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PULSE

Health Care Bankruptcies Hit Three-Year Low in Q2 2025

Health care bankruptcies reached a three-year low in the second quarter of 2025, with only seven companies with at least $10 million in liabilities filing for Chapter 11 protection, according to a recent report from Gibbins Advisors. This marks a significant decrease from the 14 filings in the same period last year, Healthcare Dive reported.

Gibbins Advisors predicts a 16% reduction in filings this year compared to 2024, as fewer large health care companies and providers declare bankruptcy. However, this dip may be short-lived, as challenging market conditions and impacts from Medicaid cuts could hit providers' bottom lines as early as 2026, potentially triggering a new wave of bankruptcies.

The second quarter saw zero provider bankruptcy filings, with pharmaceutical companies accounting for five of the seven total filings. One medical supply company and one senior care company also declared bankruptcy during the period.

Despite the recent decline in bankruptcies, the report does not indicate optimism about the sector's financial health. Providers have been hit hard by policy changes, including tariffs on critical supplies and general market volatility. The looming Medicaid cuts outlined in the One Big Beautiful Bill Act are expected to cause issues for hospitals serving vulnerable communities, especially those with high Medicaid populations and those dependent on supplemental payments. The legislation, signed into law by President Donald Trump on July 4, cuts roughly $900 billion from Medicaid over a decade and is expected to result in 10 million additional people becoming uninsured by 2034, according to the Congressional Budget Office. Hospitals are concerned about the potential rise in uncompensated care costs as a result of these changes.

To weather the storm, health care companies will need to critically review their budgets for waste, adjust workflows to leverage automation or outsourcing, and focus on efficient supply chain management, according to Gibbins Advisors.

Pennsylvania Lawmakers Propose Bill to Regulate AI in Health Care

Pennsylvania state representatives have introduced bipartisan legislation aimed at regulating the use of artificial intelligence (AI) in health care settings. The proposed bill, backed by Reps. Arvind Venkat, Joe Hogan, Tarik Khan, Bridget Kosierowski, and Greg Scott, would establish new regulations on how AI is used and reported by insurers, hospitals, and clinicians.

Under the proposed legislation, these groups would be required to provide transparency to patients and the public regarding how AI is being used in their companies or practice settings.

"I am grateful for my bipartisan colleagues, including fellow health professionals, who are joining me on this legislation to make sure Pennsylvanians can be confident that AI is being used responsibly and effectively in the health care industry," said Rep. Venkat, the only physician in the General Assembly.

To prevent over-reliance on AI, the bill would ensure that a human makes the ultimate decision based on an individualized assessment when insurers, hospitals, or clinicians use AI. Rep. Scott emphasized that while AI can enhance various aspects of human life, including health care, it should never replace the expertise or judgment of experienced clinicians.

The legislation would also require insurers, hospitals, and clinicians to attest to the Pennsylvania Department of Insurance and the Pennsylvania Department of Health that bias and discrimination prohibited by state law have been minimized in their usage of AI. They would also need to provide evidence of how that determination was made.

Rep. Kosierowski, a nurse for nearly 30 years, noted, "With the introduction of AI, we need experienced doctors and nurses even more now to assess the accuracy of AI to ensure that bias and discrimination haven't influenced its findings."

The proposed bill in Pennsylvania follows a similar law recently passed in Illinois, which prohibits the use of AI to aid in mental health and therapeutic decision-making while still allowing its use for administrative and supplementary support services for licensed behavioral health professionals.

Hospitals Brace for Challenges Amid Solid Financial Footing

The hospital sector is currently on stable ground, with improved balance-sheet metrics helping it prepare for the expected turmoil ahead, according to a recent report from Fitch Ratings.

As noted in an HFMA article, the median operating margin for Fitch's rated credits increased from 0.2% in 2022 to 1.1% in 2024, while the EBITDA margin rose from 7.3% to 8.6%. Days' cash on hand remains favorable at 215.1 for 2024, and ratios of cash-to-debt and cash-to-adjusted-debt are trending significantly upward.

"Despite a lot of noise and challenges in the industry, we're still in a period where most of our credits have stable outlooks," said Mark Pascaris, senior director with Fitch Ratings, as reported by HFMA.

However, the future looks daunting

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NEWS & NOTES

Employers Consider Reducing Benefits to Control Health Care Costs in 2026

Employers are grappling with the challenge of managing rising health care costs and may resort to reducing benefits in 2026, according to a recent survey by Mercer. The Survey on Health and Benefit Strategies for 2026 reveals that employers project an average health benefit cost growth of nearly 6% this year, with 2026 potentially being even more challenging.

As a result, more than half (51%) of large employers, those with 500 or more employees, are likely or very likely to make plan design changes in 2026, such as offering plans with narrow networks or raising deductibles or out-of-pocket maximums. This is up from 45% in last year's survey.

Some employers are also considering nontraditional strategies, with 35% of large employers planning to offer a medical plan option like a variable copay plan in 2026. These plans offer no or low deductibles and set copayments for services based on individual providers' fees, giving members the opportunity to select lower-cost providers.

The biggest pharmaceutical concern for employers is the cost of GLP-1 drugs, which have shifted from diabetes control to weight loss. Seventy-seven percent of employers surveyed say that managing this cost is their top priority in pharmacy benefits. Employers are weighing the high cost, estimated at $1,000 per month, against the potential health benefits.

Well-being and mental health continue to be a priority for employers, with more than 75% of large employers planning to offer digital stress management or resiliency resources in 2026, such as mindfulness and meditation apps or apps grounded in cognitive behavioral therapy.

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Over Half of Insured Patients Denied Coverage for Critical Medications

A recent survey by the PAN Foundation reveals that 54% of commercially insured adults have been told by their health insurance plan that medications for their chronic or rare disease are no longer covered. The poll also found that nearly half of these patients were referred to work with external companies to obtain their medications, causing significant delays and negative impacts on their health and lives.

The survey results highlight the prevalence of alternative funding programs (AFPs), which can lead to increased out-of-pocket costs, adverse health effects, and life-threatening delays in care.

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for the hospital sector. Fitch warns that "the tone, but not the outlook, for the remainder of 2025 and beyond has turned decidedly negative."

The company cites significant structural changes to federal health care spending as "the greatest threat to not-for-profit hospital operations and cash flow."

While most of the new law's headlining provisions will not take effect until the end of 2026 or later, some attrition in health care coverage may be felt imminently. States and hospitals also face restrictions on Medicaid provider taxes and state-directed payments.

Despite these challenges, Fitch believes that the current liquidity and leverage metrics, which remain largely unchanged and at the high end of the range for the past decade, should provide hospitals with "a brief window of time to prepare for the cuts to operating income that are inevitably coming."

The company even anticipates "an additional uptick in operating results in 2025, especially as hospital management teams accelerate cost savings efforts in advance of federal Medicaid funding cuts."

As health care providers navigate this uncertain landscape, they must maintain a strong financial foundation and proactively prepare for the upcoming changes in federal health care spending.

DATAWATCH

AI-Driven Claim Denials Disrupt Health Care Providers and Patients

Health care providers are facing increasing challenges in navigating the path to reimbursement for health care claims due to the growing use of AI by health plans to deny claims, HFMA reported. According to recent data, initial claim denial rates have climbed to nearly 12% in 2024, a 2.4% year-over-year increase, as reported by Kodiak Solutions. The rise in claim denials is occurring despite health care organizations' plans to increase spending on AI through 2026, with over 40% focusing on AI solutions for revenue cycle management. Surprisingly, the denial rate has increased even as providers have reduced prior authorization denials by 7.7%.

"Payers appear to be using initial denials to slow payments, even though they ultimately pay approximately 90% of claims, a trend we have been tracking," said Matt Szaflarski, Kodiak's vice president of revenue cycle intelligence. These initial denials cost health care providers significant resources to overturn and slow down their cash flow.

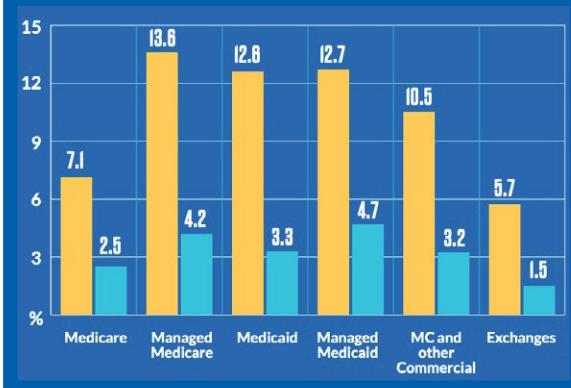
Claim denials also cause confusion and frustration for patients, who are left uncertain about their financial obligations and whether the health plan will change its decision. As one health care revenue cycle expert told HFMA, patients often direct their frustration toward the provider when procedures are rescheduled due to missing authorizations from insurance companies.

HFMA suggested these strategies to combat the rise in denials:

- Use process automation and machine learning to ensure clean claims and efficient work queue management.
- Use AI-powered bots to check claim and prior authorization status, avoiding initial denials and responding to denials more quickly.
- Have your payer liaison teams work directly with health plans to address recurring denial issues.

Claims Denials Worsen~

Denials for claims — even after receiving prior authorization — increased across payers in recent years. Share of claims denied after receiving prior authorization.



Source: *Premier Payer Data Survey 2025*

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