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TIME TO ACT

What The Future Holds For Pennsylvania's Hospitals, Patients, and Communities

January 2026

This report examines the financial challenges facing Pennsylvania's hospitals and the need to secure their future to ensure Pennsylvanians' continued access to high-quality care. Prepared by Oliver Wyman, LLC on behalf of The Hospital and Healthsystem Association of Pennsylvania.

Executive Summary

Pennsylvania's hospitals are central to their communities as care providers, clinical educators, innovators, and major employers. However, their financial stability is under significant strain from low reimbursements and rising operating costs. Today, Commercial and Medicaid reimbursements in the Commonwealth are below the national median, a tort-friendly medical liability environment persists, and extensive and costly regulations make operating a hospital in Pennsylvania more challenging than in other states. Going forward, these challenging financial conditions are projected to worsen as Medicaid reimbursements are reduced, insurance coverage declines, and costs continue to increase. Without intervention, multiple hospitals could be forced to reduce services or close, leaving vulnerable communities without local healthcare options. Immediate action is required to secure the future of Pennsylvania's hospitals and preserve access to high-quality care.

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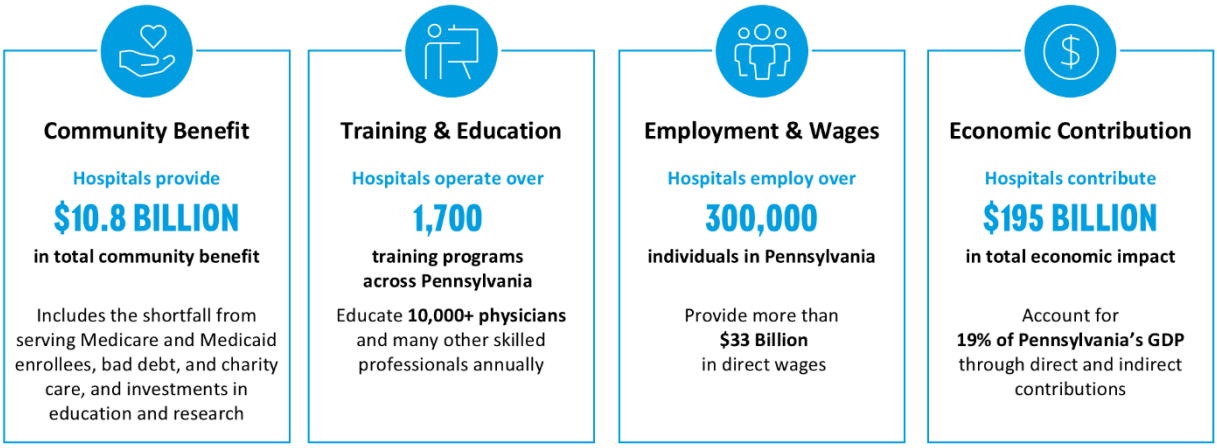
SUMMARY OF FINDINGS

The sustainability of Pennsylvania's hospitals is currently under pressure and projected to worsen over the next five years

Pennsylvania's hospitals have long been foundational to the Commonwealth's health, caring for millions of people in inpatient, emergency, and outpatient settings. The hospitals deliver high-quality care: The Commonwealth ranks 16th nationally on aggregated Hospital Compare metrics, and several institutions are recognized as global leaders in innovative healthcare.[1]

Exhibit 1: Pennsylvania hospitals are economic engines and community pillars[2,3,4,5]



The hospitals are also powerful economic engines in their communities, providing approximately $10.8 billion in total community benefit, which includes absorbing the shortfall from serving Medicare and Medicaid enrollees, bad debt, and charity care, as well as making investments in health professional education and research.[2] Pennsylvania hospitals operate more than 1,700 training programs, educated more than 10,000 physicians in the 2023-2024 academic year, employ over 300,000 individuals, and pay over $33 billion in direct wages.[2,3,4,5] Overall, hospitals comprise 19% of the Commonwealth's GDP through direct and indirect contributions of $195 billion.[2]

Despite these contributions, the economic and regulatory environment hospitals face is increasingly precarious. Operating a hospital in Pennsylvania is more challenging than in many other states due to lower reimbursements and unique cost pressures. Commercial insurers pay less to Pennsylvania hospitals than the national median.[6] Medicaid reimbursements don't come close to covering the full cost of care and are below peer states. Meanwhile, as more Pennsylvanians retire, they trade higher-paying employer coverage for lower-paying Medicare plans. On the cost side, Pennsylvania hospitals face sizeable administrative and compliance requirements from regulators and insurers, alongside a highly unfavorable medical liability litigation environment. For example, Pennsylvania has the highest malpractice payout per capita of any state at $43 per resident, with total payments of $557 million in 2024.[7] Malpractice payouts alone do not capture the full economic burden the medical liability environment imposes on Pennsylvania hospitals.

To remain sustainable, hospitals in Pennsylvania have pursued cost management initiatives. Their cost per discharge is 29% lower than in neighboring states and their operating costs have grown slower.[8] Unfortunately, these efficiency efforts have not been sufficient to overcome the inadequate reimbursement. Consequently, 51% of Pennsylvania hospitals have operating margins below a sustainable threshold of 4%, and 37% of hospitals have negative operating margins.[9] Credit agencies

acknowledge this strain, with the median bond rating for Pennsylvania hospitals below the median for hospitals nationally.[10] Lower ratings increase borrowing costs and constrain capital investment. Sustained negative margins have resulted in hospitals closing or reducing services; 25 hospitals in the state have closed since 2016.[11]

Looking ahead to 2030, the industry faces multiple converging threats that could further erode financial stability. We have developed a financial model to estimate the net profit margin of all acute care and specialty hospitals in Pennsylvania through 2030 considering these threats. The modeling demonstrates a range of plausible futures:

- **Baseline:** Under the "new normal" course of events, hospitals statewide will collectively face a -1% margin, representing $1 billion in expenses not covered by revenue. The number falls to -3%, or $2.4 billion in expenses over revenue, with the impact of H.R. 1,[12,13] the federal "One Big Beautiful Bill Act" that will reduce insurance eligibility and hospital payments.
- **Rainy Day:** Under a negative yet realistic scenario, statewide margins deteriorate markedly to -11%, representing a shortfall of $7.4 billion in revenue compared to expenses. An estimated 12 to 14 facilities could be forced to reduce services or close entirely.[13,14]
- **Sustainability Prevails:** Conversely, concerted action by state lawmakers, regulators and hospitals could return statewide margins to a sustainable 5%, with net income of $3.7 billion, and avert the most severe access losses.[13]

Without timely, targeted state support, many Pennsylvania hospitals will struggle to maintain existing services or make the necessary investments in workforce, technology, and infrastructure that Pennsylvania needs. State lawmakers have an opportunity to preserve access to high-quality care by mitigating the H.R. 1-driven reduction in Medicaid payments and coverage, bringing medical liability rules in line with national and historical norms, and identifying funding sources to help stabilize at-risk hospitals.

DEEP DIVE

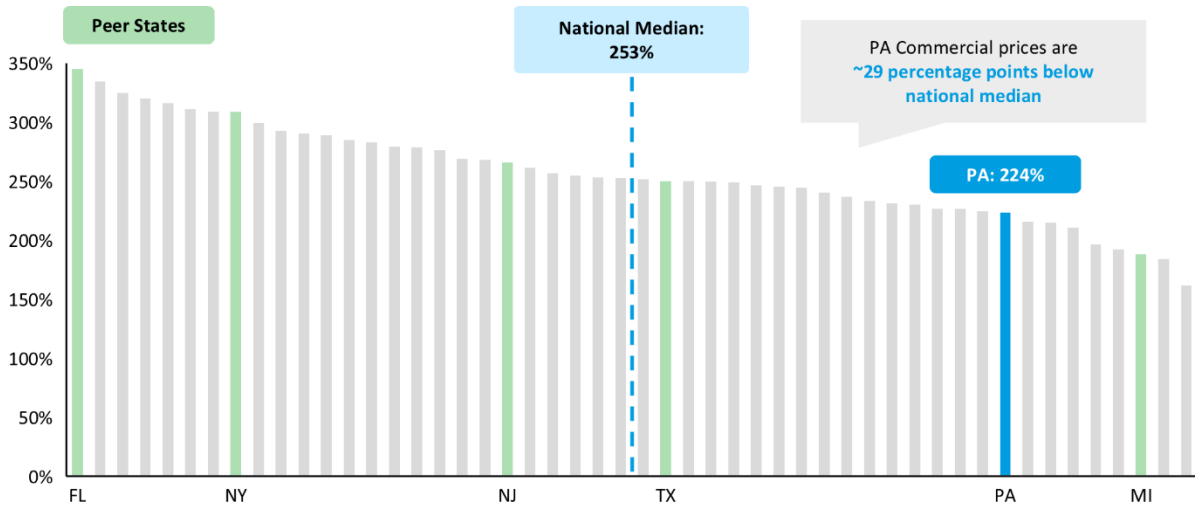
Today, hospitals face a precarious financial position due to low reimbursements and rising costs

Structural revenue shortfall

Operating a hospital in Pennsylvania is more challenging than in other states due to lower reimbursements and an extensive set of regulatory requirements. Hospitals face a structural margin shortfall.

Hospitals in the Commonwealth are paid materially below national peers. Pennsylvania hospitals are paid 29 percentage points below the national median for Commercial reimbursement rates.[6] This limits the available funds to provide care for the uninsured and the underinsured (like Medicaid recipients) and reduces hospital margins.

Exhibit 2: Commercial payor reimbursement percentage by state
Relative price by state, as a % of Medicare, inpatient and outpatient, 2022[6]



At the same time, Medicaid reimbursement in Pennsylvania leaves hospitals with a persistent gap between the cost of care and public program payments:[15]

- Pennsylvania's inpatient Medicaid reimbursement rate is 11 percentage points below the national median.[16]
- Pennsylvania's Medicaid reimbursement for inpatient and outpatient care only covers $0.87 for every dollar a hospital spends.[15]
- Reimbursements for professional services (services provided by an individual clinician rather than those associated with the healthcare facility) fall significantly below cost, resulting in additional financial pressure on hospitals.[17] When Medicaid professional services reimbursement and uninsured care is incorporated, hospitals recover only $0.71 for every dollar spent on providing care.[18]

These reimbursement dynamics, coupled with an aging population and shifts in payor mix (proportions of patients with different types of insurance), will increase the share of lower-reimbursed Medicare patients by 2030, further compressing hospitals' ability to get paid for the care they provide.

Exhibit 3: Costs covered by funding segment
Pennsylvania versus national, reimbursement for each dollar hospitals spend on inpatient and outpatient only, 2022[19]
(*Excluding shortfall from professional reimbursements*)

Funding segment	Pennsylvania costs covered	National costs covered
Medicaid	$0.87	$1.26
Medicare	*Pennsylvania's hospitals are reimbursed by Medicare at rates similar to their national peers, receiving $0.82 for every dollar of spend*	

Increasing costs amid constrained revenues

Cost-inflationary pressures are increasing as revenue is constrained. Labor is the single largest cost driver for hospitals, making up 41% of operating expenses. Despite hospitals' efforts to curtail rising costs, Pennsylvania has experienced labor expense growth of 4% year-over-year since 2011 (outpacing overall operating cost growth of 3.5%), and faces acute workforce shortages.[13] Pennsylvania is projected to have a shortage of 22,000 registered nurses by 2028, which would further escalate labor costs and may force hospitals to scale back services in some communities.[20]

Regulatory and legal costs add another layer of pressure. An analysis of state regulations determined that Pennsylvania is ranked the 24th most restrictive state for healthcare regulations.[29] In addition to regulations, Pennsylvania's medical liability environment produces outsized liability exposure and premium volatility. In 2024, Pennsylvania recorded the highest malpractice payments per capita (roughly $43 per resident and over $550 million in total malpractice payouts), a dynamic that depresses investment and raises operating risk for hospitals.[7]

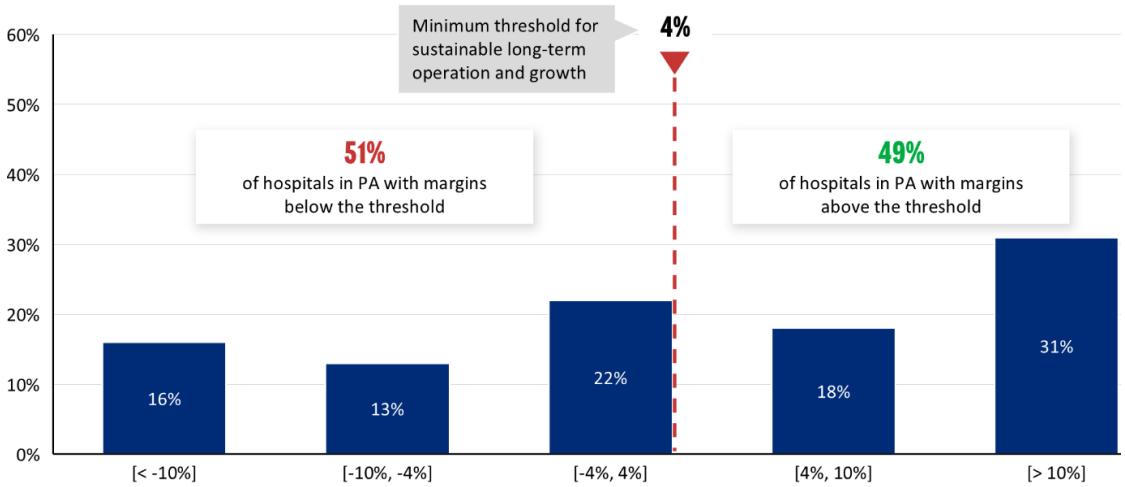
Hospitals contend with compliance requirements that have not been modernized or harmonized in some time. They are also reporting increasingly restrictive reimbursement policies from insurers. For example, nationwide, the average amount for outpatient coding-related denials (for example, diagnosis code errors, lack of medical record support) across lines of business increased 23% from 2024 to 2025, indicating increased administrative pressure on hospitals.[21]

Precarious financials

Pennsylvania hospitals have made significant efforts to manage operating costs and reduce waste without compromising safety. They have developed innovative models for coordinating care and bringing it closer to home while experimenting with value-based care arrangements.

Unfortunately, these efforts are not enough to mitigate the combined effect of lower reimbursement from Commercial and government insurers as well as rising labor and medical liability costs that have eroded hospital margins and financial resilience across the Commonwealth. Fifty-one percent of Pennsylvania hospitals have operating margins below the commonly accepted 4% margin threshold for sustainable operation, and 37% of hospitals have negative operating margins.[9] This environment caused 25 hospital closures in the state since 2016, and projections show that, without mitigation, up to 14 more hospitals are at risk through 2030.[11,14]

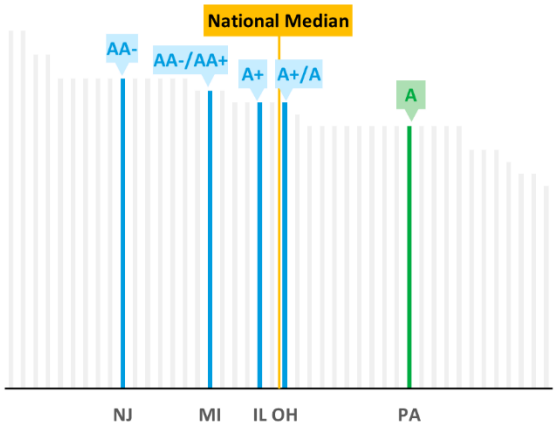
Exhibit 4: Distribution of operating margins for Pennsylvania hospitals
2024[9]



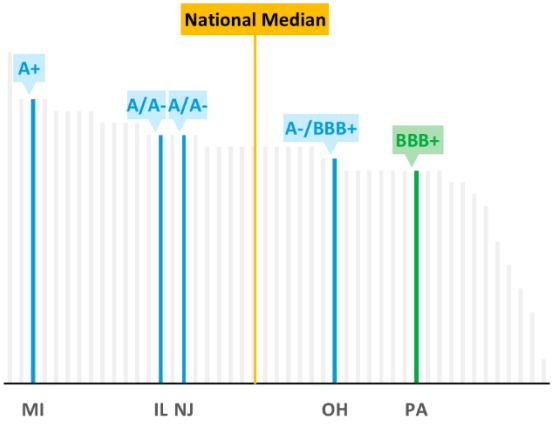
These financial stresses also appear in credit market signals. Median bond ratings for many Pennsylvania systems and stand-alone hospitals are below national medians, a dynamic that raises borrowing costs and constrains capital investment in facilities, technology, and workforce development. Statewide, operating expenses exceeded net patient revenue by $3.3 billion in 2023, underscoring the scale of the structural shortfall that hospitals are attempting to manage while maintaining clinical operations.[13]

Exhibit 5: Median hospital system and stand-alone hospital bond ratings by state
December 2024[10]

Median hospital system bond ratings by state, as of Dec. 2024



Median stand-alone hospital bond ratings by state, as of Dec. 2024



In sum, Pennsylvania hospitals operate in an environment where lower relative payment rates, rising labor and medical liability costs, and a dense regulatory framework combine to produce a fragile financial posture. Despite disciplined cost management and below-average costs per discharge, these structural imbalances have left many hospitals vulnerable, a condition that will worsen unless state policy and funding interventions realign reimbursement, reduce avoidable legal and administrative costs, and support workforce and technology investments.

LOOKING AHEAD

Hospitals face multiple threats through 2030, putting the health of Pennsylvanians at risk

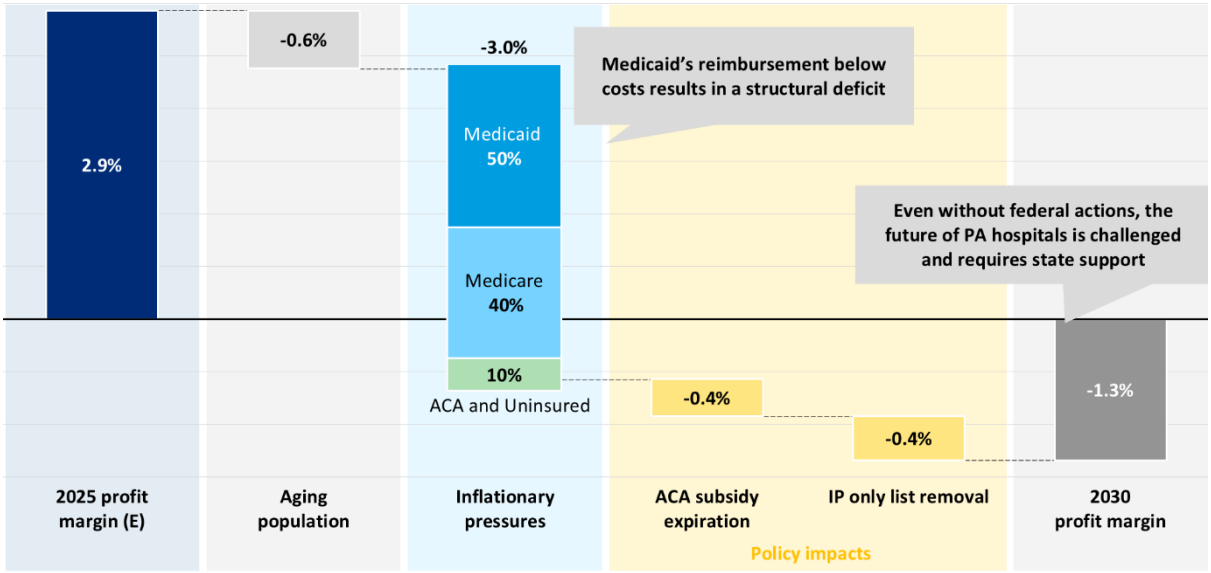
Looking ahead, the range of plausible outcomes for Pennsylvania's hospitals is wide and dependent on public policy and the reimbursement environment. Financial modeling developed for this analysis estimates that by 2030, Pennsylvania hospitals could collectively record net profit margins anywhere from -11% (a severe downturn) to +5% relative to an estimated statewide margin of roughly 3% in 2025.[13]

These scenarios were defined and quantified by focusing on the largest economic, regulatory, and technological drivers of hospital performance and stability. Modeling includes hospitals' inpatient and outpatient revenue and costs but excludes the shortfall from professional services for employed clinicians.[17] The full list of drivers and their impact is provided in the Appendix.

Baseline scenario without the impact of H.R. 1

Pennsylvania hospitals are projected to have gradually worsening financial performance through 2030, even without the potential effects of H.R. 1. The state's population is aging, which increases demand for care and shifts more patients into Medicare, a program that reimburses hospitals at lower rates than Commercial insurance. Medicaid and Medicare reimbursements are growing at a slower rate than costs, leading to a structural deficit.[22] At the same time, the enhanced Affordable Care Act (ACA) Marketplace premium subsidies expired at the end of 2025, a change projected to reduce ACA enrollment in Pennsylvania by about 150,000 people, further reducing hospital revenue while increasing uncompensated care costs.[23] Additionally, the Centers for Medicare and Medicaid Services' (CMS) recent elimination of the Inpatient (IP) Only List will move procedures into outpatient settings, reducing the inpatient payments hospitals have historically relied on. Taken together, these demographic and policy changes erode net profit margins from 3% today to -1% in 2030.[13]

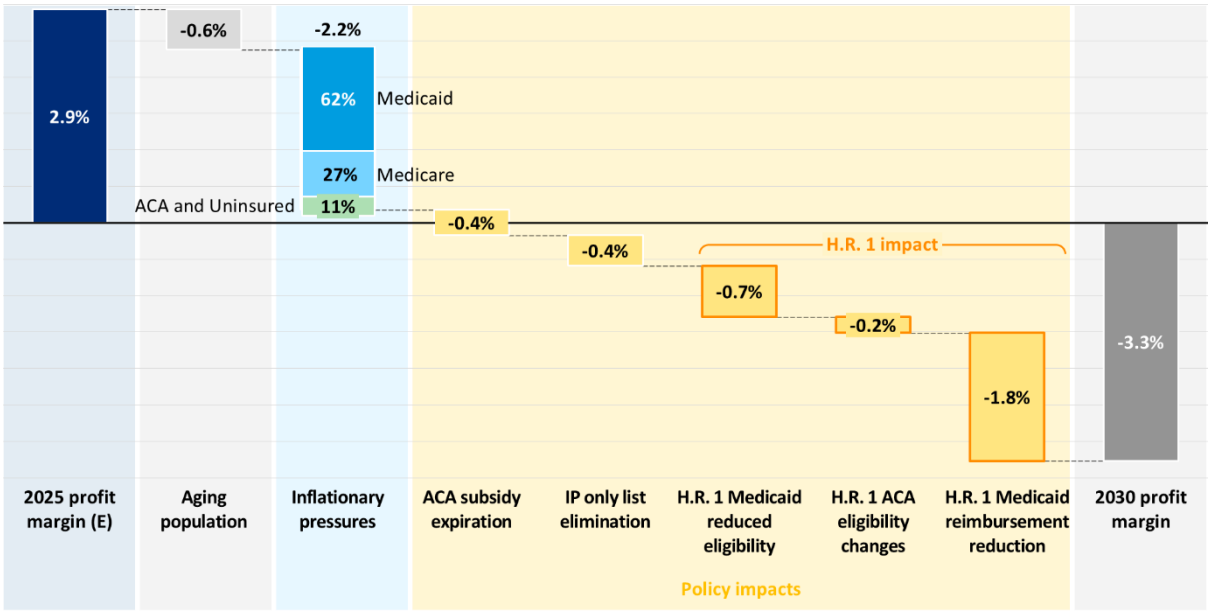
Exhibit 6: Baseline scenario without H.R. 1
2030 net profit margin trajectory, inpatient and outpatient only[13]



Baseline scenario (current course, with H.R. 1)

H.R. 1 is projected to worsen the financial health of Pennsylvania hospitals. Under the bill's provisions, 95,000 fewer individuals will be enrolled in Marketplace (ACA) coverage, and 300,000 fewer Pennsylvanians will be enrolled in Medicaid.[23,24] Additionally, Medicaid payments will be capped at Medicare rates, reducing hospital reimbursements. The enrollment losses and lower payment rates together will reduce hospital revenue across the state, shifting statewide margins to -3%.[13]

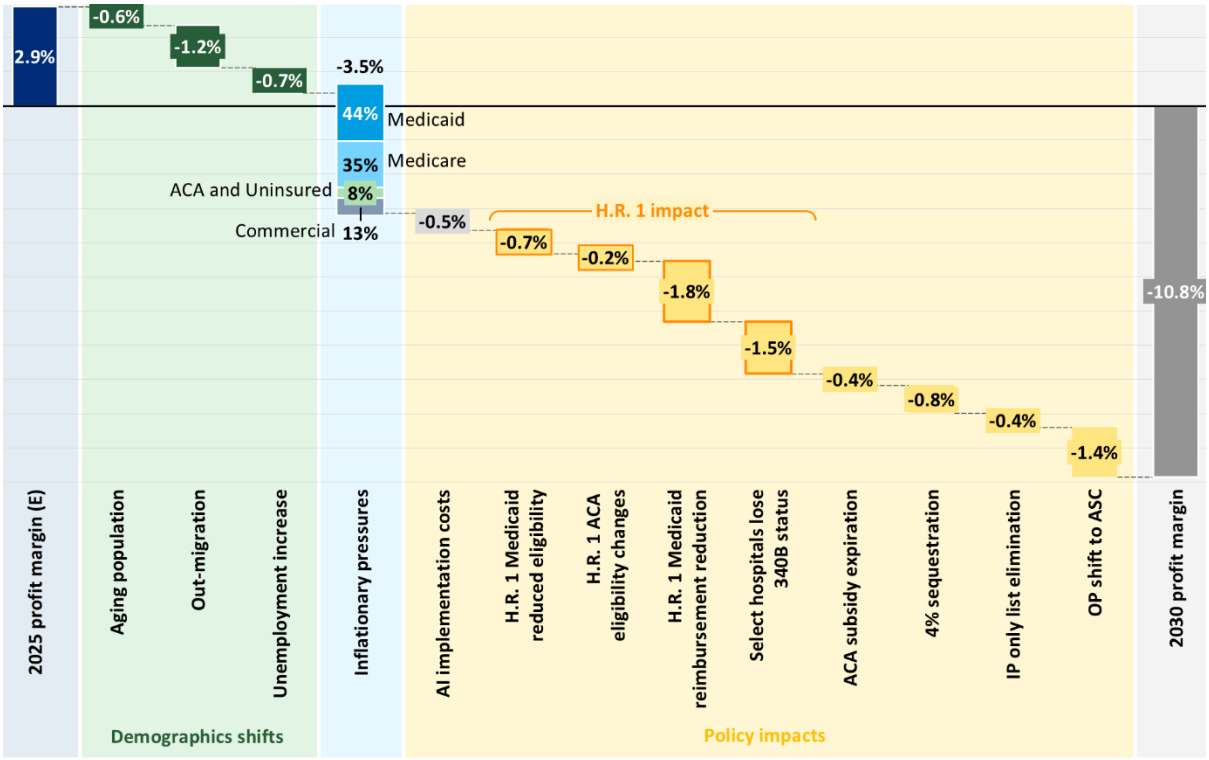
Exhibit 7: Baseline scenario with H.R. 1
2030 net profit margin trajectory, inpatient and outpatient only[13]



Rainy Day (downward cycle) scenario

Unfavorable federal and state actions beyond H.R. 1 have weakened the social safety net. Economic conditions have worsened, and Pennsylvania's unemployment has increased to 8%, resulting in working-age individuals leaving the state in search of jobs. Due to the increased unemployment and out-migration, hospitals face pressure from shrinking Commercial enrollments. The federal government has increased Medicare sequestration from 2% today to 4%, further reducing Medicare payments. Select hospitals are no longer eligible for the 340B program that provides hospitals with discounted drugs, resulting in a significant increase in costs.[25] These combined drivers create an operating environment that results in a statewide margin of -11% and as many as 12 to 14 hospital closures by 2030 absent action by the state to implement policy reforms.[13,14]

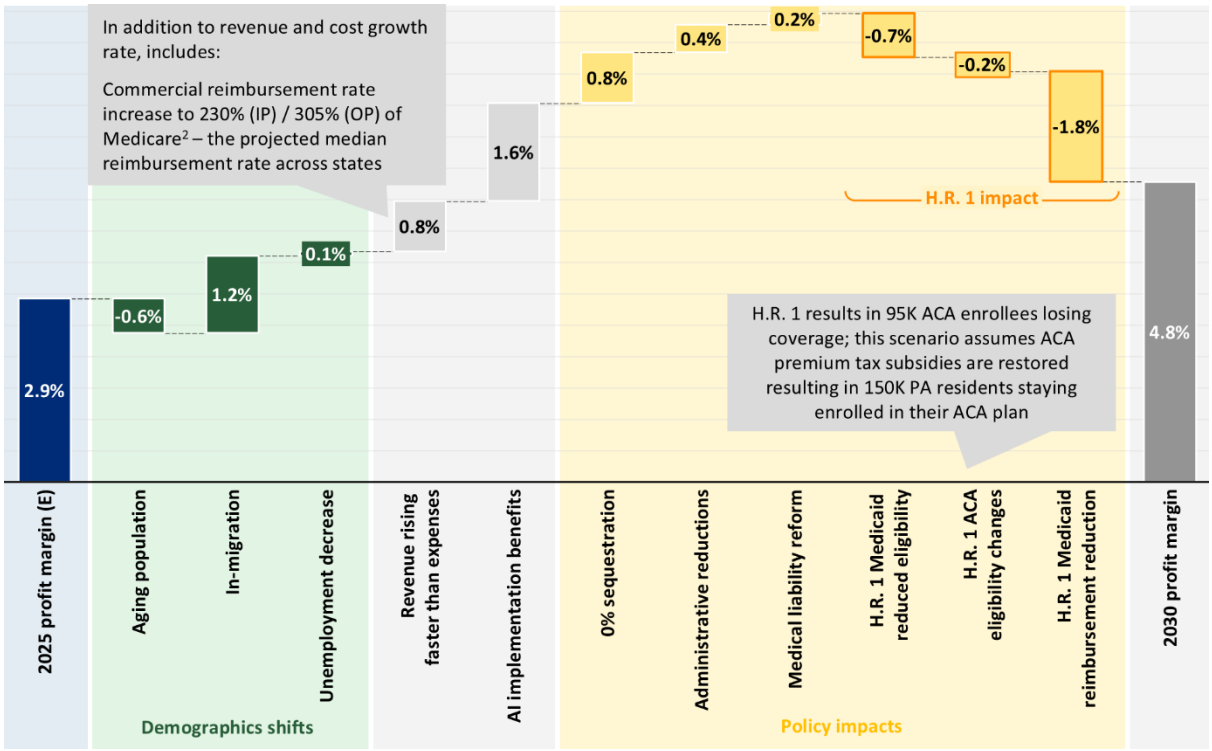
Exhibit 8: Rainy Day scenario
2030 net profit margin trajectory, inpatient and outpatient only[13]



Sustainability Prevails (upward cycle) scenario

State policies have been modernized and harmonized, strengthening support for hospitals. The medical liability environment has been reformed, making medical liability insurance costs more manageable (the full impact is likely materially larger). At the federal level, the restoration or replacement of ACA premium subsidies has reduced the number of uninsured residents in Pennsylvania. An increase in Commercial reimbursements to the national median and productivity improvements from hospitals' adoption of AI, which could also improve quality, have improved hospital finances across the state, producing an estimated statewide margin of 5%.[13]

Exhibit 9: Sustainability Prevails scenario
2030 net profit margin trajectory, inpatient and outpatient only[13]



Absent intervention, Pennsylvanians will face reduced access to care

Absent action by policymakers, the road ahead could lead to additional hospital closures. We know that most hospitals do not close immediately but reduce services gradually until the facility is no longer viable, resulting in a prolonged negative impact on communities. Without interventions that allow hospitals to be reimbursed commensurate with their operating expenses, and regulatory changes to help ease growing costs, multiple hospitals could be forced to reduce or eliminate service lines, reduce staffed beds, defer capital projects, or close entirely.

Historical experience underscores these risks: 25 hospitals have closed in Pennsylvania since 2016.[11] Closures pose many harms and risks to communities, including longer travel times to alternate hospitals, increased ambulance response times, job losses, and contraction of economic activity tied to hospital payrolls and supplier networks. The Rainy Day scenario quantifies this: If 14 hospitals closed, affected communities would, on average, face about a 22 minute longer drive to the nearest hospital and emergency room, and could face thousands of lost jobs and over $900 million in lost wages.[14,26]

Implications for state legislators

Policymakers face difficult choices as they balance stakeholder interests and navigate budgetary constraints. Helping the state's hospitals thrive would have an outsized impact on public health, economic development, and innovation. Legislative actions to improve Medicaid reimbursement, reform medical liability rules, streamline administrative requirements, and support AI implementation could materially improve financial outcomes. Absent these interventions, communities risk reduced hospital services, further closures, and diminished economic viability because companies and individuals are less likely to relocate to communities without hospitals. These consequences can be mitigated by timely, targeted state action.

Regardless of the scenario, hospitals will continue to manage expenses, experiment with AI, and investigate new care models and technologies to improve efficiency and quality of care. Despite these efforts, reimbursement and insurance enrollment changes erode financial resilience. Reimbursement dynamics of Pennsylvania's insured population leave hospitals with persistent shortfalls: Medicaid and Medicare pay substantially less than the full cost of care, and reimbursement for Pennsylvania's Commercially insured remains below national medians.[6,15] These imbalances, combined with an aging population enrolling in Medicare and projected reductions in Medicaid/ACA coverage, produce a structural gap that cost management alone would not be able to close for some hospitals.

Hospitals that serve a high proportion of Medicare, Medicaid, and uninsured patients — which includes many rural hospitals — are more exposed to payment shortfalls and coverage losses. The Commonwealth previously supported these hospitals through the Rural Health Model, but that program recently ended. The federal Rural Health Transformation Program (RHTP) may offer some mitigation, but it provides limited direct funding to hospitals. In most states, estimates indicate that the RHTP will replace less than 25% of Medicaid funds lost due to federal spending reductions; Pennsylvania ranks third lowest in the percentage of lost funds restored.[28] The combination of the Rural Health Model's expiration, reductions in Medicaid payments, and declines in Medicaid and ACA eligibility has therefore intensified rural hospitals' financial fragility and raised the likelihood of service reductions or closures in communities that depend on local hospitals.

State policy and funding interventions are therefore essential to preserve access and sustain the investments hospitals must make in community services, workforce, technology, and administrative tools. Scenario modeling shows what can happen under an unfavorable "Rainy Day" path: Hospitals statewide would face materially worse margins and 12 to 14 facilities could be forced to close by 2030 while others reduce services.

Conversely, targeted state actions can restore statewide margins to sustainable levels (approximately 5%) and avert the worst access reductions.[13,14] High-impact state levers could include increasing Medicaid reimbursement, instituting pragmatic medical liability reform to reduce outsized liability exposure, streamlining and modernizing state healthcare regulations, and making targeted investments (for example, workforce support, AI and other cost-mitigating technologies) to buffer hospitals' operational budgets.

The implications of the scenario modeling are clear: Without a change, Pennsylvania could continue losing two to three hospitals per year or more, hurting local communities and rippling out to surrounding areas. The alternative is for the state to partner with hospitals through increased reimbursement, regulatory reforms, and targeted investment to preserve reliable, high-quality local care and secure the economic contribution hospitals deliver to communities. The evidence in this report supports a focused, data-driven state response to secure healthcare access for Pennsylvanians.

Appendix A.

Table A1: Description of key drivers and modeled impacts by scenario

Highlighted cells show influenceable drivers at the state level and within hospitals

Driver	Description	Modeled impacts
Inflationary pressures (expenses rising faster than revenue)	Ongoing inflationary pressures in labor (wages, salaries, benefits), supplies (surgical supplies, wound care, IV administration equipment, PPE), drugs, technology, and purchased services (laboratory testing, environmental services, etc.) continue to outpace revenue growth in all but one scenario	**Rainy Day and Baseline:** Expenses are growing faster than revenue, driven mainly by Medicaid reimbursement that has not kept pace with cost increases **Sustainability:** Commercial insurance reimbursement has increased to the national median resulting in revenue growth outpacing cost growth
AI implementation	Hospitals are pursuing technology-driven cost reductions that in the upside case will realize benefits from a reduction in labor costs, and in the downside assumes hospitals incur AI implementation expenses without realizing productivity gains due to technical, operational, or regulatory barriers	**Rainy Day:** Hospitals implement AI tools, realizing the costs, but failing to achieve productivity improvements **Sustainability:** Hospitals implement AI resulting in improved productivity that reduces labor costs
Administrative reductions	Reduction of outdated state regulations and those duplicative of federal rules, together with insurers streamlining administrative processes, would reduce hospitals' costs	**Baseline and Rainy Day:** Hospitals continue the current trajectory of administrative costs **Sustainability:** State regulations and payor policies are revised to reduce the administrative requirements on hospitals
Medical liability reform	The state's medical liability environment becomes more favorable for hospitals, reducing medical liability premiums. Our estimate of the impact is based only on the cost of medical liability insurance premiums and does not include a variety of other medical liability-related costs.	**Baseline and Rainy Day:** Hospitals' medical liability premiums remain on their current trajectory **Sustainability:** Hospitals realize savings due to reduced medical liability premiums
H.R. 1 federal policy impacts	H.R. 1 will reduce Medicaid reimbursements to 100% of Medicare and reduce Medicaid and ACA enrollments. The reduction in Medicaid enrollees may result in the loss of Disproportionate Share status and 340B eligibility for certain hospitals	**All scenarios w/ H.R. 1:** Medicaid reimbursement is 100% of Medicare in 2030, 300,000 Pennsylvanians lose Medicaid coverage, and 95,000 residents lose ACA coverage[23,24] **Rainy Day:** In addition to above, drug costs increase due to the loss of 340B status for select hospitals

Driver	Description	Modeled impacts
IP only list elimination **OP utilization shifts to ASC**	Payor behaviors and CMS rule changes (e.g., elimination of the inpatient-only list) accelerate site-of-care shifts from inpatient to lower-paid outpatient or ASC settings, eroding hospital volume and average revenue per case	**Baseline and Rainy Day:** Elimination of the IP Only list shifts utilization from the IP setting to the OP and ambulatory settings **Rainy Day:** In addition to the IP Only list elimination, a portion of hospitals' OP volume is shifted to the ambulatory setting due to site-neutral payments
State migration	Migration of working age individuals may occur into or out of the state based on scenario, varying the number of Commercial enrollees	**Sustainability:** Migration into the state, increasing Commercial enrollees **Rainy Day:** Migration out of the state, reducing Commercial enrollees
Employment change	Unemployment rate changes based on scenario, varying the rate of Commercial enrollees and the uninsured	**Sustainability:** Unemployment rate is reduced **Rainy Day:** Unemployment rate is increased
Sequestration/ Medicare payment reductions	Federal budget shortfalls automatically trigger a percentage reduction in Medicare payments to hospitals	**Baseline:** 2% reduction **Rainy Day:** 4% reduction **Sustainability:** No reduction
Aging population	Pennsylvania's share of residents aged 65+ is projected to rise 3% by 2030, shifting residents to Medicare which has lower average hospital reimbursement than Commercial insurance	**All scenarios:** Medicare enrollee share increases to 23% in 2030[27]
ACA subsidy expiration	Expiration of Marketplace subsidies results in Pennsylvanians losing ACA coverage, who are assumed to become uninsured	**Rainy Day and Baseline:** 150,000 Pennsylvanians lose ACA coverage[23]

A.1. Endnotes

(1) Statewide Health Compare ratings are an average of facility ratings in the state. Health Compare summarizes select measures into a single star rating: mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care and effective use of medical imaging; 2024, Definitive Healthcare, HospitalView.

(2) "Pennsylvania Hospitals' Community Impact, FY 2024," The Hospital and Healthsystem Association of Pennsylvania.

(3) "Hospital Report," 2023, Pennsylvania Department of Health.

(4) "Data Resource Book, Academic Year 2023-2024," Accreditation Council for Graduate Medical Education.

(5) "Beyond Patient Care: Economic Impact of Pennsylvania Hospitals," Spring 2024, Pennsylvania Economic Review.

(6) Commercial payor reimbursement as a % of Medicare: relative price by state, inpatient and outpatient care; "Prices Paid to Hospitals by Private Health Plans Study", 2022, RAND.

(7) Total medical malpractice payments in the state divided by state residents, data includes settlements and judgements that result in a payout on behalf of a healthcare practitioner, excludes payments made on behalf of an entity (hospital, clinic, group practice); "Adverse Action and Medical Malpractice Reports," 2025, National Practitioner Data Bank, Health Resources and Services Administration.

(8) Statewide Pa. hospital operating cost per discharge grew 3.5% year over year from 2011 to 2023, reaching $10,446 in 2023, compared with a 4.5% growth rate and a 2023 median cost of $14,756 across Delaware, Maryland, New Jersey, New York, Ohio and West Virginia; Hospital Cost Tool, NASHP, 2011-2023.

(9) Operating margin; Volume One, General Acute Care Hospitals Dataset, FY 2024, PHC4.

(10) Analysis includes only bonds rated by S&P Global. Hospital systems nationally have a median bond rating of A+ compared with Pa.'s A, and stand-alone hospitals nationally have a median bond rating of A- compared with Pa.'s BBB+; "U.S. Not-For-Profit Health Care Outstanding Ratings and Outlooks as of Dec. 31, 2024," S&P Global.

(11) "Analysis of Hospital Closures in Pennsylvania, 2016-2025," The Hospital and Healthsystem Association of Pennsylvania.

(12) H.R. 1 (2025), the congressional bill also called "One Big Beautiful Bill," is projected to reduce ACA and Medicaid eligibility and cap Medicaid payments at Medicare rates.

(13) 2011-2023 data is from NASHP's Hospital Cost Tool. Post-2023 values are scenario modeling projections by Oliver Wyman derived from historical NASHP data using the methodology in the appendix; Hospital Cost Tool, 2011-2023, NASHP; OW analysis.

(14) Hospital closure analysis is a qualitative assessment of short-term acute, children's and critical access hospitals at risk of closure, the majority of which had negative profit margins from 2022 to 2024 and are not part of a financially healthy Pa.-based health system; Definitive Healthcare, HospitalView, 2022-2024; OW analysis.

(15) "Hospital Medicaid and Uninsured Payments Compared With Costs in the Commonwealth of Pennsylvania," 2024, Health Management Associates, prepared for The Hospital and Healthsystem Association of Pennsylvania.

(16) "2024 Approved Medicaid State Directed Payment Preprints," CMS; "2024 Medicaid-to-Medicare Fee Index," KFF; OW analysis.

(17) Reimbursement for clinical services provided by licensed health care professionals, using professional fee codes and clinician identifiers to obtain reimbursement.

(18) "Pennsylvania Medicaid Physician Payment Analysis," 2025, Health Management Associates, prepared for The Hospital and Healthsystem Association of Pennsylvania.

(19) National Medicaid costs covered are derived from the Medicare payment rate per dollar spent by a hospital multiplied by the national average Medicaid reimbursement rate[16]; Medicaid costs covered for Pennsylvania are based on HMA's analysis[15]; "Medicare significantly underpays hospitals for cost of patient care," 2022 AHA; OW analysis.

(20) "Health Workforce Projections," 2028, Health Resources and Services Administration.

(21) "Revenue Integrity Redefined Annual Benchmark Report," 2025, MDaudit.

(22) Medicaid reimbursement rates are rising slower than costs: Medicaid growth is 2.11% for inpatient and 1.76% for outpatient, compared with supply cost growth of 4.24%, drug cost growth of 5.24% and labor cost growth of 3.94%; "Prices Paid by Private Insurance," KFF, 2017-2024; Hospital Cost Tool, 2018-2023, NASHP.

(23) "PA's Health Insurance Marketplace (Pennie) Updated: Estimated Impacts of Federal Provisions," Aug. 2025, Pennie.

(24) "Impact of U.S. House GOP Medicaid and SNAP Budget Reconciliation Proposals on Pennsylvania," May 2025, Office of the Governor of Pennsylvania.

(25) 340B reductions were estimated by identifying hospitals near the Medicaid share threshold for Disproportionate Share Hospital (DSH) designation, modeling how projected Medicaid enrollment shifts would push hospitals below that threshold resulting in loss of DSH and 340B eligibility, and applying each hospital's historical drug spend and the standard 340B discount to quantify the impact; "The OBBB May Disqualify Hundreds of Hospitals From the 340B Program," 2025, PricePoints Health.

(26) Job and wage losses included hospital employed roles, excluding the indirect effect of additional jobs and wages lost in a community. Job losses are based on the number of FTEs employed at at-risk hospitals in 2024. Wages and benefits lost are based on 2024 salary data for at-risk hospitals projected to 2030; Definitive Healthcare, HospitalView, 2022-2024; OW analysis.

(27) "U.S. Population, 2020-2030," S&P Capital IQ Geographic Intelligence.

(28) "Analysis of the Rural Health Transformation Program", Dec. 2025, Leonard Davis Institute of Health Economics, University of Pennsylvania.

(29) Restrictions based on Mercatus machine learning algorithm that identifies regulatory restrictions by instances of terms "shall," "must," "may not," "prohibited," and "required" within state law since they can signify legal constraints and obligations; "State Healthcare RegData 1.0: A Quantification of State Healthcare Regulations", Oct. 2020, George Mason University Mercatus Center.