EXECUTIVE BRIEFING

16 Things CEOs Need to Know in 2023

Advisory Board

In 2023, the health care industry faces an increasingly tough business climate dominated by rising costs and prices, tightening margins and capital, staffing upheaval, varied demand, and fragmented policymaking. The array of urgent, disruptive market forces today means that leaders must navigate an unusually high number of short-term crises and opportunities.

Leaders' strategic choices now will have an outsized impact—positive or negative—on their organization's long-term goals. Those choices will also affect the equitability, sustainability, and affordability of the industry as a whole.

This briefing examines the biggest market forces to watch, the key strategic decisions that health care organizations must make to influence how the industry operates, and the emerging disruptions that will challenge the traditional structures of the entire industry.

Read on to learn the top 16 insights about the state of the health care industry today.

16 things CEOs need to know in 2023

PART I: TODAY'S MARKET ENVIRONMENT

INCLUDES AN OVERWHELMING DELUGE OF CRISES—AND THEY ALL COMMAND STRATEGIC ATTENTION

01 The converging **financial pressures** of elevated input costs, a volatile macroeconomic climate, and the delayed impact of inflation on health care prices are exposing the entire industry to even greater scrutiny over affordability.

02 The **clinical workforce** shortage is not temporary. It's been building to a structural breaking point for years.

03 **Demand** for health care services is growing more varied and complex—and pressuring the limited capacity of the health care industry when its bandwidth is most depleted.

04 **Insurance coverage** shifted dramatically to publicly funded managed care. But Medicaid enrollment is poised to disperse unevenly after the public health emergency expires, while Medicare Advantage will grow (and consolidate).

PART II: COMPETITION FOR STRATEGIC ASSETS

CONTINUES AT A RAPID PACE—INFLUENCING HOW AND WHERE PATIENT CARE IS DELIVERED

05 The current crisis conditions of **hospital systems** mask deeper vulnerabilities: rapidly eroding power to control procedural volumes and uncertainty around strategic acquisition and consolidation.

06 Health care giants—especially national insurers, retailers, and big tech entrants—are building **vertical ecosystems** (and driving an asset-buying frenzy in the process).

07 As employment options expand, physicians will determine which owners and partners benefit from their talent, clinical influence, and strategic capabilities—but only if these organizations can create an **integrated physician enterprise**.

08 Broader, sustainable shifts to **home-based care** will require most care delivery organizations to focus on scaling select services.

09 A flood of investment has expanded **telehealth** technology and changed what interactions with patients are possible. This has opened up new capabilities for coordinating care management or competing for consumer attention.

10 Health care organizations are harnessing data and incentives to curate **consumers choices**—at both the service-specific and ecosystem-wide levels.

PART III: EMERGING STRUCTURAL DISRUPTIONS REQUIRE LEADERS TO RECKON WITH IMPACTS TO FUTURE BUSINESS SUSTAINABILITY

11 For value-based care to succeed outside of public programs, commercial plans and providers must coalesce around a sustainable **risk-based payment** approach that meets employers' experience and cost needs.

12 Industry pioneers are taking steps to integrate **health equity** into quality metrics. This could transform the health care business model, or it could relegate equity initiatives to just another target on a dashboard.

13 Unprecedented **behavioral health** needs are hitting an already fragmented, marginalized care infrastructure. Leaders across all sectors will need to make difficult compromises to treat and pay for behavioral health like we do other complex, chronic conditions.

14 As the population ages, the fragile patchwork of government payers, unpaid caregivers, and strained nursing homes is ill-equipped to provide sustainable, equitable **senior care**. This is putting pressure on Medicare Advantage plans to ultimately deliver results.

15 The enormous pipeline of specialized **high-cost therapies** in development will see limited clinical use unless the entire industry prepares for paradigm shifts in evidence evaluation, utilization management, and financing.

16 **Self-funded employers**, who are now liable for paying "reasonable" amounts, may contest the standard business practices of brokers and plans to avoid complex legal battles with poor optics.

Part II

Today's market environment includes an overwhelming deluge of crises—and they all command strategic attention.

The near-term business environment is a volatile, chaotic moment in health care. From extreme financial pressures and a workforce in crisis, to compounding demands for care and dramatic shifts in coverage—there is no shortage of market pressures that are overwhelming for some, while tempting others into overambitious initiatives.

Facing urgent priorities that can divert attention from future goals is a position familiar to any business leader. But for most health care executives, **the present feels *aggressively* urgent**. Leaders must take care to navigate the immediate needs of today with the strategic ambitions of the future in mind, so the health care landscape does not transform without their guidance.

01

The converging **financial pressures** of elevated input costs, a volatile macroeconomic climate, and the delayed impact of inflation on health care prices are exposing the entire industry to even greater scrutiny over affordability.

During the first few years of the Covid-19 pandemic, service volumes were the principal business concern for many health care executives—whether from worry about diminished revenue streams, unexpected utilization expenses, or displacement of other care. Those volumes have largely recovered to pre-pandemic levels (Figure 1.1) and crowd-out from Covid-19 cases has mostly subsided, though local and seasonal surges will present routine spikes to deal with.

Now, the entire industry is reeling from the dramatic cost increases seen across 2022. Labor costs are the most severe, with growing employment numbers maintaining slack in the market. Persistent inflation and global supply chain disruptions have led to upwardly creeping input costs across supply and drug expenses.

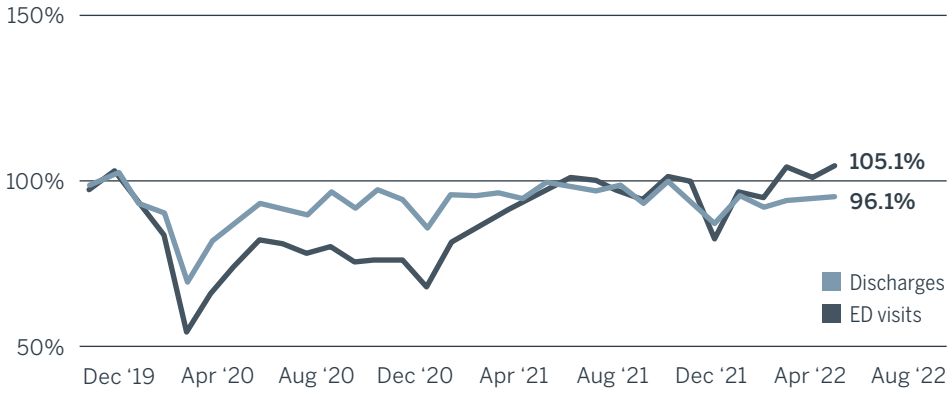
All of this poses an escalating affordability problem for the whole industry. Providers, especially hospitals and post-acute care facilities, are struggling to keep their margins positive and face unprecedented operating losses. In turn, that financial pressure is beginning to appear in reimbursement rate negotiations and ultimately premium increases, as providers seek to pass on some of their higher costs to commercial payers. Interest rate hikes to combat inflation now threaten organizations' abilities to raise capital for future investments and put pressure on new ventures to find sustainable revenues faster than anticipated (Figure 1.2).

The uncertain macroeconomic climate complicates these problems for health care leaders. While a recession is possibly on the horizon, the greatest challenge for executives is to adequately match the timing of economic swings. The nuances of health care contracting mean that inflation lags in health care prices and rate changes can leave providers, insurers, and suppliers out of step with the rest of the consumer economy amid a downturn—exposing the industry to even greater scrutiny over its affordability.

FIGURE 1.1: **TRENDS IN HEALTH SYSTEM SERVICE VOLUMES**

National median for total hospital volumes

Indexed to December 2019



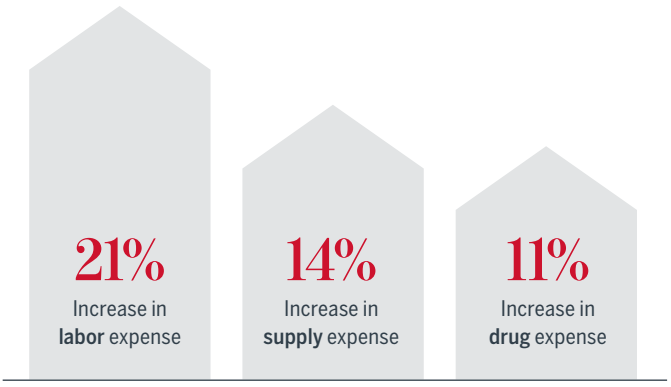
92%

Of health system strategic planners report volumes are no more than 5% lower than pre-pandemic levels

FIGURE 1.2: **HEALTH CARE INPUT EXPENSES AND FINANCIAL RAMIFICATIONS**

Increase in expense per adjusted discharge

December 2019 to August 2022



Eroded margins

69%

Of health system strategic planners report operating margins **below** pre-pandemic performance, 2022

Higher premiums

6.5%

Expected average increase to employer health care benefits costs for 2023

Capital scrutiny

375 bps

Increase in federal funds target interest rate from March to November 2022

02

The clinical workforce shortage is not temporary. It's been building to a structural breaking point for years.

Nowhere has the current social and economic landscape affected health care more acutely than in its workforce. Clinical staffing is at a crisis point across practically all direct care and support roles. In particular, nursing staff are not in the geographic areas, sites of care, or roles where they're needed most. As staff consider their roles, work environments, and benefits, they are increasingly seeking out alternative opportunities.

Many of these opportunities are still in health care: on net, the direct health care sector added about 520,000 jobs (October 2021 to 2022)[1] and average hourly earnings in health care grew 7.4% compared to 5.2% in all private sector jobs (July 2021 to 2022).[2] Rather than a "great resignation," health care workers' job changes are amounting to a "great realignment"—many nontraditional ventures and ambulatory providers are disproportionately attracting talent and accelerating the growth of alternative sites of care, while hospitals and post-acute care facilities are struggling most to retain staff (Figure 2.1).

While any future tightening of the broader labor market may give slight reprieve to clinical workforce shortages, leaders must recognize that the health care industry is not facing a temporary shortage. Instead, it's reaching a structural breaking point that has been mounting for years. The challenges provider organizations face today reflect worker concerns about a lack of flexibility, safety in the workplace, and respect from their employers and leaders. None of these concerning trends are new, but economic and social conditions associated with the pandemic have worsened them. Prolonged vacancies, high turnover rates, and unchecked use of premium labor are now common—leading to a vicious cycle where key personnel are disproportionately overworked, undercompensated, and unequipped for exacting, complex working conditions (Figure 2.2).

Health care leaders need to confront today's workforce challenges with an eye toward restructuring clinical care models for future sustainability, including integrating complementary workflow technology, investing heavily in assistive personnel, and recruiting candidates from underrepresented minorities. Leaders must appreciate that staff's heightened expectations about their working environments are valid—especially as alternative health care employment options promising work-life balance, flexibility, and meaningful interpersonal connections abound.

1) Bureau of Labor Statistics, "Employees on nonfarm payrolls by industry sector and selected industry detail, seasonally adjusted," November 2022. Includes ambulatory health care services, hospitals, and nursing and residential care facilities.
2) Altarum, "Insights from Monthly National Health Employment Data through August 2022," September 2022.

FIGURE 2.1: **RELATIVE IMPACT OF THE WORKFORCE CRISIS ON KEY INDUSTRY SEGMENTS**

*Staff limitations and margin crunch force some organizations to **pull back on strategic priorities***

*Nontraditional organizations position themselves to **siphon talent from provider organizations***

POTENTIAL TO **LOSE** TALENT ← STRATEGIC IMPERATIVES AND DISRUPTED INITIATIVES → POTENTIAL TO **GAIN** TALENT

Hospitals and post-acute care
- Elevated staffing costs
- Worsened experience-complexity gap
- Capacity constraints

Physician practices
- Care team burnout
- Referral constraints
- Heightened partnership expectations

Life sciences
- Challenges to engage target client base
- Delayed clinical trials
- Difficulty building RWE collection workflows

Health plans and purchasers
- Pressure to offset provider costs
- Membership churn
- Demand for hyper-attractive benefits

Ambulatory and virtual providers
- Increased appeal of alternative clinician employment
- Opportunity to capture market share

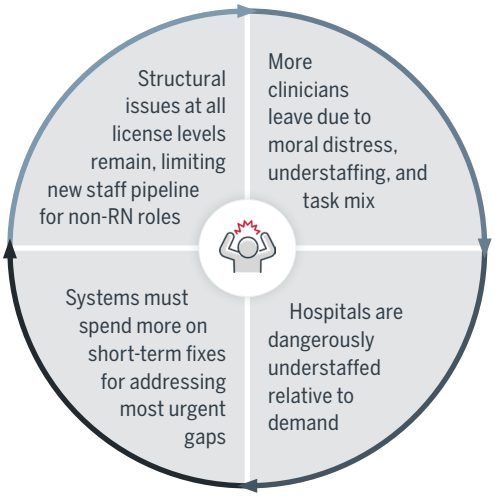
Big tech, big retail, and startups
- Arms race to attract talent
- Increased urgency and appetite for innovation

FIGURE 2.2: **FACILITY-BASED CLINICAL STAFFING SHORTAGE CREATES TREACHEROUS FEEDBACK LOOP**

Top factors nurses report for leaving their job[3]

1. **Insufficient staffing**
2. Workload intensity
3. Emotional toll of job
4. Don't feel supported or listened to at work

2x Increased spending on agency and traveling labor in 2021



3) Survey conducted spring 2021, n=314.

03

Demand for health care services is growing more varied and complex—and pressuring the limited capacity of the health care industry when its bandwidth is most depleted.

The health care industry assumed that readily available and effective vaccines, coupled with popular sentiment that Covid-19 was becoming endemic, would be enough to rebound volumes. But *stable* demand hasn't come back as expected or hoped.

Today our health care demand problem is disproportionately a health care supply problem. Staffing gaps not only limit capacity, they also lead to bottlenecks across the care continuum—particularly in the ED and upon transfer to post-acute settings.

But site-of-service is shifting too. Ambulatory competitors are siphoning profitable care from traditional care sites and expanding options virtually, in the home, and in the community. Some volume redirection may be welcome as the national disease burden grows (Figure 3.1), the population ages, and respiratory illness forces hospitals to prioritize needs they can adequately serve.

The overturn of *Roe v Wade* adds another level of complexity. Ending long-standing medical precedent delegates abortion regulation to a patchwork of state reproductive care laws. The sudden shift upends typical care patterns, and legal abortion providers have seen influxes in patients traveling from out-of-state. Clinicians in many states must now contend with navigating a distressing legal gray area as they interpret how newly applicable state laws intersect with their clinical decision-making autonomy—and care protocols will likely be undefined until exemplar cases are heard in courts (Figure 3.2).

More predictable demand may still emerge, but regional and seasonal Covid-19 surges will continue to arrive alongside other contagious diseases, environmental events from floods to wildfires will bring unpredictable emergency utilization, and reproductive care policy will continue to shift at the state level in the immediate future. These fluctuations will further strain capacity—at a time when clinicians, in particular, are facing sustained emotional and financial distress.

Health care leaders will need to prioritize among many essential strategic initiatives, including supporting distressed staff, adapting care models, and reallocating resources.

FIGURE 3.1: **TOP 10 MOST COMMON CHRONIC CONDITIONS BY SEX IN 2008 AND 2014**

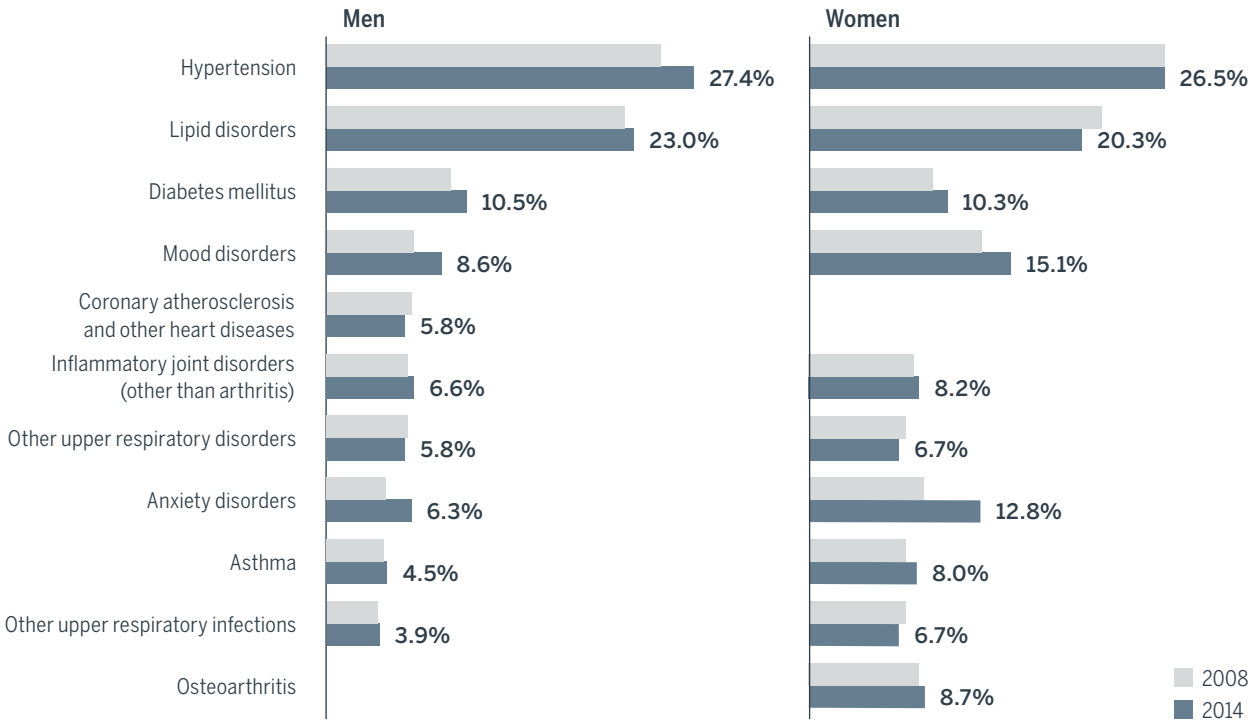


FIGURE 3.2: **SELECT IMPLICATIONS OF ROE V WADE OVERTURN FOR CLINICAL SETTINGS**

Impact on access capacity

Average patient travel time to facility providing abortion services

29.8 min

Before *Dobbs v Jackson* decision, 2021

100.4 min

After *Dobbs v Jackson* decision, 2022

Impact on clinical practice

"New Insurance to Cover Docs' Post-Roe Legal Battles Over Abortion"

Washington state's largest ***malpractice insurer****, Physicians Insurance, will offer the "add-on" rider beginning 2023*

Impact on physician training

43.9%

Of obstetrics and gynecology residents are likely to lack access to abortion training (a required component for OB-GYN board certification) within their state residency program

"We feel that abortion, or evacuating the uterus, is a core procedure for OB-GYN."

Dr. John Combes
Accreditation Council for Graduate Medical Education
The New York Times, October 27, 2022

04

Insurance coverage shifted dramatically to publicly funded managed care. But Medicaid enrollment is poised to disperse unevenly after the public health emergency expires, while Medicare Advantage will grow (and consolidate).

Demand for health care is influenced by more than just the underlying profile of needs—it's also driven by the source and structure of financing. The pandemic brought about enormous shifts in the country's health insurance coverage mix (Figure 4.1), due to shifting employment patterns and flexibilities put in place under the federal public health emergency (PHE).

Notably, employer-sponsored coverage enrollment decreased significantly—initially as a direct consequence of job losses at the onset of the pandemic, and then as alternative coverage options became more available through the safety nets. The overall uninsured rate has dropped to a rate well below that before the pandemic began (Figure 4.2). Most enrollment gains accrued to Medicaid managed care, as the PHE expanded funding and access to Medicaid and suspended states' ability to disenroll people. Because these policies will end when the PHE expires. An estimated 15 million enrollees[4] will gradually leave Medicaid: some will shift to other coverage through Marketplaces or employers, but others may become uninsured.

For providers and suppliers, the ultimate coverage mix equilibrium will affect reimbursement rates and levels of bad debt—and the current uncertainty complicates financial planning. On the other end of the spectrum, health plans with Medicaid businesses have seen massive growth in their managed care enrollment—a higher-margin product than self-funded commercial coverage.

While the anticipated reduction in Medicaid enrollment will hit health plan revenues, many plans are focused on the rapidly growing Medicare Advantage (MA) business—which is set to become the majority of Medicare coverage as soon as 2023. National plans made some of their biggest MA enrollment gains yet (Figure 4.3), and the three largest plans—UnitedHealthcare,[5] Humana, and Aetna (CVS)—own over half of the total MA market.

For these plans, the currently attractive (though increasingly scrutinized) finances can be used to fund capabilities such as care management and provider services that can further help grow enrollment—a virtuous strategic investment cycle. As MA plans grow to dominate senior coverage, providers and suppliers may find opportunities for flexible, innovative partnerships, but they'll need to adapt to more fragmented contracting and rate negotiations.

4) HHS Assistant Secretary for Planning and Evaluation, "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 19, 2022.

5) Advisory Board is a subsidiary of UnitedHealth Group, the parent company of UnitedHealthcare and Optum. All Advisory Board research, expert perspectives, and recommendations remain independent.

FIGURE 4.1: **UNEMPLOYMENT AND UNINSURED RATE**

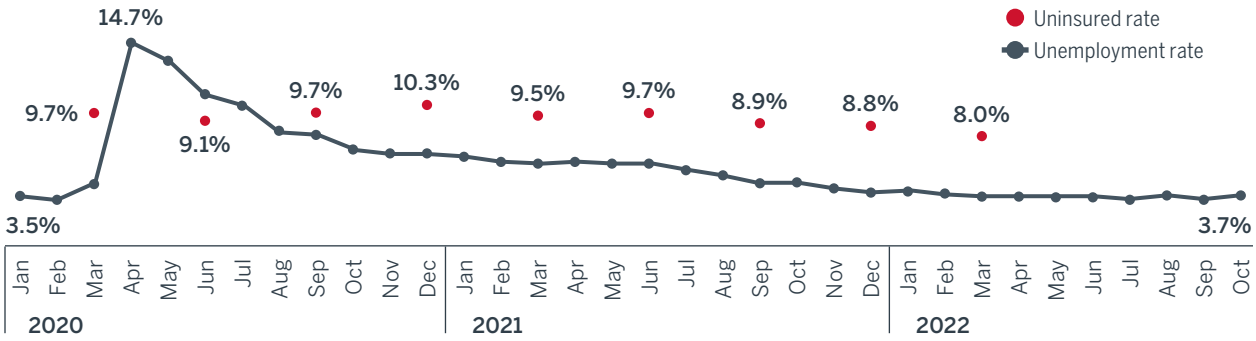


FIGURE 4.2: **INSURANCE ENROLLMENT CHANGES**

2019 Q4 to 2022 Q2

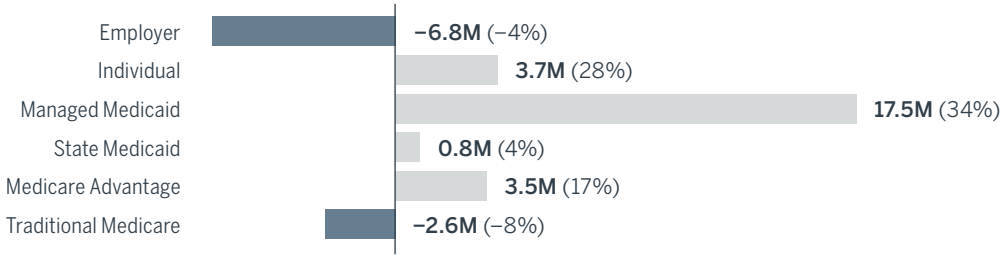
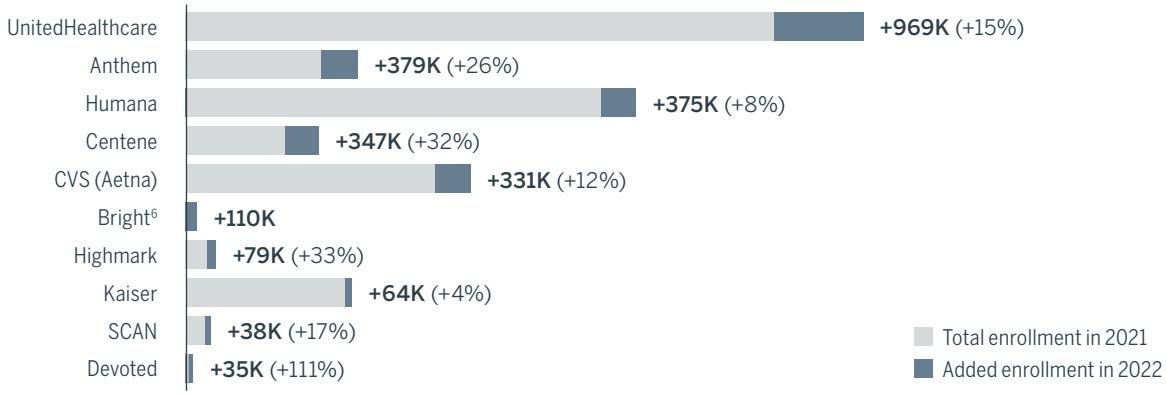


FIGURE 4.3: **LARGEST MEDICARE ADVANTAGE ENROLLMENT INCREASES**

January 2021 to January 2022



6) Bright Health made its main entry into Medicare Advantage in 2021, and thus a percentage calculation would be misleading.

Part II

Competition for strategic assets continues at a rapid pace—influencing how and where patient care is delivered.

The last few years brought enormous shifts in the fortunes of health care organizations. Some organizations have been able to accumulate capital, while others have been forced to confront difficult business constraints.

At the same time, investment in technology, adoption of alternative payment models, evolution of consumer preferences, broader availability of health care data, and new expectations for the workplace experience have shifted the playing field for how health care services can—or should—be offered.

Amid this landscape, assertive organizations are jockeying for strategic partnerships and acquisitions to take advantage of the **current appetite and capabilities to transform approaches to patient care**—including who makes treatment decisions, where services are delivered, and what care modalities are deployed.

05

The current crisis conditions of **hospital systems** mask deeper vulnerabilities: rapidly eroding power to control procedural volumes and uncertainty around strategic acquisition and consolidation.

Today's combined forces of input cost growth, labor shortages, and diverse demands on health care services collectively make for possibly the worst financial environment that hospital businesses have ever experienced. Though margins partially recovered from their initial cratering at the beginning of the pandemic, over the course of 2022 hospitals saw their margins collapse (Figure 5.1). Over half of hospitals are projected to end the year with negative margins according to KaufmanHall.[7]

The present crises are prompting hospital systems toward a range of difficult mitigation strategies—service line closures, reprioritization of capital expenditure projects, reductions in force, executive team changes, and in some extreme cases, bankruptcies and facility closures.

But hospitals' difficult finances today are a part of a much bigger, more painful arc, as the broader health care industry becomes increasingly aligned against the capital-intensive, fixed-cost hospital business model. The activities of most purchasers, health plans, and risk-bearing providers are heavily centered on circumventing hospital-based care. Roughly a third of the market share for total knee arthroplasties, prostatectomies, and sacroiliac joint fusions—high-frequency, high-margin procedures that bolster hospital finances—has shifted to outpatient care settings since 2014.[8]

Amid the combination of today's dire business climate and these evolving struggles for control over care delivery, many health systems are ripe targets for strategic acquisitions. While the overall number of transactions has leveled off in recent years, the average size of the deals has become enormous (Figure 5.2) as systems seek refuge in gigantic mergers that create protective scale—even across incongruent geographies.

However, health systems are encountering barriers to their defensive growth ambitions. The Federal Trade Commission (FTC) has become increasingly successful in blocking these horizontal mergers over the last few years, out of concern over monopolistic pricing and labor competition practices. And many hospital executives indicate that their ability to acquire other strategic assets—like ambulatory care and physician groups—is hampered by the alternative partnership opportunities stemming from a flood of private equity funding and range of disruptive health care ventures.

7) KaufmanHall, "The Current State of Hospital Finances: Fall 2022 Update," September 2022.
8) Advisory Board, "Understanding how procedures shift out of the inpatient setting," November 2021.

FIGURE 5.1: **HOSPITAL MARGINS RELATIVE TO PRE-PANDEMIC BASELINE**

National median for total hospital margins (less CARES Act funding, when applicable)

Indexed to December 2019

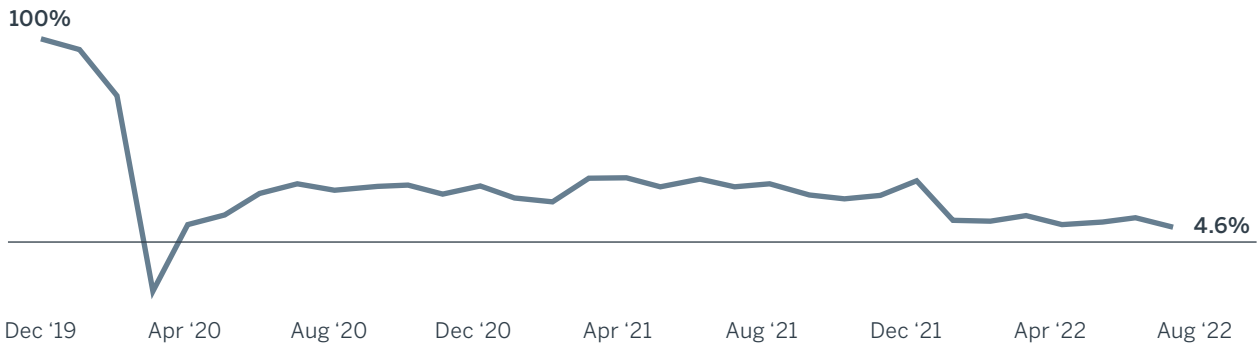
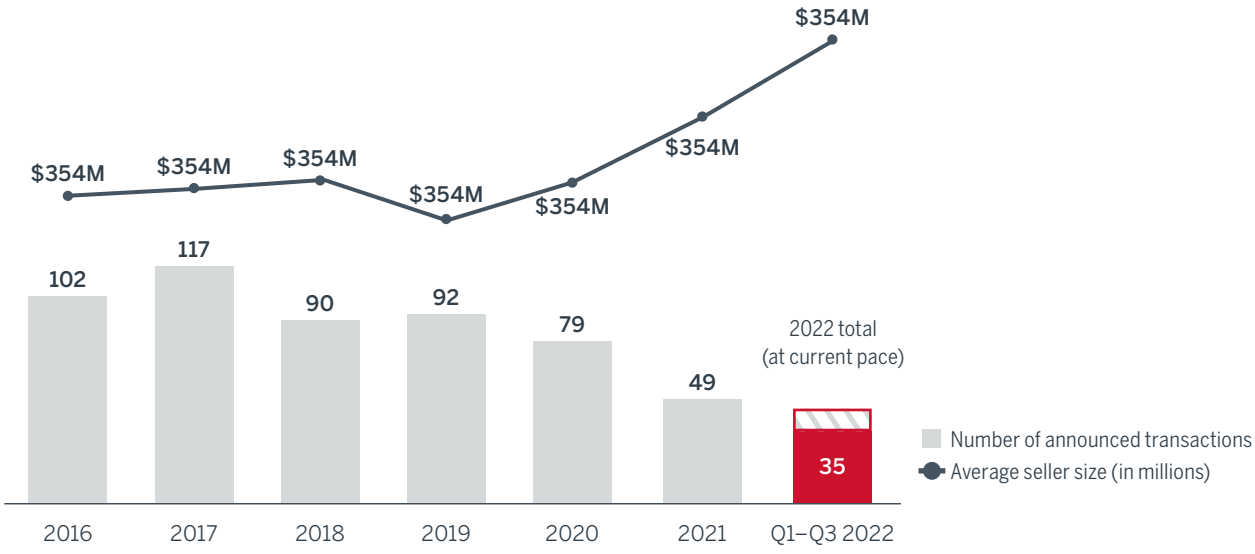


FIGURE 5.2: **FEDERAL COVERAGE REFORMS FACE A DAUNTING BARRIER**



06

Health care giants—especially national insurers, retailers, and big tech entrants—are building **vertical ecosystems** (and driving an asset-buying frenzy in the process).

In contrast to the horizontal consolidation efforts of hospital systems, certain well-resourced health care giants are successfully pushing vertical acquisitions faster than ever, confronting few barriers beyond exorbitant sale prices. Mega-players with ample capital like UnitedHealth Group, CVS, and Amazon are throwing around enormous resources to procure a range of assets—especially ones with clinicians and care delivery capabilities (Figure 6.1).

This uptick in prominent buying activity has spurred other health care organizations—from other peer behemoths to smaller, local businesses—into a frenzy of chasing after commensurate assets of their own and to stress about the capabilities they need to build just to keep up (regardless of the strategic merits of the initial acquisitions).

As a result, almost no health care entity is staying in their lane, as health care businesses increasingly blur the lines of what functions they perform and (for the moment) largely ignore the contradiction between competition and partnership. But the industry does not have infinite running room for all players to perform all health care functions in all markets. Ultimately, competition at this scale will require organizations to use their collection of assets to entirely dominate their target market or find a differentiated niche.

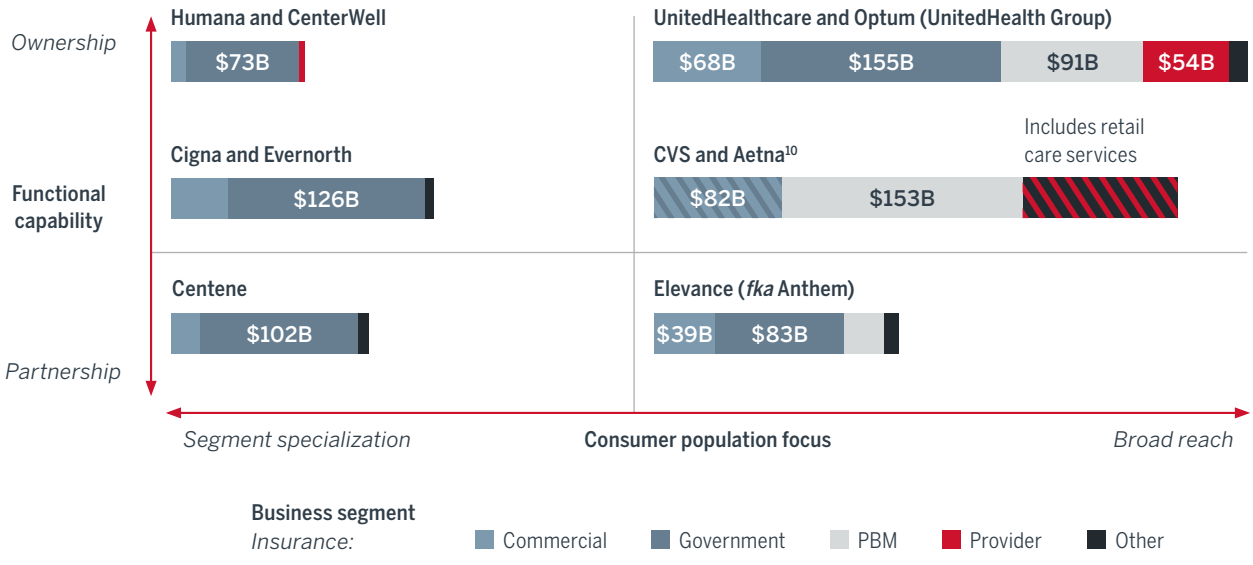
Notably, national health plans have vastly diversified their businesses—with other segments like pharmacy benefit management and care providers approaching the revenues of their insurance businesses (Figure 6.2). The true value of these sizable divisions will depend on how these insurers move from *owning* multiple businesses to *coordinating* multiple businesses—and if they begin to require shared strategic control of client and patient services in a contained vertical "ecosystem." This is already starting to happen in Medicare Advantage home-based care offerings.

Most other health care organizations—especially smaller provider systems—will be unable to compete at this level, and will have to make strategic choices now to prepare for this future. Some organizations will benefit by forging an exclusive alliance with a larger ecosystem organization, while others must guarantee cost-effective, high-quality delivery of a specific product or service.

FIGURE 6.1: **RECENT MAJOR INVESTMENT OR ACQUISITION ACTIVITIES THAT ALIGN WITH BROADER BUSINESS GOALS**

Investor	VillageMD (Walgreens) with Cigna	CVS	Amazon	Optum (UnitedHealth)
Organization and deal value	Summit Health **$9B**	Signify Health **$8B**	One Medical **$4B**	Change Healthcare **$13B**
Assets	Population health platform practice with primary, specialty, and urgent care	Value-based care analytics and care coordination tools; national network of home-based care providers	Consumer-focused and tech-enabled hybrid primary care	Electronic data clearinghouse; revenue cycle management service
Investor goals	Deliver value-based primary care	Expand comprehensive, multimodal care reach	Elevate consumer experience in health care	Support administration for strategic provider partners

FIGURE 6.2: **NATIONAL HEALTH PLANS' RELATIVE VERTICAL INTEGRATION STRATEGIES AND 2021 SEGMENT REVENUES[9]**



9) Sum of segment revenues is larger than total revenues due to internal transfers and eliminations.
10) CVS' 10-K filing does not further break its Aetna insurance business into specific insurance segment revenues.

07

As employment options expand, physicians will determine which owners and partners benefit from their talent, clinical influence, and strategic capabilities—but only if these organizations can create an **integrated physician enterprise.**

Increasingly sought after by a range of health care stakeholders today, physicians find themselves in a position of greater bargaining power over their work environment. At a time when burnout and discontent are high, physicians have more options than ever for alternative employers—meaning that in aggregate, they can swing market dynamics.

Over half of physician practices are now owned by hospitals or corporations—such as health plans, practice aggregators, private equity firms, and even tech ventures. This year, corporate ownership surpassed hospital ownership, increasing 10 times faster over the last three years (Figure 7.1).

Unlike past eras of physician practice management, these corporate owners have a range of business goals besides scale and have established themselves as capable physician employers with robust patient panels. Notably, well-resourced, tech-enabled corporate groups that Advisory Board now calls "superpractices" often focus on avoiding hospital care, centralize their care protocols, referrals, and patient communications, and rely on a holistic, multidisciplinary care team—and are growing rapidly (Figure 7.2).

These attributes mark a distinct shift in physician approaches to autonomy—away from an all-or-nothing binary, and toward a spectrum of trade-offs on different types of autonomy, such as scheduling, visit types, patient panels, or clinical decisions. Increasingly, different corporate owners offer different types of autonomy, but most exert some degree of control over clinical protocols to achieve more consistent cost and quality outcomes.

For many organizations that are actively acquiring physician practices and hiring physicians, clinical control is the ultimate ambition as those organizations aim to shift patient volumes and influence care patterns. While this currently concentrates with primary care physicians, specialists involved with chronic condition management or outpatient procedures will likely become increasingly relevant as risk-based contracting and site-of-care shifts progress.

However, owner organizations seeking to harness physicians' capabilities must keep in mind that employment of physicians alone does not guarantee certain behaviors or translate to automatic retention of an increasingly unstable workforce. To be successful, physician employers and partners will have to focus on meaningful integration that balances appropriate customization with standardized strategic goals. And parent organizations must make compromises on their legacy business priorities that can interfere with the integrated strategy: for hospitals, an imperative to refer all volumes internally; for payers, a tendency to prefer broader networks.

FIGURE 7.1: **PHYSICIAN PRACTICE OWNERSHIP TRENDS**

n≈248,000 primary practice locations of physicians with NPIs in the IQVIA OneKey database

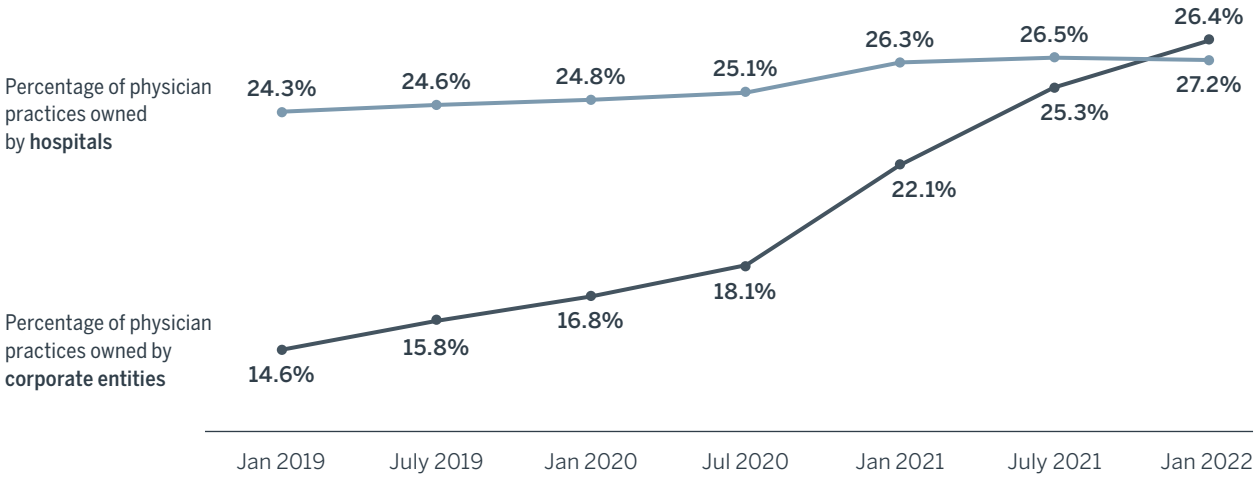


FIGURE 7.2: **NATIONAL PHYSICIAN SUPERPRACTICE ARCHETYPES**

PRESERVE AUTONOMY	ENABLE INTEGRATION	*Growth trends in representative organizations, 2017-2022*
Service partner Organization that sells services to physician practices, often forming a loose affiliation between practices	**Aggregator** Corporate entity that acquires physician practices and strives to create an integrated group at scale	Estimated increase in providers: • **Summit Health**: +1,100 • **Optum Care**: +23,000
Coalition Organization formed by physician practices that share knowledge and resources while maintaining individual identities	**National chain** Corporate entity that seeks to replicate a physician practice model and brand across multiple markets, often through building new practices	Estimated increase in clinics: • **ChenMed**: +50 • **Oak Street Health**: +100 • **One Medical**: +50

Common features of superpractices

Holistic, coordinated care team

Standardized care pathways

Centralized referral management

Complementary ambulatory infrastructure

Care and risk management analytics

Shared, integrated EHR

08

Broader, sustainable shifts to **home-based care** will require most care delivery organizations to focus on scaling select services.

The momentum and investment for growing home-based care services that exploded during the pandemic continues, as industry stakeholders invest in home care capabilities from pilots to acquisitions. These organizations are hoping to manifest their potential to improve health outcomes and control costs while meeting patient and clinician preferences.

There are a vast range of services that fall under the home-based care umbrella. Each service is different in terms of how it operates and what its demands and inputs are. They target different patient populations and acuity levels. They require vastly different staffing models, logistics, supplies, and payment structures—and offer different levels of cost or quality improvement.

Therefore, there are different expectations for growth for each service—depending on the financial incentives, available staffing, burden on unpaid caregivers, logistics for transporting and storing supplies, and overall clinician and patient comfort. Accounting for these criteria, some home-based care services should be more narrowly deployed with the right subset of patients and will succeed only in niche markets with capacity constraints or risk-based payments, like SNF-at-home. Other services—like telehealth and home infusion—can (and should) become the new standard of care, as they have sizeable demand, broad appeal to patients, and the potential to be lower-cost (Figure 8.1).

However, scaling all home-based care services poses real risks to the health care industry, including worsening care coordination, burdening an already strained staffing supply, and exacerbating health inequities. A sustainable path forward will depend on how organizations engage in the home-based care boom, especially since there isn't one clear, winning strategy for every type of organization nor for every type of home-based care model.

Large Medicare Advantage (MA) plans have been steadily building up their ecosystem of home care infrastructure, as the flexible financial and benefit MA model creates a conducive environment to expand home-based care—especially for targeted services like home-based primary care and acute care at home. For each home care service, other organizations will need to decide whether to emulate these pioneers and compete directly, or pursue a complementary role in partnership with a few core home care providers. Since there will be few organizations that can do it all, it's likely that most will pursue both approaches, depending on the type of service (Figure 8.2).

FIGURE 8.1: **ASSESSMENT OF HOW HOME-BASED CARE SERVICES MEET CRITERIA REQUIRED FOR GROWTH**

Criteria for growth	SNF-at-home	Hospital-at-home	Home primary and specialty care	Home dialysis	Home infusion	Telehealth
Reimbursement status	✗	▲[11]	▲	✓	▲	✓
Staffing supply	✗	✗	✓	✓	✓	✓
Unpaid caregiver requirements	✗	▲	▲	✗	✓	✓
Logistics and supplies	▲	▲	✓	▲	▲	✓
Clinician and patient comfort	▲	▲	✓	▲	▲	✓

Scale of use →

Criteria status
- ✓ Generally met currently
- ▲ Some challenges to overcome
- ✗ Extreme barriers in place

Targeted deployment in markets with capacity constraints or risk payments

Broad implementation by most providers as a care standard

FIGURE 8.2: **OPTIONS FOR HOW HEALTH CARE ORGANIZATIONS CAN APPROACH THE GROWING LANDSCAPE OF HOME CARE SERVICES**

Competitive approach

Scale of service	*Complementary support*	*Direct offering*
Broad implementation	**Adapt current services for new expected care standards** Organizations not directly involved in providing or paying for scaling home care services must adapt to their ubiquity in care.	**Ramp up competitive investments in most scalable services** Organizations providing or paying for scaling home care services must prepare for an increasingly crowded, competitive marketplace.
Targeted deployment	**Identity unique value-add to join partnerships on targeted services** Organizations with narrow but specialized expertise across the home care-adjacent continuum can find key gaps to address and own, in partnership with market leaders.	**Build alignment in funding and care infrastructure within a market** Organizations with substantial market power can broker partnerships to align incentives and resource allocation.

11) Reimbursement for Hospital-at-Home is currently bolstered by the public health emergency but may subside in the future.

09

A flood of investment has expanded telehealth technology and changed what interactions with patients are possible. This has opened up new capabilities for coordinating care management or competing for consumer attention.

To the relief of payers and purchasers, the explosion in virtual visits over the last few years did not increase total utilization (Figure 9.1)—and for some conditions, follow-up utilization decreased.[12] This validation, coupled with indications from regulators and payers that reimbursement flexibilities will continue to expand, is encouraging organizations to broaden their telehealth strategy.

The industry is still in the early stages of deploying other telehealth modalities like remote patient monitoring (RPM) and asynchronous care. Traditional providers delivered the majority of virtual visits across the pandemic due to existing patient relationships, but few have RPM and asynchronous platforms in place—though many are investing to expand their capabilities (Figure 9.2).

These tools open new possibilities for improving health care outcomes and efficiencies in care delivery—from allowing earlier treatment interventions and avoiding adverse events, to enabling more efficient staff deployments and better patient communication. Those new capabilities represent major changes to a modern consumer's journey through health care. Increasing digital enablement adds both new ways of accomplishing an existing interaction, such as scheduling an appointment, and entirely new touchpoints altogether, such as remote monitoring device setup (Figure 9.3).

All of these touchpoints are new mechanisms for other health care stakeholders—including vendors, plans, and employers—to grab consumers' attention with better digital tools, and potentially inflect their downstream care choices through more real-time engagement.

While 2022 funding for digital health ventures has not kept pace with the record levels of investments from 2021, the sector is still on track to get nearly 15% more total funding than the previous record in 2020.[13] As these ventures seek sustained financial support in an economic climate of increased scrutiny, they will more aggressively aim to prove their value—through services that either produce better health care outcomes or enable these new interactions with consumers.

Ultimately, the new standards for telehealth care will depend on which goal health care organizations prioritize as they set their strategy: capturing consumer attention or improving care efficiency. Most organizations will pursue both goals, but they must prepare for internal tensions to prompt conflict.

12) "Outcomes of In-Person and Telehealth Ambulatory Encounters During COVID-19 Within a Large Commercially Insured Cohort," JAMA Network, April 2022.support employees," Willis Towers Watson, February 2021.

13) "Q3 2022 digital health funding: The market isn't the same as it was," Rock Health, October 2022.

FIGURE 9.1: **TOTAL VISIT VOLUMES COMPARED TO TELEHEALTH AND IN-PERSON VISITS**

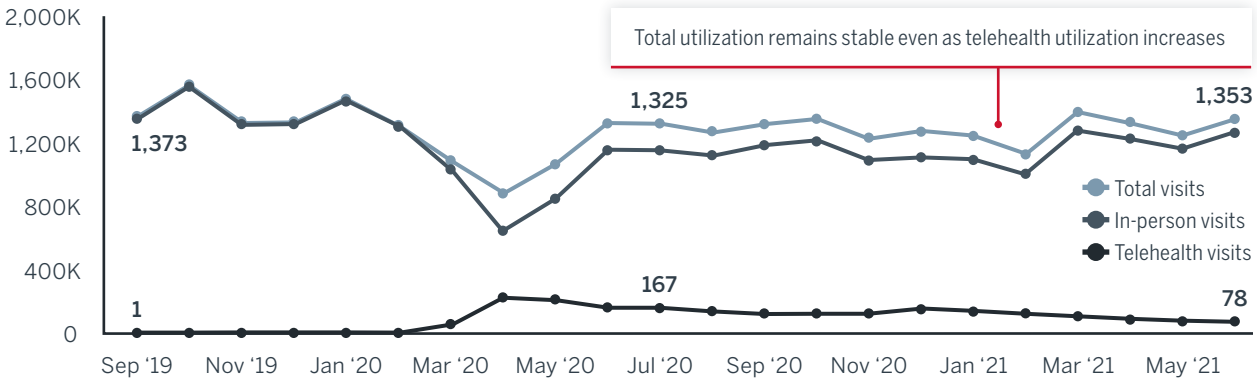
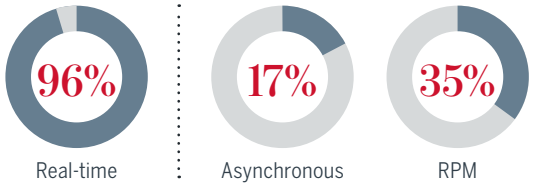


FIGURE 9.2: **PROVIDER INTENTIONS TO INVEST IN NEW TELEHEALTH MODALITIES**

Providers with specific telehealth platforms in place

n=146 leaders from care delivery organizations, 2021



Top provider telehealth investment priority for 2021

n=44 strategic planning leaders at provider organizations

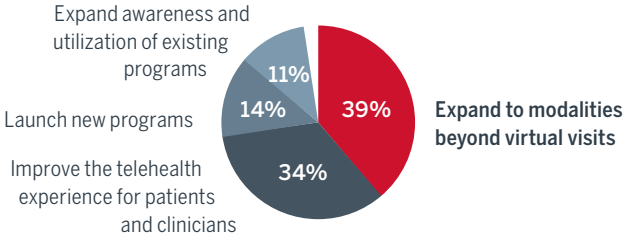
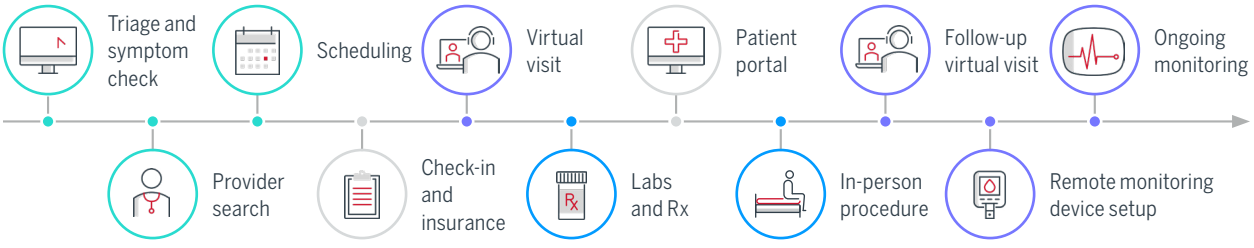


FIGURE 9.3: **THE MODERN PATIENT'S HEALTH CARE JOURNEY**



Digital tools with ability to **influence** downstream care

Potential replacements for traditional care services or management, with ability to **influence** downstream care

Downstream care services that often vary in cost and quality

10

Health care organizations are harnessing data and incentives to curate **consumers choices**—at both the service-specific and ecosystem-wide levels.

Consumers, as they deal with the aftermath of the continuing pandemic and the current economic situation, have a vast range of health care needs. And the array of options they must navigate through to receive care is increasingly confusing.

To truly make informed, appropriate decisions in the health care market, consumers need several conditions to be true (Figure 10.1). While consumers certainly have options and their access to information is increasing, other key factors are missing—including their very awareness that they have a choice to make at a given moment.

As health care organizations compete for influence over consumers' care decisions, they are increasingly recognizing that more care options and information haven't made health care consumers better shoppers. Instead, health care organizations are focused on crafting the environment that influences consumers' default care choices. The approaches vary by the level of choice: steering consumers between increasingly granular choices about specific services, or keeping them in a managed ecosystem to coordinate all of their steps along a care journey.

Organizations that aim to consistently push obvious choices to consumers are focused on disaggregating the network structures that patients usually encounter and offering service-specific information about their options. Many are harnessing new price transparency data to change how consumers think about *who* should be involved in their care decisions. Turquoise Health, for example, created a platform for payers and providers to create on-demand contracts for specific services—and present those to consumers on a one-off basis (Figure 10.2).

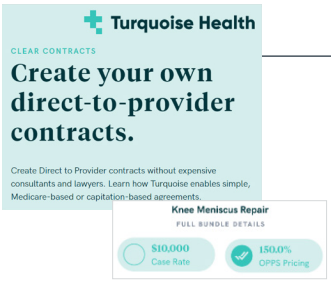
At the other end of the spectrum, some organizations are building mechanisms for steering all downstream choices in a care journey by capturing a consumer's attention at the "starting place" and connecting them to follow-up steps. Numerous health plans have launched virtual-first insurance products, which aim to appeal to consumers as the most convenient, affordable entry point for all health care choices. None of these plans so far have partnered with providers they do not own (Figure 10.3).

Organizations are actively pursuing both routes to influence consumer decision-making. Success will depend on how well each organization's individual patient relationships and overall market negotiating power enable the organization to create the path of least resistance for consumers.

FIGURE 10.1: **NECESSARY CONDITIONS FOR CONSUMER SHOPPING IN HEALTH CARE**

CONDITION	DESCRIPTION	CURRENT STATE
Options to select	Meaningful differences in price and/or quality across providers	✓ There is significant variation across new and existing players
Awareness of choice	Consumer knows the moment they are making a decision	✗ Most services are presented as a default next step
Transparent information	Ability to accurately compare between available options	▲ Price data is still messy and quality metrics remain elusive
Financial impact	Consumer has a personal financial stake in specific purchasing process	✗ Incentive to shop is limited to services under deductible; coinsurance impact is limited
Willingness to self-refer	Consumer feels calm and confident in making a choice for their health issue	✗ Majority of services are for urgent, complex, or undiagnosed conditions

FIGURE 10.2: **TURQUOISE HEALTH'S SERVICE-SPECIFIC CONTRACT NEGOTIATION PLATFORM**



Advertised features of platform

Software lets payers or self-insured employers submit a bid and negotiate directly with providers

Product brings payers and providers to a shared platform with standard payment model options

Contract platform has rate benchmarking and analytics built directly into the bidding process

FIGURE 10.3: **VIRTUAL-FIRST PRODUCTS AND RELATIONSHIP WITH VIRTUAL CARE PROVIDER**

	Type of provider	
	Digital vendor	*Medical group*
Partner-owned asset	• **Alignment** AVA HMO • **Anthem** (with Hydrogen Health) • **Cigna** (with MDLive)	• **Kaiser** Virtual Plus • **United** NavigateNOW • **Oscar**
Relationship with plan		
Partner	• **Priority Health** MyPriority Telehealth PCP • **Harvard Pilgrim** Virtual Choice HMO • **Community Health Choice** Virtual Bronze • **Premera** NOW • **Humana** On Hand • **Centene** Ambetter Virtual Access • **Trustmark** myVirtualCare Access	*Not yet seen*

Part III

Emerging structural disruptions require leaders to reckon with impacts to future business sustainability.

The future holds several growing, unsustainable challenges: an aging population, costly specialty therapeutics, rampant inequities, unmanaged behavioral health needs, and disagreements about appropriate spending. These issues represent current and emerging "tragedies of the commons," where individual organizations' business models are often in conflict with the broader mission of health care.

While many health care organizations loudly proclaim their efforts to mitigate these issues, their actions will make little meaningful progress unless leaders commit to **broader, shared transformation of the industry to match their stated values**.

As leaders make decisions today about their strategies and investments for the future, they need to consider the biggest vulnerabilities these looming forces will expose. They must either assume some risk of first-mover disadvantages to experiment with solutions, or accept that they will always be operating small-scale pilot programs and seeking to dodge the collective consequences of unfunded health needs.

11

For value-based care to succeed outside of public programs, commercial plans and providers must coalesce around a sustainable **risk-based payment** approach that meets employers' experience and cost needs.

The health care industry has made clear progress in shifting to risk-based payment in the public sector—chiefly through Medicare Advantage payment models, which saw a 15 percentage point increase in population-based payments from 2017 to 2021. However, while participation in risk-based payment is gradually increasing, commercial payers still have nearly two-thirds of their payments not linked to any performance-based financial risk (Figure 11.1).

Commercial payers don't yet have a fully formed risk-based payment model. There have been a wide range of experiments with mixed success, but no consistent roadmap emerging from a central body with a standard path to make commercial risk widely attainable.

The industry may continue to follow Medicare's lead, especially Medicare Advantage, with a focus on longitudinal population-level payment structures along the "glide" path to risk. This may be more feasible for providers on an administrative day-to-day basis, as the complex array of quality metrics and processes across all payers is increasingly burdensome. As a result, payers need to pursue some standardization if they want to make progress.

But the Medicare risk pathway is challenging to adapt for commercial payers because of the substantial differences between the commercial and Medicare segments. Beyond structural benefit complexities like employees churning across multiple payers, the appropriate population health approach and day-to-day clinical model is necessarily different from what works for the senior population. In the senior population, the emphasis is about broader disease management: increasing primary care utilization, condition management, and specialist coordination for chronic conditions and discharges. Conversely, the focus for the commercial population is on preventing conditions from occurring and overutilization of unnecessary care and then, when members do need care, connecting them to the most cost-effective treatment, provider, and site of care.

Thus, the commercial sector could diverge further and definitively anchor their payment approach around bundles, episodes, and consumer steerage tactics targeted to procedures in a population that will always be subject to churn. These models need to be tailored to what employers want, what employees will tolerate, and what is meaningful for the commercial population's utilization patterns. This way, the models can be limited in scope and would come at the cost of providers who would be required to split their focus across multiple processes and capabilities needs.

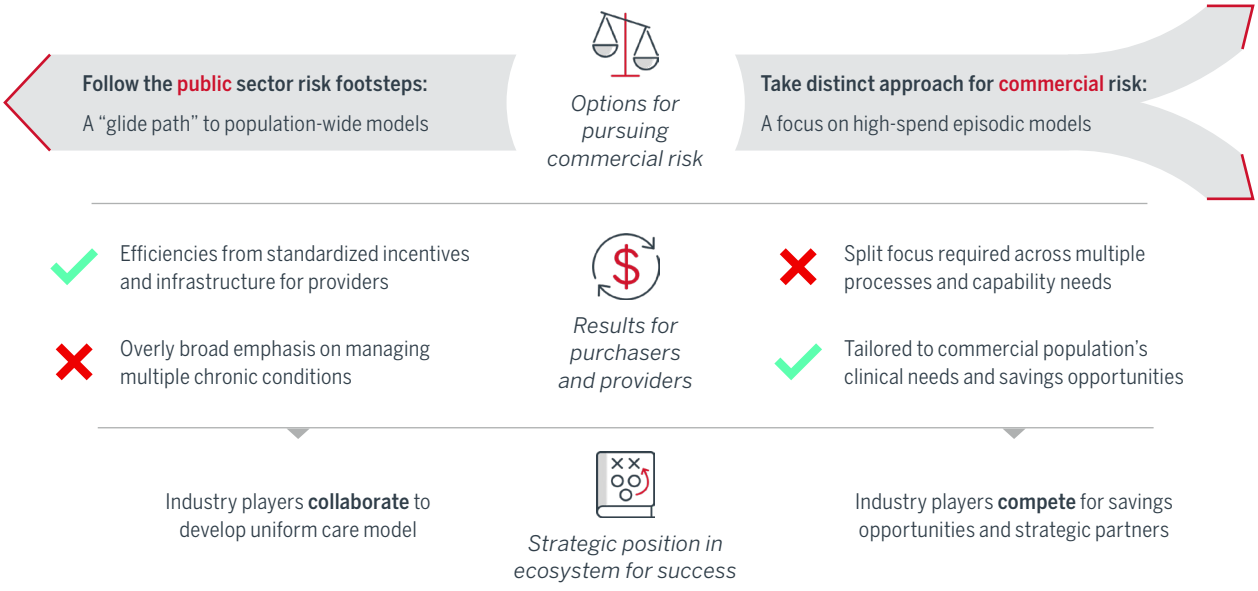
Ultimately, the industry must collectively determine whether there will be more appealing savings and efficiencies to gain through mirroring the public approach or tailoring the model for commercial needs (Figure 11.2).

FIGURE 11.1: **PAYMENTS MADE IN CY 2021 AND PERCENTAGE POINT CHANGE FROM PAYMENTS MADE IN 2017**

	Traditional fee-for-service	Fee-for-service linked to quality and value[14]	Shared savings and bundles[15]	Population-based payment[16]
Medicare Advantage	39.4% –8.6 pts	3.8% +1.3 pts	31.5% –7.7 pts	25.3% +15 pts
Original Medicare	14.9% +4.4 pts	44.9% –6.3 pts	34.3% +0.5 pts	5.9% +1.4 pts
Medicaid	52.3% –15.5 pts	7.6% +0.4 pts	32.3% +11.5 pts	7.8% +3.6 pts
Commercial	53.7% –2.8 pts	11.8% –3.4 pts	31.9% +5.3 pts	2.6% +0.9 pts
All-payer	**40.5% –0.5 pts**	**19.5% –5.9 pts**	**32.6% +2.8 pts**	**7.4% +3.6 pts**

Progression to alternative payment methodology

FIGURE 11.2: **COMMERCIAL RISK OPTIONS HAVE TRADE-OFFS ON BOTH SIDES**



14) Includes foundational payments for infrastructure and operations (e.g., care coordination fees) and fee-for-service plus pay-for-reporting payments and pay-for-performance payments.

15) Includes alternative payment models with shared savings with upside risk only and shared savings with downside risk. These are built on FFS architecture.

16) Includes condition-specific payments (e.g., PMPM for oncology or mental health), comprehensive population-based payment (e.g., global payments), and integrated finance and delivery systems (e.g., global budgets).

12

Industry pioneers are taking steps to integrate health equity into quality metrics. This could transform the health care business model, or it could relegate equity initiatives to just another target on a dashboard.

By and large, leaders have decided that health equity is central to their mission as health care organizations—or at least, that it should be. The past two years ushered in unprecedented experimentation and investment in health equity as many organizations waded into these waters for the first time.

That experience solidified for leaders just how daunting the path is ahead, as most organizations still grapple with conflicting incentives that put health equity goals at odds with other strategic priorities. While the industry could restrict its efforts to solely a mission imperative, many organizations, along with the federal government, are increasingly taking action to solidify health equity as a transformative business imperative.

Most notably, plans and employers have started to coalesce around a new tactic: holding provider organizations accountable for delivering equitable care by weaving equity into quality metrics. BCBS of Massachusetts has led the charge, but other entities—including Morgan Health, CMS with its new ACO REACH model, and NCQA—quickly followed to begin building the foundations for data collection. In the coming years, providers in these new contracts will also be accountable for any gaps between demographic groups and will face financial incentives or penalties depending on the variation (Figure 12.1).

This approach could mark a turning point in how the industry defines quality, how much health equity data the industry has (and how standardized it is), and how organizations conceptualize the financial impact of health inequities on their business. But there's also a risk that organizations hyper-focus on specific metrics rather than design holistic strategies to impact the root causes of health inequities.

Either way, this new strategy won't be a silver bullet since it focuses narrowly on provider organizations, while all stakeholders in the industry play a role in mitigating (or perpetuating) inequities. A comprehensive health equity strategy must touch on all three pillars of an equitable health care organization—the workforce, the community, and patients. Every health care organization can make a meaningful difference in advancing equity by expanding partnership strategies beyond community-based organizations, advocating for policies that address the root causes of inequity, and uplifting local economic outcomes through hiring and supplying decisions (Figure 12.2).

FIGURE 12.1: **INDUSTRY PLAYERS INCLUDE HEALTH EQUITY IN QUALITY PERFORMANCE**

Blue Cross Blue Shield of Massachusetts
becomes first health plan in market to incorporate equity measures into its payment models

PR Newswire, September 2021

JPMorgan and Kaiser Permanente
plan to roll out performance guarantees tied to health equity on certain quality measures for JPMorgan employees

Fierce Healthcare, January 2022

National Committee for Quality Assurance
adds health equity metrics to quality data

Modern Healthcare, August 2022

How it works: BCBSMA's role

Across 2022

- Gather **member demographic data**, including race, ethnicity, and language
- Distribute **tailored reports** to participating provider organizations that highlight disparities in quality within their patient population
- Offering **coaching and support** to help providers organizations reduce disparities in quality

Starting 2023

Begin **tying payments to health equity performance** for participating provider organizations

FIGURE 12.2: **THREE STRATEGIES EVERY HEALTH CARE ORGANIZATION CAN—AND SHOULD—TAKE ON**

Universal tactic	**Expand partnership strategy** beyond community organizations to include all industry players, including competitors	**Advocate for policies** that address the root causes of inequity—intergenerational poverty and structural racism	**Uplift economic outcomes** by adopting an anchor approach to hiring and supplying decisions
Why it's a no-brainer for you	Cross-industry partnerships can create mutual accountability for progress, reduce duplicative efforts, and maximize impact	Industry leaders can't go it alone—ask local, state, and federal policymakers for what you need to make progress more possible, faster	Diverting existing dollars to local economic development builds a more favorable payer mix, reduces plan membership churn, and strengthens the workforce pipeline

13

Unprecedented behavioral health needs are hitting an already fragmented, marginalized care infrastructure. Leaders across all sectors will need to make difficult compromises to treat and pay for behavioral health like we do other complex, chronic conditions.

The health care system was already insufficient to meet behavioral health needs well before the pandemic. Patients with behavioral health conditions have long experienced worse access and outcomes than patients without—Americans with serious mental illness die 15 to30 years younger than those without.[17] But because of stigma against people with behavioral health conditions and because these challenges primarily affected already marginalized groups (including individuals in low-income and minority racial and ethnic communities), there was limited urgency to address the problems.

Enter Covid-19: the pandemic and its economic and social ripple effects created unprecedented behavioral health needs, with dramatic increases in substance use disorders, anxiety, and depression across *all* populations, including children and wealthier groups. This increase in demand means that even people who could previously pay out-of-pocket for high-quality care are now running into access barriers. But patients are not alone in feeling the strain—providers, plans, and purchasers all fear the future ramifications of these unmet needs, because unmanaged behavioral health needs lead to worse health outcomes and higher costs (Figure 13.1).

Society has historically de-prioritized and separated behavioral health care from traditional health care, leading to multiple compounding challenges within the behavioral health care system, including insufficient research, low reimbursement rates, and few clinicians (Figure 13.2). While health care stakeholders collectively experience the negative consequences of these industry challenges, the costs and benefits of investing in behavioral health accrue to different stakeholders at different times—so no one player is clearly motivated to lead change.

Record-breaking investment in digital behavioral health startups undeniably expanded access for some consumers, particularly affluent, low-acuity consumers. But these tools also risk increasing fragmentation, exacerbating inequities, and diverting an already limited workforce—and do little to fix the marginalized behavioral health care system.

Instead, leaders must better integrate behavioral health into existing physical health infrastructure. This includes recognizing behavioral health as an integral part of health care, treating behavioral health needs like we do other complex, chronic conditions, and paying for more care under insurance structures. To make this possible, industry stakeholders will need to better calculate the direct and indirect value of behavioral health services on health outcomes and costs, come to consensus on how to define quality care and outcomes in behavioral health, and collectively agree to increase investment in behavioral health care without a clear short-term payoff.

17) "The Largest Health Disparity We Don't Talk About," The New York Times, May 2018.

FIGURE 13.1: **ATTENTION ON ADDRESSING BEHAVIORAL HEALTH CARE NEEDS EMERGING FROM THE PANDEMIC**

Pandemic increased behavioral health care demand, compounding access challenges

33%

Of adults **reported symptoms of anxiety or depression** in June 2022, compared to 11% pre-pandemic

#1

Priority ranking by large employers[18] for adding or expanding programs to increase access to behavioral health, 2021

15%

Increase in **drug overdose deaths** in 2021, compared to 2020

60%

Of psychologists report having **no openings** for new patients in 2022

Health care spending by behavioral health diagnosis, 2021

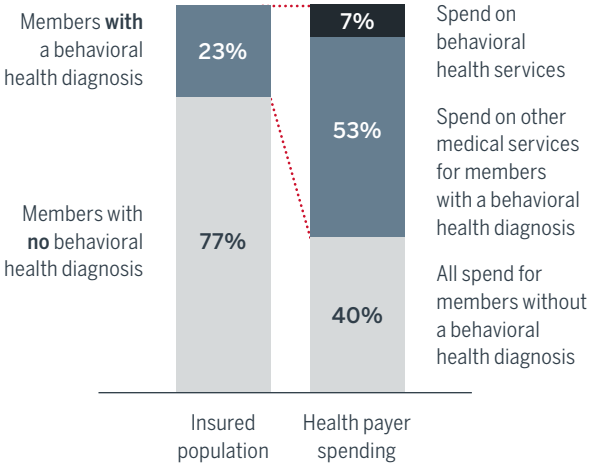


FIGURE 13.2: **LEGACY CAUSES OF BEHAVIORAL HEALTH INEQUITY REINFORCE STRUCTURAL FAILURES**

Historical societal dynamics marginalize care and discourage investment ⟷ **Health care structural issues yield inaccessible, unaffordable care with poor outcomes**

Stigma from society viewing people with behavioral health conditions as outliers and beyond help.

Structural inequalities including structural racism and economic injustice have led to behavioral health needs compounding in marginalized communities (including low-income communities and communities of color) whose needs are consistently neglected.

Few clinicians choose to enter or stay in the field, which makes it difficult for patients to access the right care in the right place at the right time.

Low reimbursement rates drive many providers to operate outside of the insurance market and disincentivize other providers organizations from entering the space at all, driving up wait times and costs for patients.

Less research results in a limited understanding of the scientific mechanisms behind behavioral health conditions and a lack of agreement on recovery milestones and appropriate treatments for diverse scenarios.

18) Employers with at least 20,000 employees.

14

As the population ages, the fragile patchwork of government payers, unpaid caregivers, and strained nursing homes is ill-equipped to provide sustainable, equitable **senior care.** This is putting pressure on Medicare Advantage plans to ultimately deliver results.

As the baby boomer generation continues to age into Medicare, the senior population will rapidly become larger, more racially diverse, and more medically complex—with a much greater share of seniors above age 75 than ever before (Figure 14.1).

This growth in population size and needs will severely strain senior care and payment infrastructure, which historically needed to accommodate shorter life expectancies. Cuts to reimbursement, increases to premiums, and potential (though less likely) tax increases will be needed to stave off the rapidly approaching insolvency of the Medicare Trust Fund. Compared to previous generations, seniors today have lower overall savings and are less likely to have pensions or adequate retirement savings—increasing spillover into Medicaid spending, which will dwarf state budgets.

Nursing homes, which were never intended to be a long-term care option for the entire older adult population, have become the default for older adults approaching end of life. But staffing shortages, limited capacity, and the high cost of care at nursing homes mean that many older adults who rely on a patchwork of Medicare and Medicaid must look to other options for support. This often forces people to turn to unpaid personal caregivers, who may not be able to provide adequate care (Figure 14.2).

Beyond the difficulties of changing demographics, the health care system has historically been reactive rather than proactive. This has made it difficult for seniors to access primary care and other preventive services such as paid caregiving and home-based care that could prevent high hospital utilization rates. Medicare Advantage (MA), poised to become the dominant form of Medicare within the next two years, offers the potential to transform this paradigm through its more flexible supplemental benefits and financing structure.

Thus far, MA plans have already driven change in care delivery structures. They have spurred investment in home-based care supports to enable aging in place, a focus on care coordination for those with more complex medical conditions through Special Needs Plans, and use of senior-focused primary care to help older adults navigate the health care system and manage their conditions.

But as MA plans absorb a larger share of federal funding and increasingly become the default source for long-term care, they will be under increased pressure and scrutiny. The government, the industry, and patient advocates will want to ensure that MA plans deliver improved access and quality for seniors—and equitably improve overall resource use.

FIGURE 14.1: **NUMBER OF AMERICANS AGE 65 AND OVER**

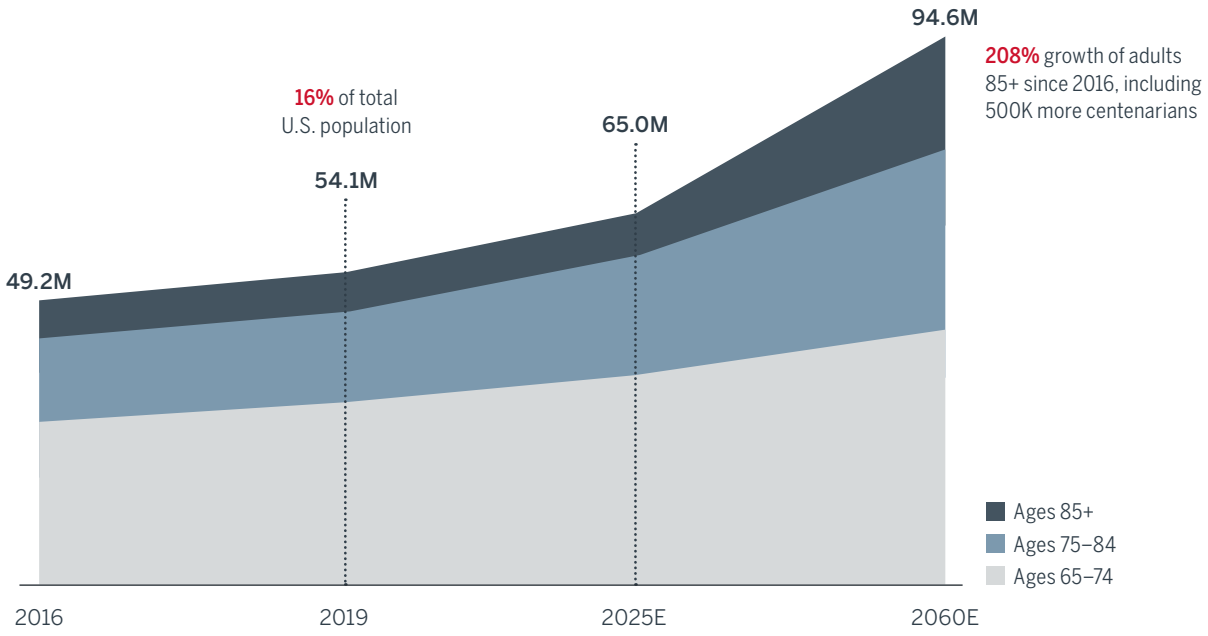


FIGURE 14.2: **OUTLOOK FOR THE FUTURE SENIOR CARE WORKFORCE**

Insufficient supply of senior care workers

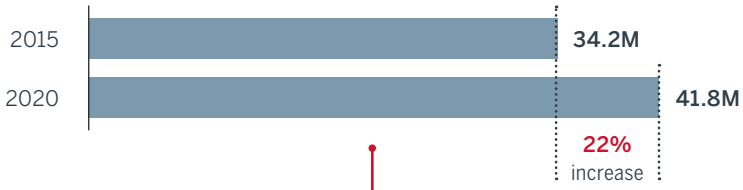
3.2M

Shortfall between recent supply and projected demand for **direct care workers** for older adults

16K

Shortfall between recent supply and projected demand for **geriatricians**

Number of Americans providing unpaid care to adults age 50+



66% of unpaid caregivers are over age 50

15

The enormous pipeline of specialized **high-cost therapies** in development will see limited clinical use unless the entire industry prepares for paradigm shifts in evidence evaluation, utilization management, and financing.

Despite recent fluctuation in the biotech and digital health investment markets, there is one inevitability: vast numbers of more diverse, targeted, and expensive therapeutic innovations on the horizon.

There are currently more drugs in the research pipeline than ever before (Figure 15.1). But the growing volume alone is not the greatest disruption: the curative nature of the treatments and the patient populations impacted create new challenges. Enabled by scientific and computing advances—and motivated by patent limitations on blockbuster drugs and federal scrutiny on traditional drug prices—pharma manufacturers are dramatically shifting their innovation efforts to more personalized therapies and rarer diseases.

Further, the pandemic catalyzed an increase in decentralized clinical trials. This is an important step toward diversifying the types of patient populations that will have representative evidence available about their responses to new treatments, which is essential information for justifying insurance coverage and clinical selection.

As these targeted, high-cost therapies become more prevalent, the health care industry must prepare for existing financial management and treatment decision structures to fall short.

For payers, purchasers, and health system pharmacy and therapeutic committees, the emerging therapies likely mean enormous expenses. For example, bluebird bio, Inc. recently launched a new curative gene therapy priced at $2.8 million.[19] Organizations must expect that decisions for small patient populations will set precedents for future therapies, and confront the structural challenges preventing sharing the financing burden over time or ensuring appropriate diagnostic targeting of therapies.

Given the personalized nature of many emerging therapies, the clinical decision-making process is crucial for ensuring appropriate access to these treatments. That landscape is rapidly evolving to enable clinicians to make more precise, ongoing treatment decisions—if the industry collaborates to make the changes needed. Clinicians must grow comfortable shifting from memory-based to technology-assisted practice, aided by digital technology tailored to their information needs. Life sciences firms and provider organizations must assemble evidence in new formats to help clinicians quickly digest, interpret, and translate complex information into real-time, individualized decisions. And as diagnosis and treatment become less binary, technology firms and payers must allow greater flexibility to monitor disease progression and adapt therapies for distinct changes in patient care journeys (Figure 15.2).

19) "With $2.8M gene therapy, Bluebird sets new bar for US drug pricing," BioPharma Dive, August 2022..

FIGURE 15.1: **UPCOMING PHARMACEUTICAL PIPELINE CHARACTERISTICS**

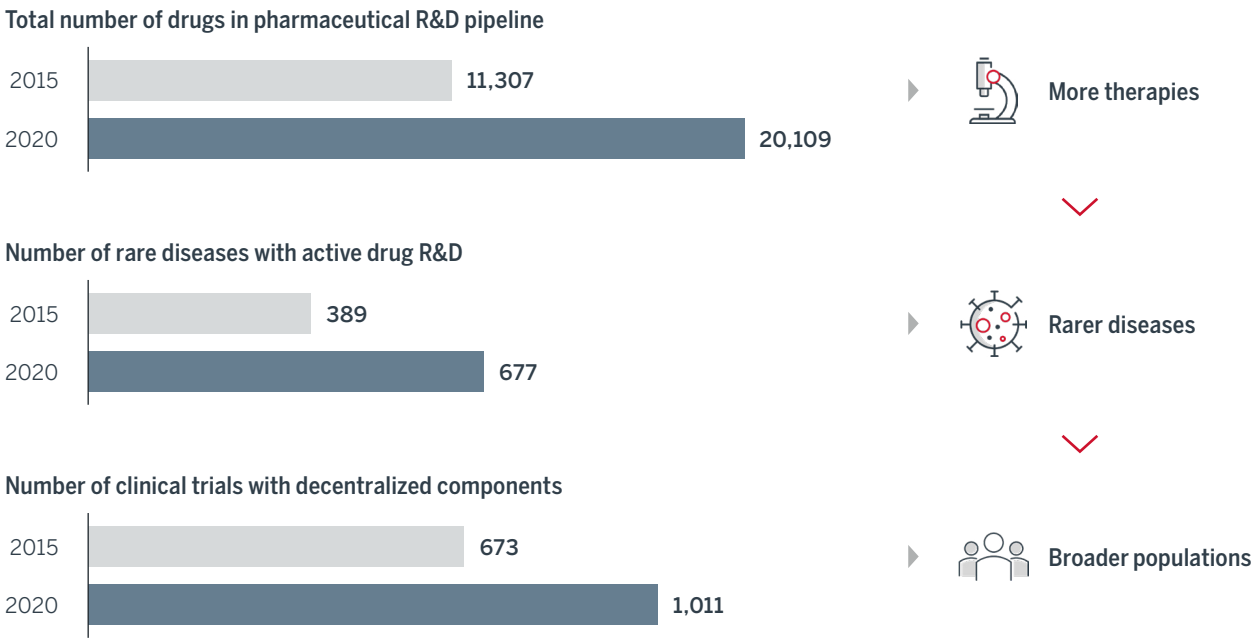


FIGURE 15.2: **KEY PREDICTIONS ABOUT THE FUTURE OF CLINICAL DECISION-MAKING**

1

Clinical practice will shift from a memory-based to technology-assisted approach

2

Data and technology will enable a graded, proactive approach to treatment, diagnosis, and stratification of patients

3

Technology innovation will shift from "building" a better clinician to complementing them

4

Not all organizations will have the resources and infrastructure to integrate cutting-edge tech and treatments

5

Not all patients will have the means, trust, and confidence to take advantage of technological breakthroughs

16

Self-funded employers, who are now liable for paying 'reasonable' amounts, may contest the standard business practices of brokers and plans to avoid complex legal battles with poor optics.

In the current competitive labor market, employers are eager to offer attractive compensation. While at least 70% of large employers indicate they are making benefit enhancements for 2023,[20] they are also extremely concerned that the costs of their health care benefits may limit opportunities to increase other forms of compensation, particularly wages. Increasingly, employers are looking for ways to offer richer health benefits—at minimal additional cost.

Amid this ambition, the Consolidated Appropriations Act of 2021 now requires employers to obtain the compensation of brokers and consultants and review its "reasonableness."

This new requirement has the potential to dramatically reshape self-funded employer approaches to their health plan benefits designs—and their choice in partners. Plan sponsors must ensure that they are acting in the "sole and best" interest of their beneficiaries. That means ensuring that the compensation they are paying to their partners is getting them the highest value health benefits.

Whether this requirement leads to new demands from employers will demand on how "reasonableness" is defined. If employers obtain their own claims data and scrutinize it against other market rates—potentially aided by payer price transparency data released in July 2022—they may be able to discern where the lowest discounts or fees are not translating into the lowest unit or total costs for health care services (Figure 16.1).

Employers may also be spurred to scrutinize benefits partners by class action lawsuits. Several legal experts expect that the new requirement will open the door to litigation similar to that brought for retirement benefits, where compensation disclosures are already required. The stakes for noncompliance are high, with 2021's top 10 ERISA settlements totaling $837 million[21] (Figure 16.2).

This new opportunity (and liability) may prompt employers to explore more disruptive benefit design strategies, including centers of excellence and reference pricing. The outstanding question is whether employers will be able to find sufficient value while still maintaining the broad networks that are so popular today—or whether fully meeting their fiduciary duty will require the formal exclusion of high-priced sites, narrower networks, and a potential return to HMO-like structures. At a minimum, responsible employers will aim to better understand their health care costs, coordinate their finance and benefits departments, and scrutinize benefits partners more closely.

Employers may also find themselves further spurred by the growing contingent of state health care cost commissions seeking to set targets for health care cost growth—with California's new Office of Health Care Affordability representing the most comprehensive proposed enforcement to date.

20) "Health & benefit strategies for 2023," Mercer, 2022.
21) "The 10 biggest ERISA class action settlements of 2021," BenefitsPro, January 2022.

FIGURE 16.1: **COMMENTARY ON NEW FIDUCIARY REQUIREMENTS FOR ERISA PLAN SPONSORS**

Temporary Enforcement Policy Regarding Group Health Plan Service Provider Disclosures Under ERISA

"The required disclosures are intended to provide the responsible plan fiduciary with sufficient information to assess the reasonableness of the compensation to be received and potential conflicts of interest that may exist as a result of a covered service provider receiving indirect compensation from sources other than the plan or the plan sponsor."

Employee Benefits Security Administration, U.S. Department of Labor

Field Assistance Bulletin No. 2021-03

A new tool in the employer CFO toolbox

"Reasonableness doesn't just mean the lowest per-employee-per-month fee as a TPA. It means what brings the most value to the plan… I could find a TPA with the lowest ASO per-employee-per-month fee, with the biggest and broadest network, with the biggest and baddest discounts—and still lose value.

"Value means sending your members to the best providers in your network, it means perhaps paying a bit more on an ASO fee in order to provide navigation services and concierge-like primary care.

"It's about people bearing more of the costs through increased cost share or forgone wages. If you're not paying reasonable fees, you're using plan assets to enrich a hospital that performed an unnecessary surgery or enrich a carrier that wasn't vigilant in overseeing claims integrity."

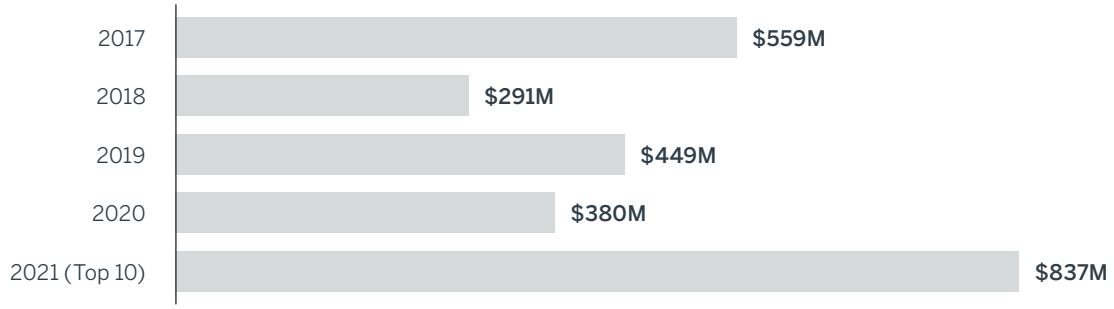
Christin Deacon

Director of Health Benefits Operations and Policy and Planning, State of New Jersey

FIGURE 16.2: **EMPLOYER ERISA RETIREMENT SETTLEMENTS**

ERISA class action settlement amounts, 2017–2021

For all defendants within the year unless specified



Ultimately, leaders' strategic decisions today will bring the industry toward a future defined either by flexible fragmentation or by coordinated control.

One future is a competition of diverse, flexible, fragmented players—likely if we push for more consumer choices, varied physician partnerships, and hospital business model diversification.

The other future is a coordinated order controlled by comprehensive behemoths—likely if we organize care delivery into closed ecosystems and rely on integration and standardization for generating value.

Each market will move in its own direction (and neither future is *necessarily* better or worse) but certain organizations may prefer one over the other depending on their own capabilities and operations.

To chart their strategic course, executives should consider carefully which future is best for their own organization, as well as the broader industry they want to shape—and carefully track the leading indicators that show where we're heading.

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