toby Cosgrove said the EpiPen hike took 10 percent out of the pharmacy and led to a major cost reduction. Two drugs that have been around for 50 years increased costs by 11 percent, Cosgrove said, calling the price hikes on generics "unscrupulous, unethical and words I can't use in a mixed audience."

Steve Ubl, president and CEO of PhRMA put it this way: "The entire supply chain will need to be evaluated."

5. Healthcare policy changes

Changes in leadership at the Centers for Medicare and Medicaid Services, a cut-back on mandatory bundles, a change in direction for CMMI, the new tax law ending the individual mandate and GOP aims to tackle some entitlement programs next year, add to market uncertainty.

6. Mega-mergers continue

While the unsuccessful Anthem-Cigna and Aetna-Humana mergers were winding down by the end of the first quarter of 2017, mergers and integration continued as a way to get the efficiencies of scale needed to stay competitive.

Some of the notable not already mentioned included the alignment of Penn State Health and Highmark on a $1 billion care network; Cigna's acquisition of IT startup, Brighter; Walgreens partnering with NewYork-Presbyterian to offer in-store telemedicine; and Advocate and Aurora Health Care combining to create an $11 billion health system. And these are just from December.
7. Instability in the individual insurance market

President Donald Trump said after the tax reform vote that Congress has essentially repealed Obamacare. While Maine Senator Susan Collins' explanation for why she voted for the bill in the Portland Press Herald on Wednesday said, correctly, that the bill takes no one's insurance away, the bill does end the incentive to avoid the financial penalty to get health insurance.

Without that individual mandate, only those needing healthcare will be certain to buy coverage, hiking premiums and putting the Affordable Care Act in a death spiral.

Collins had voted for the tax plan after voting against ending the ACA on assurances that individual health insurance market stability would be addressed through reinsurance and cost-sharing reduction payments to insurers in a year-end spending bill. But without full GOP support, Collins and Senator Lamar Alexander of Tennessee said those measures will have to wait until after the first of year, when Congress considers reauthorizing the Children's Health Insurance Program, or CHIP.

8. Cost-sharing reduction payments

Insurers in the Affordable Care Act market for 2018 lost the cost-sharing reduction payments from the federal government. But by law they're still mandated to help pay the deductibles and out-of-pocket costs for lower-income consumers on their ACA plans.

Some insurers were able to increase their premiums to reflect the increased expense, while others were not. Do insurers remaining in the market need another reason to leave the ACA business?

9. Physician shortages

Healthcare executives are facing a physician shortage due to an aging physician population and that of the general population. It's not that young people no longer want to become physicians, but there's a lack of residency slots.
Efficiencies include making sure physicians have a full appointment schedules, but those doctors in high demand are commanding ever-increasing salaries.

10. MACRA

MIPS and APMS are challenges providers and physicians have only started to get a handle on with the 2017 reporting period that will count towards payment in 2019.

As more providers aim for advanced alternative payment models to get better financial results, hospital executives will be planning for more change to their business model to reflect value-based care.