As seen in ***Healthcare Business Today***

Hospitals Cannot Continue to Foot the Bill: What's at Stake for Patient Care

By Carol Wesley

For decades, hospitals have served as the healthcare system's safety net, absorbing financial pressures that other stakeholders could not or would not bear. They have cared for uninsured patients, maintained essential community services, funded unprofitable but necessary programs, and continued investing in quality and safety despite mounting economic challenges.

Today, however, that model is reaching a breaking point.

Recent reporting from *Becker's Hospital Review* points to a convergence of proposed reimbursement reductions, Medicaid coverage losses, expanded site-neutral payment, and rising uncompensated care that could significantly weaken hospital finances beginning in 2027. For organizations already operating on razor-thin margins, the question is no longer whether they can absorb additional pressure. It is which services, investments, and community benefits will be lost when they cannot.

The Perfect Storm Facing Hospitals

Hospital leaders are accustomed to managing policy changes. They have navigated reimbursement cuts, regulatory reforms, labor shortages, and economic downturns before.

What makes the current environment different is the cumulative impact of multiple policies arriving at the same time.

According to *Becker's*, hospitals are preparing for:

- Significant reductions in 340B reimbursement
- Expanded site-neutral payment policies
- Medicaid work requirements and eligibility changes
- Rising uninsured populations
- Increasing bad debt and charity care
- Continued workforce and operating cost pressures

Individually, each challenge would be significant. Together, they create a degree of financial strain that many health systems have never faced at the same time.

The Myth of Endless Efficiency

There is a common belief that hospitals can simply become more efficient whenever reimbursement declines. While healthcare organizations should always pursue operational improvement, that perspective often overlooks the reality of what has already taken place inside hospitals over the past two decades.

Having spent years as both a bedside nurse and later as a healthcare leader, I have witnessed firsthand the relentless focus on efficiency. Hospitals have not been standing still waiting for financial pressure to arrive. They have been responding to it for years by:

- Streamlining operations
- Consolidating services
- Implementing technology solutions
- Optimizing staffing models
- Reducing administrative costs
- Standardizing clinical processes
- Improving supply chain management

In leadership meetings, every expense is scrutinized. Every vacancy is evaluated. Every process is reviewed for opportunities to eliminate waste while preserving quality and safety. And as a nurse, I saw the impact of those decisions translated into daily operations, with caregivers continually being asked to do more with the same or fewer resources.

The reality is that many hospitals have already captured the most obvious efficiencies. There comes a point when further reductions are no longer about eliminating waste. They begin affecting people, programs, and services.

When reimbursement cuts continue after efficiency opportunities have largely been exhausted, the decisions become far more difficult. Leaders are no longer debating operational improvements. They are evaluating whether they can continue to support behavioral health programs, rural clinics, community outreach initiatives, maternity services, or other essential offerings that may not cover their costs but are critical to the health of the community.

Having stood at the bedside and later sat in the boardroom, I can say with confidence that hospital leaders do not take these decisions lightly. They understand that every budget reduction ultimately has the potential to affect a patient, a caregiver, or a service that a community relies upon. The challenge facing hospitals today is not a lack of commitment to efficiency. It is the growing gap between the cost of delivering safe, high-quality care and the reimbursement available to support it.

The Real Value of 340B

Much of the current discussion focuses on proposed changes to the 340B program, but this is not simply a pharmacy issue.

Across the country, hospitals use 340B savings to support services that often cannot sustain themselves financially, including:

- Oncology programs
- Behavioral health services
- Community outreach initiatives
- Rural health clinics
- Medication assistance programs
- Care coordination efforts

When reimbursement is reduced, the impact does not remain within the pharmacy department. It ripples throughout the organization, affecting programs that improve community health and provide access for vulnerable populations.

The reality is simple: Every dollar removed from these funding mechanisms ultimately has to come from somewhere else. If an alternative source does not exist, services become vulnerable.

The Financial Squeeze: Hospitals Are Being Pressured from Both Sides

While much of the current attention is focused on federal reimbursement changes, government policy is only part of the challenge facing hospitals today.

For decades, hospitals have operated within an imperfect but workable financial model. Reimbursement from commercial insurers helped offset chronic underpayments from Medicare and Medicaid while also supporting charity care, uncompensated services, trauma programs, emergency departments, behavioral health services, and other essential community resources. This cross-subsidization allowed hospitals to continue meeting their mission even when certain services consistently operated at a loss.

That model is becoming increasingly difficult to sustain.

Commercial insurers are under growing pressure from employers and consumers to control healthcare costs and moderate premium increases. In response, many health plans have adopted strategies aimed at reducing spending, including lower reimbursement rates, site-neutral payment policies, narrower provider networks, increased prior authorization requirements, more aggressive denial management practices, and greater cost-sharing responsibility for patients.

Viewed independently, many of these approaches can be justified as efforts to improve affordability and efficiency. However, when combined with declining government reimbursement and increasing levels of uncompensated care, they create a compounding financial burden for hospitals.

The reality is that hospitals are being squeezed from both directions. Government programs continue to reduce funding or tighten reimbursement, while commercial payers increasingly seek to lower healthcare expenditures. At the same time, hospitals remain responsible for caring for patients regardless of their insurance coverage, financial circumstances, or ability to pay.

As a result, the longstanding cost-shifting model that helped stabilize healthcare delivery is beginning to break down. Hospitals can no longer rely on commercial reimbursement to make up for losses elsewhere in the system. The gap between the actual cost of providing care and the payment received for that care continues to widen.

When that gap becomes too large, the consequences extend far beyond a hospital's balance sheet. Leaders are forced to make difficult decisions about staffing, service lines, facility investments, technology upgrades, and community programs. These are not simply financial decisions; they directly affect access to care, patient experience, workforce sustainability, and the long-term health of the communities hospitals serve.

The challenge facing healthcare today is not the result of any single policy or stakeholder. Rather, it is the cumulative effect of a system in which nearly every participant is trying to reduce costs while hospitals continue to bear responsibility for maintaining access, quality, and safety. Eventually, that burden becomes unsustainable—and patients and communities feel the impact first.

Financial Stability and Quality Are Inseparable

One of the most dangerous misconceptions in healthcare policy is the idea that financial performance and patient outcomes exist independently.

I say they do not.

High-quality care depends on investments in:

- Clinical staffing
- Patient safety programs
- Cybersecurity
- Medical equipment
- Facility modernization
- Workforce development
- Quality improvement initiatives
- Emergency preparedness

Every community expects its hospital to deliver safe, reliable, high-quality care. Yet all of these capabilities require sustainable funding.

When financial pressure increases, organizations often postpone technology upgrades, delay capital investments,

freeze hiring, or scale back support services. While these actions may preserve short-term stability, prolonged financial strain eventually affects operational performance.

Patient safety, workforce resilience, and quality outcomes all require resources.

Communities Ultimately Pay the Price

The biggest risk facing healthcare is not declining hospital profitability.

The biggest risk is declining access.

Hospitals across the country are closing departments, reducing services, and eliminating positions as financial pressures increase. Many communities—particularly rural and safety-net markets—have little excess healthcare capacity to absorb those losses.

When hospitals cannot sustain services, communities may face:

- Longer emergency department wait times
- Reduced behavioral health access
- Closure of maternity programs
- Fewer specialty services
- Longer travel times for care
- Delayed treatment
- Reduced preventive and outreach programs

These consequences extend far beyond hospital balance sheets.

They affect families seeking care close to home, employers trying to maintain a healthy workforce, and communities depending on healthcare as a foundational public service.

A Shared Responsibility

This is not about assigning blame to any single stakeholder.

Policymakers are trying to manage federal spending. Insurers are attempting to control premium costs. Employers want affordable coverage. Hospitals are working to maintain access and quality.

The problem arises when every sector assumes hospitals can continue absorbing the resulting financial burden indefinitely. They cannot.

If communities expect hospitals to provide emergency care 24 hours a day, maintain specialized clinical programs, invest in technology, train future caregivers, care for vulnerable populations, and respond to public health emergencies, the healthcare financing system must support that mission.

Healthcare leaders must continue driving efficiency and innovation. But efficiency alone will not solve a growing mismatch between the cost of care and the funding available to deliver it.

As we look toward 2027, the conversation must move beyond reimbursement policy and operating margins. The real issue is whether communities will continue to have access to the safe, high-quality care they expect and deserve.

Hospitals have carried the financial burden for years. The system now faces a pivotal question: **If hospitals can no longer foot the bill, who will, and what happens to patient care if no one does?**



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