EXECUTIVE BRIEFING

16 Things CEOs Need to Know in 2022

Advisory Board

The past two years have left an indelible mark on the world, as well as on the health care industry. And as the Covid-19 pandemic continues to wear on, the health care industry has found itself in an unprecedented state of flux. Long-standing assumptions about utilization, demand, consumer preference, and the regulatory landscape have all been challenged. As a result, today's health care leaders face many strategic decisions that will have enduring and far-reaching implications for the future of this industry, even after the acute phase of the crisis has waned.

As pivotal as the past two years have been, we believe the coming year will determine the future trajectory of this industry. What will the future of the virtual care landscape—and the broader home-based care market—look like? Will Covid-19 be a turning point for risk-based payment and, if so, in which direction? Will the health care industry rise to the challenge of addressing persistent disparities in health outcomes?

This briefing examines which structural shifts are most important, how those shifts might play out, what steps leaders can take to inflect the direction and pace of change, and how the Covid-19 crisis has shifted the dynamics of power and influence across the 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 2022

PART I. THE PANDEMIC'S IMPACT: THE EFFECT OF COVID-19 ON FINANCES, COVERAGE, AND UTILIZATION

01 National health plans are deploying outsized gains achieved amid the pandemic to fuel strategic consolidation and diversification.

02 With the hospital sector experiencing significant levels of divergence in financial performance, further consolidation is likely on the horizon.

03 The primary threat to the physician landscape is not financial sustainability, it's workforce sustainability.

04 Suppliers have largely seen financial performance and political scrutiny return to pre-pandemic norms—except for digital health companies, which are gaining new levels of influence.

05 The uninsured rate did not increase significantly due to Covid-19, but further national coverage expansion is unlikely.

06 Concerned about impending spikes in health spending, employers are doubling down on steerage as their preeminent cost control-strategy.

07 Buoyed by federal assistance and stronger-than-expected tax revenues, states have shifted their focus to longer-term ambitions like health equity.

08 As Medicare insolvency inches closer, painful cost-cutting measures aimed at plans and providers are likely within the next few years.

09 Covid-19 is unlikely to prompt big shifts in aggregate demand, but there will be meaningful changes to individual service lines and sites of care, particularly among highly profitable procedures.

01

National health plans are deploying outsized gains achieved amid the pandemic to fuel strategic consolidation and diversification.

As 2022 approaches, every sector of the health care industry continues to grapple with the ongoing effects of Covid-19. For insurers, the steep decline in health care utilization early last year appeared to translate to a financial windfall. But deeper analysis reveals a more nuanced picture than the headlines suggest.

Medical loss ratio (MLR) requirements limit the extent to which health plans can pocket or reinvest revenue gains. And the massive profits that initially grabbed headlines proved fleeting as plans confronted rebounding utilization later in 2021.

Perhaps most important, profits provide only one snapshot into plan performance—shifts in membership are critically important too. An analysis of 2020 enrollment trends shows that not all plans weathered the pandemic equally well.[1] As expected, commercial enrollment declined slightly or remained steady for most, while managed Medicaid and Medicare Advantage enrollment climbed. But that growth in enrollment was not evenly spread. National insurers captured significantly more members than state-based Blues or regional plans (Figure 1.1).

National plans have moved quickly to translate that growth into further strategic advantage. While acquisition is a common strategy, there are clear distinctions in each organization's approach.

When it comes to horizontal consolidation, some (such as Centene) are focused on specialization, doubling down on specific populations and business lines. Others, such as CVS/Aetna and UnitedHealth Group,[2] are focused on broad reach across multiple segments. Plans similarly vary in their approach to vertical consolidation, with some clearly focused on revenue diversification, while others are prioritizing synergistic acquisitions (Figure 1.2).

1) AIS Directory of Health Plans, 2018 Q4, 2019 Q4, and 2020 Q4.
2) Advisory Board is a subsidiary of UnitedHealth Group. All Advisory Board research, expert perspectives, and recommendations remain independent.

FIGURE 1.1: **TOTAL HEALTH PLAN ENROLLMENT BY PLAN TYPE**

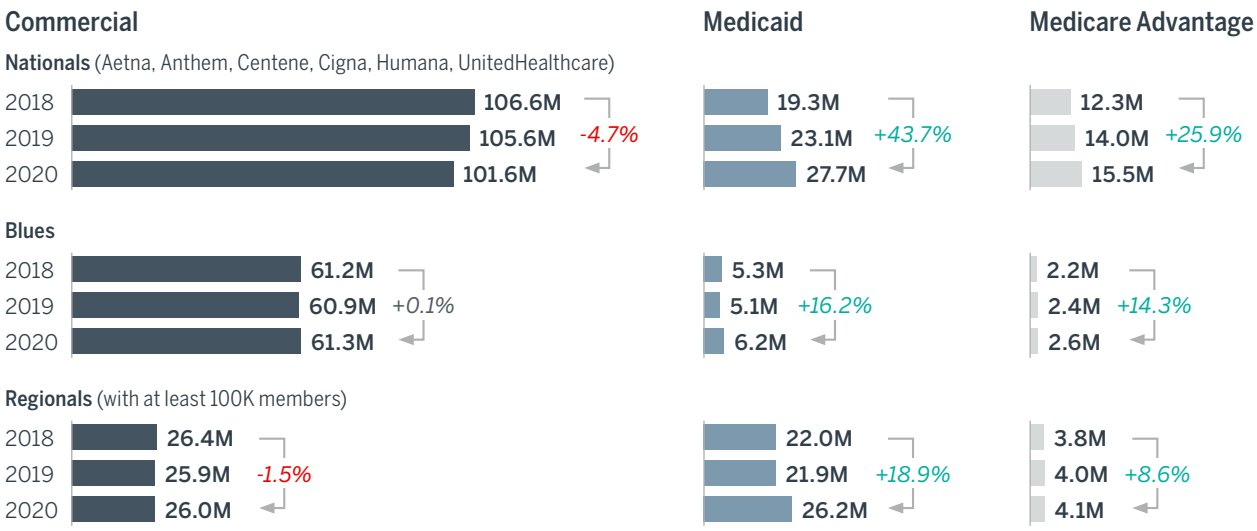
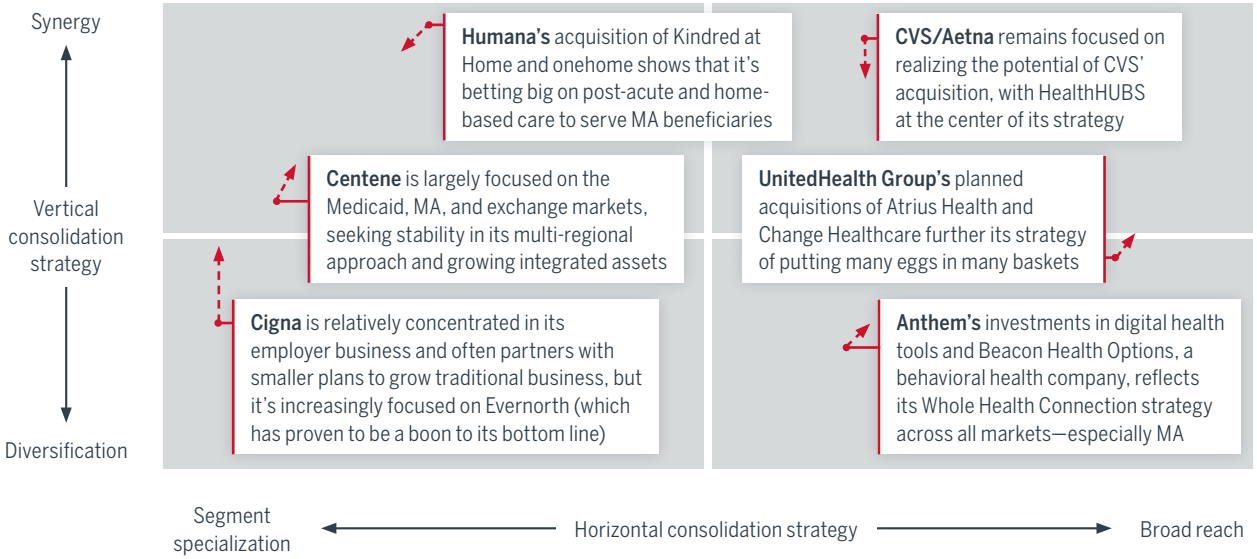


FIGURE 1.2: **RELATIVE CURRENT CONSOLIDATION STRATEGIES OF THE NATIONAL HEALTH PLANS—AND WHERE THEY'RE TRENDING**



02

With the hospital sector experiencing significant levels of divergence in financial performance, further consolidation is likely on the horizon.

The financial reality of hospitals is even more opaque than that of health plans. The past two years have given rise to two seemingly contradictory narratives: either Covid-19 was disastrous for hospital finances or hospitals are doing better than ever.

An Advisory Board analysis of health system margins between 2018 and 2020 reveals that both narratives have some element of truth (Figure 2.1). In the first half of 2020, average operating margins plummeted as hospitals suspended elective procedures. But even as median margins began to return to pre-pandemic levels, many individual organizations saw margins that were either significantly higher or significantly lower than historical norms.[3] While some hospitals made it through the acute phase of the pandemic stronger than ever, others have remained in crisis mode.

Whether any individual organization falls on the high or low end of this spectrum depends on a variety of factors, including how Covid-19 played out regionally. An Advisory Board survey conducted in early 2021 also revealed that larger systems (those with five or more hospitals), integrated delivery networks (those with health plans), and academic medical centers recovered more quickly than smaller systems and stand-alone hospitals.[4] The health crisis provided a burning platform for larger organizations to finally embrace the "systemness" that has long proved elusive for most of the sector.

Any industry experiencing significant divergence in financial performance often sees an uptick in consolidation. Recent years have been characterized by an increasing focus on headline-grabbing mega-mergers designed to build cross-regional scale. But the value of localized systemness during the pandemic appears to have driven renewed interest in regional scale. As consolidation activity picked up across 2021, many deals share a common goal of building strength at the local level (Figure 2.2).

The ability to flex staff, supplies, and patients across sites of care has been crucial in the past year and a half. Hospitals must continue to embrace this agility, as we do not expect cost pressures to subside. The need to fortify supply chains, invest in new technologies, and foster a stable and resilient workforce has only grown. Well-integrated systems will ultimately find it easier to navigate those challenges.

3) Health Systems Financials (Quarterly), Modern Healthcare, September 2021.
4) "How Covid-19 has impacted 2021 provider volume outlooks," Advisory Board, March 2021.

FIGURE 2.1: **INTERQUARTILE RANGE IN HEALTH SYSTEM OPERATING MARGINS, Q1 2018–Q4 2020**

Modern Healthcare health system financials database

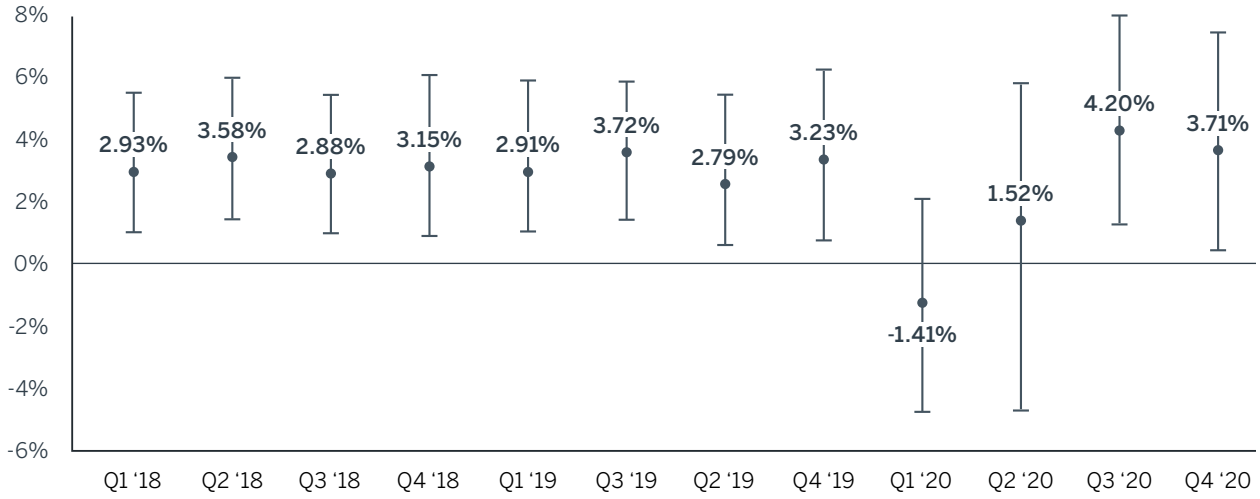


FIGURE 2.2: **AS M&A PICKS UP, DEALS CENTER ON REGIONAL STRENGTH**

Acquisitions of community hospitals

- WVU Health System acquires two community hospitals
- HCA Healthcare buys Meadows Regional Medical Center

Mergers between regional systems

- LifeSpan and Care New England sign definitive agreement to merge
- Beaumont Health and Spectrum Health sign letter of intent
- NorthShore and Edward-Elmhurst plan nine-hospital merger

Divestitures by national systems

- HCA sells hospitals to Piedmont Healthcare and AdventHealth
- Ascension sells seven hospitals to Aspirus
- Steward selling five Utah hospitals to HCA's mountain division

Deal ambition

Regional players expanding and solidifying regional strength

Multi-regional players doubling down in certain markets, ceding others

FOR MORE INFORMATION

See our infographic **Weave these threads together to strengthen your systemness** on advisory.com.

03

The primary threat to the physician landscape is not financial sustainability, it's workforce sustainability.

While hospitals have borne the unique challenge of treating the sickest Covid-19 patients, pandemic-related declines in in-person care also impacted physician practices. When outpatient volumes plummeted, fears surfaced that many independent groups would not survive. Ultimately, average physician income barely budged between 2019 and 2020, and nearly half of physicians reported no ill effects to their practice due to Covid-19. As with hospitals, however, performance varied widely, with nearly one-eighth of physicians experiencing a period of no earnings (Figure 3.1).[5]

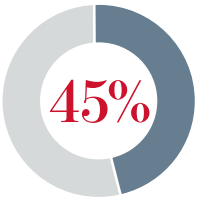
Once again, the local severity of Covid-19 affected how any individual practice fared. Large and multispecialty groups weathered volume fluctuations more easily, as did groups with capitated arrangements. Agile governance structures also proved critical, especially as practices had to move quickly to embrace new delivery models such as virtual care. By contrast, small, single-specialty, and non-diversified practices faced greater financial hardship.

Ultimately, these financial challenges pale in comparison to the mounting workforce crisis facing physicians. The burnout rate among physicians hit 42% in 2020, and almost half of those experiencing burnout report that it has had a severe impact on their life.[6] A growing number are considering early retirement or even leaving the practice of medicine entirely—moves that would put further pressure on the remaining workforce. An even greater proportion of physicians are open to switching employers (Figure 3.2).[7]

5) Kane L, "Medscape Physician Compensation Report 2021: The Recovery Begins," Medscape, April 2021.
6) Frellick M, "COVID-19 Drives Physician Burnout for Some Specialties," Medscape, January 2021.
7) Stajduhar T, "On the Verge of a Physician Turnover Epidemic: Physician Retention Survey Results — February 2021," Jackson Physician Search

FIGURE 3.1: **DESPITE INITIAL ALARM, OVERALL PHYSICIAN EARNINGS STEADY**

Average **portion of 2019 income** earned by PCPs and specialists in 2020

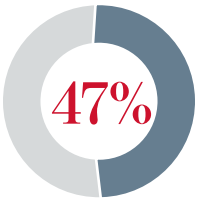


Percentage of physicians who experienced **no financial or practice-related ill effects** due to Covid-19

Percentage of physicians who experienced a **temporary period of no earnings**, averaging three months

FIGURE 3.2: **BURNOUT MOTIVATING PHYSICIANS TO CONSIDER CAREER SHIFTS**

Clinicians in desperate need of a break



Physicians experiencing burnout who report that it has a severe impact on their life

Physicians leaving due to Covid-19

Survey conducted February 2021

27% Considering leaving for a **new employer**

11% Considering **early retirement**

8% Considering **leaving medicine** entirely

FOR MORE INFORMATION

See the article by Advisory Board's Rachel Woods, **Give Clinicians Time to Recover from the Pandemic**, in Harvard Business Review.

04 Suppliers have largely seen financial performance and political scrutiny return to pre-pandemic norms—except for digital health companies, which are gaining new levels of influence.

Like providers, pharmaceutical companies played a crucial role in the fight against Covid-19. But that effort has done little to shift the financial performance of the sector. With few exceptions—such as the meteoric rise of Moderna's market capitalization after the company produced an effective mRNA vaccine—the stock prices of pharmaceutical and medical device manufacturers have tracked with the broader market.

Successful vaccine production has also not deterred political scrutiny. Congress continues to debate drug reforms as most voters support government action.[8] The pharmaceutical lobby opposes nearly all proposed reforms, but the high-profile rollout of pricey pharmaceuticals—including Biogen's Alzheimer's drug Aduhelm—has reignited efforts to regulate the drug pricing and approval process.

There have been major changes to how life sciences companies operate, including how and where clinical trials are conducted, how researchers generate evidence to support efficacy claims, and where patients access both infused and non-infused drugs. These all evolved rapidly in ways that will have spillover effects for other sectors of the industry (Figure 4.1).

But perhaps the most seismic shift in the supplier sector has been the remarkable rise of digital health. Billions of dollars in venture funding have flowed into technology start-ups. Meanwhile, incumbent health plans, health systems, and pharmaceutical companies have doubled down on their own offerings (Figure 4.2).[9]

The focus of these investments has evolved as well. Attention has shifted away from non-clinical technologies such as IT and wellness to those focused on the development and delivery of care. R&D, on-demand health care services, and disease treatment top the list. These new technologies—and the vendors that own them—are poised to have a larger and more direct impact on care delivery (Figure 4.3).

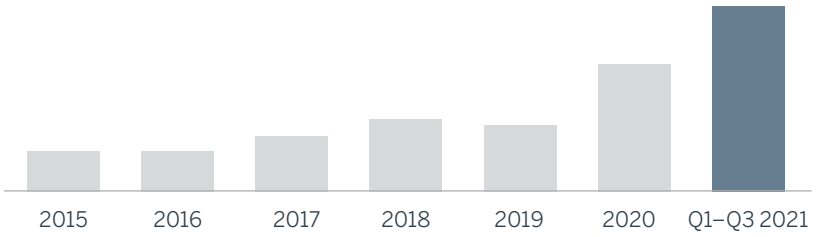
8) Galvin G, "Half of Voters Support Plan to Let Medicare Negotiate Drug Prices," Morning Consult, September 2021.
9) Hawks C, et al., "Q3 2021 digital health funding: To $20B and beyond!" Rock Health, October 2021.

FIGURE 4.1: **STRUCTURAL SHIFTS STAND TO RESHAPE LIFE SCIENCES INDUSTRY**

	Decentralization of **clinical trials**	Acceleration of **evidence generation**	Acceleration of **site-of-care shifts**
Impact on life sciences:	• More efficient trial enrollment and data collection • Stronger evidence that drugs work in diverse populations • Greater risk of complications with compliance and privacy	• Diminished concerns around real-world evidence, data sharing, and patient privacy • New access to previously untapped patient-data sources	• Increased demand for diagnostics, drugs, and medical equipment for use in the home • Producers must adapt to new relationships with home care customers
Impact on other stakeholders:	• Lower barriers to health systems that are not major AMCs conducting trials • Payers reassess which treatments will be covered	• Providers and health plans may struggle to keep up with the pace of change • Outdated guidelines hamstring efforts to establish quality standards and value-based contracts	• Revenue shifts from hospitals to payers, specialty pharmacies, freestanding infusion centers, and home infusion agencies • Greater burden on patients and providers to avoid care fragmentation

FIGURE 4.2: **TOTAL VENTURE FUNDING FOR DIGITAL HEALTH**

Full year 2015-2020 and Q1–Q3 2021



$21.3B
Digital health venture funding, Q1–Q3 2021

FIGURE 4.3: **TOP THREE FUNDED DIGITAL HEALTH VALUE PROPOSITIONS, FY 2015–2020 AND Q1–Q3 2021**

	2015	2016	2017	2018	2019	2020	Q1–Q3 2021
1	Fitness and wellness	Fitness and wellness	Consumer health information	On-demand health care services	Fitness and wellness	On-demand health care services	Research & development catalyst
2	Consumer health information	Treatment of disease	Fitness and wellness	Fitness and wellness	On-demand health care services	Research & development catalyst	On-demand health care services
3	Nonclinical workflow	Monitoring of disease	Research & development catalyst	Research & development catalyst	Monitoring of disease	Fitness and wellness	Treatment of disease

05

The uninsured rate did not increase significantly due to Covid-19, but further national coverage expansion is unlikely.

While the digital health sector flourished, many other industries did not, as evidenced by the millions laid off across the past two years. However, the country's rise in unemployment did not produce a commensurate increase in the uninsured rate, which grew only slightly and has nearly returned to pre-pandemic levels (Figure 5.1).[10]

This is partially explained by the fact that many of the individuals who lost their jobs did not have employer-sponsored insurance to begin with. Those who did were able to turn to Medicaid and the individual market exchanges to maintain coverage.

To further bolster the insurance safety net, Congress also suspended Medicaid disenrollment for the duration of the public health emergency (PHE). Once the PHE ends, states will have 12 months to implement eligibility checks and remove those who no longer qualify. Some of those individuals will likely go without coverage, but evidence suggests that most will have other options. Because the U.S. labor market is strong, countless employers are trying to attract workers—and boosting benefits to do so. The federal government has also enhanced ACA insurance subsidies for the next two years, making exchange coverage more accessible to individuals across all income levels. Congress appears poised to extend those subsidies through an upcoming budget reconciliation bill.

Additional expansions beyond the individual market seem unlikely, despite the central role health coverage played in the 2020 presidential election. Medicare for All proposals have been off the table since President Biden became the Democratic candidate, and the policies that he endorsed—like a public option—are not on Democrats' list of immediate priorities. Because passing legislation for any of these policies would require a filibuster-proof Senate majority, they remain highly unlikely to reemerge so long as moderate Democrats such as Senators Manchin and Sinema remain opposed to filibuster reform (Figure 5.2).[11]

In the near term, meaningful increases in coverage are most likely at the state level. In recent years, a few states that had resisted Medicaid expansion have begun to reconsider those decisions. Congress attempted to further incentivize this shift by temporarily boosting federal funding to states that expand, although there has been little interest thus far. Undeterred, congressional Democrats have drafted a proposal that would grant private

10) "Predicting Enrollment Changes in the COVID Era," MMIT, May 2021.
11) "Joe Manchin: I will not vote to eliminate or weaken the filibuster," Washington Post, April 2021.

ACA market coverage to expansion populations in non-expansion states. This plan still faces many barriers—including resistance from within Democrats' own caucus—but if successful, more than 2.2 million people would become newly eligible for insurance.[12]

FIGURE 5.1: **UNEMPLOYMENT RATE AND UNINSURED RATE, JAN 2020–MARCH 2021**

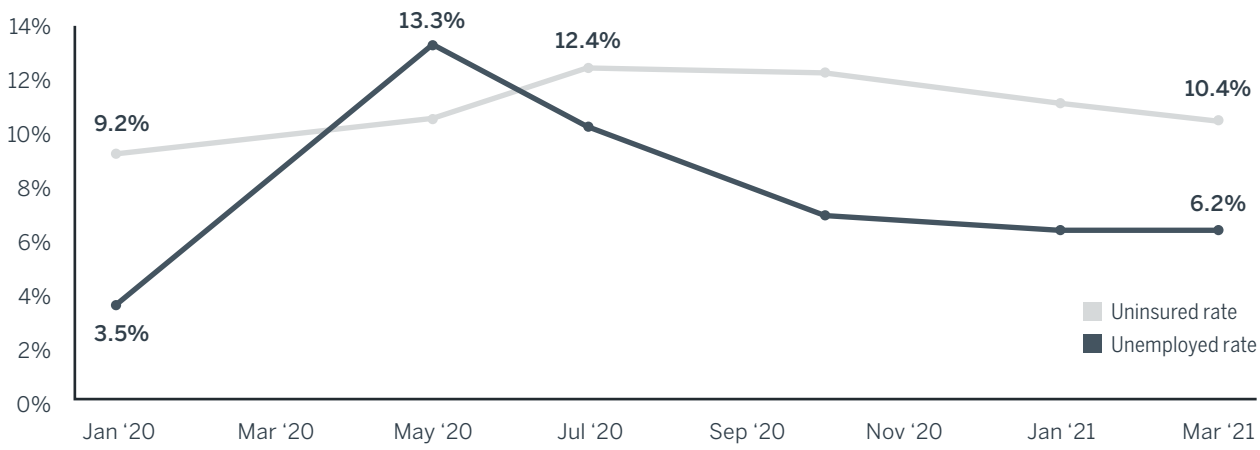
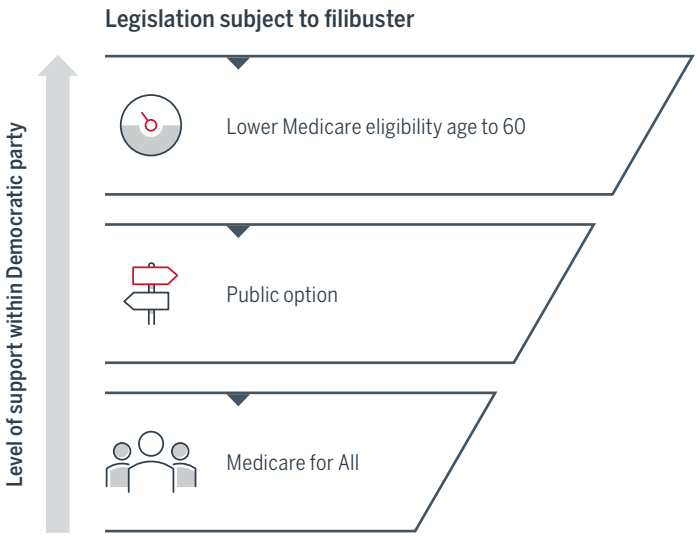


FIGURE 5.2: **FEDERAL COVERAGE REFORMS FACE A DAUNTING BARRIER**



> The filibuster is a critical tool to protecting that input and our democratic form of government. That is why I have said it before and will say it again to remove any shred of doubt: **There is no circumstance in which I will vote to eliminate or weaken the filibuster."**
>
> **Senator Joe Manchin** (D-WV)

12) Keith K, "Unpacking the Coverage Provisions in The House's Build Back Better Act," Health Affairs, September 2021.

06

Concerned about impending spikes in health spending, employers are doubling down on steerage as their preeminent cost-control strategy.

The declines in utilization at the beginning of the pandemic were financially beneficial for employers. Health care costs came under budget for most organizations in 2020.[13] With HR teams overwhelmed by other priorities, most employers refrained from implementing major changes to health benefits in 2021.[14] That said, every employer we interviewed expressed concerns that care deferrals and worsening mental and physical health will increase health care spending growth in the near future, perhaps as soon as 2023 (Figure 6.1).

In theory, employers have many tools to combat a potential surge in spending. A growing number have pointed to drug spending as a target but acknowledge that the complexity of the pharmacy space makes this an uphill battle. Moreover, most employers' pharmaceutical costs pale in comparison to their medical spend, making the latter a more attractive target. Shifting costs to employees was the preferred option for targeting medical spend after the 2008–2009 global financial crisis but appears to have reached its limits. Employers are not seeing the financial benefits they'd hoped for, and employees are not satisfied with their growing out-of-pocket spending.[15]

As a result, steerage has emerged as a dominant strategy for reducing medical spending growth. Employers are particularly interested in the notion of "soft steerage," by which they navigate employees to preferred providers and settings without making formal changes to network status, for example, through Center of Excellence programs (Figure 6.2).

13) "Few employers say their current wellbeing and caregiving programs effectively support employees," Willis Towers Watson, February 2021.
14) "Health benefit costs expected to grow 4.4% in 2021 as employers face continued economic uncertainty, Mercer survey finds," Mercer, October 2020.
15) "Consumer Engagement in Health Care Survey," The EBRI, Greenwald & Associates, December 2019.

FIGURE 6.1: **EMPLOYER BUDGETS STABLE, BUT LONG-TERM CONCERNS LOOM**

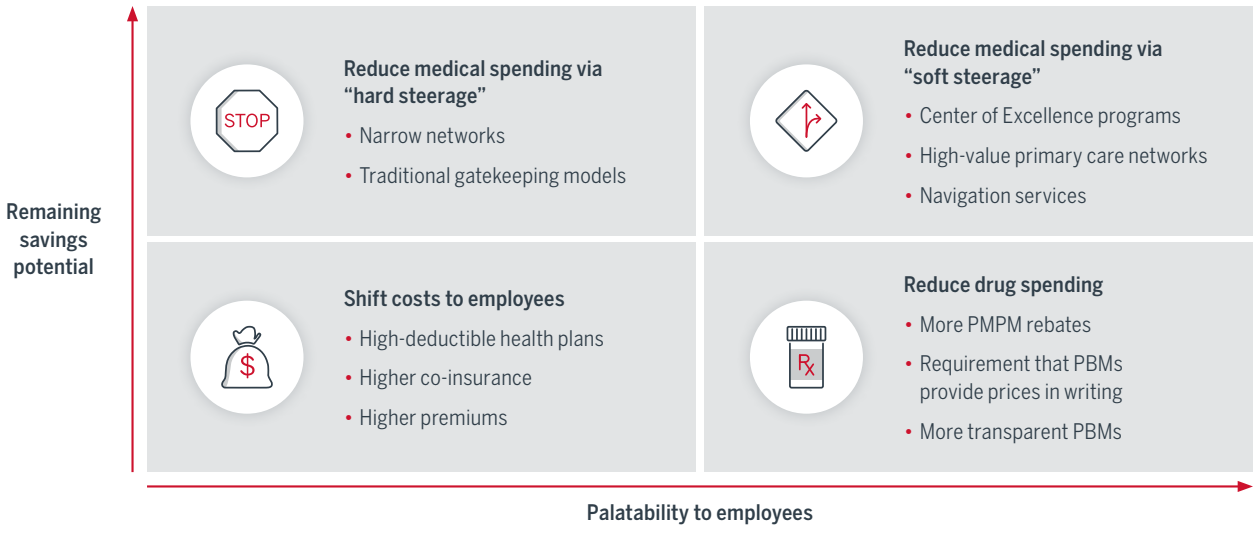
2020 Over one-third (**37%**) of employers reported health care costs that were **8% or more** below budget

2021 Employers budgeted for a **5.2% increase** in health benefits costs for 2021 as utilization bounces back

2022 With cost growth expected near pre-pandemic levels, HR leaders are prioritizing well-being and affordability

2023 Employers fear that deferred care and worsening mental and physical health will start accelerating spending growth

FIGURE 6.2: **EMPLOYER OPTIONS FOR REDUCING HEALTH BENEFITS SPENDING**



07

Buoyed by federal assistance and stronger-than-expected tax revenues, states have shifted their focus to longer-term ambitions like health equity.

As was previously noted, employer-sponsored coverage shrank amid the pandemic, and many of those who lost coverage qualified for Medicaid. States were also required to suspend disenrollment from Medicaid for the duration of the public health emergency. Together, these two trends collectively led to a 16% increase in Medicaid enrollment between February 2020 and May 2021, the most current data available as of this writing.[16]

Despite this remarkable growth in enrollment, most states are not looking to cut Medicaid spending. Only seven states recommended reducing provider payments for fiscal year 2022. By contrast, 39 states cut or froze rates in the wake of the global financial crisis.[17] This is largely because state budgets did not suffer as much as originally expected. In fact, states had used only about 2.5% of the emergency relief funding allocated to them in the American Rescue Plan as of late summer 2021.[18] Without the originally anticipated financial limitations, Medicaid programs are instead focusing their attention on longer-term programmatic improvements (Figure 7.1).

These improvements include traditional enhancements, such as increased rates and expanded benefits. But states are also using their relative financial stability as an opportunity to confront long-overlooked health disparities. Half of states are taking advantage of an American Rescue Plan provision that allows them to extend Medicaid coverage to 12 months postpartum.[19] A growing number are also requiring managed Medicaid plans to implement measures tackling social determinants of health (SDOH) (Figure 7.2).[20]

16) "May 2021 Medicaid & CHIP Enrollment Data Highlights," Medicaid.gov, October 2021.
17) "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends," Kaiser Family Foundation, September 2010.
18) Lieb D, "States and cities slow to spend federal pandemic money, report finds," Associated Press, October 2021.
19) Medicaid Postpartum Coverage Extension Tracker," Kaiser Family Foundation, October 2021.
20) Hinton et al., "10 Things to Know about Medicaid Managed Care" Kaiser Family Foundation, October 2020; "FAQs: Health Equity Accreditation," NCQA, 2021; "Multicultural Health Care," NCQA, November 2020.

FIGURE 7.1: **STATE PROPOSALS FOR MEDICAID PROGRAM ENHANCEMENT AND COST CONTAINMENT IN FY 2022**[21]

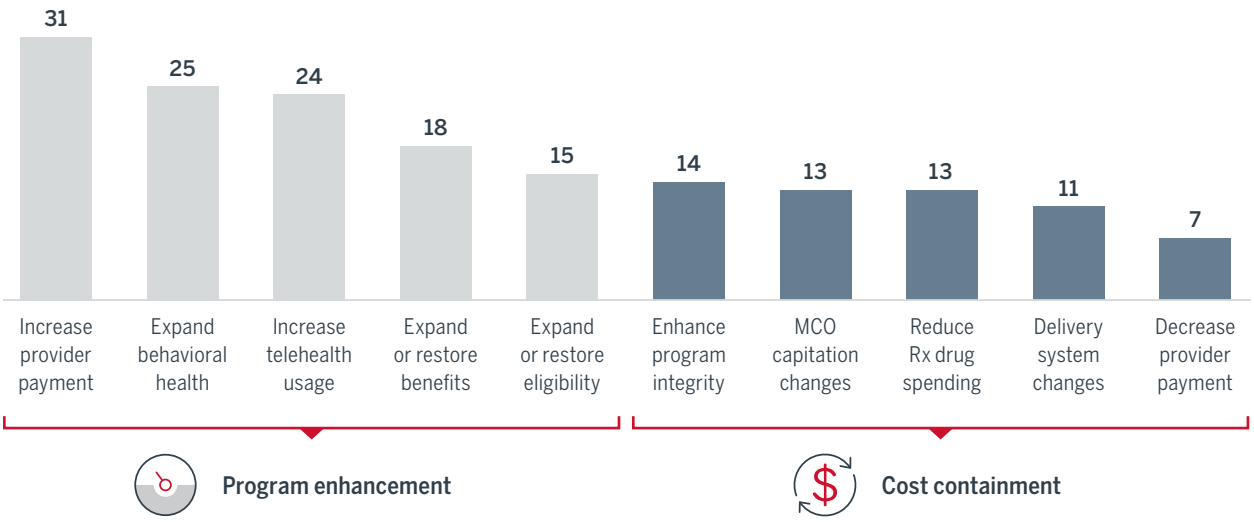


FIGURE 7.2: **STATE MEDICAID PROGRAMS TACKLING HEALTH DISPARITIES**

Expanding postpartum coverage

26

States extending Medicaid coverage to 12 months postpartum in 2022

Building SDOH requirements into MCO contracts

140%

Increase in number of states mandating MCOs track the outcomes of social services referrals in 2020

Adopting health equity standards

5

States in the process of requiring Medicaid MCOs achieve NCQA's Health Equity distinction

FOR MORE INFORMATION

See our research report **How to Engage Medicaid Members in Closing Care Gaps** on advisory.com.

21) "Fiscal Survey of States, Spring 2021," National Association of State Budget Officers, June 2021.

08

As Medicare insolvency inches closer, painful cost-cutting measures aimed at plans and providers are likely within the next few years.

Medicare is facing a very different, and more dire, financial reality. The Medicare Trustees report released in August 2021 estimated that the Hospital Insurance Trust Fund would become insolvent—no longer able to meet 100% of its financial commitments—by 2026. Notably, this is the same insolvency date the trustees had projected prior to the Covid-19 crisis (Figure 8.1).

While it was relief that the pandemic did not worsen the outlook for the Trust Fund, it has inched another year closer to insolvency. This is the closest Medicare has come to insolvency since the passage of the Balanced Budget Act in 1997.

The federal government has an array of options to increase Trust Fund revenue or decrease expenditures (Figure 8.2). Policies such as value-based payment arrangements and shifting to lower-cost sites of care are among the least controversial, but they're also the slowest to produce savings. More decisive actions, like raising premiums or cutting benefits, would risk upsetting the country's most reliable voting block: senior citizens. Far more politically popular would be cuts to drug spending. But because drug spending is not paid for through the Hospital Insurance Trust Fund, Congress would have to allocate Part D savings specifically for the purpose of bolstering the Trust Fund. As of this writing, Democrats have expressed intentions to use any savings from potential drug reforms for other priorities.

Reimbursement cuts—to either providers or plans—are the best balance of savings and political palatability. Providers have been a target in previous efforts to bolster the Trust Fund. But Medicare Advantage plans should also expect scrutiny as growing enrollment has made MA a bigger target than in the past. The Biden administration has voiced explicit concerns about the bonus payment structure and potential coding discrepancies. Possible interventions range from continued downward pressure on risk scores to outright reductions to plan payment rates.

FIGURE 8.1: **NUMBER OF YEARS PROJECTED UNTIL HOSPITAL INSURANCE TRUST FUND INSOLVENCY**[22]

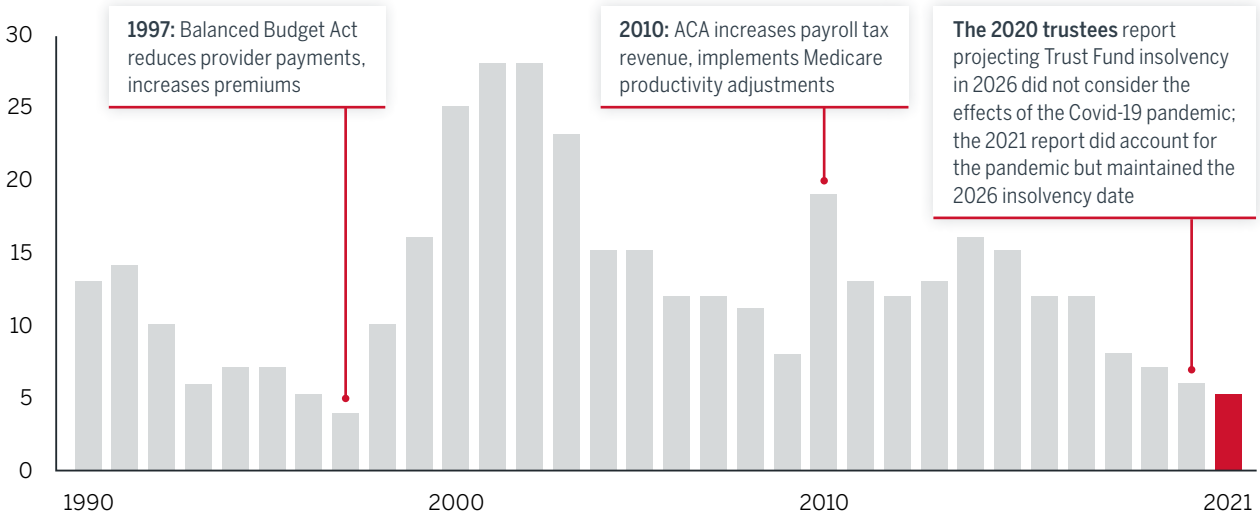
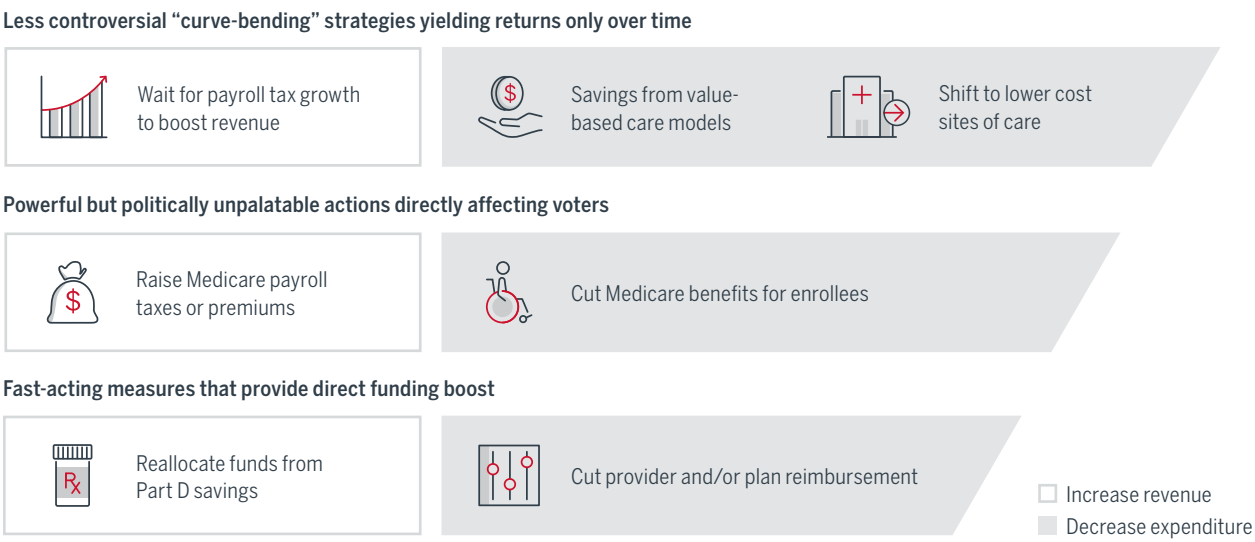


FIGURE 8.2: **OPTIONS FOR TRUST FUND SOLVENCY BALANCE POLITICS AND TIME**



22) "Medicare: Insolvency Projections," Congressional Research Service, May 2020.

09

Covid-19 is unlikely to prompt big shifts in aggregate demand, but there will be meaningful changes to individual service lines and sites of care, particularly among highly profitable procedures.

Ultimately, the extent to which any purchaser has to embrace drastic cost-cutting measures will depend on how health care demand evolves in the coming years. Between the threat of long and endemic Covid-19, worsened health status due to care deferrals, and growing mental health need, many stakeholders worry that utilization will increase in the coming years. Others posit that ongoing financial insecurity and shifts in consumer behavior (e.g., reluctance to visit the ED) will continue to suppress volumes for years to come.

Advisory Board's own five-year utilization projections suggest that overall utilization will not fluctuate beyond the typical variation seen from year to year as a result of Covid-19. The upward and downward pressures created by the pandemic balance each other out at an aggregate level (Figure 9.1).

We do, however, expect significant shifts in where volumes are concentrated. For example, care delays are likely to increase the need for oncology and orthopedic services. Conversely, financial exposure is likely to decrease demand for elective procedures such as bariatrics and specialty pharmaceuticals. These effects will be most acute in the next year or two (Figure 9.2).

The site-of-care shifts provoked by the pandemic are likely to be far more permanent. The leading indicator that this is a structural shift is the sustained drop in emergency department use that has persisted even as other volumes have rebounded. Inpatient care, diagnostics, and evaluation and management services have all seen an accelerated shift to less acute settings, including the home.

FIGURE 9.1: **ADVISORY BOARD 5-YEAR GROWTH PROJECTIONS**

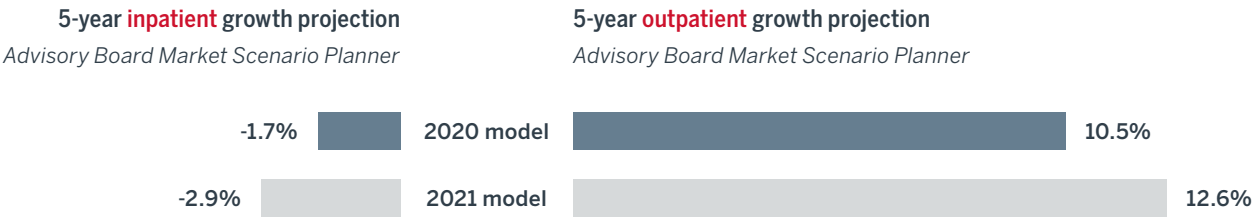


FIGURE 9.2: **COVID-19-RELATED IMPACTS ON SERVICE LINE DEMAND**

Future demand influenced by...		Observable impact...	Today → 2025
Deferred care	• Higher-complexity, later-stage patients requiring treatment interventions • Recovered elective surgery volume (with some loss due to non-surgical condition management)	• Oncology • General surgery • Orthopedics • Cosmetic surgery	
Social stressors	Greater prevalence of chronic disease, including anxiety, depression, and eating and substance use disorders	• Behavioral health • Evaluation and management • General medicine	
Covid-19 infections, complications	• Long-haulers with organ damage and symptomatic illness after recovering from Covid-19 • Hospitalizations due to Covid-19 infection	• Infectious disease • Cardiovascular • Pulmonology • Neurology • Rehabilitation	
Covid-19 mortalities	Deaths of elderly and vulnerable populations due to past or future Covid-19 infection	• End-of-life, geriatric care • Long-term care	
Financial exposure and health benefits	• Increased price sensitivity due to job loss • Benefit design and coverage changes for employees of businesses impacted by pandemic, including small businesses, entertainment, travel, commercial real estate and retail	• Elective care • Spine • Bariatrics • Specialty pharmaceuticals	

Impact to annual service line volume +/-3% +/-0.3%

FOR MORE INFORMATION

See our **Market Scenario Planner** tool on advisory.com.

10

A new equilibrium for the health care industry will emerge in the coming years—but the window of opportunity to shape that future will be brief.

On the surface, the U.S. health care industry appears to have weathered the pandemic reasonably well. But a deeper look reveals significant turmoil below the surface—and the possibility of further disruption on the horizon. These shifts are setting the stage for major structural change, the implications of which are likely to be far more permanent and far-reaching than the immediate impact of the pandemic.

But not everyone has recognized the significance of the present moment. Most health care leaders have embraced one of two common mentalities (Figure 10.1). The concept of "the new normal" was particularly salient in early 2020, when there was a sense that considerable change was already underway. As the months wore on, more leaders have come to embrace the concept of "the recovery period," with the ambition of helping guide their organizations' return to the pre-pandemic status quo.

We believe both these frameworks fall short of capturing the critical nature of the coming months. Leaders today face a number of strategic decisions that will determine what the future landscape will look like: How should we pay for virtual care? Should we speed up—or slow down—the transition to value-based payment? How do we move the dial on health equity? The question leaders should be asking themselves is not how to adapt to a predestined new normal or revert to a pre-pandemic norm, but how to actively shape the future to their preference.

Advisory Board has identified six points of inflection that are of unique significance in the peri-pandemic era (Figure 10.2). The future of each of these remains an open question at the time of this writing. But the window of opportunity to influence these issues will be time-limited, and decisions made in the coming months will have implications that cut across multiple sectors of the industry for years to come. The remainder of this briefing will explore each of these six inflection points in turn.

FIGURE 10.1: **BEWARE THESE PHRASES**

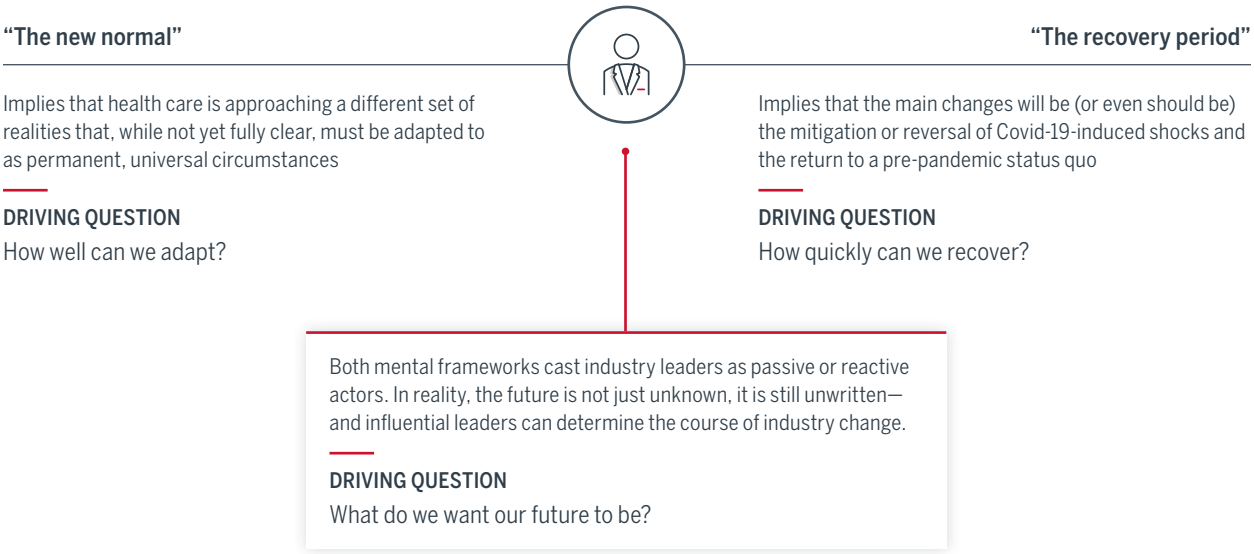
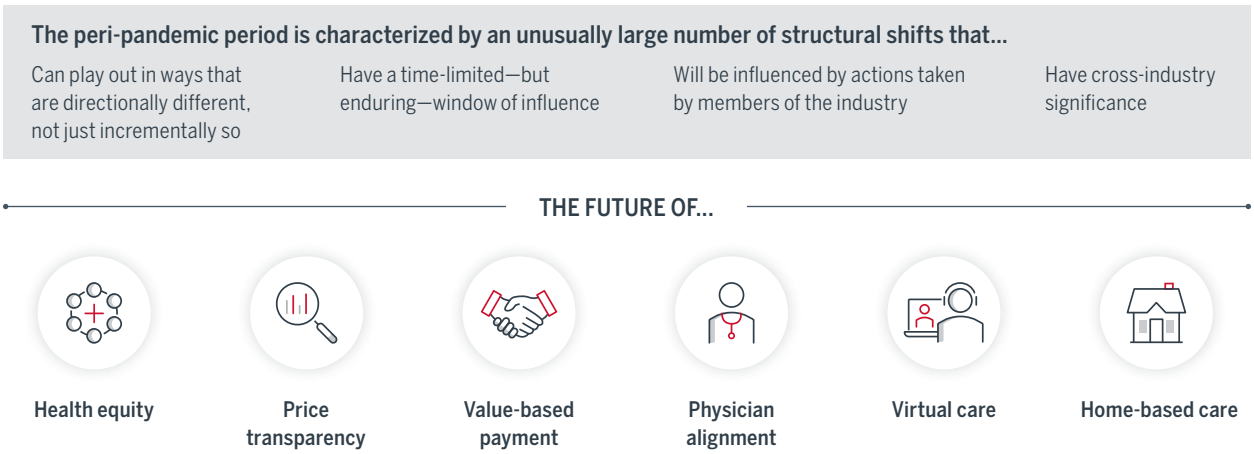


FIGURE 10.2: **THE POINTS OF INFLECTION ARE ALREADY KNOWN**



11

Health equity is an increasingly common mission imperative, but the industry will make more meaningful progress if leaders can solidify it as a business imperative.

While reducing health disparities was a growing area of focus before Covid-19, the past year has ensured that no health care leader can afford to ignore this critical issue.

Executives have an outsized role in driving change. While there may be value in hiring dedicated equity leaders, some responsibilities cannot be delegated. In particular, CEOs and other senior executives are responsible for establishing clear frameworks for accountability, ensuring that talent management processes are redesigned, creating—and communicating—a clear framework for justifying decisions and making trade-offs where necessary, and modeling a commitment to equity through actions that signal their personal dedication (Figure 11.1).

Leaders must also determine equity's positioning as an organizational goal. At a minimum, equity should be a clear mission imperative for any health care organization. This ensures continued investments and progress. Some leaders may choose to go beyond this by solidifying health equity as a business imperative—that is, an ambition with clear, measurable targets that hold real financial consequence for the organization, its leaders, and its employees (Figure 11.2).

In many ways, health equity is emblematic of the broad challenges and opportunities facing health care leaders today. While no single leader or organization will make or break the industry's progress on this issue, the collective actions of individual leaders in the coming months will determine our trajectory on this issue for years to come.

FIGURE 11.1: **EXECUTIVES HAVE OUTSIZED ROLES AND RESPONSIBILITIES**

Common pitfalls—and how to overcome them

Over-delegating responsibility

Position health equity as an executive and organizational priority by dedicating staffing, resources, time, and data to ensure progress.

Lack of accountability

Apply an equity lens to the performance goals, behavioral expectations, and decision-making processes of all staff and leaders.

Myopic view of DEI

Redesign talent management processes to center underrepresented groups and create an environment where all team members feel included.

Fear of failure

Be ready to justify difficult choices that your peers might not immediately favor. Clarify what trade-offs you are willing to make, then get other leaders on board.

Toothless commitments

Go beyond proclamations and commit to a life-long, personal journey that allows you to lead a truly equitable organization.

FIGURE 11.2: **HEALTH CARE LEADERS WILL SET THE COURSE FOR HEALTH EQUITY**

SCENARIO 1

Solely mission imperative

Leaders continue to make investments in health equity, but efforts remain largely programmatic and pilot-based. Efforts are also siloed across the industry due to a lack of clear financial incentives encouraging specific behaviors.

Possible if:

- Leaders continue fund programmatic or pilot-based efforts
- Health equity is delegated down from the CEO level
- Federal government does not tie reimbursement to equity

SCENARIO 2

Emerging business imperative

Clear incentives cement health equity as a strategic imperative, with clear negative financial consequences enforced by the government, the market, or organization boards for falling short of industry-wide health equity goals.

Possible if:

- Executives maintain focus on DEI, collaborate to set clear roles for each sector, and dedicate adequate resources to the effort
- Leaders usher in a new wave of equity-focused policies and incentives that align the moral case with the business case

FOR MORE INFORMATION

See our research report **The CEO's Role in Advancing Health Equity** on advisory.com.

12

How providers and plans respond to new price transparency requirements will determine whether these policies reinforce existing market structures or break them.

As with health equity, increasing price transparency has been a policy goal for years. But only recently have we seen those aspirations manifest into national action. Between new hospital transparency requirements, recently released surprise billing regulations, and impending health plan requirements for 2022, the market will soon be inundated with an unprecedented level of pricing information (Figure 12.1).

While all this activity is driving renewed conversation about consumerism, our perspective is that the more important implications of transparency are likely at the wholesale level. Employers, in particular, are eager for more transparency. This new influx of information could enable them to accelerate their steerage ambitions, especially as third-party vendors will be ready to develop solutions to make this information more accessible for smaller, more resource-strapped employers.

This information will also be of interest to plans and providers themselves, who will largely be motivated to use transparency to reinforce existing pricing structures. Because transparency does very little to change the balance of power within any given market, dominant providers or plans could use this information to identify outliers in their pricing structures and bring those outliers closer to their typical standards.

The feasibility of both of these scenarios depends on the usability of the data. Will enough organizations comply to paint a complete picture? Will the information be published in a standardized way? The government will have an important role to play in compliance, but the answers to these questions also rest with providers and plans themselves. The collective actions of those three stakeholders will ultimately determine whether the current push toward price transparency upends the market—or makes little mark (Figure 12.2).

FIGURE 12.1: **NEW TRANSPARENCY LAWS AIM TO GREASE MARKET'S WHEELS**

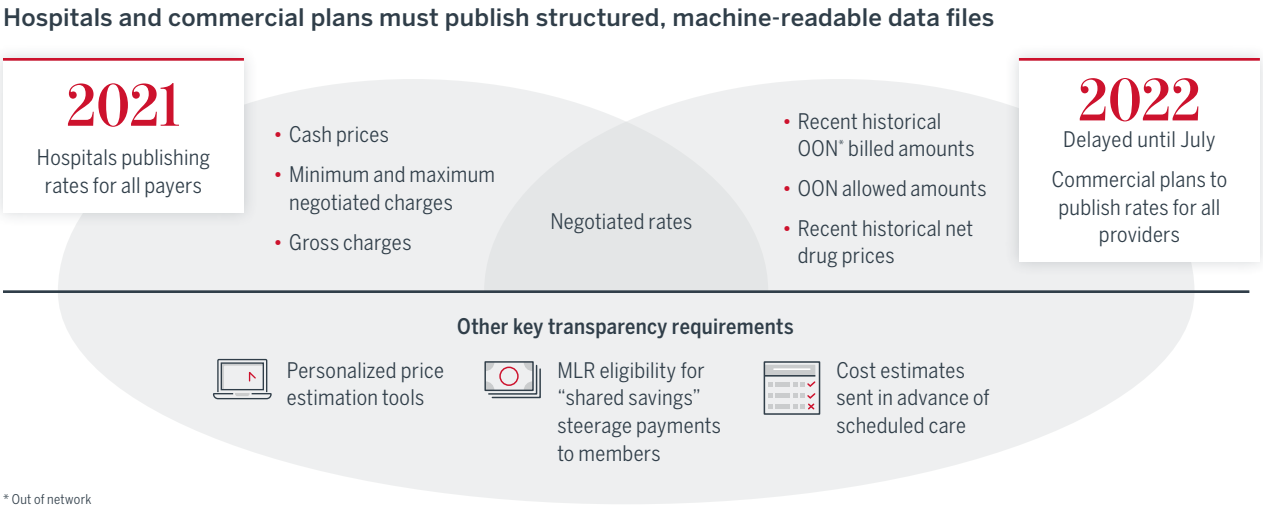
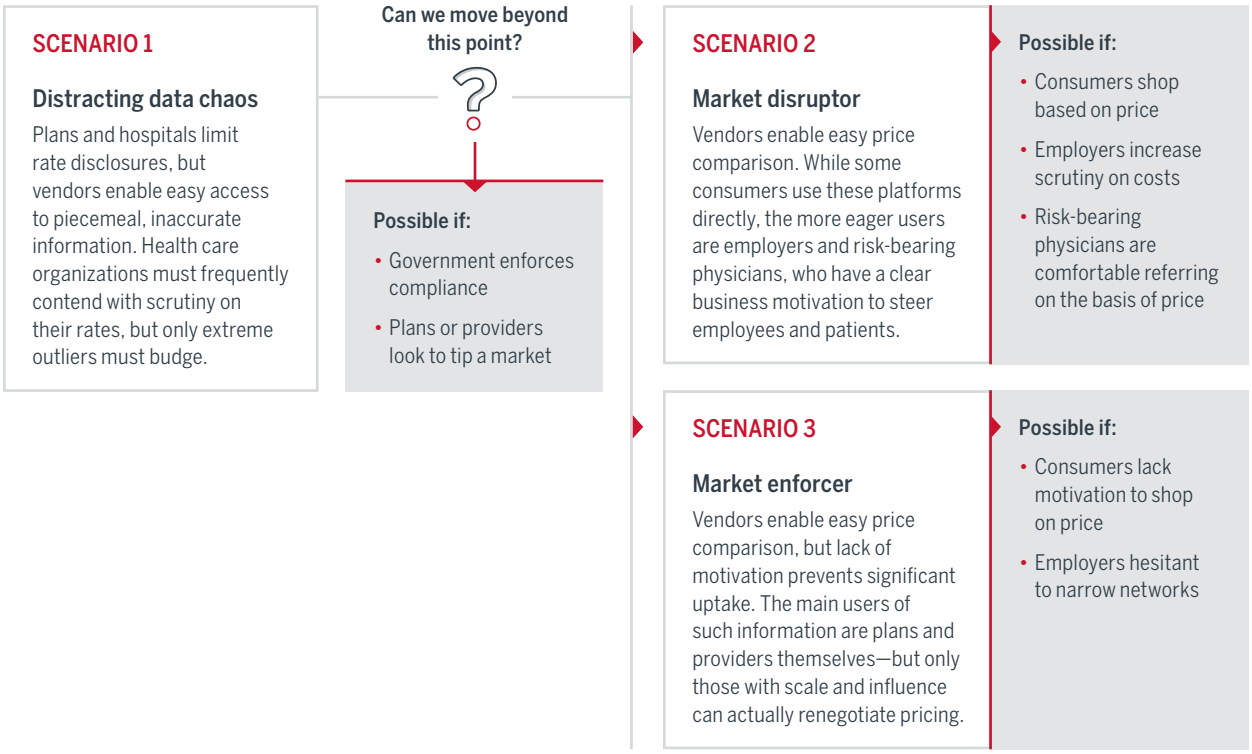


FIGURE 12.2: **TRANSPARENCY COULD UPEND MARKET—OR MAKE LITTLE MARK**



13

Despite renewed and widespread interest in value-based payment, uptake is more likely among physicians than other provider groups such as health systems.

While transparency could theoretically tip the industry toward a more competitive, price-driven reality, the pandemic has also reinvigorated interest in a very different vision for the future—one which relies heavily on the benefits of integration. Risk-based payment and value-based care received considerable attention in the early days of the Covid-19 crisis. As providers cancelled procedures and shut down services, the industry experienced firsthand the major downside of fee-for-service reimbursement.

For those who were already believers in value-based payment, this was a moment of vindication. But support was not universal. Some providers expressed significant reservations about pursuing additional financial risk amid so much uncertainty. An Advisory Board survey of health system planners conducted in May of 2020 clearly showed these two extremes (Figure 13.1).

As the months went by, industry views have shifted in two ways. By February 2021, attitudes had moderated. There was a reduction in the number of providers on both extremes. But overall interest in risk-based payment grew. Nearly three-quarters of providers said they were at least somewhat likely to accelerate adoption of value-based payment models moving forward.

Whether that interest has translated into adoption has been difficult to pin down. While tracking of value-based payments slowed amid the crisis, early evidence suggests that adoption rates may have decreased slightly. For example, participation in the Medicare Shared Savings Program declined in 2021.[23] On the other hand, private plans have continued to advance their value-based programs. In particular, commercial payers have doubled down on efforts to transition independent physician groups to risk-bearing models. Several plans, such as BCBS of North Carolina and BCBS of Massachusetts, offered groups advanced payments to help protect against revenue losses, in return for those groups' participation in their risk-based payment programs.

By contrast, risk contracting between plans and hospitals does not appear to have accelerated during the pandemic. Hospitals and plans continue to struggle to find mutually beneficial contract terms that deliver the necessary revenue growth to hospitals, while also providing the necessary cost savings for the

23) "2021 Shared Savings Program Fast Facts," CMS, January 2021.

plan. The pandemic has done little to shift those long-standing barriers.

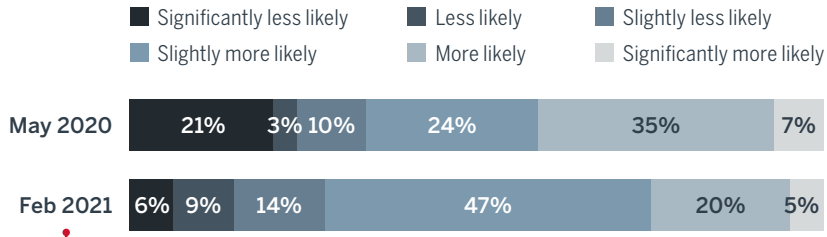
We believe it's not a question of whether risk-based payments will continue to grow—it's a question of who will participate in those contracts. Will activity increasingly shift toward, or even be limited to, the physician sector? Or will hospitals and other providers have a seat at the table as well? (Figure 13.2)

FIGURE 13.1: **AS UNCERTAINTY WANES, ATTITUDES TOWARD RISK MODERATING**

Advisory Board strategic planning survey

n=81 provider organizations

How likely is your organization to accelerate adoption of risk-based payment models?



Compared to early phases of pandemic, an increased number of providers today say they are likely to accelerate adopt of risk-based payment models

FIGURE 13.2: **THE RISK PARTY CONTINUES—BUT WHO'S INVITED?**

SCENARIO 1

New reimbursement standard

Both public and private payers funnel most of their payments through true (downside) risk models. Payments are made to both physicians and hospitals across a wide range of specialties. Most patient care is reimbursed under value-based payment models.

Possible if:

- Federal government mandates risk-based payment at scale
- Health systems and plans can strategically align (that is, pick preferred partners) to overcome core incentive alignment problem

SCENARIO 2

Next-generation physician compensation

Risk-based contracting continues but is primarily focused on physician practices (particularly primary care and multispecialty groups), plus a small number of health systems. Health plans deepen their relationships with physicians as a result.

Possible if:

- Federal government continues to rely primarily on voluntary models OR doubles down on physician-led models
- Plans choose to use risk as a carrot reserved for strategically aligned physicians

FOR MORE INFORMATION

See more results from our **2021 Strategic Planner Survey Results** on advisory.com.

14

Whether physicians continue to migrate to health systems or instead align with alternate partners will depend on which suitors can look beyond the binary choice of employment or independence.

Plans' efforts to transition physician groups to risk-bearing models points to a larger shift in the health care ecosystem: growing interest from a wide range of stakeholders in solidifying their alignment with physicians.

For many years, hospitals have been viewed as the partner of choice for physicians seeking an alternative to traditional private practice. The percentage of physicians employed by hospitals has grown steadily over time, from about 20% in 2012 to nearly 30% by 2020.[24] But there are signs that interest in hospital employment may be plateauing. A 2021 survey of final-year medical residents showed no increase in the proportion of respondents ranking hospital employment as their practice setting of choice (Figure 14.1).[25]

Some of this is likely due to specific concerns around the pandemic itself—residents may be wary of working for the organizations on the front lines of Covid-19. But our research has also revealed a growing perception among physicians that hospital employment requires significant sacrifices in autonomy. And as physicians become more interested in embracing value-based payment arrangements, some have expressed that hospitals may not be the most natural partners in that transition.

At the same time, a growing number of other stakeholders have begun to align more closely with physicians, whether through outright employment or looser partnership. Health plans, private equity firms, and nationally branded independent groups, coalitions, and service partners are all eager to offer physicians the benefits of scale without the perceived downsides of hospital employment.

We believe the physician landscape is at a critical turning point (Figure 14.2). The next few years will reveal whether physicians continue to gravitate toward hospitals as their primary partners, or whether the market splinters around several competing models. Which direction physicians go will have important implications for the industry as different partners have distinct incentives around reimbursement structure, referral patterns, and physician behavior.

24) Kane C, "Physician Practice Benchmark Survey," American Medical Association, May 2021.
25) "2021 Survey of Final-year Medical Residents," Merritt Hawkins, May 2021.

FIGURE 14.1: **INTEREST IN HOSPITAL EMPLOYMENT MAY BE PLATEAUING**

What practice setting are final-year medical residents most open to?

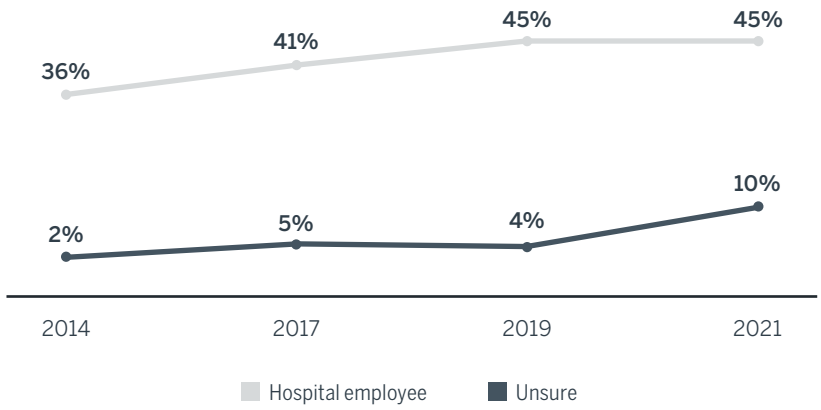


FIGURE 14.2: **AS PHYSICIANS GO, SO GOES THE INDUSTRY**

SCENARIO 1

Hospitals as loci of control

Current trend toward greater hospital employment, ownership, and influence keeps apace while other players operate around the margins, filling in specific care gaps and targeting niche populations. This gives systems the time and resources necessary to stay ahead of new entrants.

Possible if:

- Health systems broaden their physician-alignment toolkit to include more than acquisition
- Hospitals recognize physicians' changing priorities and invest now to ensure future sustainability

SCENARIO 2

Hospitals as commodities

As more physicians join organizations rooted in value, with the incentive structures and assets to be successful, hospitals become increasingly commoditized. Systems will be reduced to their acute care value proposition, competing on unit price and relying on COE programs to capture shrinking volumes.

Possible if:

- Hospitals are unable to recover from the damage that the trauma of Covid-19 on frontline workers has done to their reputations and their workforces during the pandemic
- Non-hospital partners and employers can demonstrate value for physicians and payers

15

The future of virtual care is not merely a question of how much, but of whom: third parties are working aggressively to chip away at the lead local providers have gained.

The question of who to align with is not the only major decision facing physicians today. With the explosion of virtual care across the past two years, physicians—and clinicians of all types—must also make decisions about how and where to practice medicine.

The increase in telehealth utilization across 2020 and into 2021 has been widely documented.[26] What received less attention is who actually delivered most of that care. Despite the explosive growth of large telehealth vendors in the past year, the vast majority of virtual care patients actually report receiving their care from their own local providers (Figure 15.1).[27]

The open question is whether that trend will continue to hold true. Technology vendors are working quickly to expand their service offerings to make them more compelling to consumers and employers. In particular, these companies are trying to address concerns about care fragmentation by moving beyond urgent care services into primary care and chronic disease management, investing in downstream navigation, and aligning more closely with health plans to provide a more seamless benefits experience.

For care to remain with local providers, health systems and physician groups will also need to evolve their models. This will require greater investment in technology and digital experience, along with proactive negotiation with health plans to secure sufficient reimbursement. While providers have been eligible for enhanced telehealth reimbursement amid the Public Health Emergency, there is no guarantee that reimbursement will remain high.

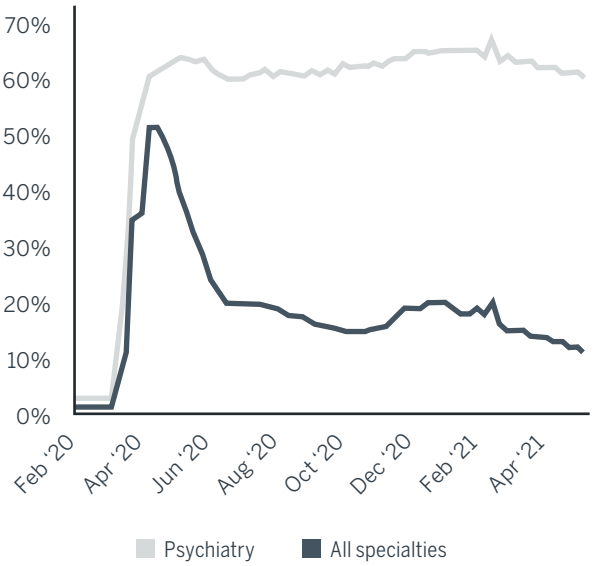
Which direction the market tips will ultimately determine telehealth's ubiquity. Should the majority of virtual care remain with local providers, telehealth is poised to become widely used by both patients and providers. On the other hand, if the market tilts more heavily toward third-party technology vendors, virtual care is likely to become much more specialized—a service that is heavily used by a smaller number of physicians and patients for the majority of their care delivery needs (Figure 15.2).

26) "Telehealth Adoption Tracker," The Chartis Group, January 2021.
27) "Telehealth impact: Patient survey analysis," Covid-19 Healthcare Coalition, April 2021.

FIGURE 15.1: **SO FAR, INCUMBENTS SHOULDER MAJORITY OF TELEHEALTH SURGE**

Telehealth visits as percentage of total visits*

Chartis Telehealth Adoption Tracker



* April peak in telehealth visits is due to both higher telehealth volumes and a lower number of in-person visits.

Virtual care patients who received care from...

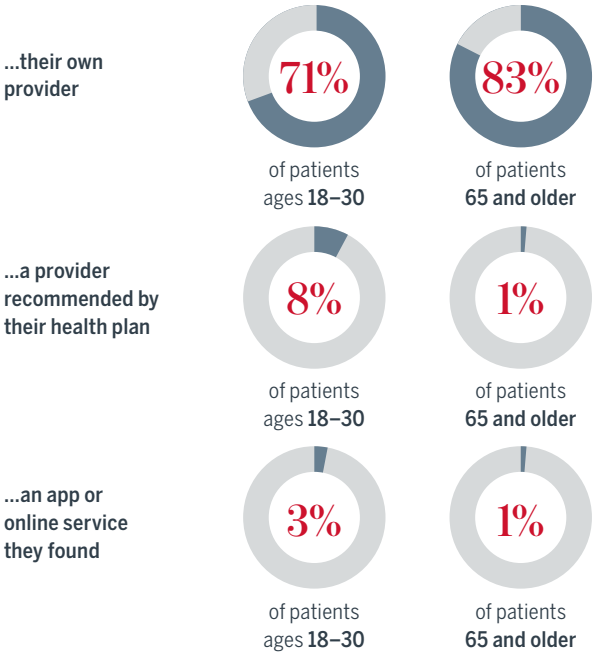


FIGURE 15.2: **WILL TELEHEALTH BE A UNIVERSAL SKILL OR A NEW SPECIALTY?**

SCENARIO 1

Universal care standard

Telehealth is used widely by both patients and physicians as a complement to in-person care. Virtual care is used as a means to maintain and reinforce existing relationships and referral patterns.

Possible if:

- Local providers and plans can make the necessary compromises to maintain reimbursement near parity
- Local providers invest in digital experience and use virtual care to improve physician workflows

SCENARIO 2

Niche market

Telehealth is used heavily by patient segments targeted by third-party vendors, who focus primarily on selling to self-funded employers. Existing relationships and referral patterns are disrupted.

Possible if:

- Third parties expand beyond acute care services to meet employer and consumer demand for more integrated solutions
- Plans opt to align with third parties, either through benefit design/reimbursement or acquisition

16

Unless leaders can balance speed-to-market with intentionality, the burgeoning home-based care market will exacerbate existing fragmentation, labor, and equity challenges.

The explosion in virtual care is only one manifestation of a broader shift to home-based care that has accelerated as a result of the pandemic. Stakeholders from across the health care industry (including providers, plans, and tech firms) have invested heavily in home-based care (Figure 16.1).

This wave of investment does not necessarily point toward long-term, systemic change. Much of the activity occurring today centers around one-time start-up investments or grants, which are inherently short-term in nature. The establishment of more permanent funding and reimbursement streams will be a critical first step if home-based care is to become a long-standing feature of the industry.

Should the industry successfully secure sustainable funding, the potential for home-based care is clear. Patients have an obvious and growing preference for care in the home, and early pilots have emphasized the potential for both quality and cost gains. But achieving these benefits is far from a given.

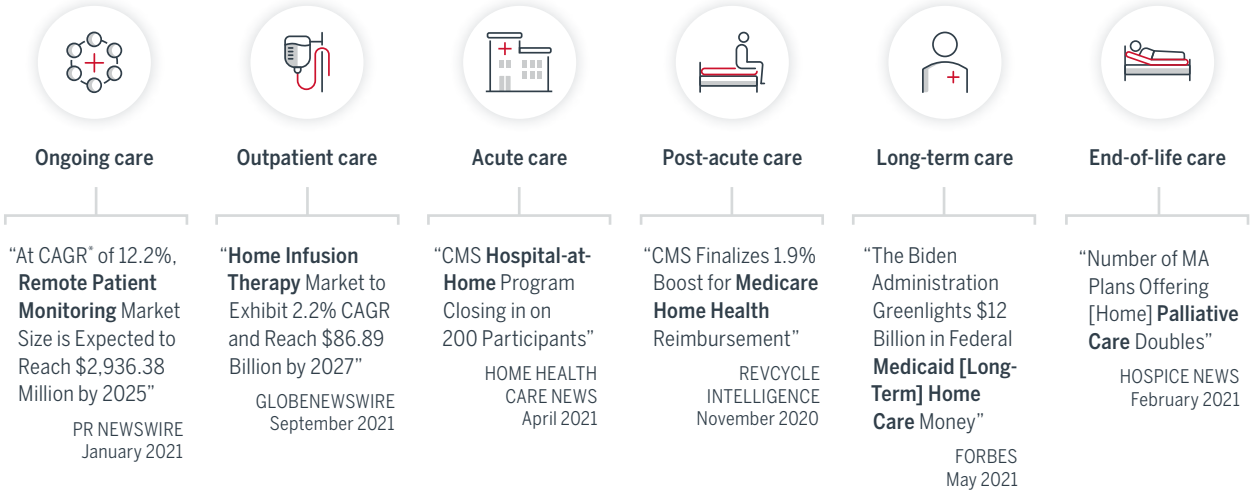
The current rush to secure share has put the industry at risk of not only falling short of the potential benefits, but actually exacerbating existing challenges across the industry. In particular, we have identified three potential unintended ripple effects of the rush toward home-based care:

1. **Exacerbations in care fragmentation:** The health care industry is hardly known for enabling a seamless patient experience. Adding millions of patients' homes as a care delivery setting will be logistically difficult and could lead to further deterioration in care continuity.
2. **Strains in staffing supply:** Like many other industries, health care is experiencing significant levels of workforce burnout and shortage. The logistical complexities of home-based care (e.g., needing to drive to patients' homes) could further strain already-limited workforce supply.
3. **Worsening health inequities:** Historically, home-based services have primarily catered to the wealthy—those who could afford to pay out-of-pocket for services such as live-in caretaking. Beyond the cost of the service itself, research has suggested that the average home-based care patient spends thousands of dollars on home renovations, technologies, and other "enabling" tools. Without the appropriate reimbursement structures, home-based care could serve to exacerbate inequities in access and care quality that already exist today.

Whether home-based care is a benefit—or a hindrance—to the industry will depend on the collective action of all of stakeholders who are investing in these services today. For example, close alignment between home care providers and payers will be necessary for ensuring that reimbursement structures promote access to all patient populations, not merely the

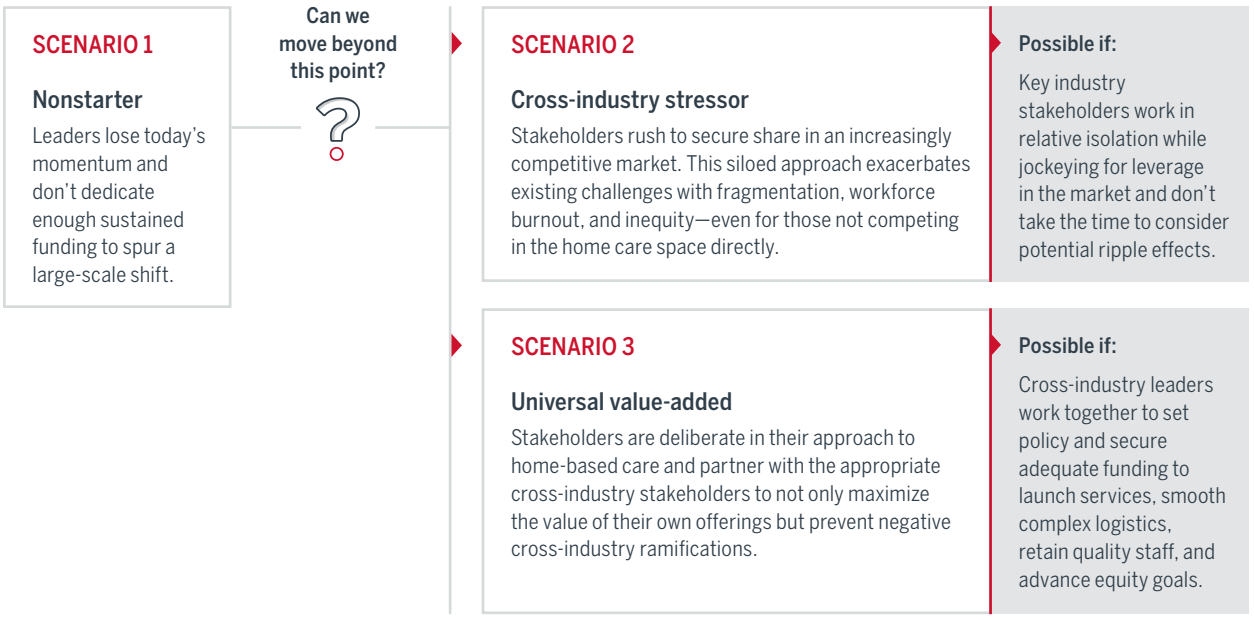
wealthy. Technology vendors and providers should collaborate to ensure that programs are developed for rural populations in addition to urban markets. Only through stronger cross-industry partnerships will home-based care achieve its true potential (Figure 16.2).

FIGURE 16.1: **INTEREST AND INVESTMENT IN HOME-BASED CARE SPANS THE CARE CONTINUUM**



* Compound annual growth rate.

FIGURE 16.2: **HOME-BASED CARE COULD BE A STRESSOR, SALVE, OR NONSTARTER**



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