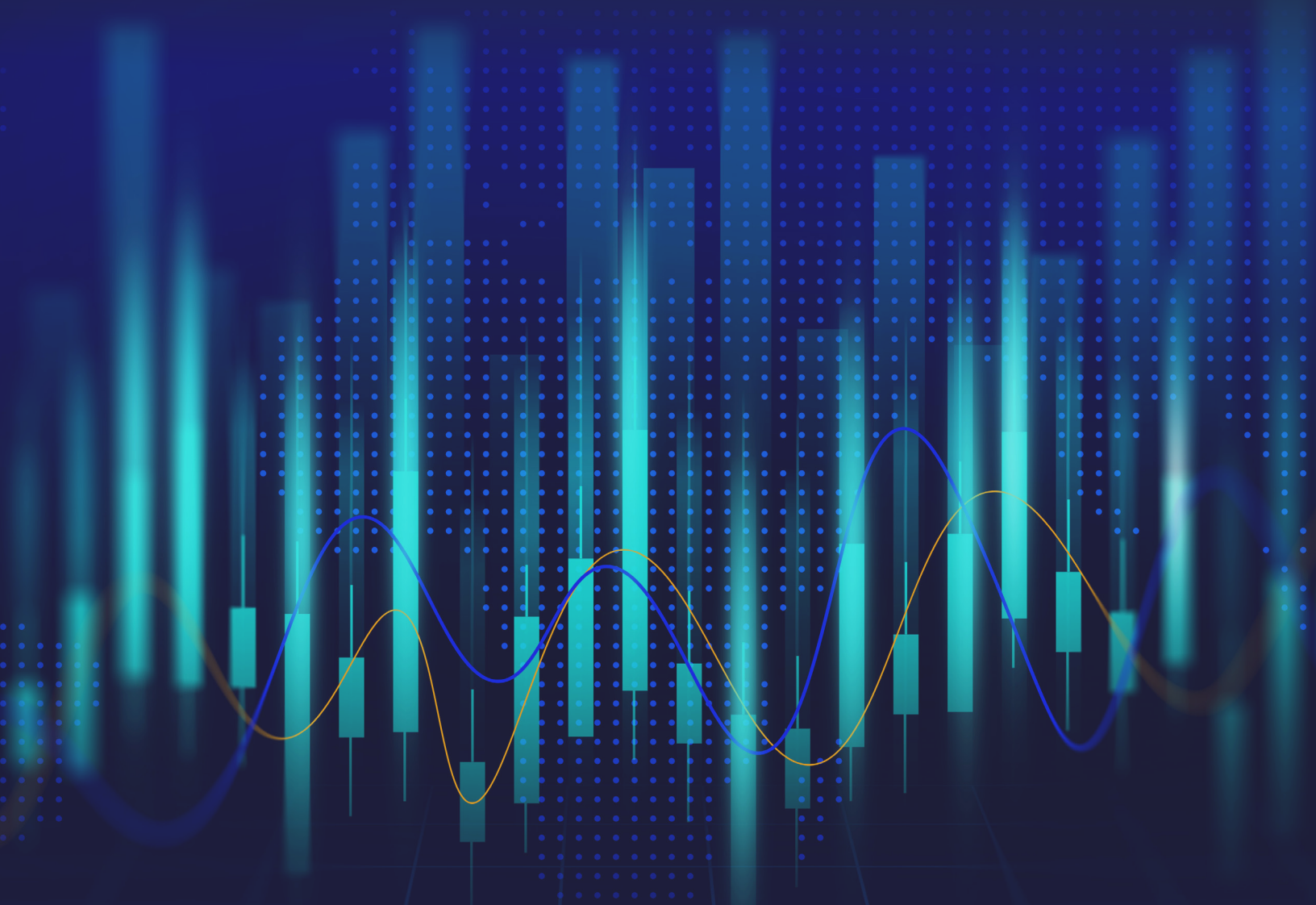
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Financial Health and Investment Benchmark Study



Executive Summary

The "HFMA Financial Health and Investment Benchmark Study," sponsored by Fidelity Investments®, aims to inform health system CFOs about market challenges, opportunities, and emerging trends.

An independent research company conducted the study with healthcare industry CFOs, subject matter experts from Fidelity and the HFMA, and included secondary research to provide context and support findings when applicable.

Here are the key findings from the study:

THE CORE PARADOX: 'PAYING MORE TO EARN LESS'

U.S. healthcare organizations face a persistent financial squeeze: They are paying more to earn less. While top-line revenues remain steady, operating expenses for labor, medical supplies, utilities, and high-cost specialty pharmaceuticals continue to climb faster than reimbursement rate increases.

RISING EXPENSES OUTPACE REIMBURSEMENT GROWTH

Higher costs for labor, medical supplies, and network infrastructure are keeping hospital operating margins below the 6% EBITDA level needed for ongoing capital planning.[1]

- **Labor Expenses:** According to the American Hospital Association (AHA), personnel costs account for about 60% of hospital budgets.[2] During the study, industry experts reported annual healthcare costs rising 8% to 9%, showing how inflation greatly affects the financial strength of health systems.
  - **Wages:** Payroll represents the largest slice of operating expenses; wage increases directly shrink operating margins.
  - **Benefits:** Health systems allocate an average of 10% of their net revenue to employee healthcare benefits, with prescription drugs accounting for 22% of their overall healthcare spending.
  - **Pensions:** Nearly 30% of health systems have active pensions.
- **Supply and Drug Costs:** The study found that medical supplies make up 17% of net patient service revenue. Industry experts reported a "double whammy" on drug costs—rising employee pharmacy costs alongside the need to acquire expensive patient drug treatments. Half (54%) of health systems face moderate-to-high tariff impacts that could raise supply costs by 15% to 20%.
- **Cybersecurity Spend:** Sixty-nine percent (69%) of health systems are boosting their cybersecurity budgets to secure clinical infrastructure and avoid costly data breaches.

To counter these rising expenses, healthcare leaders are actively exploring various cost-containment strategies.

RESTRUCTURING WORKFORCE BENEFITS AND SUPPLY CONTRACTS

To offset persistent margin erosion, financial leaders are re-engineering employee benefits and renegotiating vendor supply contracts to curb non-labor spending and workforce overhead.

- **Health Savings Account (HSA) Expansion and Cost Sharing:** Over sixty-five percent of health systems have or plan to adopt High-deductible Health Savings Account plans, while over 50% plan to raise premiums to directly reduce organizational health benefit liabilities.
- **Centers of Excellence (COE), Narrow Networks and Direct Contracting:** Forty-six (46%) percent of large systems plan to expand narrow networks (27% mid-sized, 29% small), and 44% plan to expand COEs (21% mid-sized, 12% small).
- **Pharmacy Benefit Manager (PBM) Restructuring:** Over 50% of mid-to-large systems are renegotiating PBM agreements, and 41% of midsize systems (26% small, 24% large) are switching to alternative providers to eliminate hidden vendor markups and manage rising drug costs.
- **Direct Vendor Negotiations:** Seventy percent (70%) of health systems intend to negotiate better vendor pricing, while 61% intend to streamline inventory, directly lowering non-labor operating costs for medical supplies and drugs.

- **Regional Purchasing Coalitions:** Health systems are aggregating purchasing power with regional peers to negotiate directly with manufacturers.

OPTIMIZING BALANCE SHEETS AND DIVERSIFYING INVESTMENTS TO SUPPORT LIQUIDITY

With tight operating margins, CFOs are using balance sheet strategies and non-operating investments to generate supplemental capital.

- **Short-term Cash Reserves:** Over 60% of systems hold short-term capital in low-risk cash/money market accounts, 50% in bonds, and 34% in equities.
- **Preemptive Debt Issuance:** CFOs are issuing debt early ($26.2 billion in municipal bond volume year-to-date) to build liquidity before regulatory changes weaken future borrowing capacity.
- **Investment Diversification**: Systems are investing in technology (73%), service delivery (55%), and life science (31%) funds to generate nonoperating revenue.
- **Outsourced Investment Management:** Twenty-eight percent (28%) of health systems have engaged or plan to engage an outsourced chief investment officer (OCIO) to reduce administrative overhead and manage portfolio risk.

FORGING CREATIVE GROWTH STRATEGIES, PARTNERSHIPS, AND PHILANTHROPY

To offset persistent margin pressures and high borrowing costs, health system financial leaders are pivoting away from traditional, capital-intensive hospital builds and pursuing sustainable growth initiatives.

- **Capital-light Outpatient Growth:** Health systems are expanding outpatient networks to capture regional market share and drive patient volume to core hospitals at a fraction of traditional capital costs.
- **Insurance Reserves:** Health system reserves average $20.3 million overall, with 66% maintaining funding levels and 33% increasing them.
- **Regional Consolidation:** Forty-eight percent (48%) of health system executives are evaluating or pursuing mergers and acquisitions (M&A), with transactions shifting toward large, system-on-system consolidations to build regional density.
- **Joint Ventures (JVs) and Venture Funds:** Sixty-two percent (62%) of health systems currently operate or plan to operate technology JVs, while many still avoid private equity (PE).
- **Philanthropy:** More than half (57%) of health systems have already started to increase their philanthropic efforts, and 53% expect foundation dollars to grow over the next year.

LEVERAGING AI AND PAYER STRATEGY

To help lower collection costs and streamline administrative processes with commercial payers, health systems are investing in operational technologies and revisiting payer contracts to reduce claim denials and administrative workload.

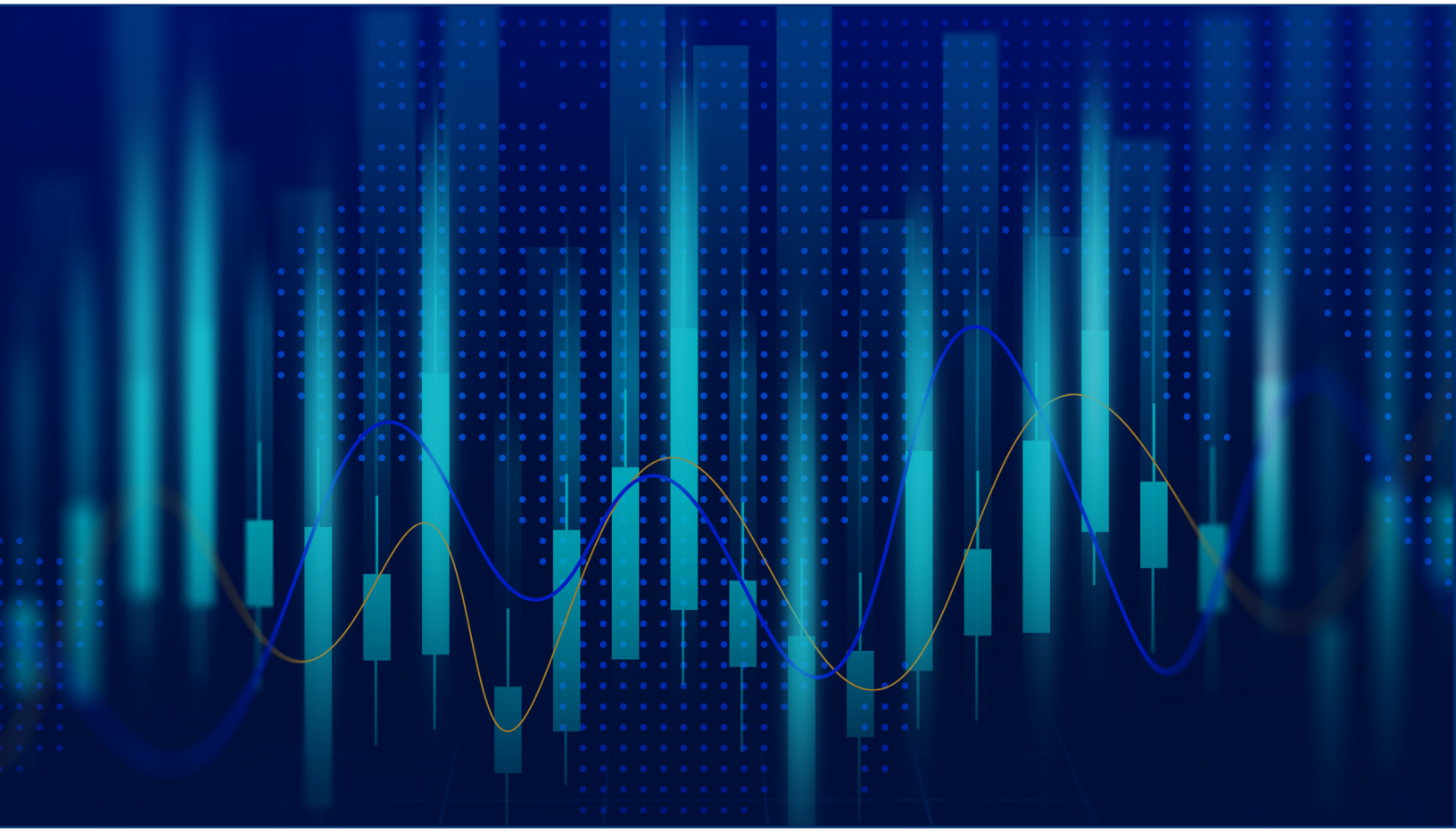
- **Targeted AI Investments:** Eighty-four percent (84%) of health systems plan to increase their AI investments, focusing on quick-return tools like ambient listening.
- **Revenue Cycle Management:** Seventy-seven percent (77%) of health systems feel frustrated by payer denials, and 67% by prior authorization requirements; many are adopting technology to reduce their administrative workload and reduce costs.
- **Direct Contracts:** Sixty-four percent (64%) of health systems are frustrated by ever-changing payer rules and policies, driving them toward direct contracts and away from Medicare Advantage plans.

STRATEGIC OUTLOOK: SECURING LONG-TERM FINANCIAL VIABILITY

Overcoming the paying more to earn less paradox has led health systems to replace traditional, capital-intensive growth models with alternative strategies that include re-engineering benefit liabilities, maximizing balance sheet liquidity, expanding capital-light outpatient networks, and deploying targeted AI to eliminate administrative friction.

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CHAPTER 1:

Market Dynamics Shaping U.S. Health Systems

Healthcare organizations across the United States face a persistent financial reality: They are paying more to earn less.

While top-line revenues remain steady, operating expenses continue to outpace reimbursement growth, pushing hospital operating margins down to an average of 2%. According to the "Kaufman Hall National Hospital Flash Report," median hospital operating margins ended 2025 at 1.3%—far below the 6% EBITDA baseline generally required to fund facility upgrades and technological reinvestment.[3]

As a result, 90% of healthcare leaders view the current U.S. healthcare model as **financially unsustainable** over the long term, and 77% anticipate a severe delivery crisis within three years.[4] As Fidelity Investments' Ben Isgur noted in a preliminary interview, "What's unique about health systems is that every operating input is one of the highest-cost inputs you could have in any U.S. industry."

Four primary market dynamics drive this ongoing margin erosion:

1 Rising Workforce and Supply Costs

According to the AHA, labor remains the largest single expense for healthcare providers, accounting for 60% of hospital operating budgets.[5] Adding to wage pressures, employee healthcare benefit costs continue to rise. Industry experts interviewed for this benchmark study report that medical cost trends are running at 8%-9% annually, outpacing general consumer price inflation and baseline wage growth.[6] Supply chain expenses also remain high, driven by expanding clinical utilization and substantial spending on specialty pharmaceuticals.

2 Payer Friction and Demographic Shifts

Health systems face mounting administrative friction with payers, driven by strict prior-authorization mandates and automated claim denials that reduce collection rates and increase overhead. At the same time, an aging population is shifting patient volume from commercial insurance to lower-reimbursing Medicare programs, lowering overall yield per clinical episode.

3 Policy, Legislative, and Regulatory Volatility

Regulatory and legislative shifts introduce additional unpredictability. Potential policy changes related to the "**One Big Beautiful Bill Act (OBBBA)**" and modifications to the **340B model** may further erode operating margins.[7] [8] A recent **report** from a healthcare thought leader shows that OBBBA's combined adjustments to premium subsidies and Medicaid eligibility are expected to cut $68.5 billion from hospital revenues nationwide. On average, this amounts to a $16.1 million loss per hospital.[9]

Routine drug purchasing and Medicaid reimbursement, once relatively predictable components of revenue cycle management, now require active risk mitigation.

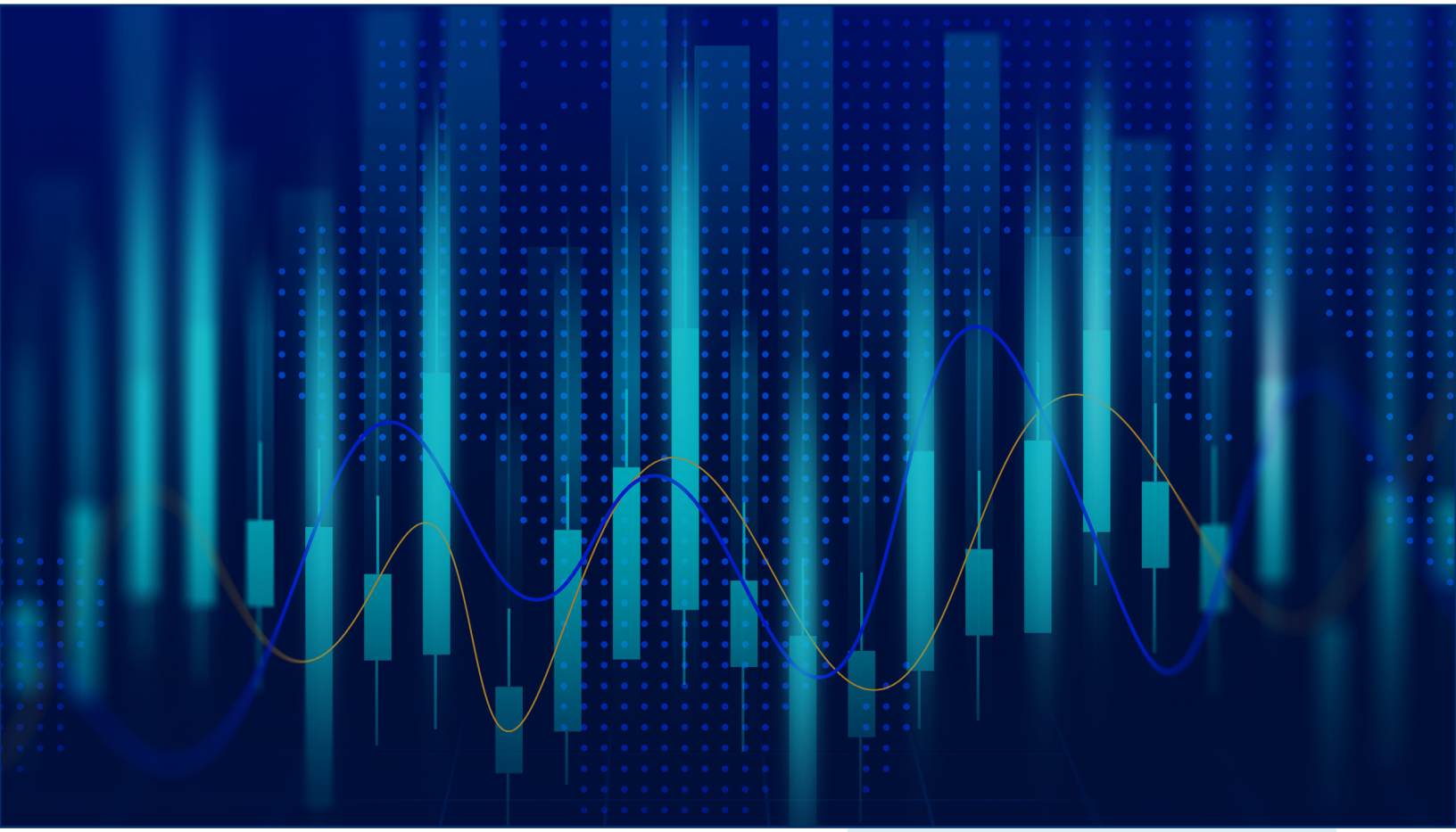
4 The Patient Affordability and Margin Feedback Loop

To protect margins, our study shows that most (73%) of large systems plan to adopt high-deductible HSA plans, shifting more of the cost burden to their workforce and patients through higher premiums and deductibles. However, this strategy creates an interdependence risk: shifting costs to individuals increases patient bad debt and delays necessary care, ultimately worsening hospital margins. As HFMA President and CEO C. Ann Jordan notes, "You cannot achieve provider sustainability by shifting costs to patients who cannot bear them. And you cannot achieve patient affordability by dismantling the operating models of the institutions that care for them."

Together, rising costs, payer friction, and policy changes continue to keep health system margins thin. Managing these pressures requires healthcare financial leaders to take a closer look at where their money is going. The next chapter presents findings from a spend analysis that shows how hospitals allocate their budgets and where CFOs are finding ways to reduce expenses.

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This report analyzes three spend categories for health systems:

1. Labor Expenses
2. Supply and Drug Costs
3. Cybersecurity Spending

CHAPTER 2:

Health Systems' Spend Analysis

To measure current financial pressures, this study evaluated proposed spending patterns across health systems nationwide for the next 12 months using primary and secondary sources.

Labor Expenses

Labor costs, a large share of overhead, leave health systems little wiggle room to absorb shrinking revenue or policy-driven margin constraints. Labor costs are primarily driven by wages and benefits.

The importance of this issue had been underscored by thought leaders; for example, in a recent Vitalic Health report Dennis Dahlen, stated it this way:

"Unless we solve the labor dimension of how to provide care, I think affordability is a faint hope, because there's a minimum level you must pay people to do the work. If you can't create efficiencies or scale, there's a minimum number of people required to do the work."

Wages

Healthcare depends heavily on a highly trained and well-compensated workforce.

Labor cost inflation has hit health systems particularly hard, as employee wage and benefit growth has outpaced economywide inflation for over a decade.

According to the AHA, to combat chronic staffing shortages and a 50% increase in monthly resignations between 2020 and 2023, **hospitals spent $51.1 billion** on contract labor in 2023 and raised advertised wages by 10.1%.[10]

Controlling nursing labor costs while maintaining care is a difficult balance for financial leaders.

Nursing, the backbone of patient care, is the **largest staffing group** and accounts for nearly 40% of a healthcare organization's total operating costs.[11]

According to industry experts interviewed for the study, shortages worsened during the pandemic, pushing wages up as hospitals relied on travel nurses and agencies.[12] Because travel nurses earn higher pay and agencies charge higher fees than permanent staff, hospital labor expenses increased nationwide. Many hospital CFOs made structural budget changes to control expenses and cut contract labor, raising nurse wages and creating internal float pools for flexible schedules to reduce reliance on third-party agencies.

Benefits

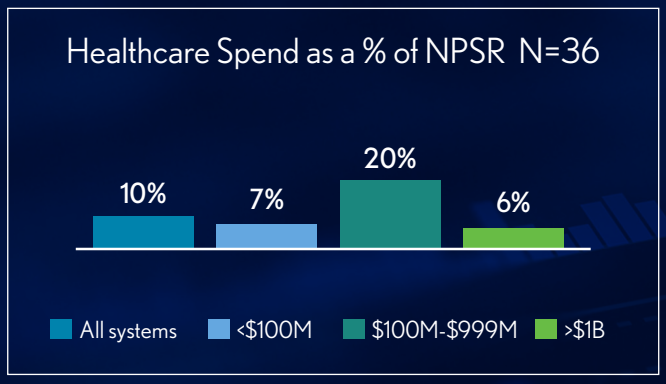
Health systems are struggling to contain their total compensation budgets, driven by escalating healthcare inflation, soaring specialty drug costs, and the need to appease strong labor unions to retain clinical talent.

How Health Systems Are Spending Benefit Money

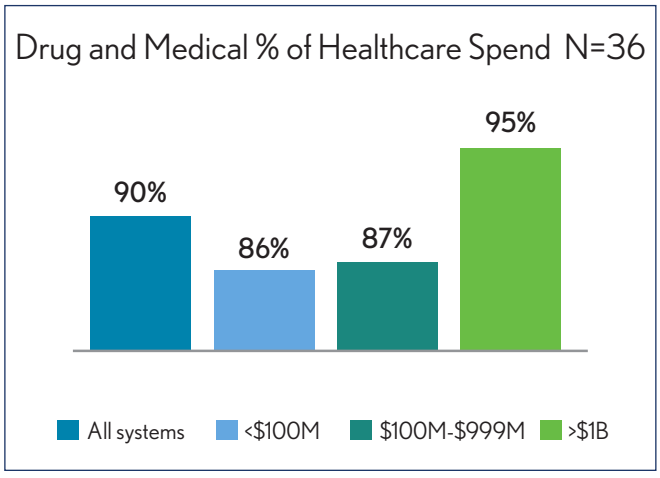
Health systems will allocate an average of 10% of Net Patient Service Revenue (NPSR) to employee healthcare benefits over the next twelve months. For midsized systems ($100 million to $999 million), the allocation averages can reach up to 20%.

SURVEY RESULTS: Healthcare Spend

Health systems report an average of 10% of NPSR allocated to healthcare spend.



Spending up to 20% of net revenue on employee benefits makes internal healthcare costs a major expenditure, particularly for midsized systems. This shifts benefit design from a routine human resources (HR) function into a key driver of overall financial performance and balance.



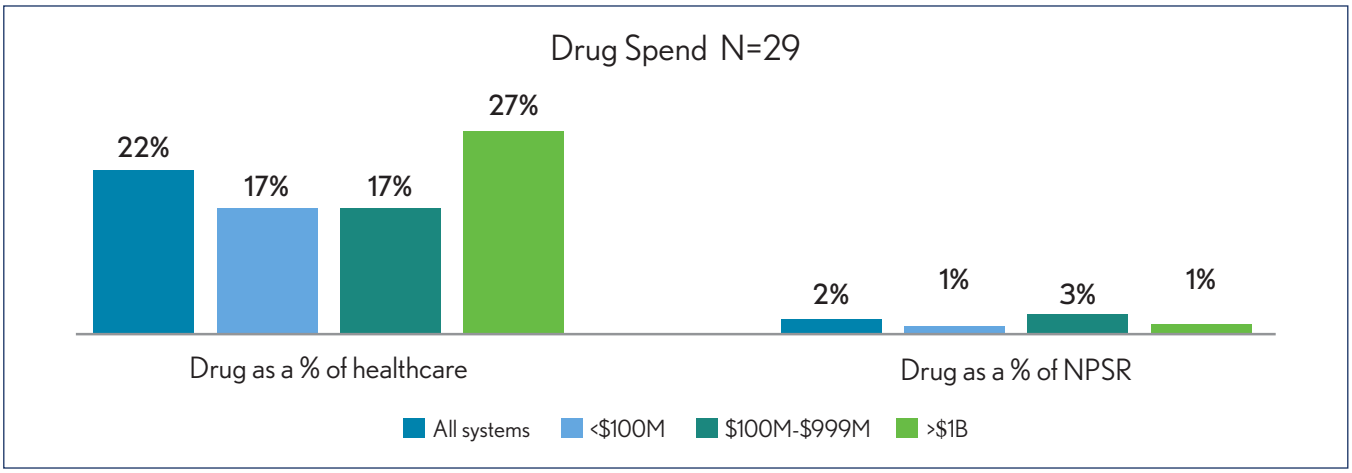
Because medical and pharmacy expenses account for the largest share of benefit spend, CFOs know meaningful cost management will depend primarily on clinical and prescription drug utilization strategies.

Prescription Drug Spend as a Percentage of Employee Benefit Spending

Prescription drugs account for an average of 22% of employee healthcare benefit spending and 2% of NPSR. In larger health systems, this increases to 27%, but prescription drugs still account for a smaller share of NPSR, at just 1%.

Because prescription drug spending accounts for 1% to 2% of overall NPSR, pharmacy expenses are a meaningful line item in budget planning. For CFOs, actively managing drug spend offers a clear, targeted opportunity to optimize benefit budgets and support operating margins.

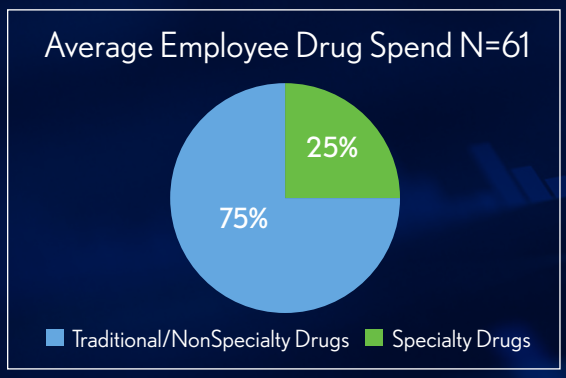
SURVEY RESULTS: Drug Spend



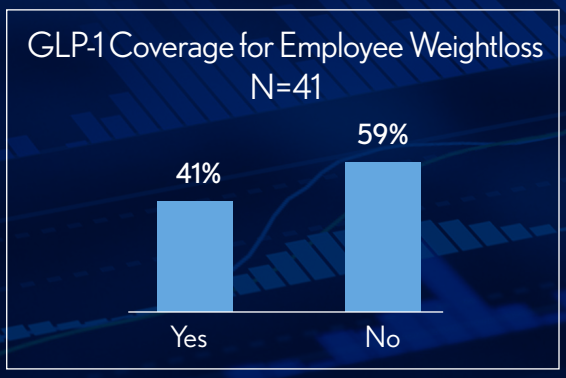
Specialty Drugs and GLP-1 Coverage

Specialty medications now account for 25% of total employee drug spend across health systems. At the same time, 41% offer employee coverage for GLP-1 weight-loss medications.

SURVEY RESULTS: Specialty Drugs



SURVEY RESULTS: GLP-1 Drugs

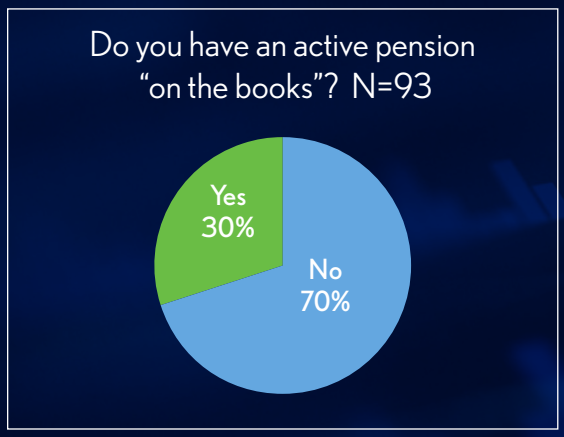


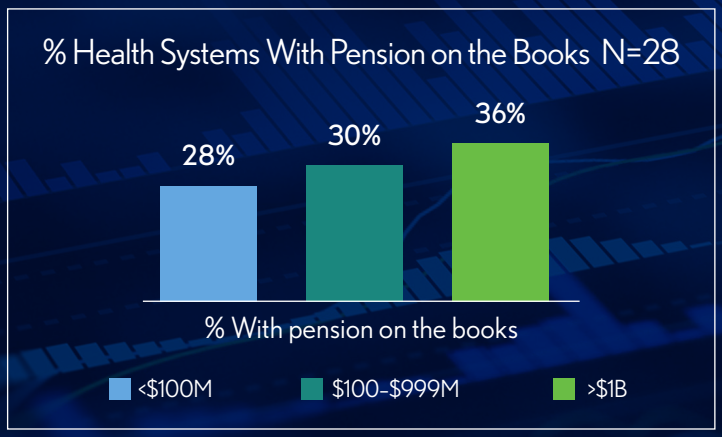
For CFOs, GLP-1 coverage represents a rapidly expanding financial exposure within pharmacy benefit costs. While weight-loss therapies can improve long-term workforce health, unmanaged adoption risks can drastically increase benefit expenses.

Defined-benefit Pensions

Nearly a third of health systems maintain active defined-benefit pension plans, even as most corporate employers have eliminated them. The health systems with active pensions often have strong nurse unions that will not bargain to freeze their pension plan.[13]

SURVEY RESULTS: Pensions





While the corporate world has largely frozen or eliminated defined-benefit pension plans, health systems still spend heavily to maintain them, often because of union demands.

Quantitative surveys and interview discussions revealed three key drivers for increased benefit costs:

1 Unprecedented Healthcare Inflation

Like all employers, health systems must pay to provide health insurance to their workforce, and rising medical costs are severely impacting their budgets. With the popularity of specialty drugs, such as GLP-1 weight-loss medications, and other high-cost therapies, health systems have seen significant increases in pharmacy spending. A study industry expert noted that healthcare inflation had crossed 9%—a rate he hadn't seen in his 30-year career.[14]

2 Structural Limits of Network Steering

While corporate employers try to control costs by implementing narrow networks or COEs that steer employees to the most efficient, high-quality providers, health systems seek alternative methods to incentivize employees to use their domestic healthcare services, e.g., tier networks.

3 Labor Union Pressures and Retention Needs

Labor unions negotiate for improved scheduling, better work-life balance, higher base wages, and expanded benefit packages. In many health systems, a strong union presence remains a primary barrier to leadership's freezing costly defined-benefit pension plans.

Supply and Drug Costs

"For health systems, drug costs are a double whammy. In their employee health plans, they pay higher costs because of rising drug prices. And then, because hospitals buy drugs to give to patients, they also experience increased drug costs."

– TODD NELSON, FORMER HOSPITAL CFO AND HFMA HEALTH POLICY DIRECTOR

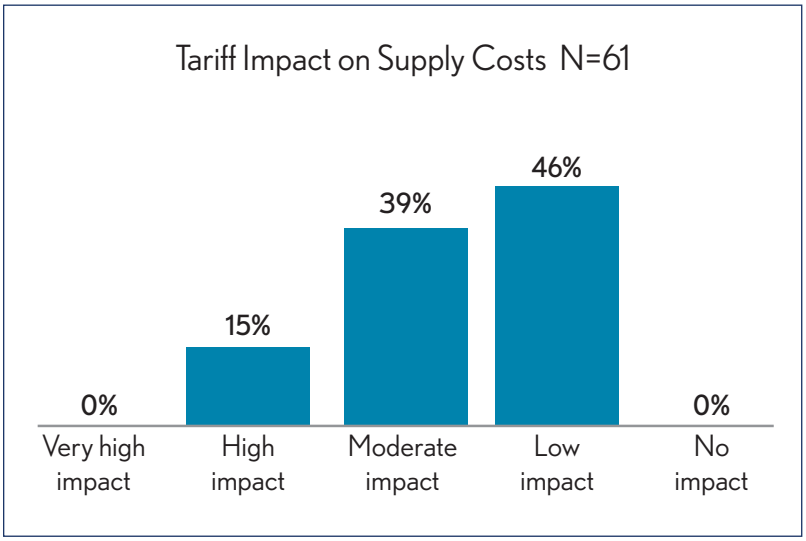
Health systems allocate 17% of their NPSR to supply-related costs.

Our study shows that health systems allocate an average of 17% of their NPSR to supply costs, and drug costs account for another 9% of hospital expenses, according to the American Hospital Association.[15]

Tariffs are directly straining hospital supply chain budgets.

More than half (54%) of surveyed health systems report that tariffs have a moderate-to-high impact on their supply costs.

SURVEY RESULTS: Tariff Impact on Supply Costs



A recent HFMA article explains that this **tariff vulnerability** stems from reliance on international manufacturing, as more than 70% of U.S. medical and pharmaceutical imports originate from just 10 countries. With overall tariff rates approaching 20%, industry projections indicate that costs for medical supplies and pharmaceuticals could rise by 15% to 20%.

Industry experts from this study reported that supply and pharmacy purchases account for a substantial portion of an average hospital's total expenses and that these tariff-driven price increases could elevate overall hospital expenses by 3% to 4%. [16]

Looking ahead, upcoming federal reimbursement changes, including site-neutrality rules and the 340B rebate model, will place further pressure on net revenue.

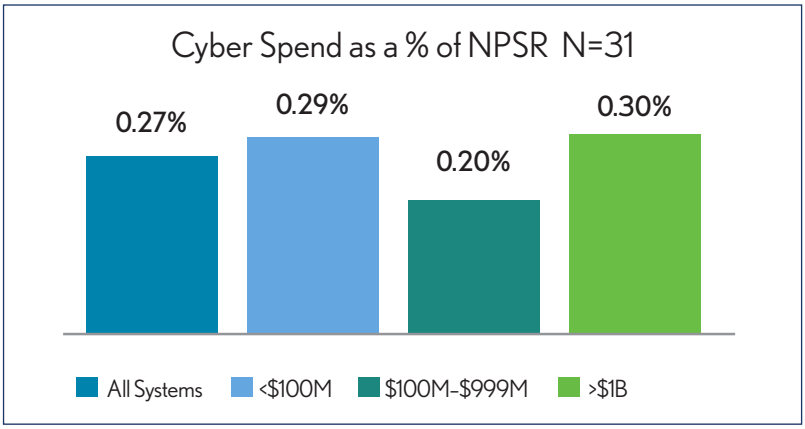
Cybersecurity Spending

"It's not a question of if you're going to get attacked, it's a question of when. With every new technology, we have concerns about cybersecurity … whether you're a large system that's very sophisticated or you're a small system, when your access to clinical care gets taken away because a device has been hacked, then you are going to feel pressure."

–TODD NELSON, FORMER HOSPITAL CFO AND HFMA HEALTH POLICY DIRECTOR

Cyber threats pose a significant financial risk to healthcare providers.

SURVEY RESULTS: Cyber Spend



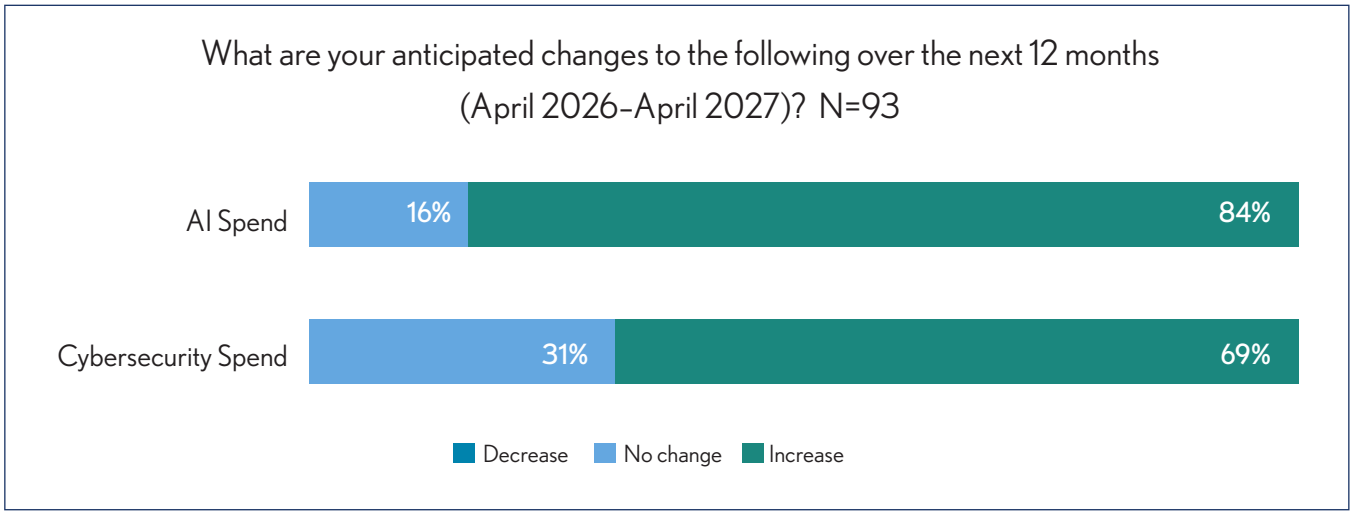
Healthcare providers are increasingly forced to invest in cybersecurity because hospitals are highly vulnerable, high-stakes targets for hackers. On average, health systems spend 0.27% of NPSR on cybersecurity.

As health systems adopt new technologies, they inherently introduce new risks. Because hacking a clinical device or system can cut off life-saving access to patient care, hospitals face immense pressure to pay exorbitant ransoms to restore operations quickly.

These disruptions carry meaningful financial implications. Data from the "IBM Cost of Data Breach Report" shows that healthcare remains the most expensive industry for cyber incidents for the 12th consecutive year, with the average breach costing $7.42 million. Healthcare organizations take an average of 279 days to identify and contain a data breach, nearly six weeks longer than the global cross-industry average. This extended downtime exponentially increases remediation expenses and operational disruption.[17]

To shield themselves against potential data breaches, health systems are increasing spending to secure their digital networks, with 69% planning to boost cybersecurity budgets over the next 12 months.

SURVEY RESULTS: Spend Changes



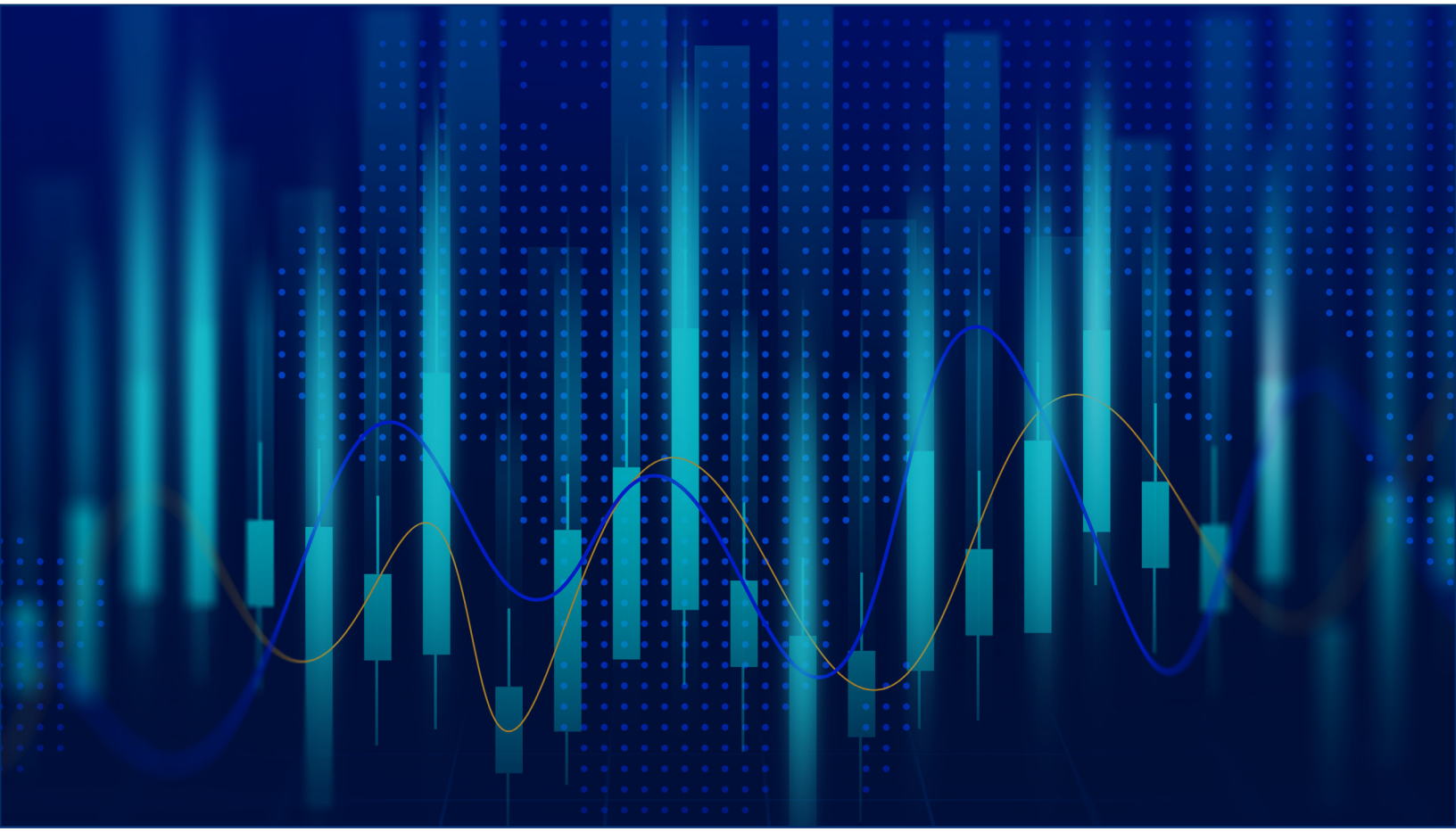
While these ongoing costs lower operating margins, financial leaders view them as necessary. Spending money on security today helps to avoid the much higher expenses and disruptions caused by data breaches.

Because healthcare cyberattacks have become so frequent, the cyber insurance market has become prohibitively expensive, forcing many health systems to self-insure or create captive insurance models to manage the financial risk, according to an industry expert interviewed early in the study.[18]

Across the industry, health system CFOs are rebalancing their budgets as high labor expenses, rising drug prices, and inflated supply costs continue to weigh on operating margins. With margins averaging around 2%, financial leaders are looking beyond conventional cost-cutting.

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CHAPTER 3:

How Health Systems Are Keeping Their Financial Health on Track

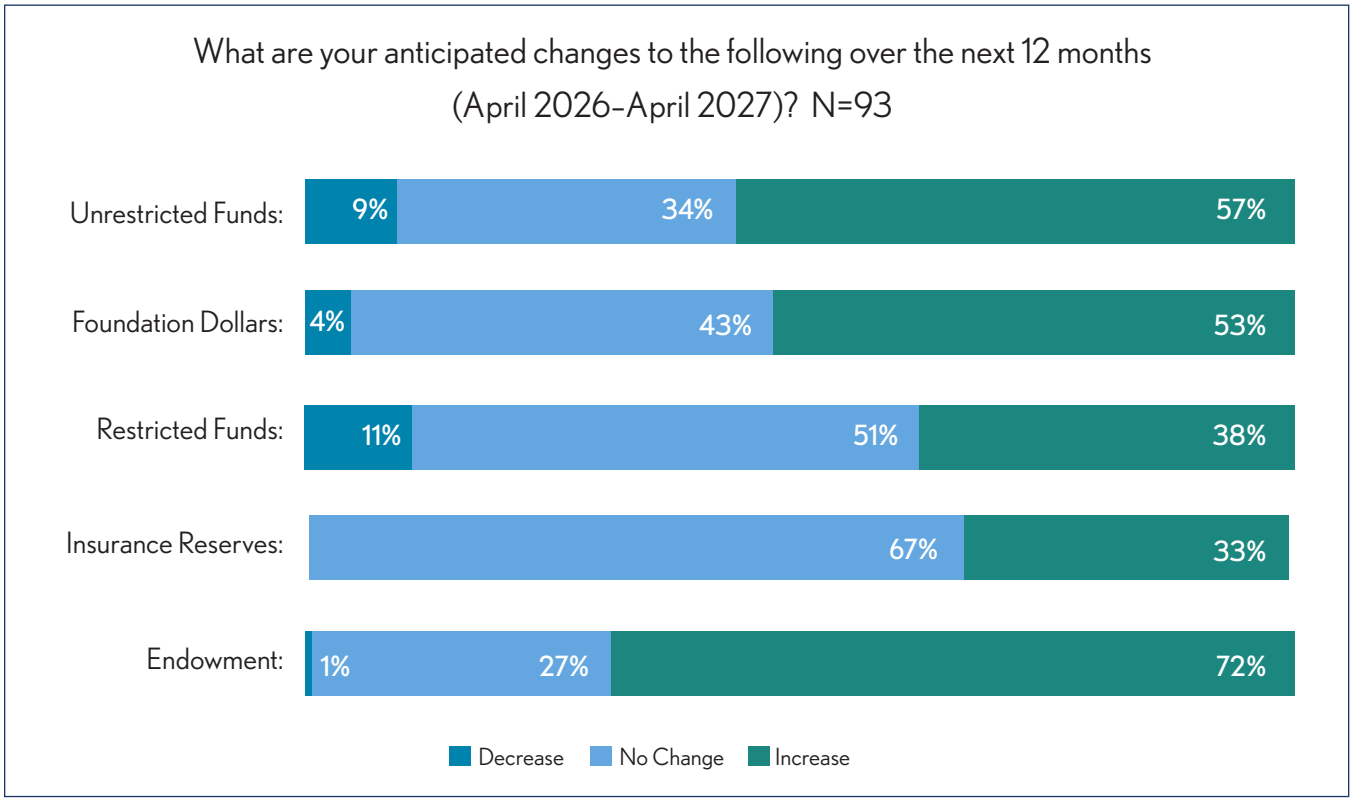
Rising operational overhead and stagnant net revenues are prompting health system financial leaders to re-evaluate traditional management models.

To maintain fiscal stability and preserve liquidity, CFOs are executing four core strategies:

1. Restructuring Workforce Benefits and Supply Contracts
2. Optimizing Balance Sheets and Diversifying Investments to Support Liquidity
3. Forging Creative Growth Strategies, Partnerships, and Philanthropy
4. Leveraging AI and Payer Strategy

CFOs are actively shifting fund allocations to support these strategic priorities. Over half of surveyed systems plan to increase their unrestricted funds (57%) and foundation dollars (53%). Meanwhile, systems are also expanding restricted funds (38%), insurance reserves (33%), and endowment funds (27%).

SURVEY RESULTS: Fund Changes



For finance leaders, prioritizing flexible, unrestricted capital provides the operational agility needed to absorb sudden cost spikes. At the same time, growing foundation and reserve pools buffer operating margins against unpredictable clinical volumes.

1 Restructuring Workforce Benefits and Supply Contracts

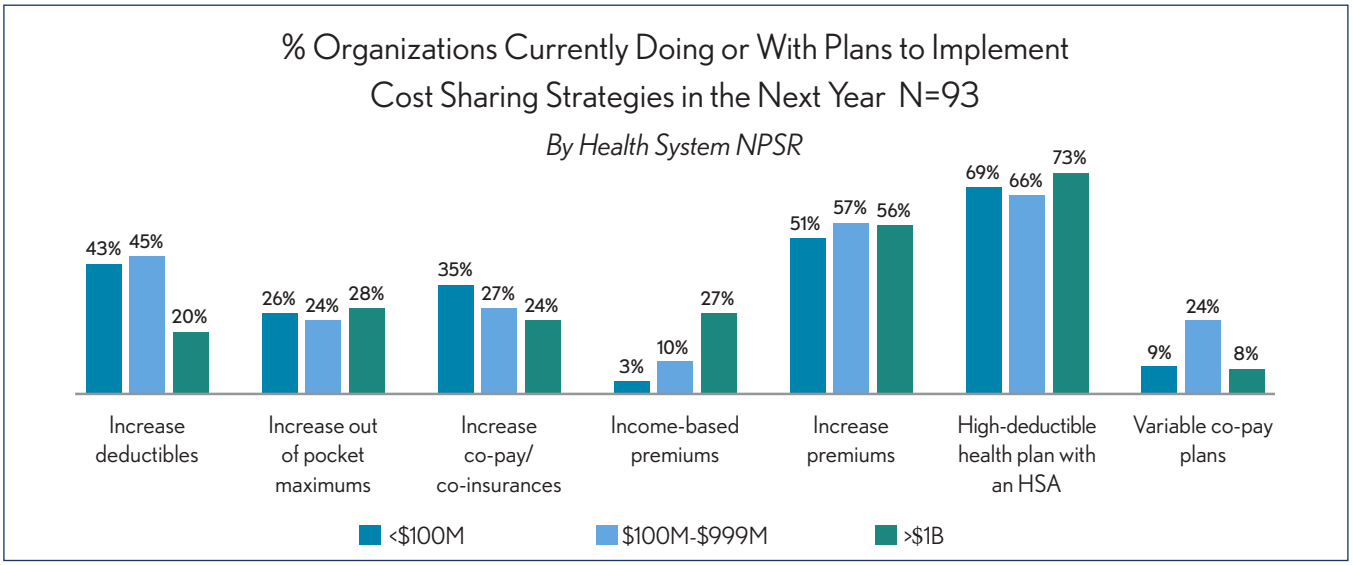
Healthcare financial leaders are actively restructuring employee benefits as a primary cost-control mechanism. With rising medical claims pressing margins, health systems are reengineering self-insured plans to mitigate risk and manage expenses.

By deploying targeted initiatives, including wellness incentives, narrow domestic networks, tiered coverage, and disease-specific point solutions, executives are limiting high-cost claims while steering care into their own facilities. This dual approach controls overall benefit expenditure while retaining internal clinical revenue, aligning workforce health management directly with enterprise financial strategy.

Cost-sharing Strategies

To manage rising benefit expenses, most health systems plan to shift costs to employees through higher premiums, increased deductibles, and high-deductible HSA plans.

SURVEY RESULTS: Healthcare Cost-Sharing Strategies



Healthcare Savings Accounts

High-deductible HSA plans represent the primary strategy for the coming year, planned by 73% of large systems, 69% of community systems, and 66% of midsized systems.

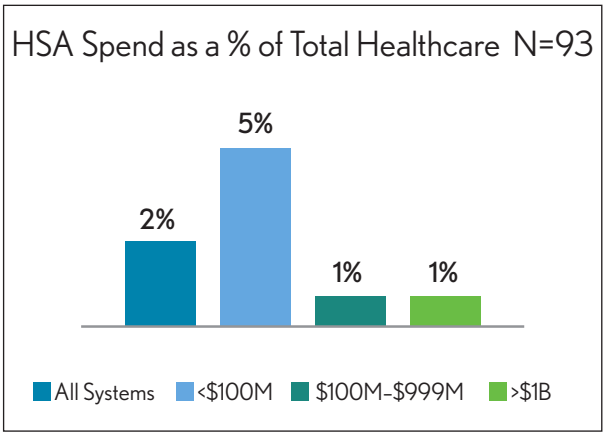
Health systems spend an average of 2% of their employee healthcare budgets on HSA contributions. Smaller systems allocate the highest share to these accounts, averaging 5% of their total healthcare spend.

While HSA contributions are a small budget item for most health systems, smaller organizations allocate a larger share of their benefit spend to these accounts. Monitoring this expenditure helps to ensure that direct employer contributions effectively support employee retention and plan adoption without adding unnecessary overhead.

Beyond HSAs, organizations are deploying several targeted cost-containment approaches:

- **Premium Increases:** Over 50% of all surveyed health systems plan to raise employee premiums.
- **Deductible Adjustments:** Over 40% of small and midsized systems plan to increase deductibles, compared with just 20% of large systems.
- **Targeted Cost Mechanisms:** Health systems are also planning to adjust copays, coinsurance, and out-of-pocket maximums, as well as introducing variable co-pays and income-based premiums.

SURVEY RESULTS: HSA Spend



The CFO Balance: Mitigating Risk vs. Maintaining Care Utilization

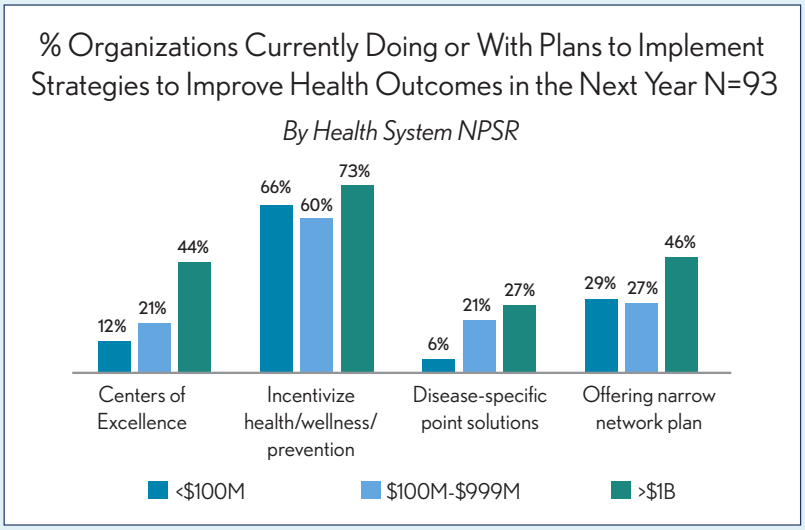
For CFOs, executing these strategies requires a delicate strategic balance. While cost-shifting offers immediate expense relief, setting out-of-pocket thresholds too high can backfire. When healthcare becomes cost-prohibitive, employees frequently delay preventive care or skip necessary treatments. Over time, deferred care drives up long-term plan costs through severe illness, acute care utilization, and reduced workplace productivity.

To safeguard both financial performance and workforce health, finance leaders must structure cost-sharing models that control spend without discouraging timely, high-value care.

Health Outcome Improvement Strategies

Health systems are deploying targeted strategies to improve employee health outcomes while containing medical spend. Key initiatives include health and wellness programs, cost-sharing models, Centers of Excellence, narrow networks, and disease-specific care management. For CFOs, pairing clinical interventions with structured network design aligns patient care with cost control.

SURVEY RESULTS: Health Outcome Improvement Strategies



Health and Wellness Program Strategies

Health systems are expanding employee wellness and preventive care initiatives to reduce high-cost medical claims, with implementation planned at 73% of large, 60% of midsized, and 66% of small health systems.

- **Variable Co-pay Structures:** Co-pay differentials redirect utilization to lower-cost care settings, such as setting nonemergent emergency department co-pays at $750 compared to $50 for urgent care and $25 for primary care.
- **Preventing Care Avoidance**: Out-of-pocket deductibles and first dollar coverage are structured to prevent lower-wage employees from delaying routine care, reducing the risk of unmanaged chronic conditions progressing to acute hospitalizations.
- **Wellness-tied HSA Incentives:** In some cases, employers provide HSA contributions, contingent on employees completing biometric screenings and clinical education modules rather than relying on standard premium increases.
- **Advanced Primary Care Strategy:** Capitated and direct primary care models replace fee-for-service reimbursement to align physician incentives with chronic disease prevention and long-term condition management.

Centers of Excellence, Narrow Networks, and Direct Contract Strategies

This study's survey data indicate that health system employers are actively deploying COEs and narrow networks within their own employee benefit plans, though adoption rates vary based on system size.

COEs are operational or planned at 44% of large, 21% of midsized, and 12% of small health systems, while 46% of large, 27% of midsized, and 29% of small systems plan to adopt narrow networks over the next year.

- **Direct Contracting and COEs:** Direct contracts between employers and health systems establish bundled pricing for complex procedures and often provide guaranteed volumes in exchange for pre-negotiated rate discounts.
- **Domestic vs. Non-domestic Utilization:** Health systems structure narrow networks to incentivize domestic care within their own facilities, minimizing non-domestic spend at competing healthcare organizations.
- **Dual Economic Role:** Unlike standard employers who manage narrow networks solely to reduce claims, health systems evaluate employee utilization as both a health plan expense and a source of internal clinical revenue.

The Three-Tiered Plan Design Strategies

> *"Health systems grapple with the domestic versus non-domestic decision. And almost all are trying to figure out a way to encourage their employees to use the domestic network. CFOs must think about whether they want to generate revenue from their employees."*
>
> **– STEVE MANN, BENEFITS CONSULTING, FIDELITY INVESTMENTS**

During the study, industry experts explained that although health systems are naturally positioned to operate narrow networks, they often choose a different benefits path than traditional Fortune 500 employers because of their unique roles as employers and healthcare providers.[19]

Designing an effective domestic network requires careful coordination among HR benefits, finance, clinical leadership, and the chief medical officer. Standard corporate employers do not face this level of cross-departmental operational complexity.[20]

Rather than completely restricting where employees can seek care, health systems steer utilization internally by structuring their health benefit plans into three distinct pricing tiers:

Tier 1
(domestic network):
This is the health system's own hospitals, outpatient facilities, and employed physicians. To maximize steerage, systems offer exceptionally rich plan designs, such as waiving coinsurance entirely or offering services completely free of out-of-pocket costs.

Tier 2
(in-network):
This includes the contracted commercial insurance carrier's broader regional or national network (e.g., UnitedHealthcare, Cigna).

Tier 3
(out-of-network):
This comprises the non-contracted, out-of-network providers.

For health systems, keeping employees within Tier 1 gives them flexibility to customize fee schedules that align with their specific financial strategies. Systems can suppress claims entirely outside the reimbursement process, set lower reimbursement rates, or process claims at full commercial reimbursement rates.

Traditional narrow networks are curated strictly based on cost efficiency and quality metrics. If an insurance carrier's objective data indicate that the health system's own providers are less efficient or lower-performing than a local competitor, a health system cannot easily exclude its own physicians or facilities from Tier 1 without triggering political fallout and physician dissatisfaction, thereby creating significant conflicts of interest.

Employee privacy also strongly limits Tier 1 enrollment. Healthcare workers may be uncomfortable receiving medical care from their colleagues or supervisors. Despite HIPAA protections, privacy concerns prompt a significant portion of health system staff to deliberately seek care outside the domestic network.

Disease-specific Point Solutions Strategies

Health system employers are **deploying disease-specific point solutions** to manage high-cost chronic conditions and control clinical spend within their employee benefit plans.[21] This study indicates that adoption is emerging across the healthcare sector, with 21% of midsized and 27% of large health systems currently leveraging these targeted disease-specific programs for their workforces.

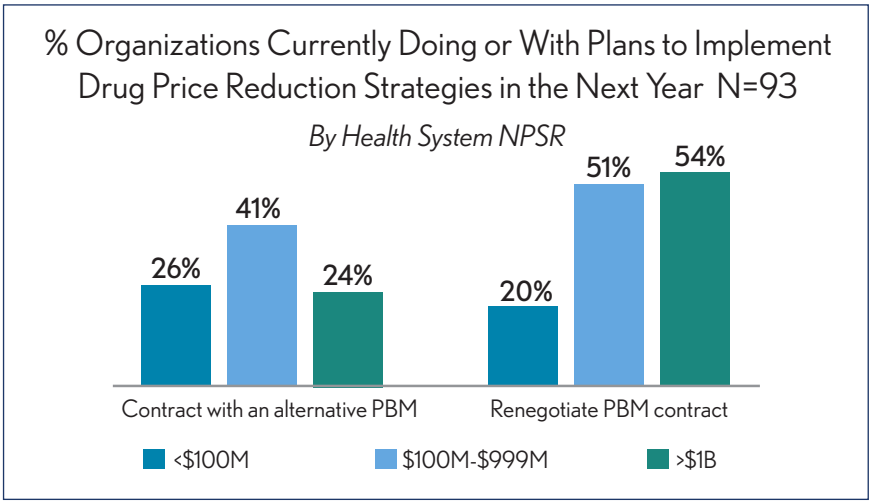
These add-on programs provide targeted care coordination and personalized coaching for prevalent conditions such as diabetes, hypertension, obesity, and behavioral health, helping to reduce unnecessary high-cost interventions.

These solutions also serve as utilization controls for specialty pharmacy spend. By establishing clinical protocols and monitoring patient outcomes, point solutions govern utilization of high-cost drug pipelines, particularly for such therapies as GLP-1 weight-loss medications.

Pharmacy Benefit Manager (PBM) Strategies

Because traditional contracts offer limited pricing transparency, health systems are actively restructuring their pharmacy benefit management partnerships. The study shows that over half of midsized and large systems are renegotiating their PBM contracts, while 41% of midsized systems are moving to alternative providers.

SURVEY RESULTS: Drug Price Reduction Strategies



To gain greater cost control, organizations increasingly are managing pharmacy functions directly, either through internal operations or transparent PBM technology. Once established, some systems also commercialize these capabilities to local employers, generating nonoperating revenue.

Health Benefit Simplification Strategies

According to a recent thought leadership article, "Softening the blow of rising healthcare costs," 39% of benefits leaders across industries say they have fully evaluated their health benefits for redundancies, yet massive savings opportunities remain on the table. Employers currently manage an average of six health benefit vendors, and many are realizing that they are paying for redundant or underutilized services. To right-size this spend, organizations are auditing their vendor ecosystems and demanding strict financial alignment.[22]

"Plan sponsors increasingly are seeking solutions with complete financial alignment and transparency. The most trusted arrangements are those in which health providers and vendors are fully transparent about their revenue sources, and when compensation comes directly from the plan sponsor rather than from third-party incentives." **– MICHAEL DRISCOLL, VICE PRESIDENT OF FIDELITY WORKPLACE CONSULTING**

Renegotiating Contracts for Supplies and Drug Costs

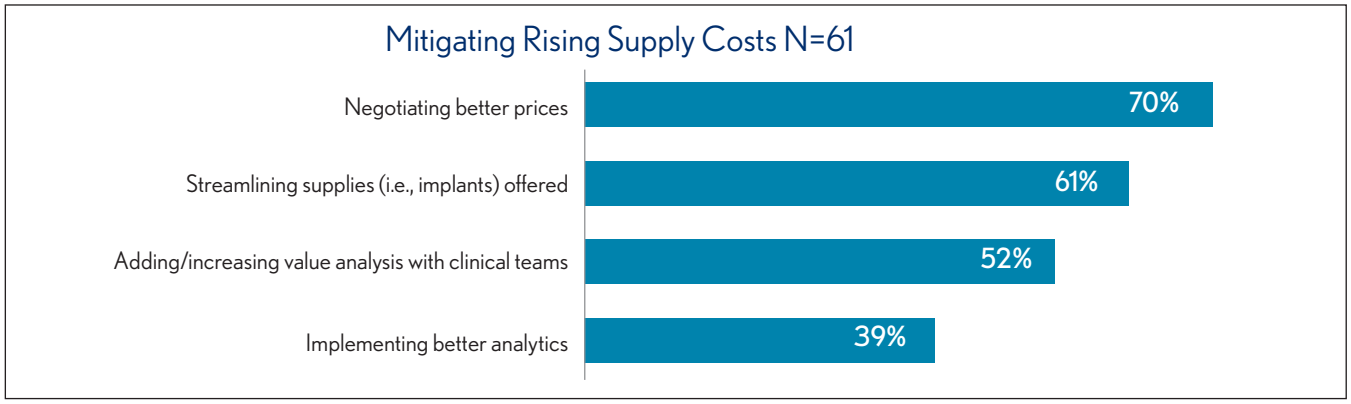
> *"Health systems are continuing to emphasize financial discipline, trying to be prepared for these big patient payment cuts. They're thinking about how to make their operations more efficient with things like renegotiating contracts for supplies and drug costs."*
>
> **– TODD NELSON, FORMER HOSPITAL CFO AND HFMA HEALTH POLICY DIRECTOR**

Health systems will need to operate on even thinner profit margins as supply and drug costs continue to rise. Upcoming changes to federal reimbursement policies likely will further lower overall hospital revenues.

In response, CFOs are focusing on lowering their costs of care. Because supply chain and pharmacy represent two of the largest nonlabor expense categories, financial leaders are actively targeting these areas to identify savings and support long-term operating margins.

This study found that healthcare leaders are taking direct action to control supply expenses: 70% intend to negotiate better vendor pricing, 61% plan to streamline inventory, and 52% plan to expand value analysis with clinical teams.

SURVEY RESULTS: Mitigating Rising Supply Costs



CFOs increasingly are treating supply management as a strategic priority rather than just an administrative cost. By examining product utilization and collaborating directly with clinical teams, financial leaders can better align procurement decisions with operational and care delivery goals.

Regional Purchasing Coalitions

According to the study's industry experts, in order to supplement traditional national Group Purchasing Organizations (GPOs), health systems are forming regional coalitions with peer organizations. By combining their purchasing power, these systems negotiate directly with manufacturers to secure lower pricing on medical supplies and clinical consumables.[23]

2 Optimizing Balance Sheets and Diversifying Investments to Support Liquidity

CFOs are actively weighing preemptive debt strategies. Knowing that upcoming legislative changes could severely challenge their financial stories by 2027 or 2028, health systems are securing capital and building cash reserves now while their current balance sheets remain relatively strong.

Recent market data supports this trend: Kaufman Hall **reports** that healthcare bond issuance volume reached $26.2 billion year-to-date (through the third week of June 2026), up $3.4 billion from the same period in 2025. [24]

Beyond debt issuance, health systems are shifting their investment strategies to secure liquid capital and unrestricted funds as a safety net. This study highlights how healthcare organizations are bolstering liquidity.

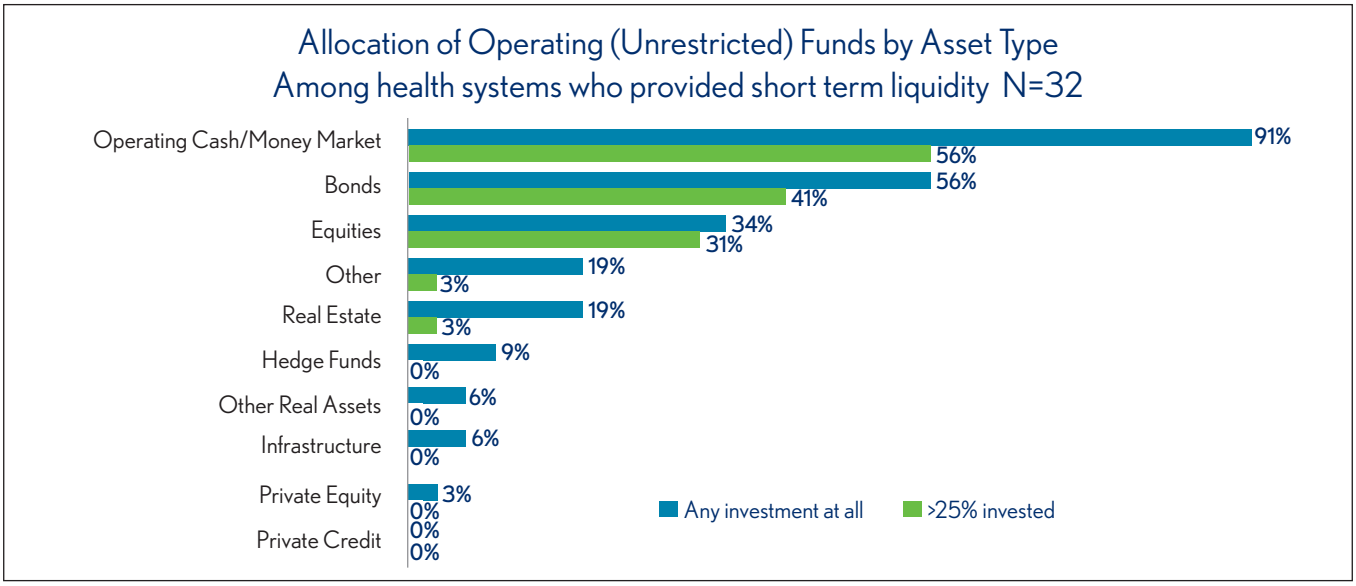
Short-term Liquidity

Health systems continue to favor conservative cash positions, with over 90% allocating short-term operating funds to cash or money market accounts. In fact, half place more than a quarter of these funds purely in cash.

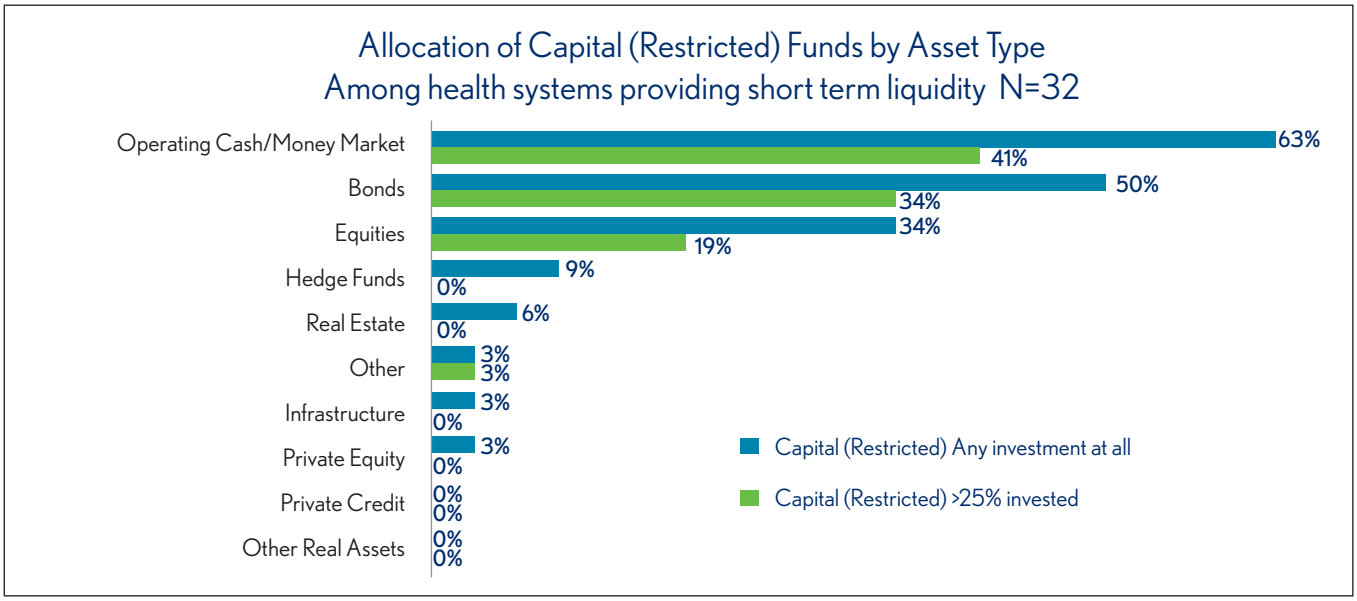
Short-term capital asset allocations lean heavily toward low-risk vehicles: cash/money markets (63%), bonds (50%), and equities (34%).

For CFOs, maintaining strong short-term liquidity secures the capital needed for payroll and supply chain costs during volatile revenue cycles. However, holding excess cash reduces overall portfolio yield, making it critical to balance daily operational needs against inflation.

SURVEY RESULTS: Allocation of Short-term Operating Funds by Asset Type



SURVEY RESULTS: Allocation of Short-term Capital Funds by Asset Type

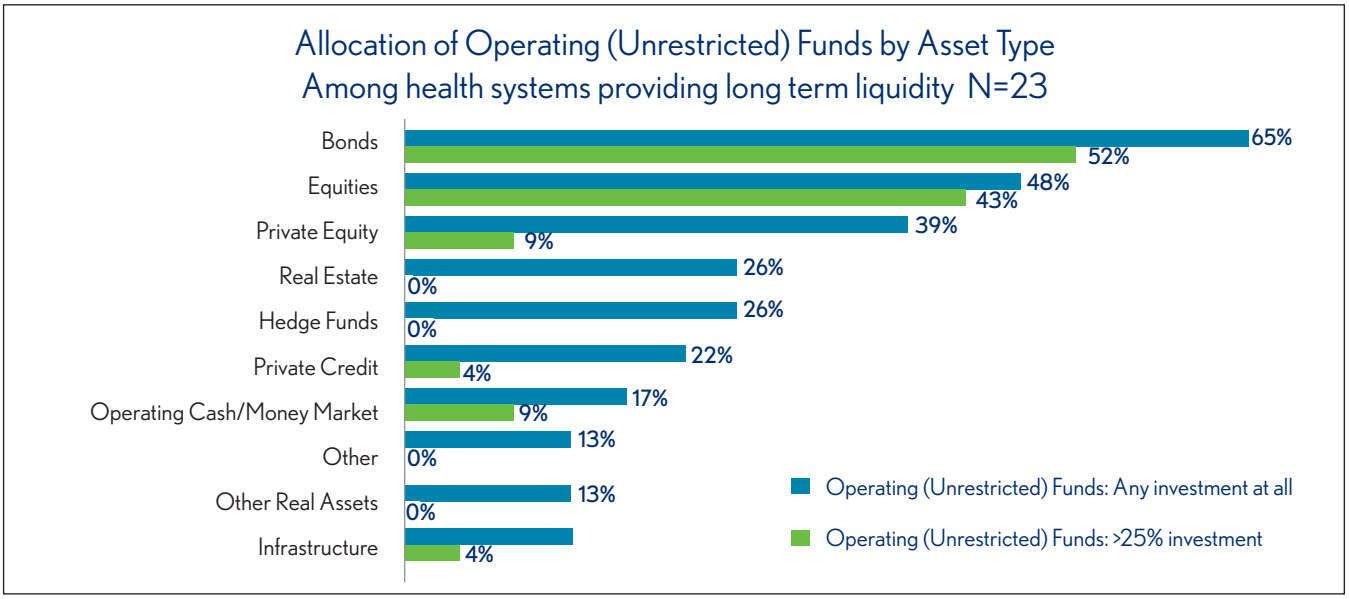


Long-term Liquidity

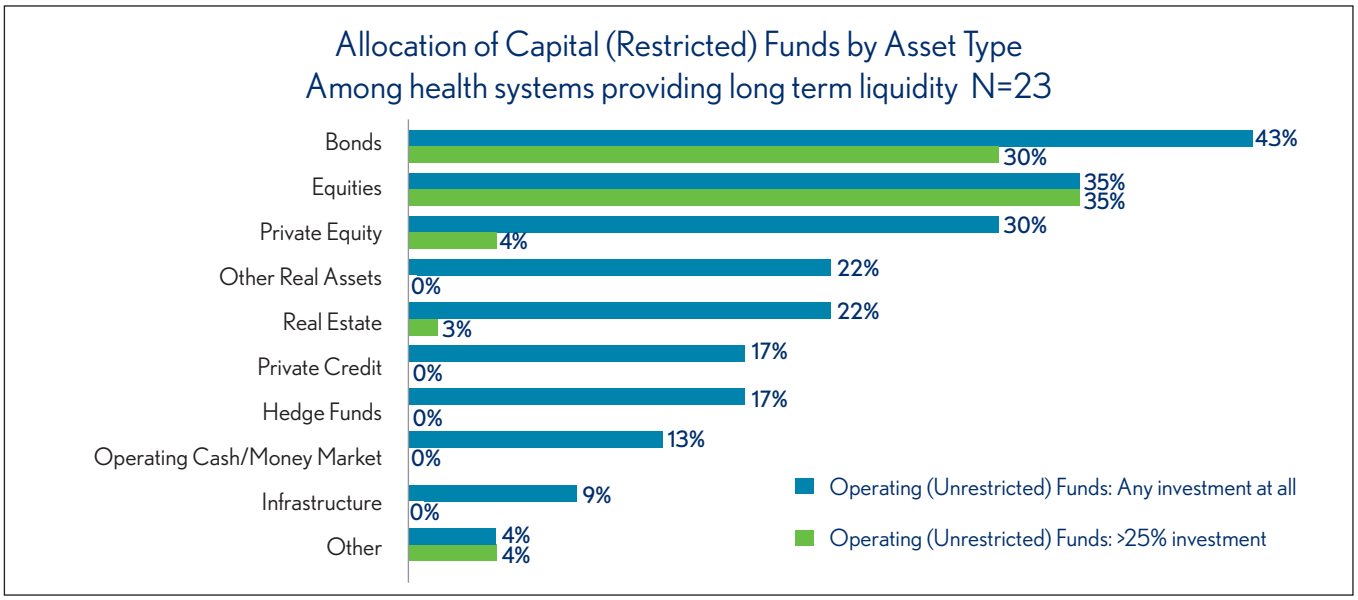
Health systems rely heavily on fixed income to balance growth and risk across extended time horizons. For long-term operating funds, 65% of surveyed systems invest in bonds, with 52% committing more than a quarter of their portfolio to them. Bond allocations are slightly lower for long-term capital funds, where 43% allocate to bonds and 30% invest more than 25%.

For CFOs, fixed income provides the reliable yield and principal stability needed to satisfy debt commitments and fund future facility projects. However, finance leaders must carefully manage duration risk to prevent inflation and interest rate swings from eroding long-term purchasing power.

SURVEY RESULTS: Allocation of Long-term Operating Funds by Asset Type



SURVEY RESULTS: Allocation of Long-term Operating Funds by Asset Type



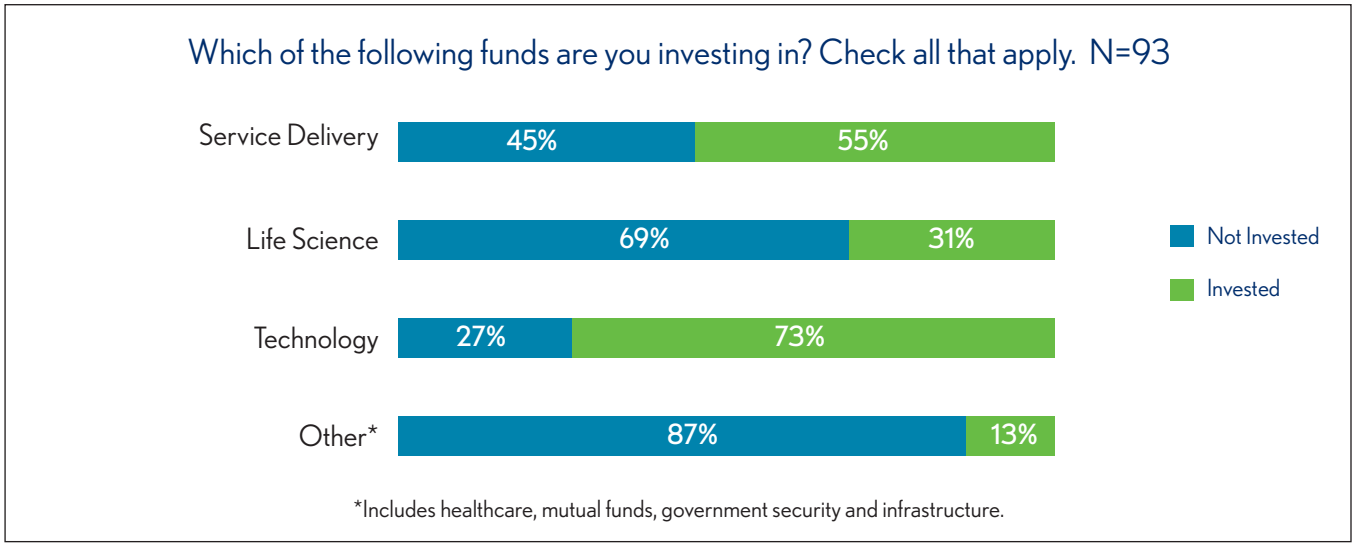
Investment Diversification

Hospitals increasingly act as institutional investors, placing balance sheet assets and unrestricted reserves into specialized, third-party funds to drive yield and access early-stage innovation.

The survey shows that 73% of health systems actively invest in technology funds. Additionally, 55% invest in service delivery funds, and 31% invest in life science funds.

When executives were asked where they see the greatest potential impact from these fund investments, the primary goal was to increase revenue (29%), followed closely by improving the patient experience (24%).

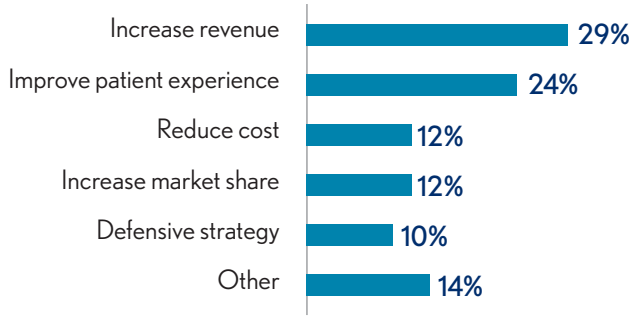
SURVEY RESULTS: Investment Areas



SURVEY RESULTS:
Investment Potential Impacts

Health systems view investing in life science, service delivery and/or technology funds as a way to increase revenue and improve patient experience.

Where do you see the greatest potential impact from investments in the fund types listed above? N=93



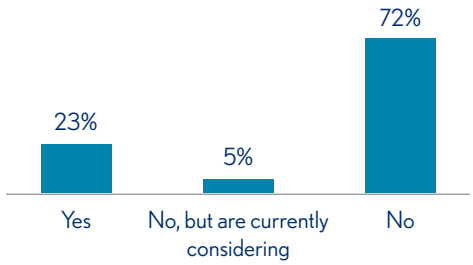
*"Other" includes health systems that say this question does not apply to them, as well as the following impacts: generate investment income to outpace inflation, principal protection and minimization of any losses regardless of market; diversifying revenue.

Investment Leadership Outsourcing

Health systems increasingly are turning to external experts to manage their complex portfolios. In fact, 28% of surveyed health systems have outsourced or plan to outsource their chief investment officer (CIO) role in the coming year.

SURVEY RESULTS: Chief Investment Officer Function

Do you currently outsource your CIO function? N=61



For CFOs, transitioning to an outsourced model eliminates the high overhead costs of an internal investment team while providing access to specialized financial talent. This shift helps to optimize risk-adjusted returns and generates reliable nonoperating income to support the organization's broader financial health.

> *"Our clients face increasingly complex decisions across liquidity and leverage, as well as enterprise expansion and capital preservation trade-offs. An OCIO provider offers a trained lens on the multiple dynamics a healthcare system can face, addressing investments, liquidity, risk, and governance. For many healthcare institutions, an OCIO is an efficient solution."*
>
> **– CHRISTIAN PARISEAULT, HEAD OF OCIO AND INSTITUTIONAL PORTFOLIO MANAGERS, FIDELITY INVESTMENTS**

3 Forging Creative Growth Strategies, Partnerships, and Philanthropy

Persistent margin pressures are prompting health system financial leaders to re-evaluate traditional capital deployment models. CFOs are shifting toward capital-light growth strategies and scaling cost-effective ambulatory networks, leveraging high-yielding insurance reserves, and allocating unrestricted funds to strategic market investments.

"Capital Light" Growth Strategies

This strategy focuses on expanding outpatient and ambulatory networks to capture market share and drive referral pipelines while protecting liquid capital.

Industry experts shared in the study's interviews that building traditional acute care hospitals is exceptionally expensive, with a new specialized tower costing upwards of $500 million. In contrast, smaller outpatient facilities (e.g., ambulatory surgery centers (ASCs), freestanding emergency departments (EDs), and urgent care centers cost between $25 million and $50 million. Leveraging these smaller facilities allows health systems to feed their acute locations at a fraction of the capital cost.[25]

While capital-light projects are significantly cheaper than acute care towers, many health systems lack the operating EBITDA to fund them outright. In these cases, finance teams rely on municipal debt markets to fund their expansions. CFOs increasingly bundle multiple smaller projects — such as ambulatory centers, freestanding EDs, and clinical equipment upgrades — into midsized bond issuances to support their balance sheets.[26]

Insurance Reserves

Data from this study demonstrates that health system insurance reserve allocations scale with organization size, averaging $591,470 for small systems (under $100 million NPSR), $20,162,668 for midsized systems ($100 million to $999 million NPSR), and $30,188,391 for large systems (over $1 billion NPSR), with an overall average of $20,273,495.

Health System NPSR	Average of Insurance Reserves ($)
<$100M	$591,470
$100M–$999M	$20,162,668
>$1B	$30,188,391
Total (all health systems)	$20,273,495

N=13

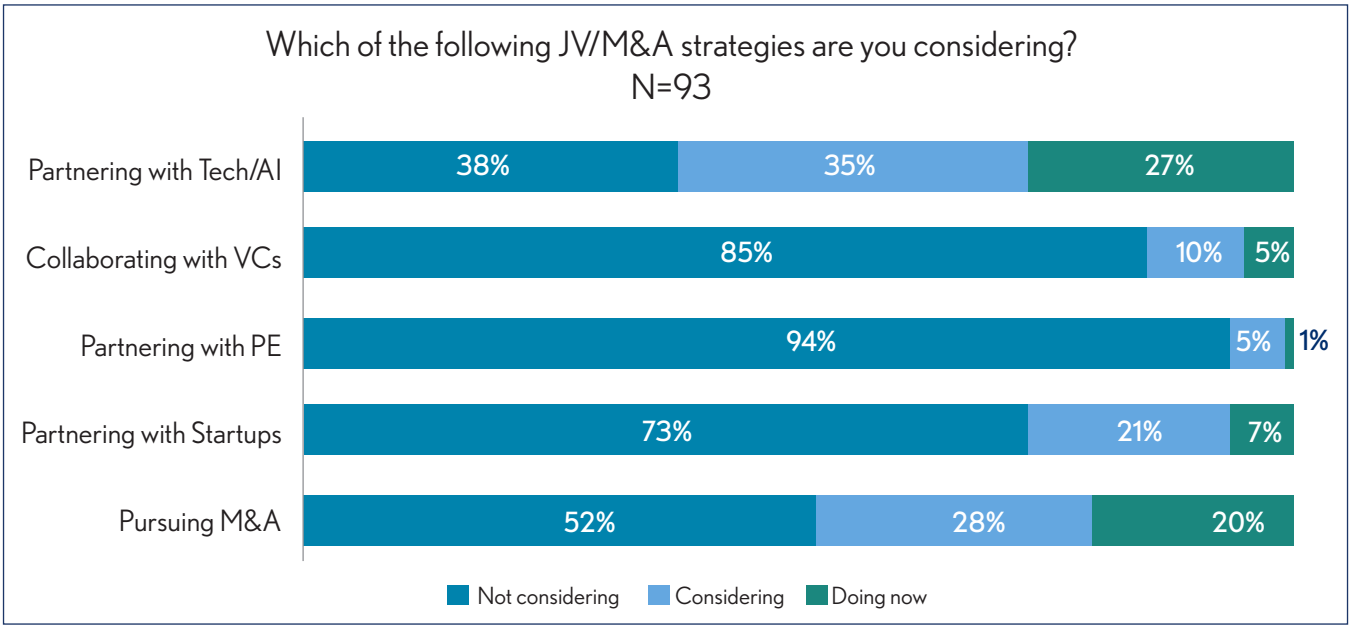
Systems tracking performance reported a 13% average return on these reserve investments, reflecting deployment into higher-yielding market assets.

Despite rising underlying risk expenses, about two-thirds (66%) of health systems plan to maintain current reserve funding levels over the next year while about one-third (33%) plan increases, as finance leaders leverage higher investment yields and structured stop-loss policies (where external insurers cover individual claims exceeding a threshold, like $1 million) to manage exposure without committing additional capital.

Partnership Strategies

Instead of relying solely on clinical billing, some hospital finance leaders are allocating capital to corporate venture programs, commercializing their own operational innovations, and deploying a merger/acquisition strategy.

SURVEY RESULTS: Partnership Strategies



Mergers and Acquisitions

Ongoing market consolidation has driven the share of system-affiliated hospitals from 58% in 2010 to 69% in 2023, with one or two health systems controlling the inpatient market across 47% of U.S. metropolitan areas, according to KFF reports.[27] In line with this trend, this study shows that 48% of health system executives are currently pursuing or actively considering traditional M&A transactions, while 52% are not evaluating them.

- **Shifting to Large, System-on-System Mergers**
  Rather than midsized regional systems simply swallowing small local hospitals, modern transactions are dominated by larger consolidations. Health systems are merging to gain the critical scale needed to offset crushing margin pressures and gain market leverage in payer negotiations.
- **Consolidating in Low-growth Markets**
  In stagnant, low-growth geographic regions like the Northeast, consolidation is being utilized as a necessity to preserve community access to healthcare rather than as a growth strategy.
- **Moving Away from Nationalization Back to Regionalization**
  Two decades ago, large health systems bought acute care hospitals nationwide to achieve scale. Today, health systems are shifting back to a regional portfolio to gain a larger share of local markets.[28]

Acquiring Innovative Technology or Services

The study data indicate that 28% of health systems are either currently partnering with startups or considering it, while 72% are not. Similarly, 15% are collaborating with or considering venture capital firms, while the remaining 85% are not evaluating these partnerships.

Pursuing M&A remains a primary partnership strategy for leverage; however, a small number of CFOs are thinking beyond brick-and-mortar acquisitions and view technology commercialization as another offensive strategy to add to their financial toolbox.

By codeveloping and scaling successful software, health systems eventually can spin off these companies or sell their holdings for capital gains to support their core mission of patient care.

Corporate JVs and Venture Funds

This research study highlights how health systems increasingly are relying on JVs, venture funds, and strategic clinical partnerships as a creative way to expand services without overstretching their finances.

Partnering With Technology/AI Companies

This study indicates that health systems are partnering with AI companies because they can design products more quickly with a lower capital investment than if they pursued development and implementation independently. Surveyed healthcare executive responses showed technology JV partnerships as the most common outside collaboration initiatives. Twenty-seven percent (27%) of health systems have tech/AI partnerships in place today, 35% are actively planning to do so, and 38% have not considered them.

The HFMA recently shared that technology joint ventures create a **symbiotic exchange**: Hospitals provide clinical data, expertise, operational acumen, and testing environments, while tech developers build tools integrated into clinicians' daily workflows, ensuring that AI safely puts patients first.[29] According to McKinsey & Co, if healthcare organizations choose a partner with shared objectives, this **approach** enables them to achieve speed and scale across complex processes such as the revenue cycle, rather than building end-to-end solutions internally.[30]

Beta Technology JVs

> *"Some health systems that are not large enough to have a venture cap fund to do things are partnering with venture cap funds to build something in their own health system, acting as betas, and then sharing in the profits once it starts to be sold to other companies, avoiding the class [capital] issue."*
> **–TIM RUGGLES, SENIOR VICE PRESIDENT AND HEALTHCARE PRACTICE LEADER, FIDELITY INVESTMENTS**

Smaller, less-resourced community hospitals that scrape along on tight operating margins and lack the capital to run large corporate venture funds, are partnering with venture capital firms as a testing ground for early-stage software in exchange for equity.

Leveraging JVs to Offer Specialized Services

> *"In some cases, health care organizations are partnering to deliver a sought-after service, like home infusion or behavioral health, but they don't have the time, talent, attention, or capital to make it successful. So, they look to partner with someone. Maybe it's another health system, maybe it's a for-profit infusion or behavioral health company."* **– TODD NELSON, FORMER HOSPITAL CFO AND HFMA HEALTH POLICY DIRECTOR**

Rather than fully owning and funding high-overhead, specialized clinical departments, health systems are leveraging JVs to bring dedicated clinical expertise, scale, and capital into their markets.

Private Equity

Healthcare executives have little appetite for partnering with PE firms to finance their organizations. This study shows that only 1% of health systems are currently partnering with PE firms. Just 5% are considering PE partnerships, while a massive 94% are not considering PE at all.

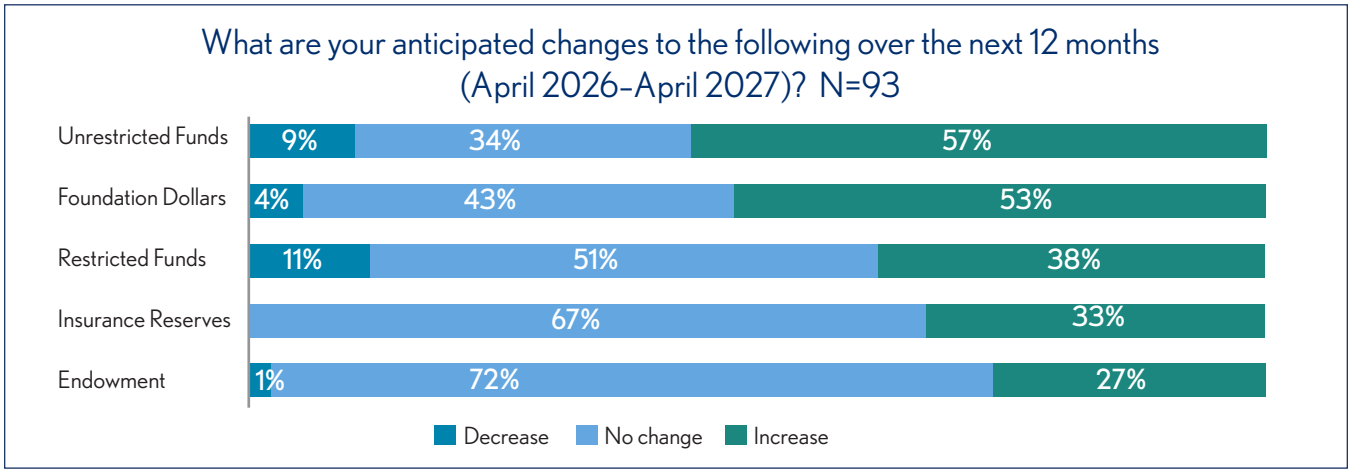
Healthcare executives widely believe PE partnerships rarely end well for healthcare organizations (or the communities they serve) because of incentive mismatches and concerns about the impact on patient care and community support.

Philanthropy

The reliance on philanthropy is expected to expand. The benchmark study reveals that health systems are actively planning to boost these funds to prepare for upcoming shortfalls.

Fifty-three percent (53%) of health systems surveyed expect foundation dollars to increase over the next 12 months.

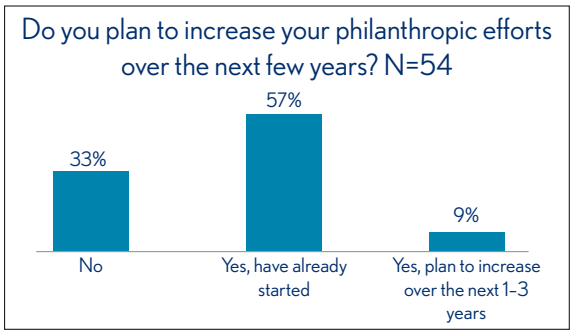
SURVEY RESULTS: Fund Changes



More than half (57%) of health systems have begun increasing their philanthropic efforts.

Industry experts shared how health systems increasingly are relying on philanthropy and foundation assets as a vital "leg of the stool" to maintain financial stability amid margin compression and rising costs .[31]

SURVEY RESULTS: Philanthropic Efforts



A primary strategy is to use philanthropy to fund highly visible, community-oriented capital projects. By funding new buildings or community-facing facilities through donations, hospitals can preserve operating cash for day-to-day expenses such as labor and drug costs.

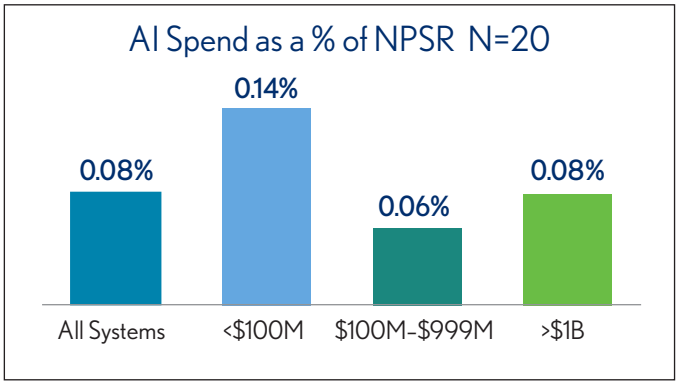
In the study, industry experts said foundation assets serve as a critical financial buffer for large health systems. These funds are treated as flexible, long-term reserves that can step in during cash-flow pressure, delayed commercial reimbursements, or rising denials.[32]

> *"Healthcare organizations are looking at philanthropy to try and offset some of their larger patient-facing project needs while they continue to spend most of their operating dollars on rising costs, etc. So, it ends up being a zero-sum game."*
>
> **– TODD NELSON, FORMER HOSPITAL CFO AND HFMA HEALTH POLICY DIRECTOR**

4 Leveraging AI and Payer Strategy

Targeted AI Investments

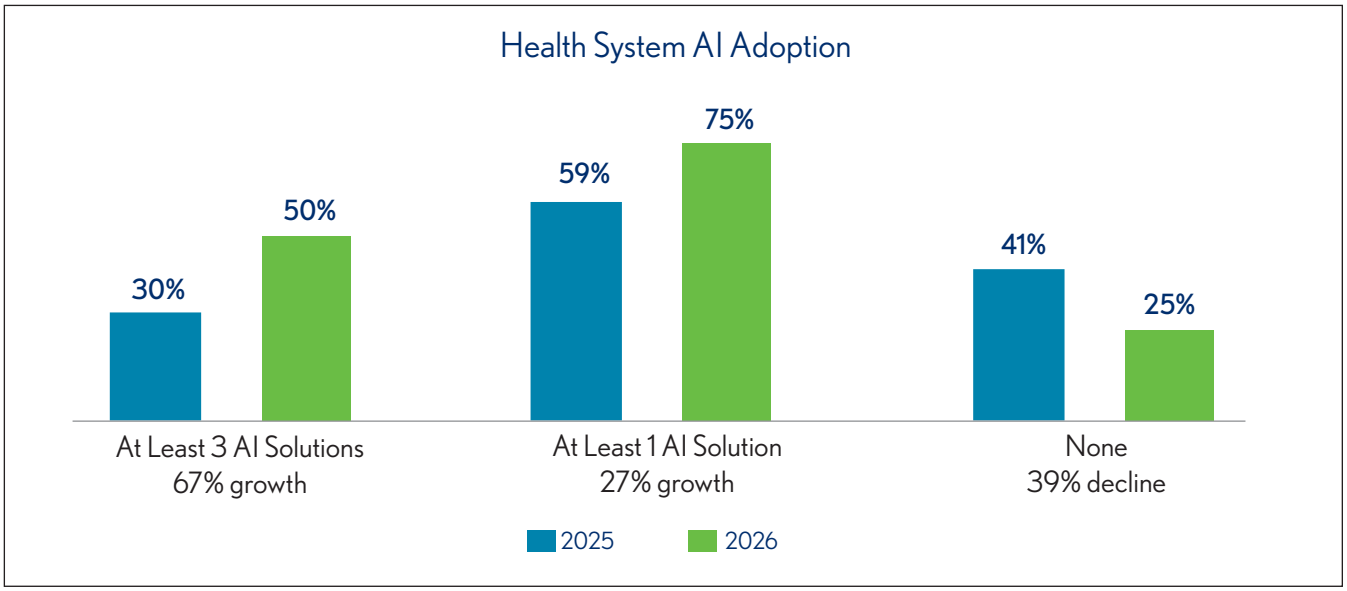
This study highlights how health systems are expanding AI investments to manage persistent labor shortages, tight operating margins, and rising claim denials. Health systems spend an average of 0.08% of net revenue on AI, with 84% planning to increase their AI investments, focusing on quick-return tools like ambient listening.



SURVEY RESULTS: AI Spend

Rather than viewing automation as optional, leaders rely on technology to protect revenue and improve operational efficiency.

Organizations are also expanding beyond single AI tools, with the number of health systems deploying three or more AI solutions growing by 67% in the past year. According to Eliciting Insights' **"2026 AI Adoption in U.S. Health Systems" study,** 75% of health systems now use at least one AI application, up from 59% in 2025.[33]



High Payback Justifies the Spend

Healthcare providers traditionally move cautiously with tech investments. Today, however, executives are breaking character to curb mounting financial and operational overhead and rapidly deploying targeted, high-yield tools.

As highlighted in the "2026 AI Adoption in U.S. Health Systems" study, health systems are adopting these tools primarily for their strong return on investment – 61% of respondents using ambient listening for clinical note-taking achieved an ROI of 2X or higher.[34]

For CFOs, AI could provide a targeted, measurable way to control labor expenses and protect operating margins across their organizations, with a quick, easy-to-measure financial return while minimizing disruption to patient care.

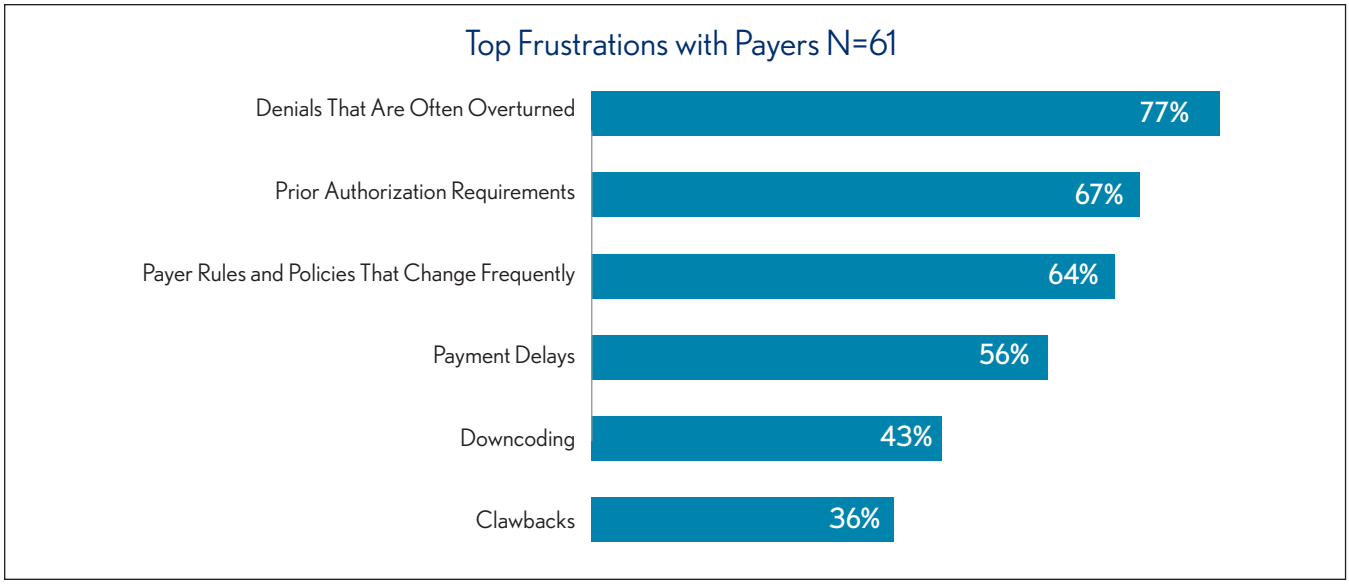
Revenue Cycle Management

McKinsey & Co reports that revenue cycle operations typically consume 3% to 4% of a health system's net revenue.[35] Overall, the American Hospital Association estimates that hospitals spent $43 billion in 2025 collecting payments owed for care.[36] An HFMA report shows that 63% of healthcare CFOs plan to dedicate more resources and focus to revenue cycle management over the coming years.[37]

Labor represents the largest share of this spend, driven by staffing needs for coding, clinical documentation, and claims rework. A revenue cycle consulting firm shared that systems also spend heavily on third-party billing vendors and offshore partners, which typically account for 4% to 10% of total collections.[38] Shifting coverage levels, rising patient out-of-pocket costs, and lower payer reimbursements (i.e., underpayments) further complicate these workflows.

This study indicates that for CFOs, reducing revenue-cycle friction offers a direct opportunity to lower the cost to collect, protect net revenue, and capture sustainable operational efficiencies. The survey results show that over 75% of health systems report frustration with payer denials that ultimately are overturned. Another 67% are frustrated with prior authorization requirements.

SURVEY RESULTS: Provider Frustrations with Payers



Clash of the AI Titans: Health Systems vs. Payers

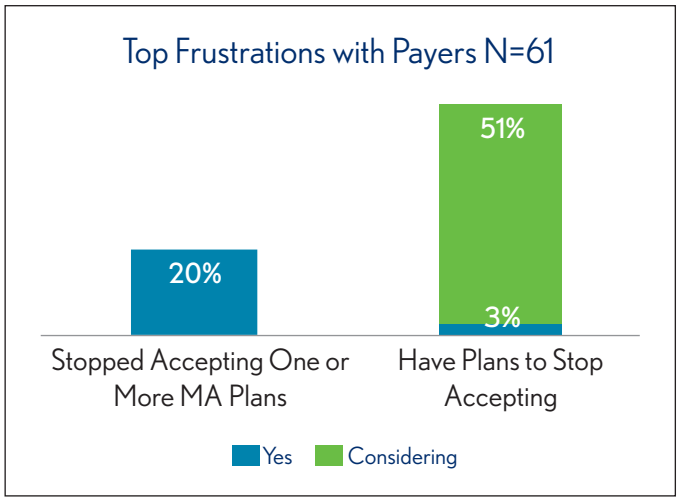
> *"Healthcare providers realize that payers are using AI 'against them' and they better do something, because they can't continue to fight the volume of denials or underpayments manually or the way that they've always done it. So, providers are investing in AI technology to do it."*
>
> **– TODD NELSON, FORMER HOSPITAL CFO AND HFMA HEALTH POLICY DIRECTOR**

Health systems and payers increasingly are using automation on opposite sides of the revenue cycle. While providers deploy technology to protect revenue, payers leverage algorithms to rapidly review and deny claims.

For example, **legal filings** reported by Thompson Coburn LLP show that Cigna's PxDx algorithm allegedly automatically denied more than 300,000 claims in two months, averaging 1.2 seconds per claim without individual physician review.[39]

To keep pace with automated denials, health systems are adopting agentic AI platforms. These systems process clinical records, evaluate payer guidelines, and generate automated appeal letters at scale, making AI an essential tool for managing revenue cycle operations.[40]

Reassessing Contracts



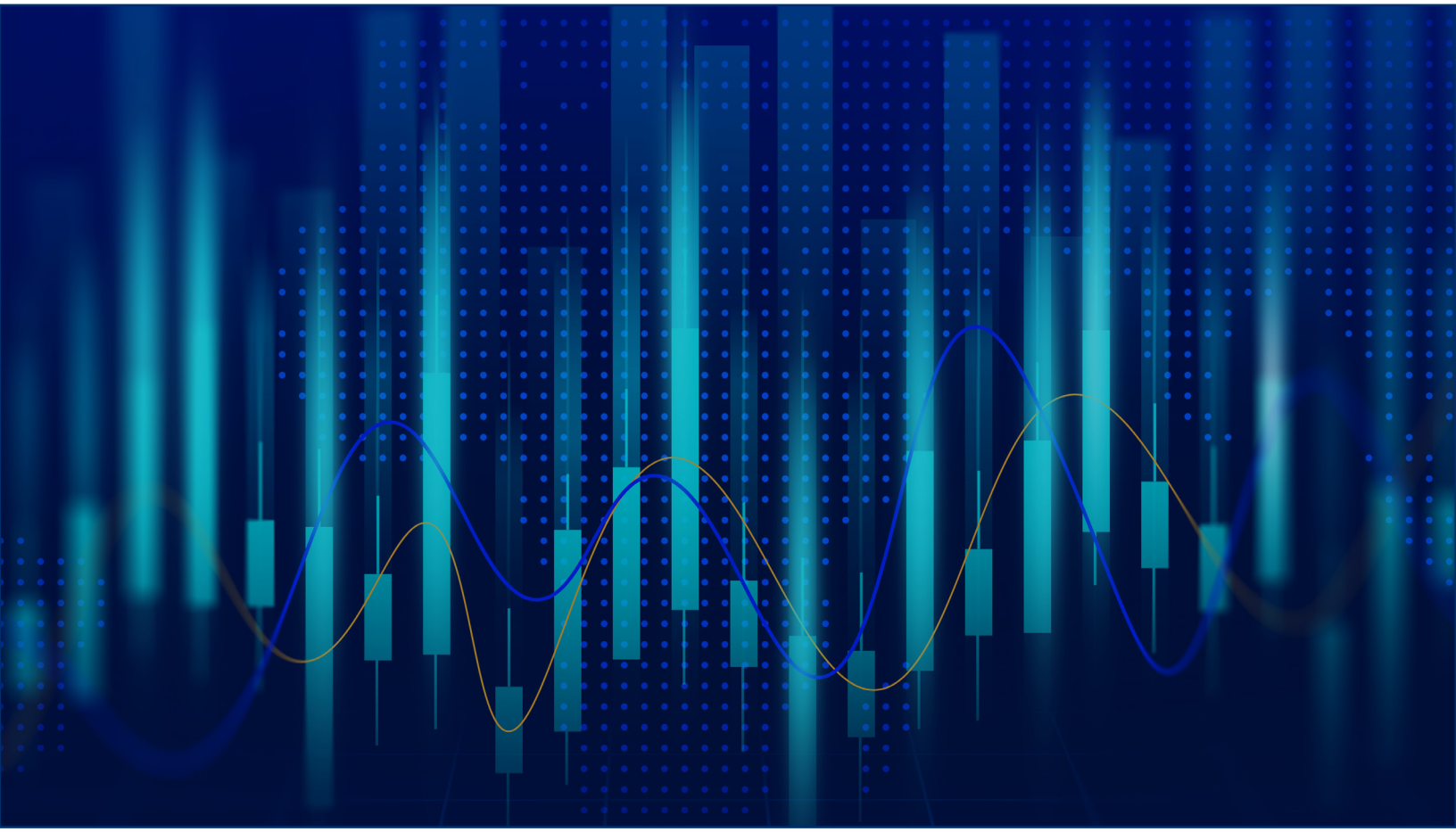
This study highlights how the frustration over high denial rates and complex prior authorization processes is driving health systems toward direct contracts and away from Medicare Advantage plans. Twenty percent (20%) of health systems have stopped accepting Medicare Advantage plans over the past three years, and 54% are planning to end or are considering ending acceptance of one or more plans in the next 12 months.

To manage tight margins and rising costs, health system financial leaders are taking direct action to protect their budgets. Organizations are reengineering employee benefits, renegotiating supplier and pharmacy contracts, and building liquidity by issuing debt early and maintaining conservative cash reserves.

This study demonstrates how CFOs are moving away from expensive hospital construction, choosing instead to open outpatient centers, form JVs, and expand philanthropic fundraising. At the same time, finance teams are using targeted AI tools to manage payer claim denials and lower billing costs. By pairing balance sheet flexibility with tight cost controls and practical technology, health systems are building operational models designed to handle ongoing economic pressures.

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CHAPTER 4:

Looking Ahead

The Cycle of Resilience in Healthcare Finance

Health systems face a difficult array of financial pressures: ongoing inflation, high labor costs, reduced reimbursement rates, and a shifting payer landscape. Because hospital operating margins remain near historical lows, executive finance teams frequently find themselves on the defensive.

However, healthcare financial stability moves in cycles. Health systems have repeatedly overcome major economic shocks, often bouncing back with leaner operating models and better cross-team collaboration. Maintaining a steady long-term strategy requires recognizing that today's financial strains, while challenging, fit into a longer pattern of industry recovery and operational evolution.

Lessons from Historical Financial Disruption

Over the last 30 years, healthcare organizations have repeatedly overcome major financial downturns through strict cost discipline and cross-departmental alignment:

1997

Balanced Budget Act of 1997 (BBA):

Created over half a decade of financial pressure through **unprecedented Medicare reimbursement cuts.** Finance leaders adapted by restructuring operations, forming multidisciplinary value committees, and adopting service-line accounting systems to remain viable under lower payment ceilings.[41]

2008

2008 Financial Crisis:

In Q3 2008, half of U.S. hospitals **posted operating losses,** and median operating margins fell to 0.37%. Hospital operating margins historically follow cyclical patterns during macroeconomic shifts.[42] Following the 2008 downturn, median **operating margins rebounded,** exceeding 4% across all hospital categories by Q2 2009.[43]

2020

COVID-19 Pandemic:

This resulted in **reduced patient care revenues** while sharply increasing operating expenses. CFOs worked alongside clinical directors and purchasing leaders to deploy telehealth within weeks, reallocate medical staff, and establish real-time operational dashboarding, helping many hospitals adapt and emerge in a more stable financial position.[44]

Today's financial pressures are real, but history shows that health systems recover when finance and clinical leaders work together. Current challenges force organizations to fix workflows, strengthen balance sheets, and adopt high-return technology.

By keeping a multi-year view and managing capital wisely, CFOs can guide their organizations through tough conditions. Systems that collaborate across departments today will not only handle immediate pressures but also emerge with lower costs and stronger foundations for future growth.

The Strategic Trade-off of Innovation

Evaluating technology capital during low-margin periods is challenging because upfront software costs and workflow changes increase short-term expenses. However, judging technology solely on initial spend creates long-term inefficiency. Evaluating investments by total cost of ownership over a multi-year horizon transforms technology into a margin protection tool:

- **Administrative Efficiency:** Ambient documentation tools reduce manual EHR work, lowering physician burnout and expanding clinical capacity without adding headcount.
- **Measurable ROI:** Healthcare automation averages a $3.20 return for every $1.00 spent, with returns realized in 14 months. For example, Mayo Clinic's radiology AI saw a negative return in Year 1 but achieved a 280% cumulative ROI by Year 5.[45]
- **Penalty Avoidance:** Automated clinical guidance can reduce diagnostic errors and readmissions, buffering health systems from value-based care penalties and rising uncompensated care expenses.

When leadership evaluates technology based on total cost of ownership rather than initial procurement expense, capital deployment becomes a sustainable way to protect margins.

Strengthening Operations for the Future

Health systems have a strong track record of weathering regulatory payment reductions, broader economic recessions, and unexpected operational crises. By maintaining a strategic perspective and aligning financial management closely with clinical operations, executive teams can build a long-term, healthy position.

Financial pressure forces finance, operations, and clinical leaders out of traditional silos to collaborate on budgets, supply standardization, and care delivery.

Maintaining long-term stability requires disciplined execution across three core priorities:

- **Securing Operational Liquidity:** Timing debt issuances effectively and holding short-term cash reserves to absorb revenue volatility.
- **Reducing Structural Unit Costs:** Lowering expenses through process automation and workflow improvements rather than across-the-board budget cuts.
- **Targeting High-yield Capital:** Directing funds toward tools with clear payback windows that solve operational bottlenecks for care teams.

Health systems consistently overcome payment cuts and broader recessions. Taking a multi-year view and maintaining tight alignment between financial and clinical leadership positions the organization for lasting fiscal health.

Methodology

Overview and Objective

The HFMA "Financial Health and Investment Benchmark Study" was created to inform health system CFOs about market challenges, opportunities, and emerging trends. Research for the study was conducted by Eliciting Insights, an independent healthcare market research company, in Q2 and Q3 2026 to provide insights on topics most important to health system leaders today. Interviews were conducted in three waves (24 total).

The first wave was with HFMA member CFOs to understand gaps in their current insights. From there, a series of surveys were developed to capture both qualitative and quantitative data (194 total responses): "Sentiment Survey," "Quantitative Survey Based on Health System Financials," and "Finance Trends Survey."

Next, another round of interviews was completed with CFOs and industry subject matter experts from Fidelity and the HFMA, with expertise in healthcare finance, employee benefits, technology, and payer relations to understand trends.

Finally, additional secondary research was conducted to support findings from the interviews and surveys.

Research Instruments & Sample Sizes

1 Qualitative Survey (N=93) Sentiment Survey

A primary qualitative survey was administered in Q2 2026 to a broad cohort of HFMA members (CFOs, VPs/Directors of Finance, Treasurers, and Controllers). The objective of this instrument was to gather open-ended feedback, uncover baseline sentiment, and identify overarching themes regarding current industry pressures.

2 Quantitative Survey (N=40) Quantitative Survey Based on Health System Financials

A primary quantitative survey was administered in Q2 2026 to a broad cohort of HFMA members (participants were designated by the health system CFO). The objective of this instrument was to collect organizational investment and spend data elements for FY 2025.

3 Subject-matter Expert and Partner Interviews (N=24)

To provide strategic context for the survey data, we conducted a series of structured, in-depth interviews in Q2 and Q3 of 2026. These interviews targeted two primary cohorts:

- **Health System CFOs and Executives:** Leaders discussed operational realities and institutional strategic plans, as well as gaps in current financial institutional benchmarks.
- **Industry Specialists:** Key subject-matter experts from Fidelity and the Healthcare Financial Management Association (HFMA), ensured alignment with broader economic and institutional standards.

4 Quantitative (N=61) Finance Trends Survey

A primary quantitative survey was administered in Q3 2026 to a broad cohort of healthcare financial leaders. This instrument aimed to collect additional revenue and spending data, as well as feedback on current financial trends affecting health systems.

5 Industry Scan

Secondary research also supported findings from the surveys and interviews. Sources include, but not limited to, the Healthcare Financial Management Association (HFMA), Kaufman Hall, American Hospital Association (AHA), and McKinsey & Company.

Participating Institutions

This report's validity relies on insights from a diverse cross-section of the U.S. healthcare landscape. The data and perspectives compiled reflect the participation of financial leaders from the following health systems:

Adams Health Network
Adelphoi
AdventHealth
Akron Children's Hospital
Altru Health System
Avera Health
BayCare Health System
Bayfront Health Port Charlotte
Beacon Health System
Beloit Health System
Bon Secours Mercy Health
Boone County Hospital
Brown County Hospital
CaroMont Health
Centra Health
CentraCare
Clarity Child Guidance Center
Community Health Systems
Community Healthcare
Community Hospital - IN
Community Memorial Healthcare
Confluence Health
Contra Costa Health Services
Crisp Regional Health System
Crozer Chester Medical Center
Cuyuna Regional Medical Center
Dallam Hartley Counties Hospital District
Dallas County Medical Center
Dartmouth Health
Delta Health
Dollywood Family Healthcare Center
Dolly Parton Children's Hospital
Dundy County Hospital
Edgerton Hospital & Health
Essentia Health
Fall River Health Services
Family HealthCare
Ferrell Hospital
Fillmore County Hospital
Fort Healthcare Inc.
Franklin Medical Center
Grand River Health
Guadalupe Regional Medical Center
Hancock Health
Hannibal Regional Healthcare System
Hood Memorial Hospital
Huntsville Hospital Health System
Jefferson Health
Kennedy Krieger Children's Hospital
Kennedy Krieger Institute
Lee Health
Legacy Health
Lima Memorial Health System
Lindner Center of HOPE
Livingston HealthCare
MaineHealth Franklin Hospital
Mary Greeley Medical Center
Maury Regional Health
Mayo Clinic
Memorial Health
Memorial Healthcare
Memorial Hospital
Mennonite General Hospital
Methodist Sugar Land Hospital
Millinocket Regional Hospital
Mineral Community Hospital
Morgan Medical Center
Mountain Health Network
Mountain View Hospital- NV
Nemaha Valley Community Hospital
Nemours Children's Health
Newton Medical Center
North Memorial Health Care - MN
Northern Montana Hospital
Northfield Hospital & Clinics
Northwestern Medicine
Northwest Health La Porte
Norton Healthcare
Ohio State University Wexner Medical Center
Palo Alto County Hospital
Piedmont Augusta Hospital
Punxsutawney Area Hospital
Queen's Health System
Rainy Lake Medical Center
Reedsburg Area Medical Center
RHI (Rehabilitation Hospital of Indiana)
Rice Community Hospital
Richmond University Medical Center
Riverside University Health Systems
Roane General Hospital
Samaritan Health Services
Sanford Health
Scott County Hospital
SCMG (Sharp Community Medical Group)
Sharp HealthCare
Sidney Health Center
Sioux Center Health
Skagit Regional Health
SSM Health
Stillwater Medical Center
Sturdy Memorial Hospital
Summit Health
The Estaugh
Torrance Memorial Medical Center
Trinity Health
Tucson Medical Center
Tufts Medicine
UConn Health
UF Health
UHS Delaware (Universal Health Services)
UNC Health
Unity Health
University Health
University of Rochester Medical Center
Welia Health

METHODOLOGY NOTE: All survey responses and interview transcripts were aggregated and anonymized to ensure candid feedback and compliance with institutional data-sharing policies. Percentages in the quantitative findings may not equal 100% due to rounding or multi-select survey questions.

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