The State of Healthcare 2023

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UNION
HEALTHCARE INSIGHT

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Section 1

Our research methodology

At Union Healthcare Insight, we recognize how challenging it is to separate the signal from the noise in healthcare—and to move from information to insight to action.

We've developed a methodology to address this challenge head on.

Each year, we begin by first identifying meaningful (if granular) signals: data points, dates, and developments. From that curated set of signals, we're able to distill a smaller set of core messages or insights about the state of the industry. And from those insights, we converge on a feasible number of action steps for senior executives to prioritize in any given year (fig. 1).

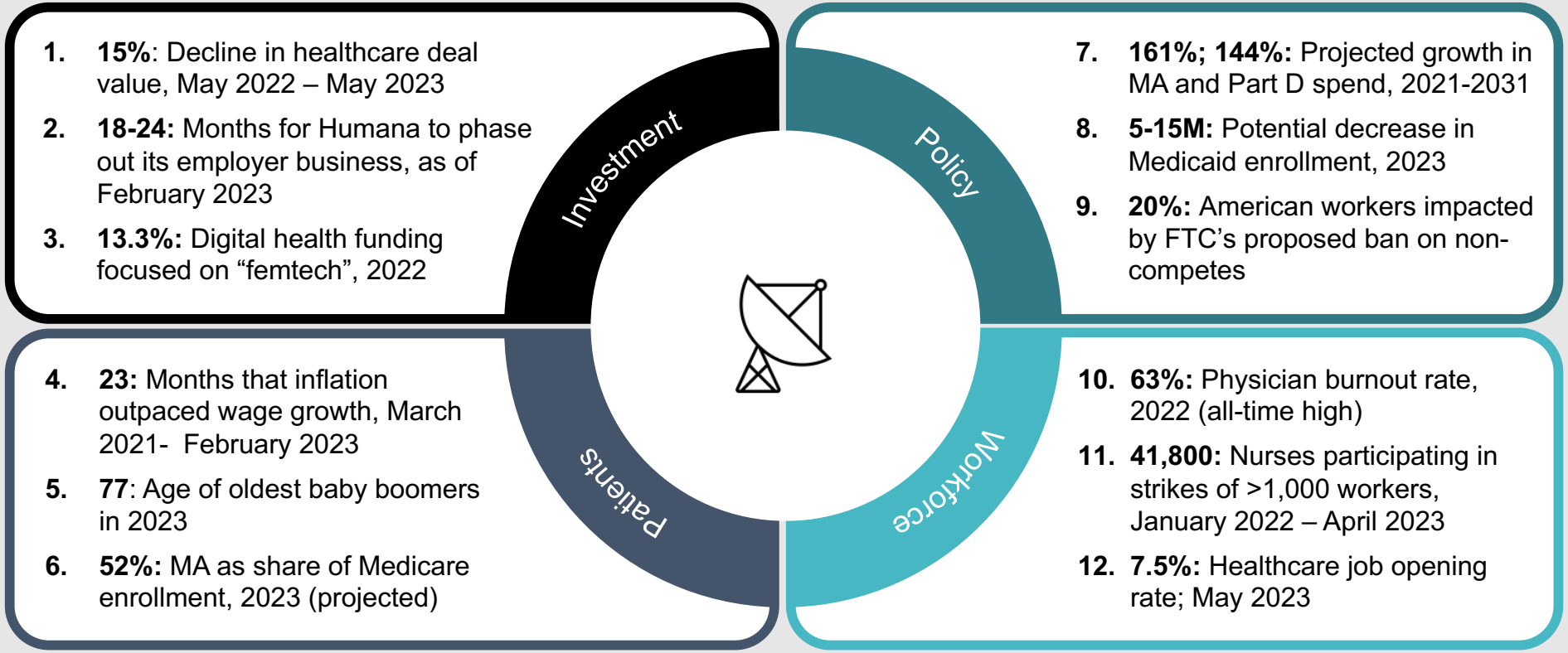
This report will cover each of those critical layers in turn, to provide leaders with a clear sense of what they need to know to set strategy in 2023.

Fig. 1: Union Healthcare Insight's State of Healthcare research methodology

Section 2

12 market signals we’re watching in 2023

Fig. 2: 12 market signals we're watching in 2023



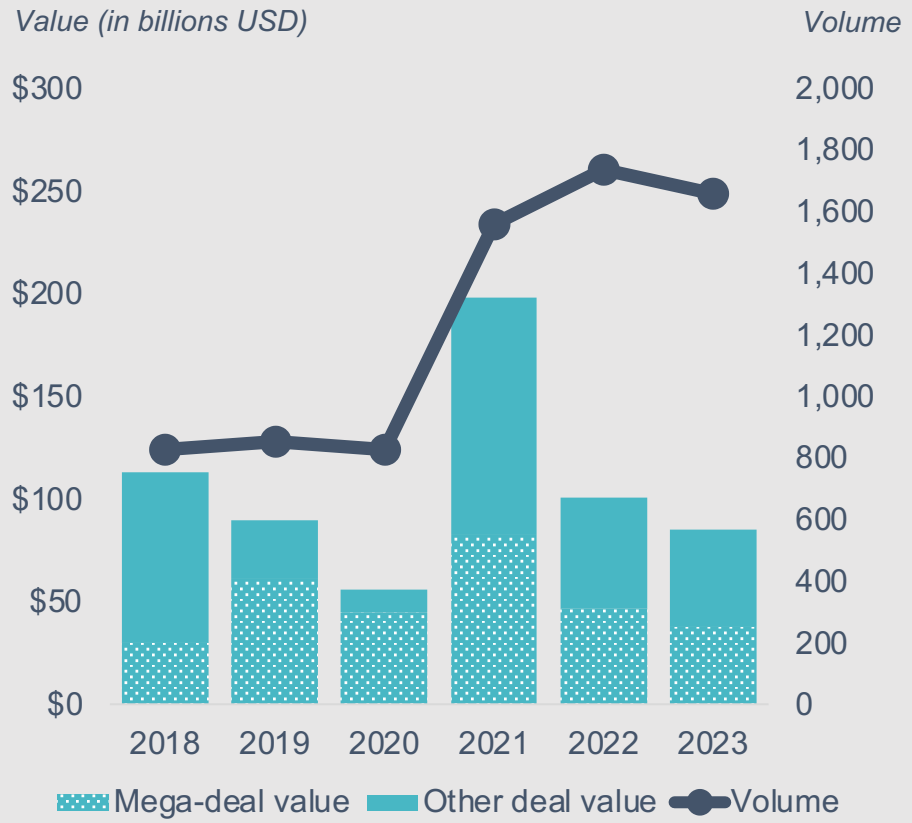
Signal #1 | 15%: Decline in healthcare deal value, May 2022 – May 2023

From 2022 to 2023 has been a record-breaking time for healthcare investment: deal volume hit an all-time high in 2022, with over 2,200 transactions by mid-November alone. This is well above what was previously an all-time high of 1,996 deals across the entirety of 2021 (fig 3). Overall deal volume numbers, however, obscure what is in reality more of a mixed bag for the current healthcare investment landscape, especially when considering recent headline-making news such as the collapse of Silicon Valley Bank, the bankruptcy filing by digital therapeutics pioneer Pear Therapeutics, and early 2023 numbers which suggest that deal volume has begun to decline precipitously.

Digging down into trends at the sub-sector level provides a more telling story (fig. 4, page 7). Medical groups, long-term care, and diagnostics drove the *entirety* of the recent spike in deal volume, with medical groups far and away the leader. But volume has been down across all other sub-sectors, and deal *value* is also down nearly everywhere. Those few areas seeing valution increases are being driven by a handful of major acquisitions. In sum: a small number of deals and sub-sectors are skewing the overall picture.

Taken together, these trends point to an ongoing shift in the investment landscape: favor is tilting away from the novelty-promising start-ups that exploded in the early days of the pandemic and toward large, established players who are now picking up smaller companies. This proliferation of value deals is logical given the larger economic headwinds in the U.S., which are prompting smaller companies to sell and curtailing mega-deals, which have become more costly due to interest rate hikes. That said, large companies can still use equity and cash on hand to acquire smaller targets.

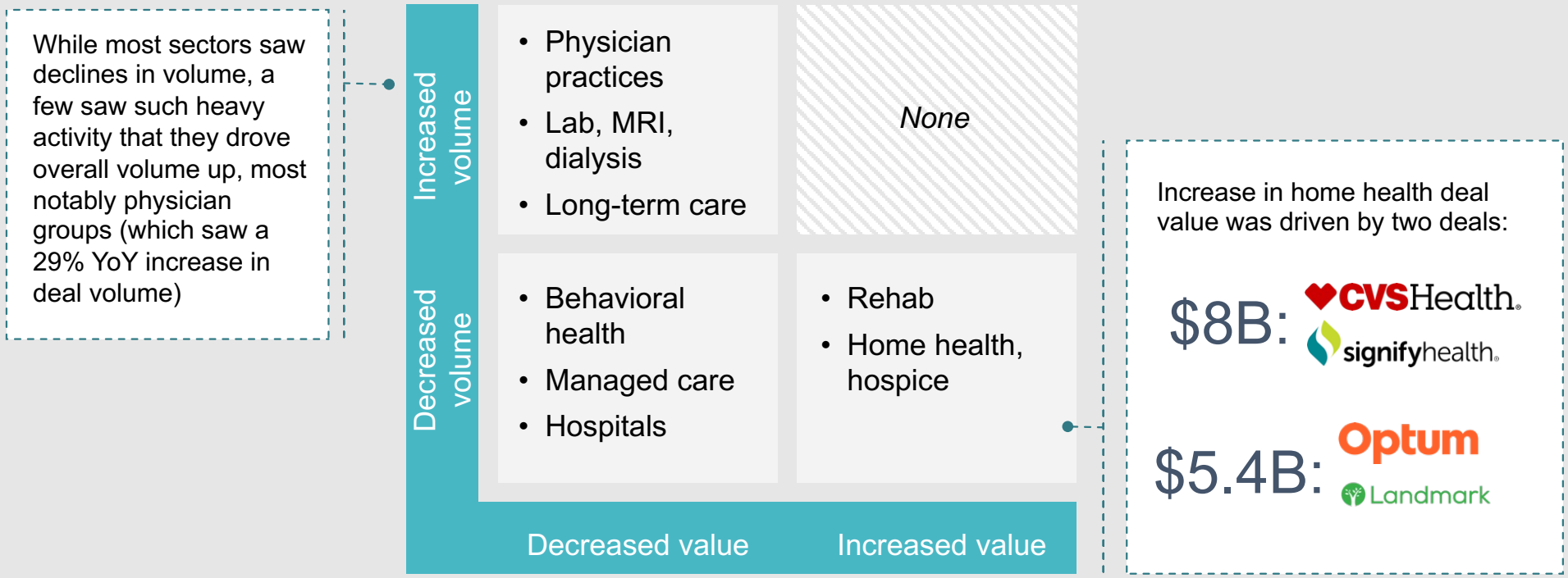
Fig. 3: Healthcare services deal value and volume, Jan. 2018 – May 2023[1]



1. Mega-deals are valued at $5B or more; 2023 numbers encompass the period from May 15, 2022 – May 15, 2023.

Source: Health services: PWC, US Deals 2023 Outlook; Health services: US Deals 2023 midyear outlook.

Fig. 4: Healthcare services by YoY change in deal volume and value, January 2021 – November 2022



Source: Health services: PWC, US Deals 2023 Outlook.

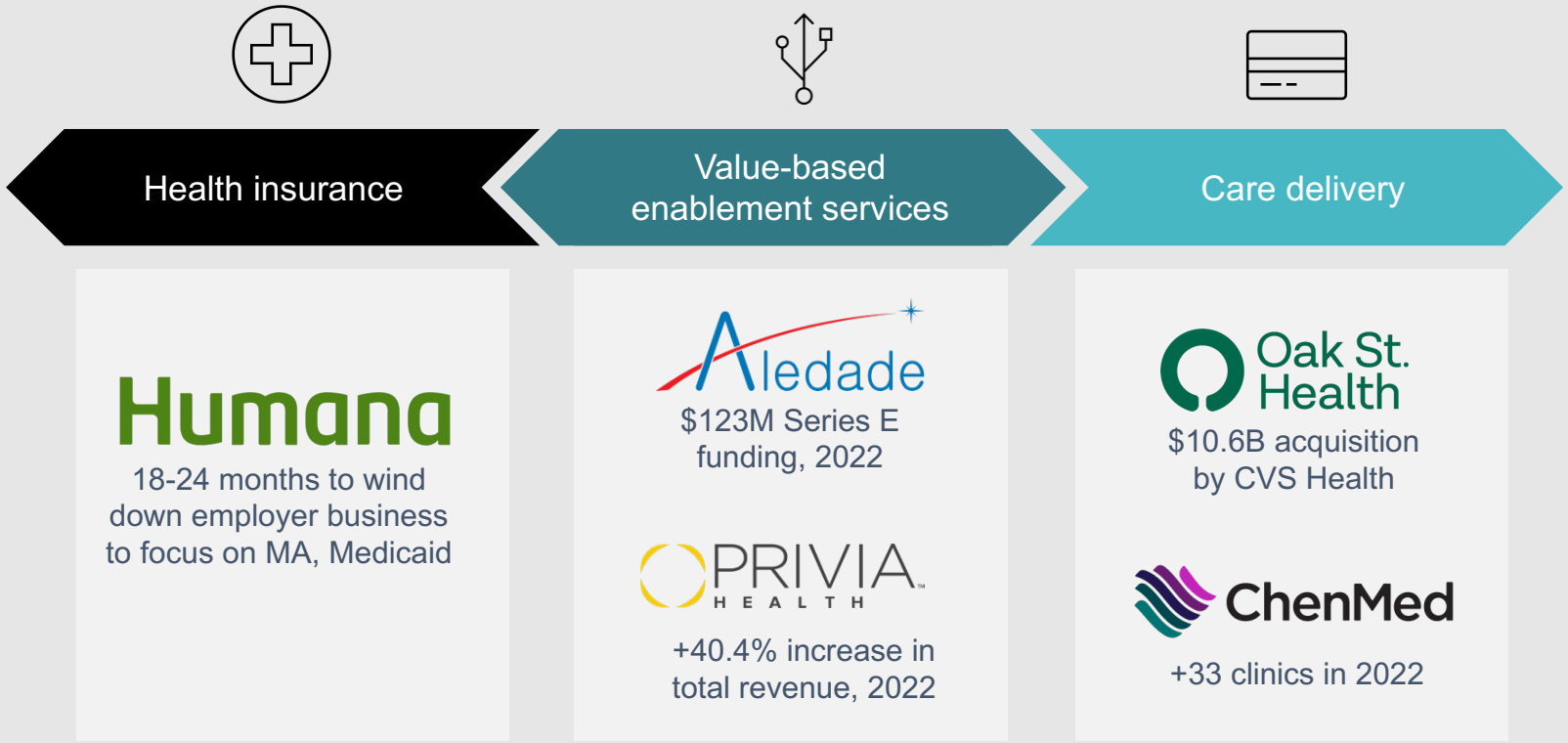
Signal #2 | 18-24: Months for Humana to phase out its employer business, as of February 2023

One of the areas that has defied the recent headwinds in healthcare investment is Medicare Advantage (MA).

This is not to say that there is a proliferation of new MA plans. In fact, many digital-forward start-up MA plans (i.e. "insurtech" players) are struggling to attract enrollment. But established plans are increasingly signaling their intent to double down on MA. There is no clearer signal of this than Humana's announcement in early 2023 that it will wind down its employer business to focus on Medicaid and MA, where the lion's share of its revenue already is today.

MA-focused care delivery organizations such as Oak Street Health and ChenMed have also grown significantly, as have value-based care enablement companies such as Aledade and Privia.

Fig. 5: Selected and notable examples of growing investment in Medicare Advantage



Source: Humana, "Humana to Exit Employer Group Commercial Medical Products Business," February 2023; Aledade, "Aledade Raises $123 Million Series E To Accelerate Growth In Medicare Advantage And Support Primary Care Physicians With Expanded Services," June 2022; Privia Health, "Privia Health Reports Fourth Quarter 2022 Financial Results," February 2023; CVS Health, "CVS Health to acquire Oak Street Health," February 2023; ChenMed, "ChenMed's Record 2022 Expansion Gives Gift of Better Health to Tens of Thousands of Seniors in Previously Underserved Neighborhoods," December 2022.

Signal #3 | 13.3%: Digital health funding focused on "femtech," 2022

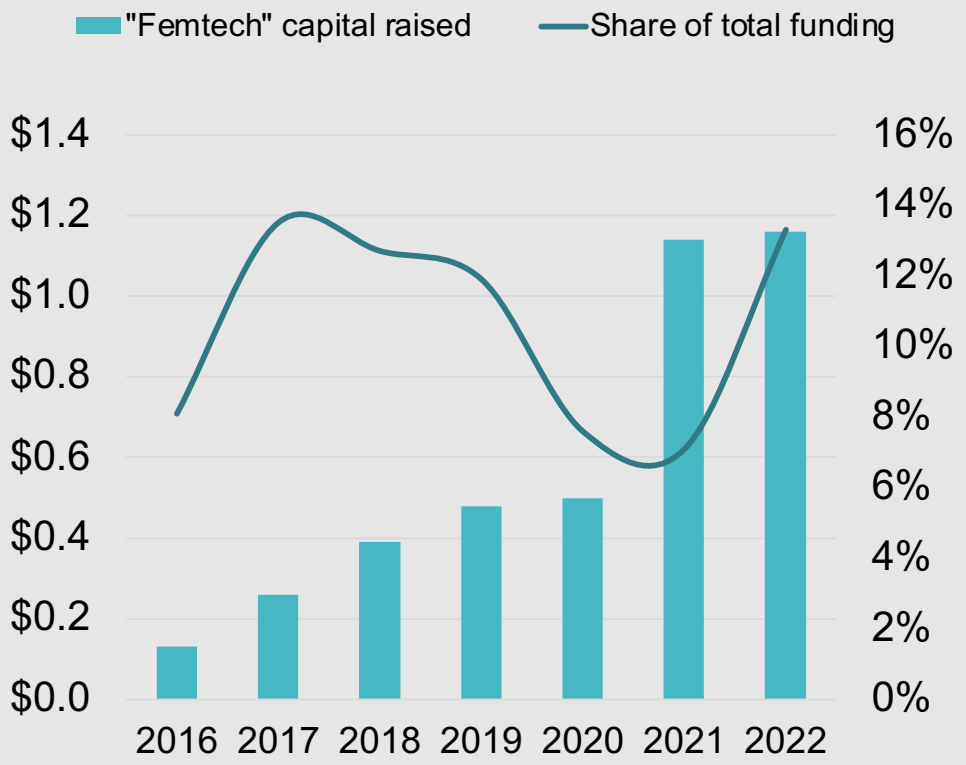
Women's health is also attracting increasing investment (fig. 6). This is true in both absolute terms (more capital raised in 2022 vs. 2021) and relative ones ("femtech" investment outpaced most other areas in 2022, accounting for a larger share of total digital health funding than in previous years).

Investors are responding to several opportunities in the women's health space. Adoption of digital health tools among women lags that of men across multiple dimensions, including wearable ownership, use of video visits, and use of health tracking technology. This has driven the recent proliferation of digital health tools designed for (and in many cases, by) women in an effort to close that gap and capitalize on that business opportunity.

Of course, that divide is far from the only disparity within the women's health space. An emerging and growing body of evidence underscores additional gender disparities; for example, women are currently delaying care at higher rates than men. There are also significant disparities *within* the female population, both by geography (e.g., large state-by-state differences in maternal health outcomes) and by race (e.g., black women die from breast cancer at significantly higher rates than white women).

Amid the growing momentum to address health inequities, investors clearly see women's health as a worthy area to focus their efforts. And this investment could not be more timely: recent data from the CDC suggests that maternal mortality in the U.S. has increased in recent years, spiking nearly 40% between 2020 and 2021 alone.

Fig. 6: Femtech capital raised, in billions of dollars and as a share of total digital health funding



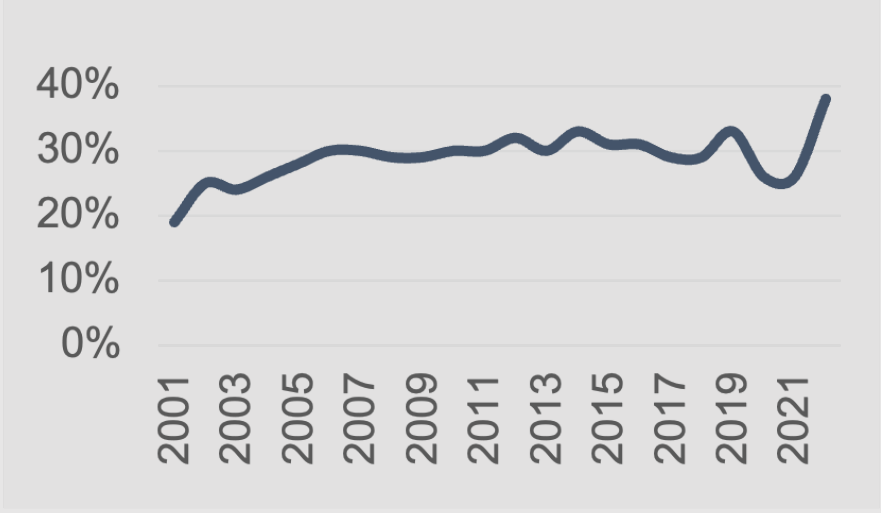
Source: TechCrunch, "Despite 2022's headwinds, women's health startups did better than ever before," January 2023.

Signal #4 | 5 23: Months that inflation outpaced wage growth, March 2021- February 2023

While more women than men are putting off care, delays are up across the board. In fact, 2022 data suggests that cost-related care avoidance may currently be at an all-time high, surpassing even levels seen during the 2008-2009 Global Financial Crisis (fig. 7).

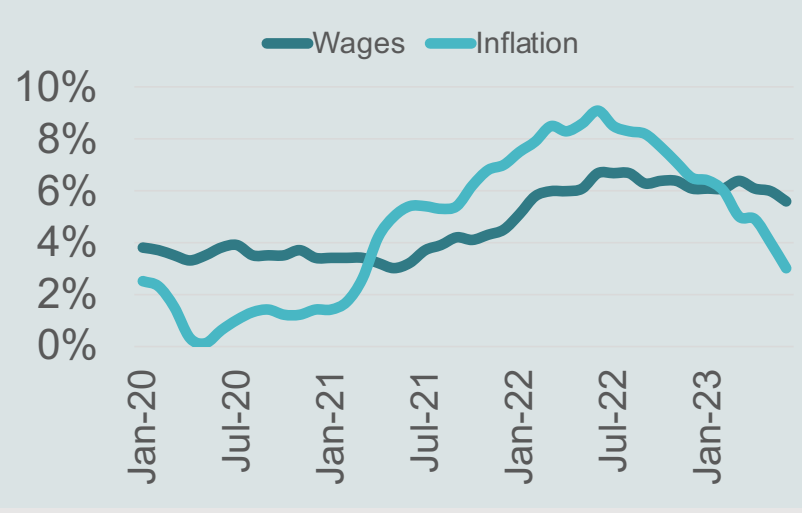
Cost-related care delays are not surprising given broader economic conditions. The rate of inflation exceeded wage growth for most of 2021, the entirety of 2022, and the beginning of 2023 (fig. 8). This gap has been present across nearly all income levels, except for those in the lowest-income quartile. This does not, however, seem to be mitigating care delays within that population segment: in addition to women, lower-income individuals and young adults are currently more likely to report cost-related care avoidance.

Fig. 7: Americans delaying care due to cost



Delays were particularly high among young adults, women, and lower-income individuals

Fig. 8: Wage growth vs. inflation, Jan. '20– June '23



Inflation growth in 2022 represented a 40-year high

Source: Bureau of Labor Statistics; Federal Reserve Bank of Atlanta; US Census Bureau, Gallup, "Record High in U.S. Put Off Medical Care Due to Cost in 2022," January 2023.

Signal #5 | 77: Age of the oldest baby boomers, 2023

In addition to rising levels of care avoidance, the patient population is also experiencing ongoing demographic shifts. Of greatest note for the healthcare industry is the continued aging of the population.

While the general population been getting older (on average), for some time, the Medicare-eligible population has been getting relatively younger as the baby boomers have have turned 65. As a result, the share of the senior population that it is over the age of 85 has been shrinking and is projected to reach a low of 11% in 2025 (fig. 9). By 2030, however, that trend will begin to reverse, as the last of the boomers turn 65. From that point on, the share of the senior population over the age of 85 will begin to increase—a trend that will continue for the next several decades.

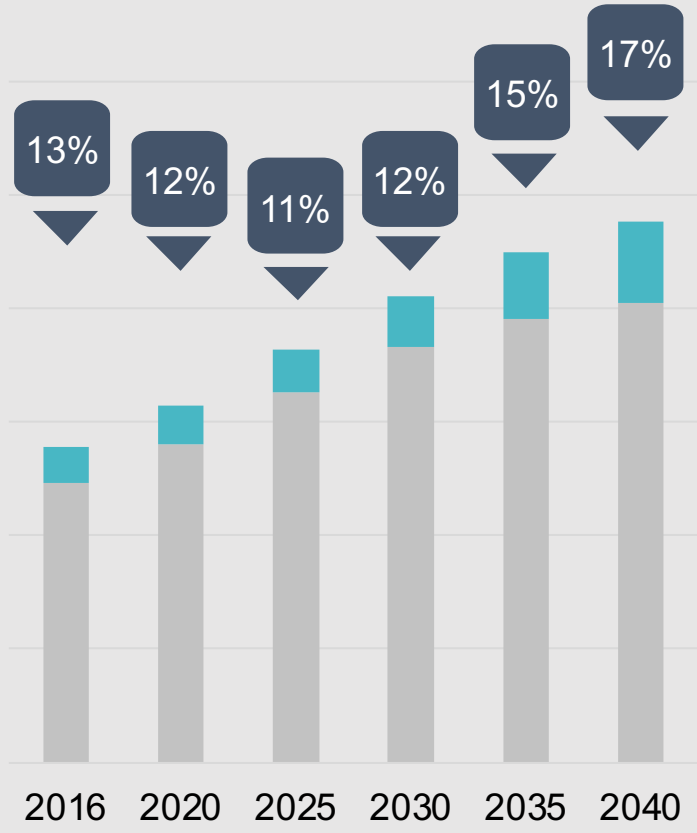
This shift will have important implications for stakeholders across the healthcare industry.

Provider implications. For provider organizations, the impact is three-fold. The shift of boomers away from more highly-reimbursed commercial insurance and into Medicare coverage represents a payment cut. The aging of the boomer population will also prompt a case mix shift away from more profitable procedural and surgical care and toward less profitable medical care. And more of that care is likely to be pushed from the more profitable inpatient setting toward less profitable outpatient settings. This shift will also put further strain on the post-acute and long-term care industries, as utilization of those sites increases among the oldest adults.

Pharmaceutical and life sciences implications. For players on the supply side of the industry, this trend will encourage a continued shift in R&D priorities toward conditions more common among the oldest adults (although policy changes could prove a counterweight here, if price controls on Medicare drugs prompt life sciences companies to limit their R&D efforts on that population).

Plan implications. For plans, the aging of the population represents both an opportunity and a challenge. The aging of the Medicare population itself will cause average enrollee complexity to increase. This represents both increased costs for the plan, but also increased complexity in patient management and navigation. On the other hand, the growing size of the Medicare population presents an opportunity for plans to grow their Medicare Advantage lines of business. And by at least some measures, MA is the most profitable business segment for plans.

Fig. 9: Proportion of the over-65 population that is over the age of 85



Source: U.S. Census Bureau.

Signal #6 | 52%: MA as share of total Medicare enrollment, 2023 (projected)

In 2023, more seniors are expected to choose an MA plan over traditional Medicare for the first time (fig. 10). By 2030, a full 60% of the senior population is expected to enroll in MA.

MA's growing popularity is partially a function of its increasing availability, which is itself a function of increasing investment by plans. The average Medicare-eligible consumer now has multiple MA plan options to select from.

But consumer preference plays a strong role as well. When asked, MA enrollees most frequently cite enhanced benefits such as vision and dental coverage, affordability, and recommendations from trusted sources such as friends or physicians as their main motivators for selecting an MA plan over traditional Medicare (fig. 11).

Fig. 10: Medicare Advantage as share of total Medicare enrollment, actual and projected

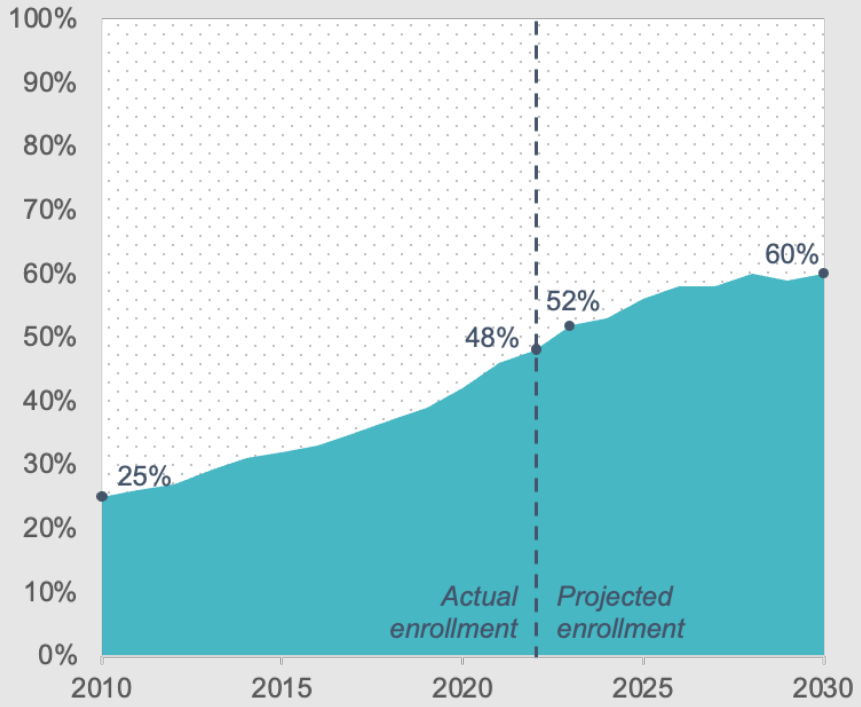
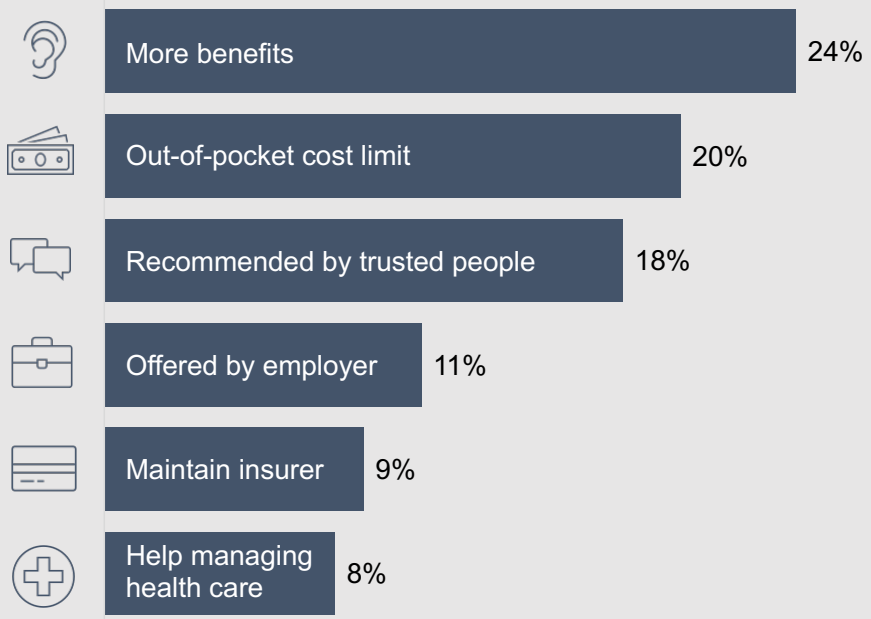


Fig. 11: Main reason people age 65 and older chose Medicare Advantage coverage



Source: Congressional Budget Office; Commonwealth Fund, "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why," October 2022.

Signal #7 | 161%; 144%: Projected growth in MA and Part D spending, 2021-2031

Given MA's growing size, it's hardly surprising that it is attracting increased political scrutiny as well. While spending on Part A and B benefits for traditional Medicare still accounts for the majority of Medicare spending today, spending growth on MA is expected to far outpace that of traditional Medicare moving forward (fig. 12). By 2031, MA will account for a majority of Medicare spending by a significant margin. Spending growth on Part D drugs is also expected to outpace Part A and B spending growth.

It is unsurprising, then, that policy changes intended to control Medicare spending growth increasingly target Medicare Advantage and Part D drugs. In particular, policymakers are focused on ensuring the accuracy of risk scoring efforts within MA, and on introducing pricing controls for Part D drugs.

Fig. 12: Actual spending, projected spending, and major spending control priorities, Medicare parts A-D

Traditional Medicare	**Major 2023 priority:** Bolster participation in alternative payment models given recent trend of flat/declining growth	$416B Spending on Part A and B benefits, 2021	66% Projected increase in spending, 2021-2031	$693B Projected spending, 2031
Medicare Advantage	**Major 2023 priority:** Continue efforts to ensure accuracy of risk scoring and explore future options for constraining spending	$361B Spending on Part A and B benefits, 2021	161% Projected increase in spending, 2021-2031	$943B Projected spending, 2031
Part D Drugs	**Major 2023 priority:** Begin implementation phase of Inflation Reduction Act's drug pricing provisions	$98B Spending on Part D benefits, 2021	144% Projected increase in spending, 2021-2031	$239B Projected spending, 2031

Source: Kaiser Family Foundation, "What to Know about Medicare Spending and Financing," January 2023; Congressional Budget Office, "Medicare Baseline Projections," Mary 2022.

Signal #8 | 5-15M: Potential decrease in Medicaid coverage in 2022

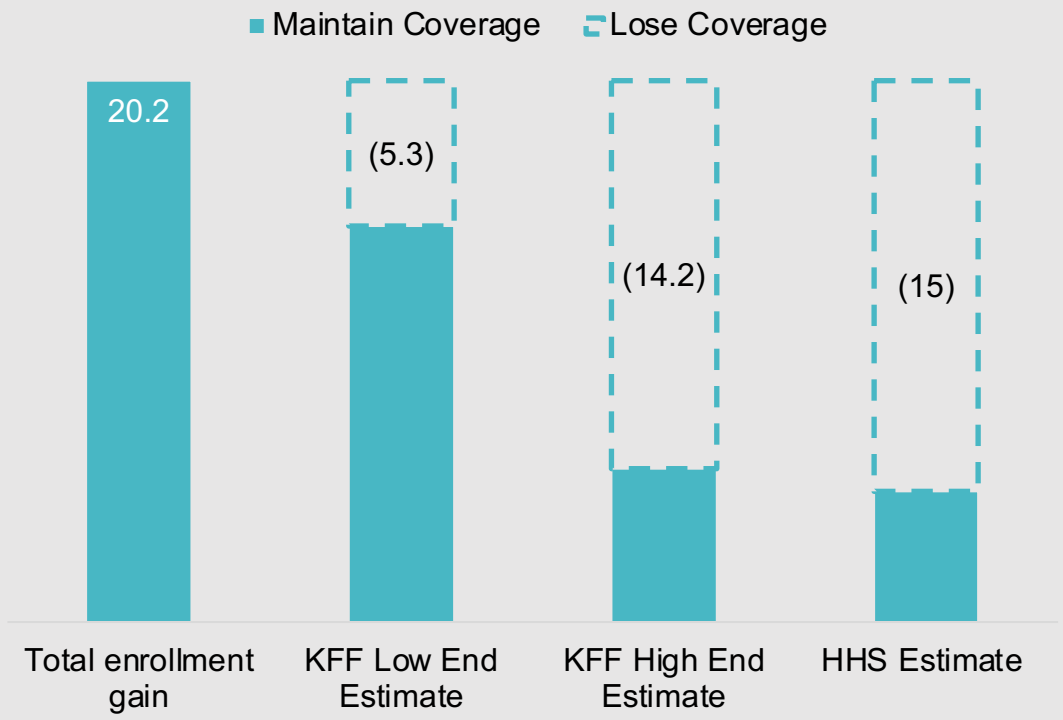
Government spending on healthcare is dependent heavily on enrollment—and enrollment in government-sponsored insurance has swelled amid the pandemic, due largely to a significant increase in Medicaid enrollment. Most of that increase has been attributed to the suspension on Medicaid disenrollment during the Public Health Emergency (PHE). Millions of individuals that would have typically transitioned off Medicaid due to changes in income or circumstance have instead remained enrolled.

However, the 2022 year-end spending bill passed by Congress officially decoupled the suspension on disenrollment from the PHE and redeterminations of Medicaid eligibility began on March 31st. Significant numbers of individuals are expected to lose coverage in the coming months. But estimates range widely, from 5.3 million on the low end to 15 million on the high end. Coverage losses will likely be highly variable by state, who have been given significant leeway in how to handle the redetermination process, and who are navigating this resource-intensive process amid a challenging labor market.

The vast majority of those losing coverage are likely eligible either for re-enrollment in Medicaid or for other forms of subsidized coverage (i.e. employer-sponsored insurance or subsidies on the exchanges). However, past experience suggests that many will instead become uninsured.

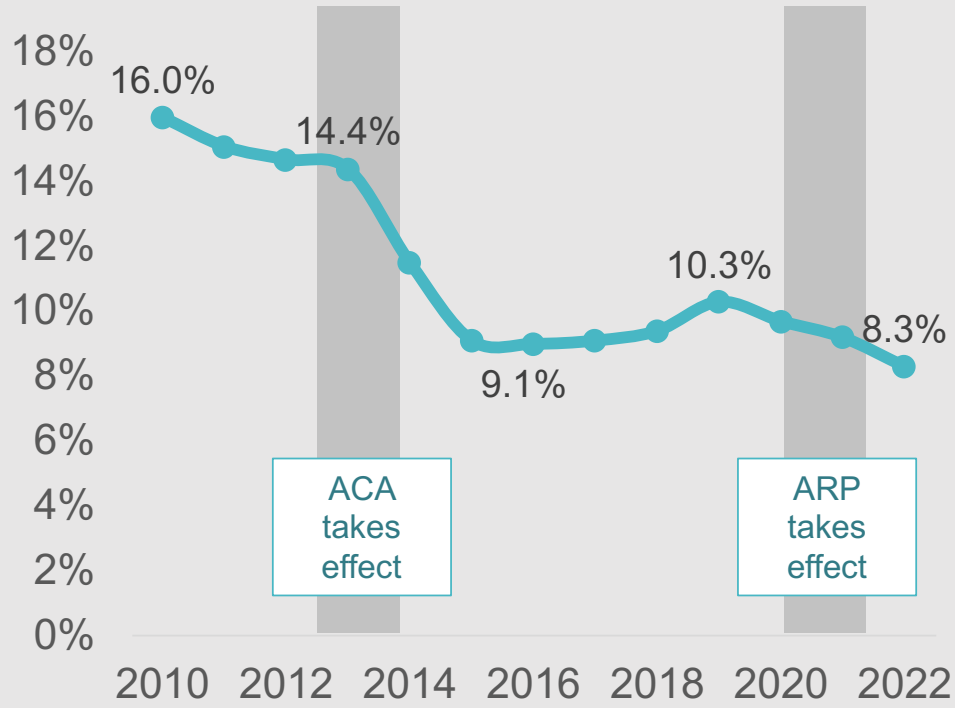
To that end, we expect not only a significant decline in Medicaid coverage, but also a notable decline in the overall insurance rate. The uninsured rate has hit an all-time low amid the pandemic, driven largely by the gains in Medicaid enrollment (fig. 14, page 15). That trend is certain to reverse itself—at least somewhat—this year.

Fig. 13: Estimates of Medicaid coverage losses



Source: Kaiser Family Foundation, "Analysis of Recent National Trends in Medicaid and CHIP Enrollment," February 2023; Kaiser Family Foundation, "Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends," May 2022; Health and Human Services, "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 2022.

Fig. 14: Percent of Americans identifying as uninsured, 2010-2022



5.2M	Net coverage gains, 2020-Q1 2022
2M	Increase in adults buying coverage on exchanges, 2020-Q1 2022
20.2M	Increase in Medicaid enrollment, February 2020 – October 2022

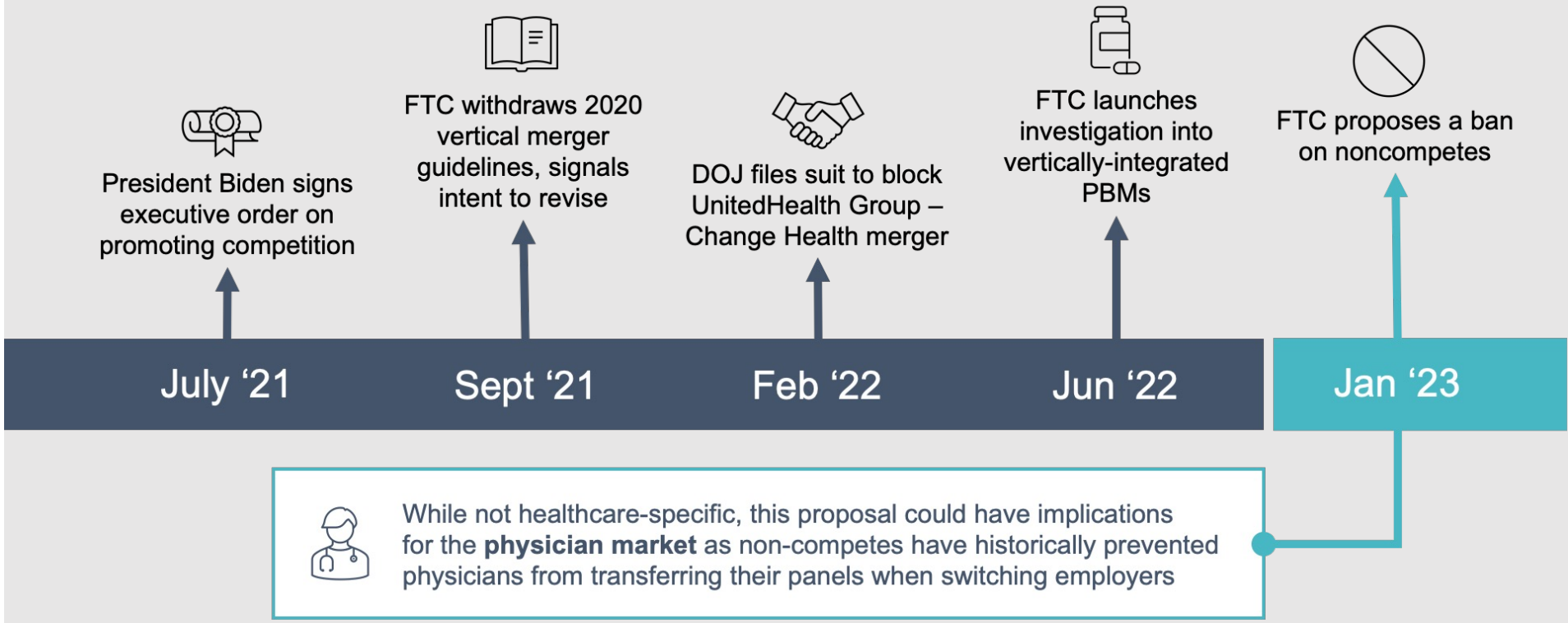
Source: ASPE, "National Uninsured Rate Reaches All-Time Low in Early 2022," August 2022; KFF, "Analysis of Recent National Trends in Medicaid and CHIP Enrollment," February 2023.

Signal #9 | 18%: American workers impacted by FTC's proposed ban on non-competes

While health policy issues related to coverage and pricing often draw the most public attention—and spark the most heated partisan debate—the issue of healthcare consolidation has quietly emerged as a bipartisan priority in recent years.

Scrutiny on horizontal consolidation has been persistent for some time, but vertical integration has begun to draw more of the limelight. The Biden administration, the FTC, and the DOJ have all signaled their concern with two particular types of vertical integration: 1) the integration between health plans and data/technology companies and 2) the integration between physicians and large corporate entities (broadly defined to include not-for-profits) such as health systems, health plans, and private equity firms (fig. 15).

Fig. 15: Proposed noncompete ban part of a larger trend



Most recently, in January of 2023, the FTC proposed a ban on non-competes. While not a healthcare-specific policy, this proposal is the latest of a series of actions that would have important implications for consolidation within the physician landscape.

Many physicians are currently bound by non-competes as part of their employment contracts. Physician non-competes typically prohibit physicians from practicing with another employer within a certain geography for a pre-defined period of time and prohibit physicians from taking their patient panels with them when changing employers.

Although the proposed rule would extend well beyond the healthcare industry, the FTC itself specifically calls out potential implications for healthcare, estimating that a ban on non-competes could "save consumers up to $148 billion annually on health care costs." It singles out healthcare as a prime example of an industry where consolidation, concentration, and high barriers to entry have led to higher prices for end consumers.

This proposal is likely to face legal challenges on many fronts, including from healthcare stakeholder, who will argue that there should be exemptions made for healthcare employers, even if the larger ban were to stand. Nonetheless, the proposal is an interesting signal of the diversity of potential tools the federal government has to promote competition within healthcare. It remains possible that Congress could pass laws with similar aims, even if the FTC is ultimately prohibited from implementing the ban through the rule-making process.

We should note, however, that federal court actions will have little impact on statehouses, which are also considering similar measures at the state level.

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An estimated

18%

of American workers are currently bound by non-compete clauses, including many physicians and healthcare executives.

Signal #10 | 63%: Physician burnout rate, 2022

Even putting aside a potential ban on non-competes, the physician market is already primed for a shakeup. After declining slightly following the onset of the pandemic, physician burnout spiked to an all-time high in 2021 (fig. 16). Nearly two-thirds of physicians reported symptoms of burnout that year.

Rising burnout, coupled with the financial uncertainty wrought by the pandemic, appear to be driving an acceleration in the number of individual physicians and physician practices seeking alignment with larger entities.

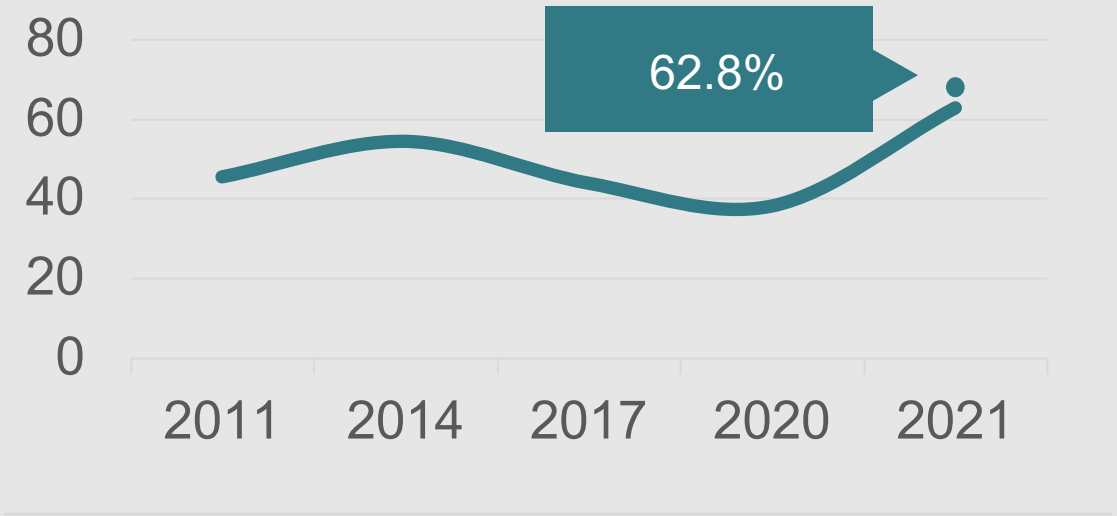
Nearly three-quarters of the physician workforce is now employed by a corporate entity (fig. 17, page 18). Employment by hospitals, which had plateaued across 2019 and 2020, has picked up again: hospitals now employ over half of physicians nationwide.

Employment by non-hospital corporations such as health plans has also grown steadily in recent years, now comprising roughly a fifth of the physician workforce. Still, when it comes to the employment of individual physicians, health systems are far and away the market leader.

The dynamics at the practice level differ notably (fig. 18, page 18). While hospitals owned a much larger share of the physician practice market as recently as 2019 (24% vs. 14% by non-hospital corporations), non-hospital corporations have not only closed that gap, but pulled into the lead (27% vs. 26% in 2022).

The difference between individual-physician-level dynamics and practice-level dynamics are likely a function of specialty, with physicians in certain hospital-based specialties more likely to seek individual employment contracts, as opposed to forming larger practices.

Fig. 16: Physician burnout rate, by year



Dropped to an all-time low amid the pandemic, but reached an all-time high in 2021

Source: Mayo Clinic Proceedings, "Changes in Burnout and Satisfaction With Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic," September 2022.

Still, the increasing penetration of non-hospital corporations into the physician landscape is a market shift that should not be underestimated. Understanding *who* these non-hospital corporations are is essential to understanding how they are likely to try and shape physician behavior.

The trend toward physician aggregation and consolidation is clear. It's also possible that rising levels of burnout could drive other types of shifts in the physician landscape: for example, increasing levels of turnover (physicians switching from one employer to another) or attrition (leaving the practice of medicine entirely; for example, by retiring early). Early evidence suggests that those numbers have held steady thus far, but they will be critical to continue tracking in the coming years.

Fig. 16: Percent of physicians, by type of employer

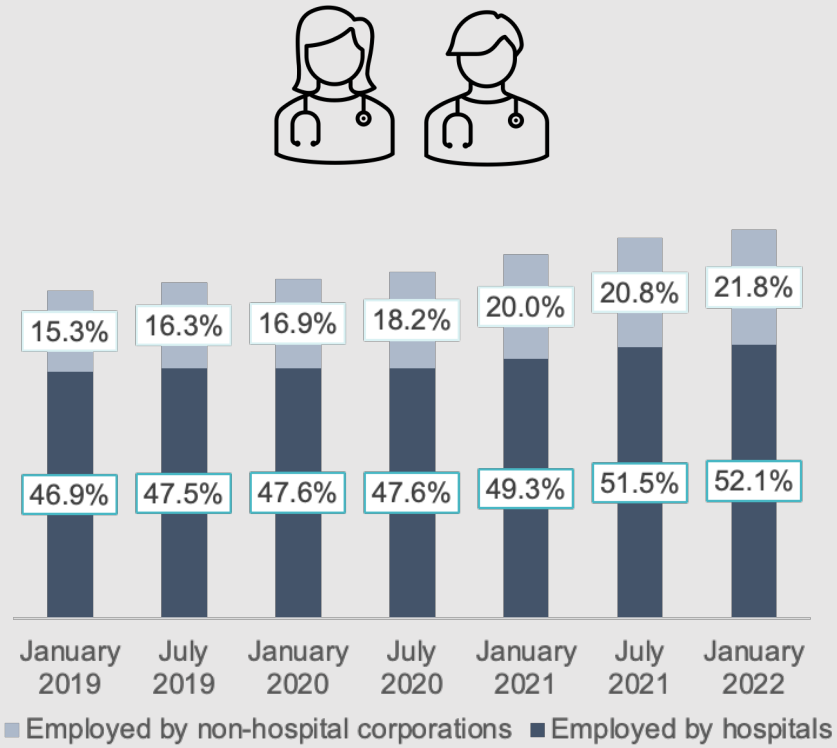
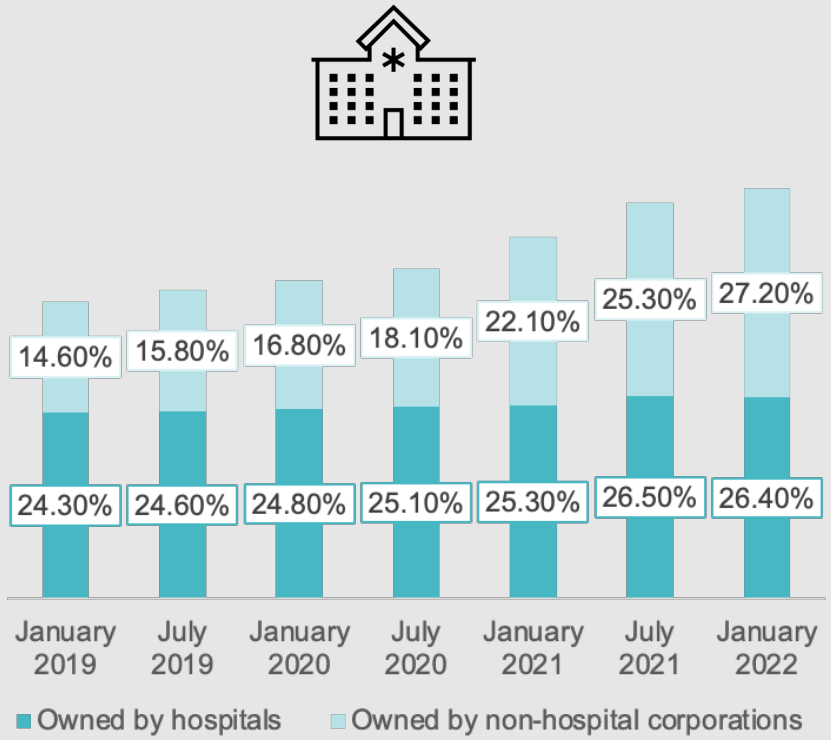


Fig. 17: Percent of practices, by type of owner



Source: Physicians Advocacy Institute/Avalere Health, "COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021, " April 2022.

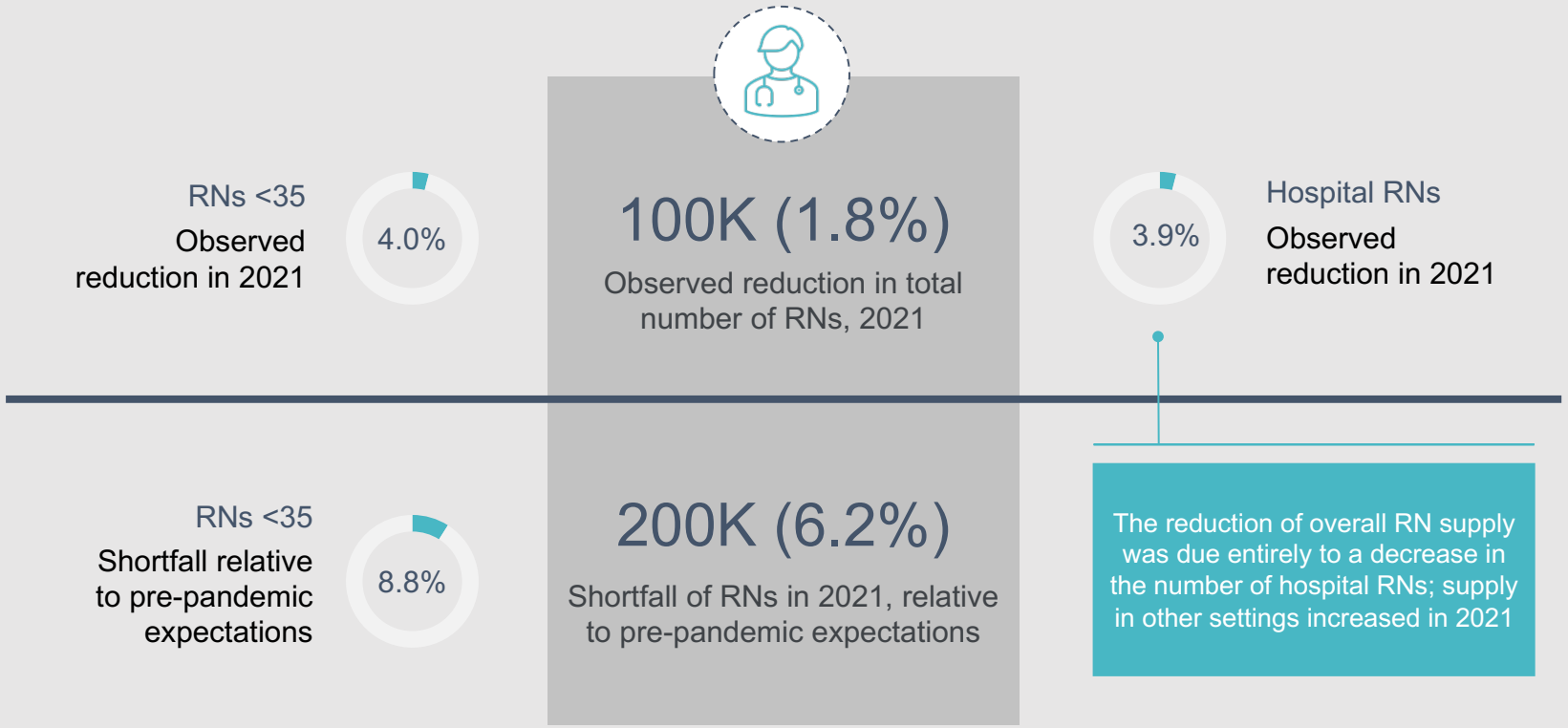
Signal #11 | 41,800: Nurses participating in strikes of >1,000 workers, January 2022 – April 2023

While rising burnout may not yet be driving attrition among physicians, evidence suggests that it is already impacting the nursing workforce.

Data from 2021 shows that the RN workforce has shrunk relative to 2020 (fig. 18). This is true in absolute terms but is even more stark considering that the workforce had previously been expected to grow slightly across that same timeframe.

A deeper look into what types of nurses were most likely to leave the workforce points to two alarming, although perhaps not surprising trends: hospital-based RNs and younger nurses were impacted the most. In fact, the overall reduction in RN supply could be attributed entirely to attrition from hospitals, with nurse supply in other settings increasing.

Fig. 18: Nursing workforce has shrunk amid pandemic



Source: David I. Auerbach, Peter I. Buerhaus, Karen Donelan, Douglas O. Staiger, "A Worrisome Drop In The Number Of Young Nurses," Health Affairs, April 13, 2022.

Those nurses who have opted to remain with the workforce have unsurprisingly been demanding more from their employers. Over 40,000 nurses participated in strikes between January of 2022 and April of 2023, including the largest-ever private sector nursing strike in Minnesota (fig. 19, page 22). This total does not include, of course, the number of nurses that threatened strikes which were ultimately averted, including a union of over 21,000 nurses in Northern California.

Examining the requests of these nurses reveals two notable themes:

1. **Sizeable (often historic) wage increases**

   In nearly every strike (and averted strike) we studied, nurses have been able to secure double-digit wage increases, nearing or even exceeding 20%—the largest-ever for many of the unions involved. Employers clearly recognize the need to acknowledge that the nature of an already-difficult job has only become more challenging amid the pandemic, in ways that are likely to be permanent.

2. **A growing focus on non-monetary commitments**

   But perhaps most notable were the non-monetary commitments that nurses have been asking for; namely, increased staffing levels, more focus on workplace safety (including explicit protections against workplace violence), and commitments to diversity, equity, and inclusion. In many instances, nurses underscore that these non-monetary measures are just as important, if not more important, than wage increases.

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41,800 nurses

participating in strikes across 2022 and 2023, including the largest-ever private sector nursing strike.

Fig. 19: Select nursing strikes and averted strikes, 2022-2023

Source: National Nurses United, "Largest private-sector nurses strike averted as 21,000 Northern California Kaiser nurses reach a tentative agreement," November 2022; Minnesota Nurses Association, "Nurses reach tentative agreements on three-year contracts to retain nurses at the bedside, avert planned strike," December 2022; New York State Nurses Association, "Nurses at Montefiore and Mount Sinai ratify contracts with historic and precedent-setting safe staffing enforcement," January 2023; Bureau of Labor Statistics.

Signal #12 | 7.5%: Healthcare job opening rate, May 2023

What the record nursing strikes highlight is the fact that the healthcare workforce—battered and burnt out as it may be—wields significant leverage right now. The healthcare job opening rate has declined slightly from the all-time high seen in April 2022, but remains at a level unprecedented by historical standards (fig. 20).

And while employers across many industries have struggled with historically high levels of job vacancies, healthcare tops tops the list in the absolute number of job openings and is exceeded only by the entertainment and leisure industries in the percentage of positions that have gone unfilled (fig. 21). While these pressure will subside with time, the changes wrought in the meantime (such as wage increases and other commitments) will likely be permanent.

Fig. 20: Healthcare job opening rate over time

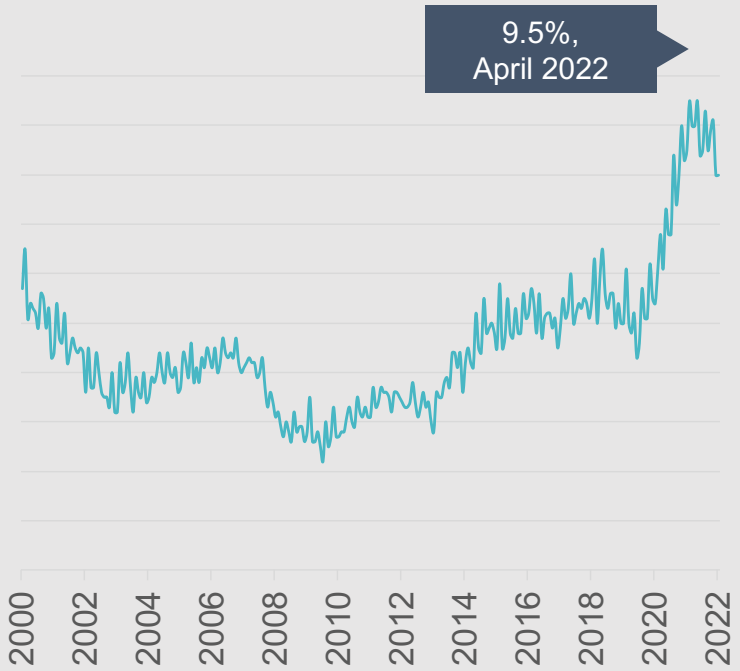
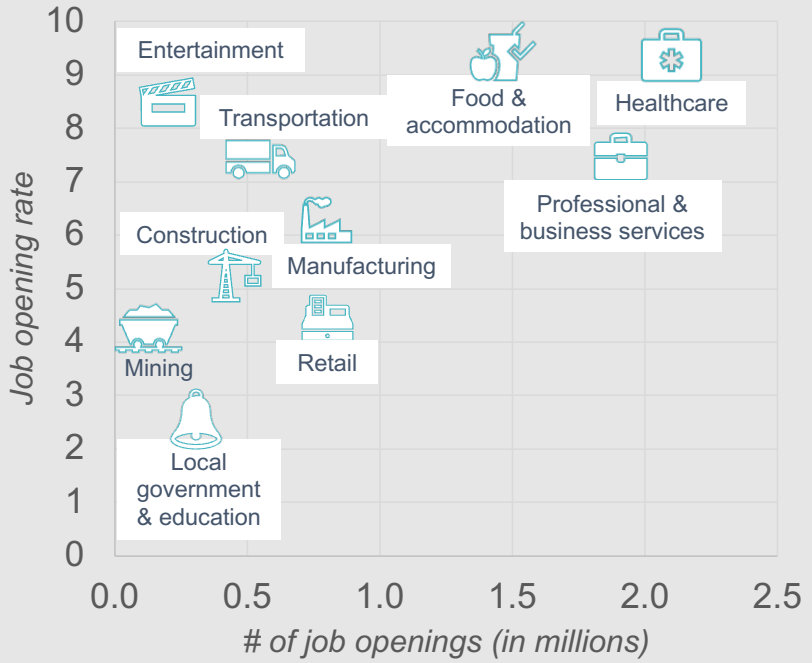
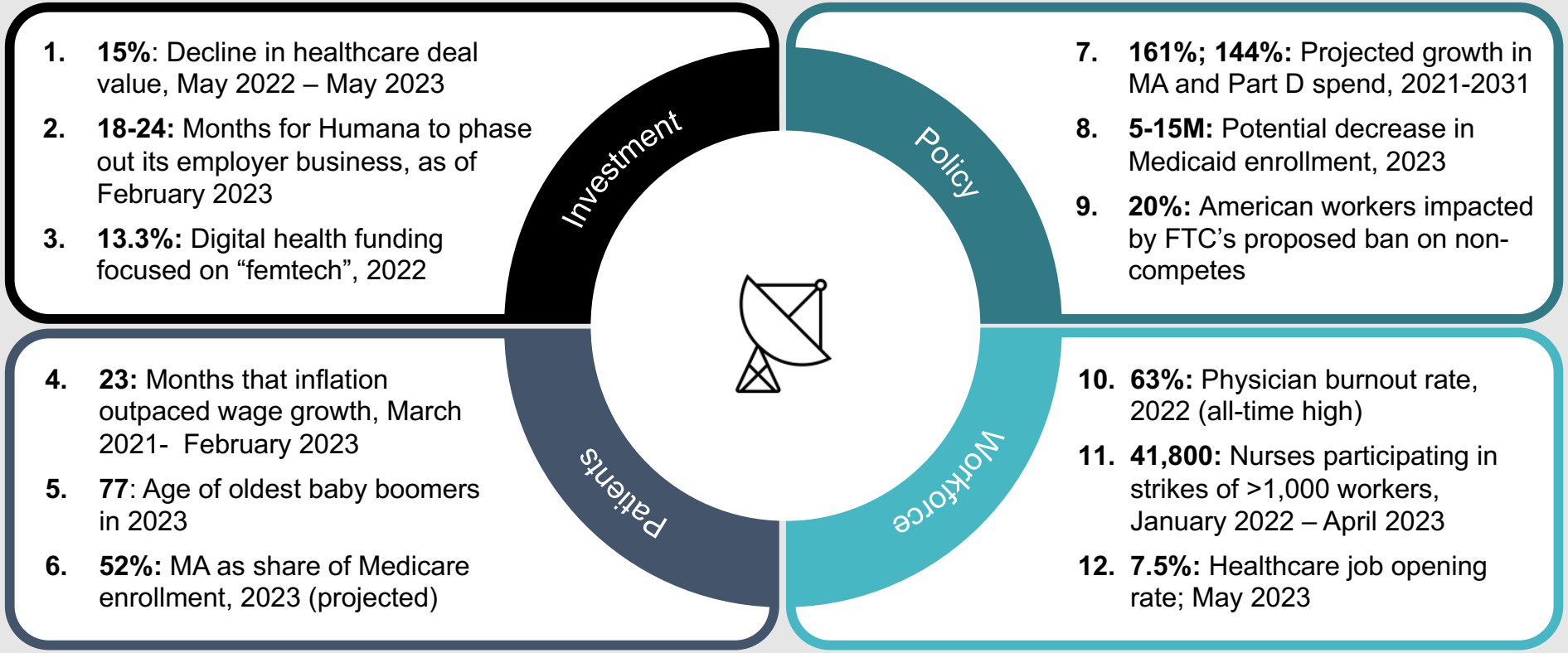


Fig. 21: Job openings by sector, September 2022



Source: Bureau of Labor Statistics.

Fig. 22: 12 market signals we're watching in 2023



Section 3

8 insights on the state of healthcare

Insight #1

MA will continue to grow in both size and strategic importance. As pressures on profitability also increase, plans will be pushed further into other parts of the value chain and providers will have to elevate their performance on value-based care.

As Medicare Advantage continues to grow in enrollment, spending, and in its strategic significance to both plans and providers, its finances are understandably attracting more attention.

In particular, the trade press and policymakers have turned a closer eye toward health plan profits from MA. When measured in terms of gross margin, MA clearly and consistently outpaces all other lines of business—by a significant margin (fig. 23, page 27). While this can at least be partially (or even largely) explained by the fact that per-enrollee spending is higher for MA enrollees because they're an older, sicker, higher-utilizing population, it nonetheless has only heightened the amount of public scrutiny on MA plans. The picture is further complicated by the fact that plans have multiple potential paths to profitability in MA (fig. 24, page 28).

Plan payments from the federal government are determined by an annual bidding process. Plans submit premium bids which are compared to regional benchmarks that are set by CMS. As is the case with any insurance line of business, the difference between plan premiums and costs incurred across the course of the year represent plan profits.

As part of the bidding process, plans who submit bids that come in under the market benchmark receive rebates to be used to provide supplemental benefits like vision and dental coverage. Supplemental benefits which are paid for using these rebates are "mandatory" in the sense that they are provided to *all* plan enrollees. The plan's premium is adjusted to account for these additional benefits, thereby providing a second potential profit lever for plans. Plans may also offer *optional* supplemental benefits that enrollees can choose to purchase out-of-pocket (a third profit lever).

All three of these types of benefits—basic benefits, mandatory supplemental benefits, and optional supplemental benefits—are subject to Medical Loss Ratio (MLR) requirements, meaning that plan profits on these benefits cannot exceed 15%.

In recent years, an increasing number of health plans have begun to operate MA-adjacent businesses such as senior-focused care delivery services. These businesses typically serve the plan's MA enrollees but are not subject to the MLR. As scrutiny on MA plans grow, the incentive for plans to double down on these related businesses will only increase, both as an alternative path to profits and to effectively control plan costs (for example, through plan-owned value-based care providers). There is also the potential for a perverse incentive for plans to use related businesses to mask their profits and potentially exceed the MLR.

Scrutiny on MA spending and cuts to MA reimbursement will have the strongest implication for plans. However, a potential downstream impact for providers could be additional efforts from plans to transition providers to value-based payment and care models. The share of MA payments that are tied to two-sided risk models has grown steadily for years now. As of 2021 (the last year for which data is readily available), over 25% of all MA payments flow through two-sided risk models. We expect that number to continue to grow as efforts to constrain MA spending growth intensify.

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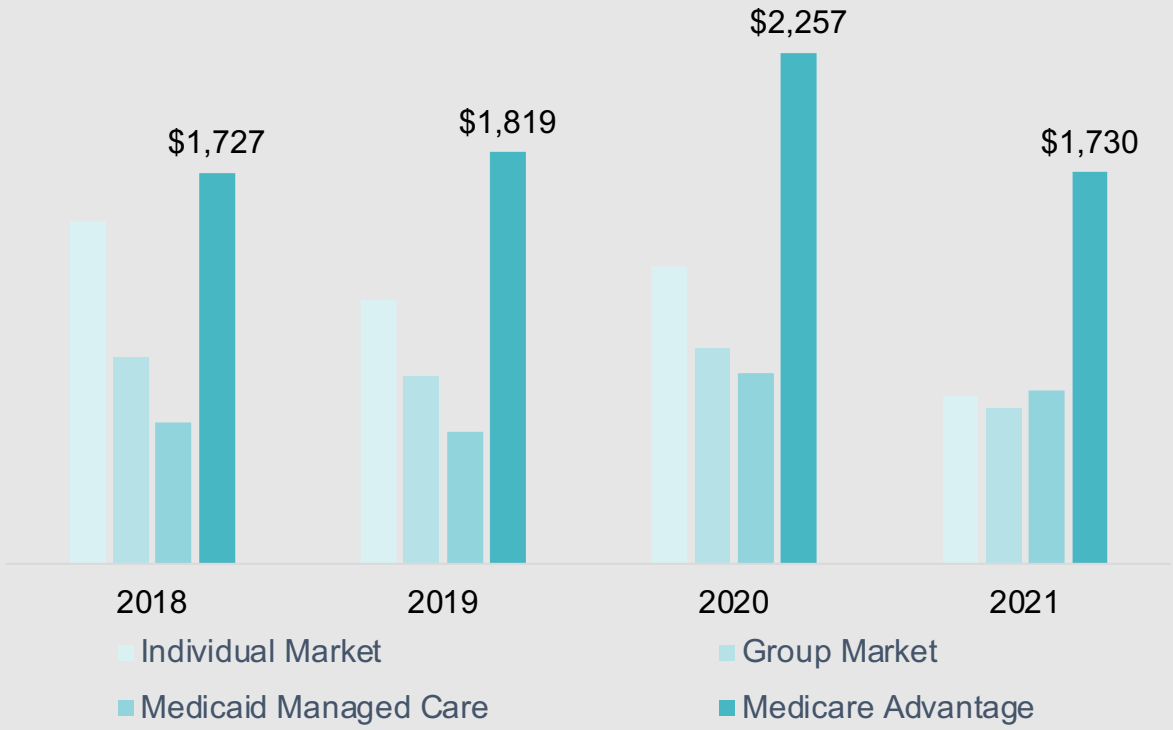
25%

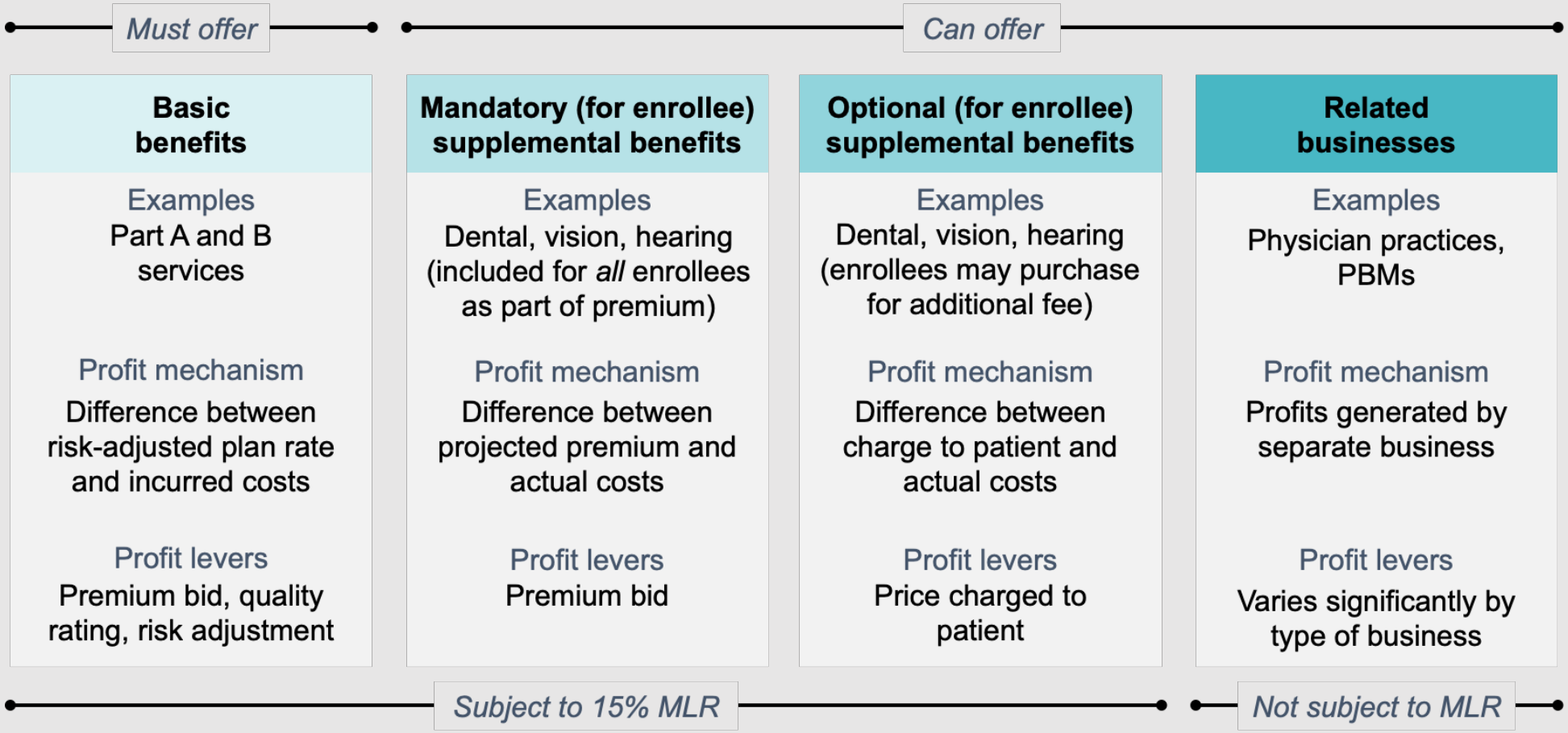
of all MA payments flow through two-sided risk models.

Fig. 23: Health plan gross margin per enrollee, 2018-2021



Source: Kaiser Family Foundation, "Health Insurer Financial Performance in 2021," February 2023.

Fig. 24: Plans have multiple paths to MA profitability



Insight #2

Drug companies could push for (more) differential pricing between public and private payers, raising costs for employers in a few key segments.

Spending on drugs continues to attract more scrutiny over time. While efforts to constrain MA spending growth have been slow and steady over time, 2022 saw the passage of a landmark drug pricing bill—one which we believe heralds a new era of drug pricing controls.

The Inflation Reduction Act (IRA) targets Medicare part D drug costs in three main ways:

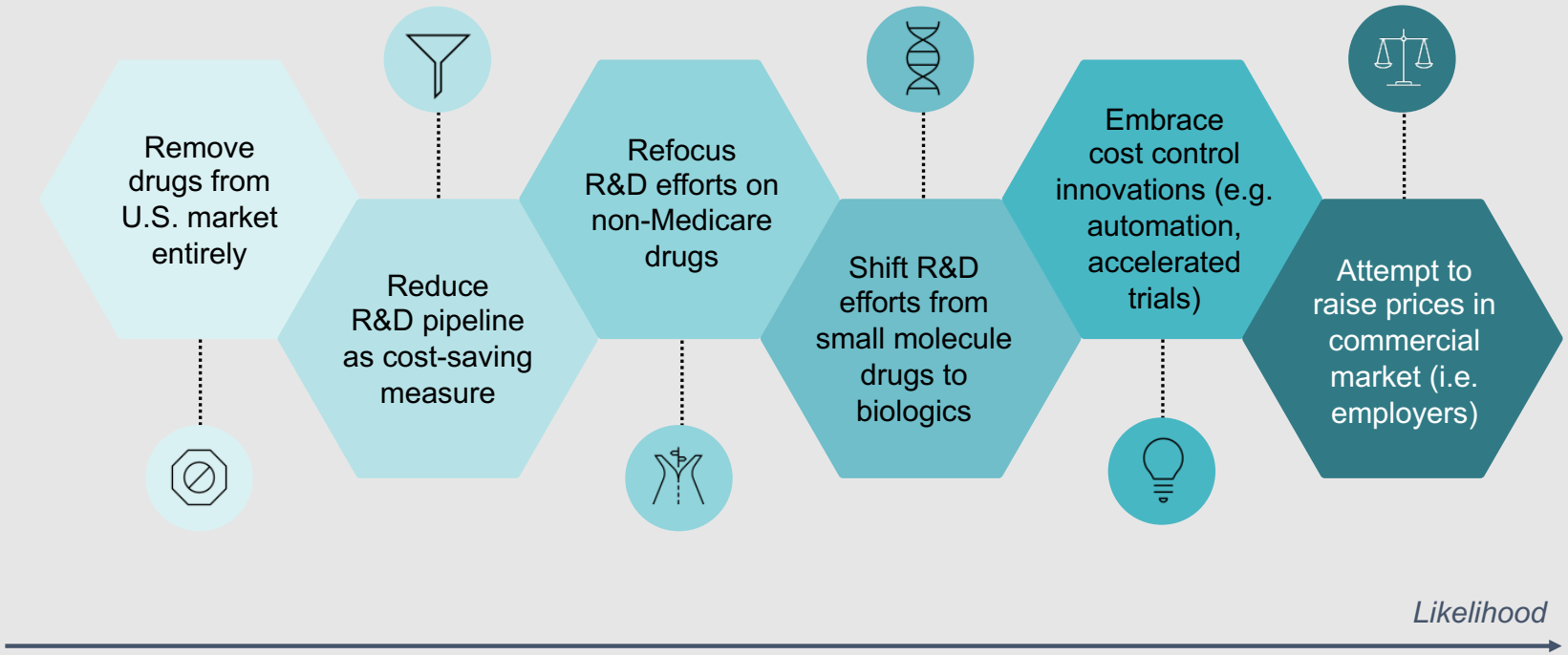
1. **Enabling price negotiation**: The IRA requires the federal government to negotiate prices for some Part B/D drugs (e.g. single-source, high-spend, non-orphan) beginning in 2026.
2. **Limiting future price increases**: The IRA requires pharmaceutical companies to pay rebates if prices increase faster than inflation for drugs used by Medicare beneficiaries, beginning in 2023.
3. **Minimizing patient exposure**: The IRA caps Part D out-of-pockets costs at $2,000 a year, caps Medicare copays for insulin at $35/month, and expands eligibility for low-income subsidies and benefits.

As with any policy, the law will generate a mix of intended consequences (those detailed above) and unintended ones. For example, it could lead pharmaceutical companies to adjust patents in order to exempt certain drugs from the price negotiation program by ensuring drugs are not classified as single source. It may also lead to higher launch prices to mitigate the impact of limitations on price increases down the line.

The impacts are likely to extend beyond Medicare (fig. 25, page 30). We believe that the most drastic measures threatened by the pharmaceutical industry, such as the removal of drugs from the U.S. market or sweeping cuts to R&D budgets are unlikely, at least not on a large scale. It is likely, however, that pharmaceutical companies will make smaller adjustments to the R&D pipeline and process to mitigate the impacts of the law; for example, by refocusing R&D efforts on non-Medicare drugs or accelerating the shift away from small-molecule drugs and toward biologics.

Perhaps most critically, while proponents of the law are hopeful that the downward pressure on Medicare pricing may spill over to non-Medicare segments, we believe the law could ultimately have the opposite effect, prompting pharmaceutical companies to raise prices elsewhere—much in the same way that prices for medical services in the commercial sector are used to offset lower prices in Medicare and Medicaid. In particular, we believe that there may be efforts to raise drug prices for employers.

Fig. 25: Potential second-order impacts of Medicare drug price controls



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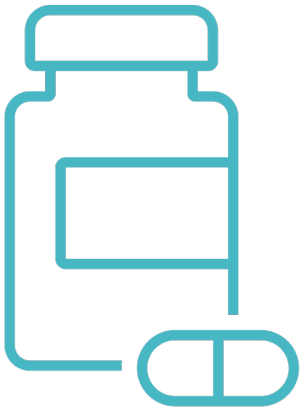

Insight #3

To grapple with steep health cost inflation, employers will pursue historically difficult aims—such as constraining drug spend or forcing patient steerage—that limit spending growth without increasing already heavy cost burdens onto their employees.

For the past decade, employer medical costs have typically increased about 5% to 7% in any given year. It's worth noting that this growth rate is relatively low by historical standards. Two decades ago, the typical annual growth rate was closer to 10%.

While the precise numbers for 2022 vary by source, all agree that the employer medical trend last year was below typical levels, by either historical *or* current standards, falling somewhere between 3%-5%. This is especially striking given that inflation in 2022 was at a 40-year high. But it is not especially surprising to us, for two reasons:

1. Employer contracts are typically renegotiated on a three-to-five-year basis, meaning that pricing updates will always lag any unexpected shifts in broader inflationary trends.
2. As noted earlier, the exceptionally high rate of inflation outpaced wage growth for most workers, driving historic levels of care delays which likely put a dampener on utilization.

Employers expect medical trend to return to more typical levels this year, as more commercial contracts come up for renegotiation. But the trend is not expected to match the rate of inflation seen in 2022 (at least, not yet), as downward pressures on utilization continue and, of course, because not all contracts will be up for renegotiation simultaneously.

Taking together the lower-than-usual growth in employer healthcare spend, and the fact that employers across most industries have struggled with historically high levels of turnover and job vacancies, it's hardly surprising that employers were hesitant to cut health benefits this year. The data bears that out: most employers say that they are prioritizing benefit enhancements over efficiency efforts for 2023 (fig. 26, page 32).

Who stands to benefit most from these enhancements? Hourly and lower-wage workers, given the difficulties in attracting and retaining such groups, according to employers.

As for *how* employers are enhancing benefits, many of the focus areas are intuitive. Virtual care and behavioral health are frequently cited priorities. Women's health has also emerged a newer focus area for enhancement efforts. In fact, most employers say they are not only prioritizing women's health as an important benefit enhancement lever, but also taking specific actions meant to address inequities in women's health.

These efforts largely focus on expanding coverage in a variety of ways. For example, an increasing number of employers are offering broad coverage for fertility benefits (i.e. not requiring employees to get a referral for fertility services). Employers are also expanding coverage for postpartum depression, women's-focused preventive healthcare services, doula services, and group-based prenatal care.

A growing number of employers are also implementing strategies meant to support under-resourced populations in particular; for example, identifying high-risk pregnancies and reducing C-section rates among historically-marginalized patient segments.

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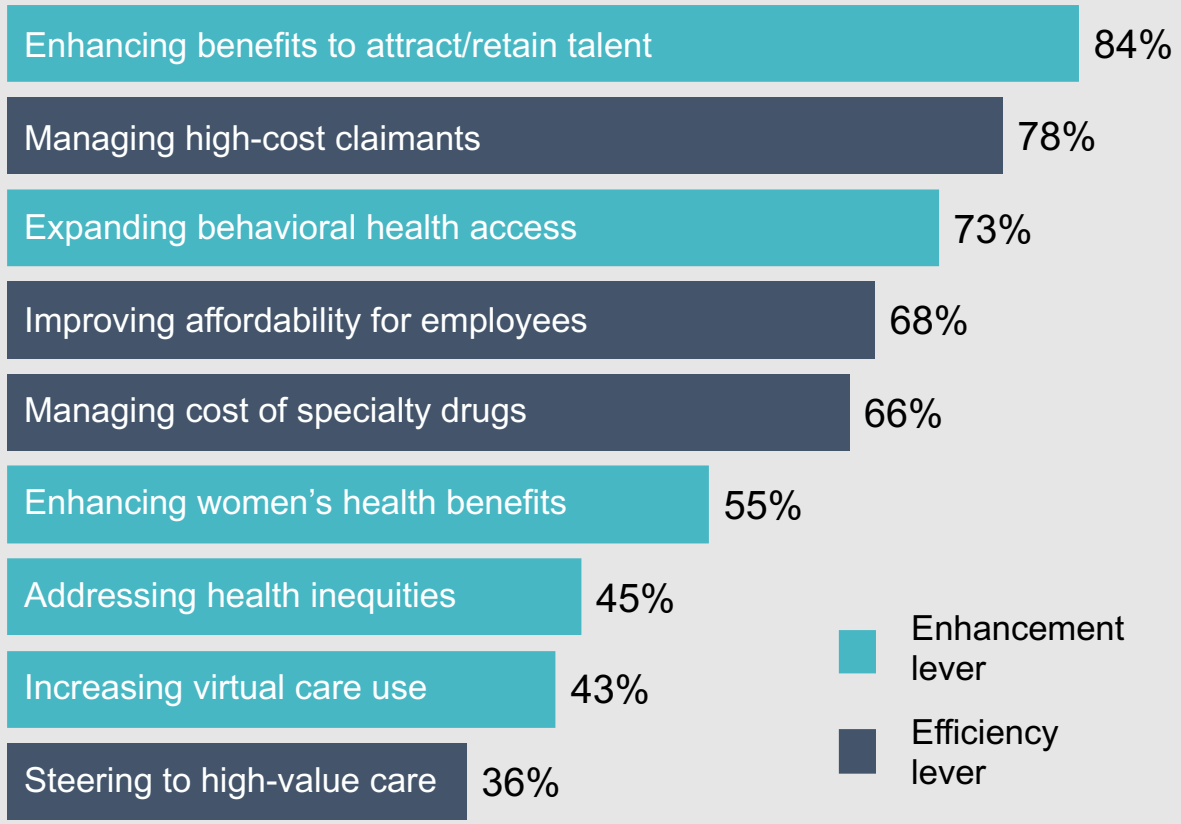
85%

of employers say they are implementing at least one strategy to address inequities in women's health in 2023

Fig. 26: Large employers rating strategies as "important" or "very important" for the next 3-5 years



Source: Mercer, "National Survey of Employer-Sponsored Health Plans," December 2022; Mercer, "Health Benefit Strategies for 2023."

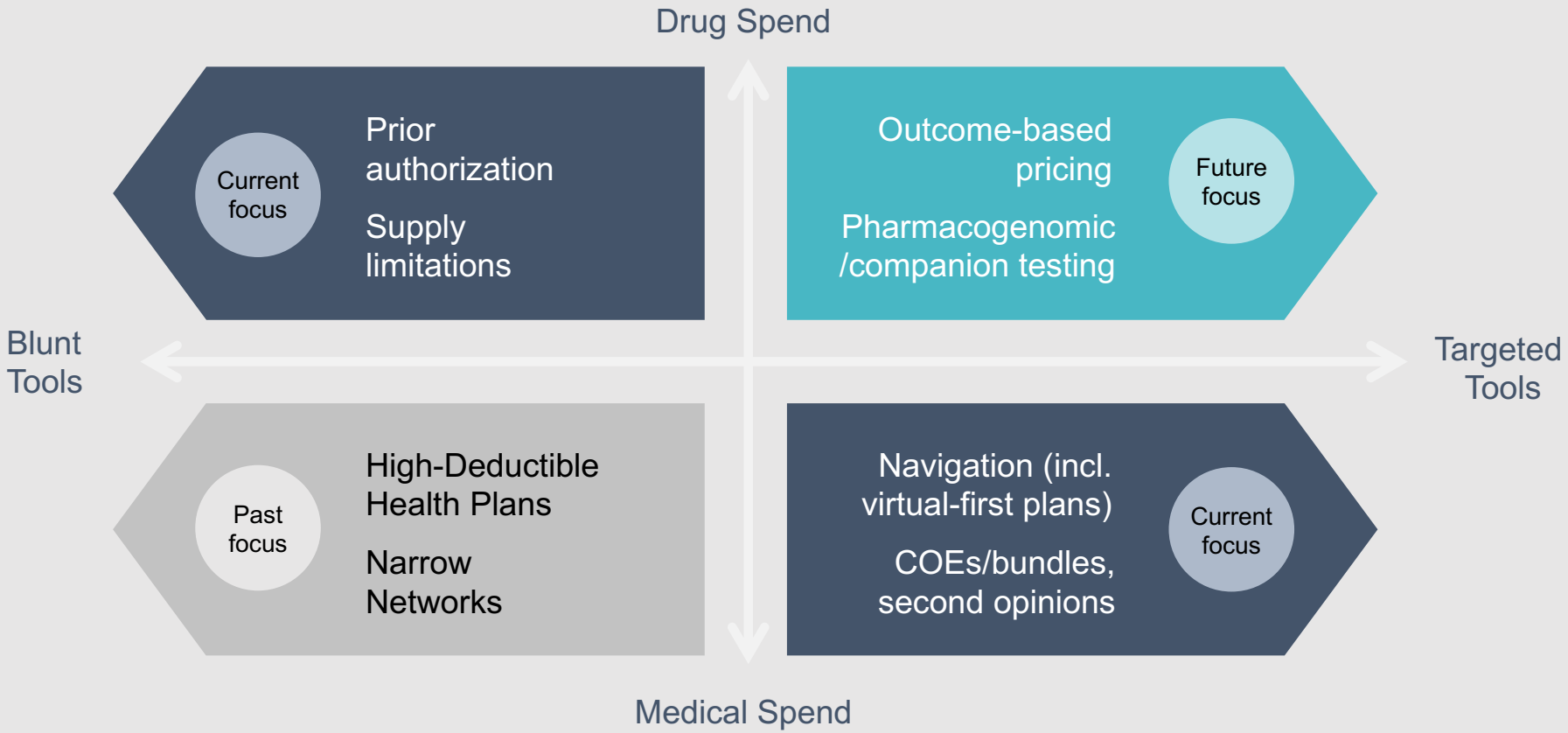
While employers may be prioritizing benefit enhancements over cost control efforts for now, that's not to say that they are abandoning cost control efforts entirely.

In fact, our study of employers suggests that they are becoming ever-more sophisticated in their efforts to improve the efficiency of their healthcare spending, in two major ways (fig. 27, page 34):

1. Employers are increasingly moving away from blunt tools such as high-deductible health plans and narrow networks which aim to constrain spending by setting large-scale, wide-ranging parameters on utilization. Instead, they're embracing more targeted forms of cost control such as concierge navigation services, virtual-first plans, centers of excellence programs, and second opinion services. These strategies all attempt to address specific instances of high-spend (or highly-variable spend).
2. Employers are extending their cost control efforts from the medical space to pharmaceutical utilization and spending. Because of the exceptional complexity of the drug, pharmacy, and PBM industries, employers have been slower to adopt strategies targeting these sources of spending. But given the tremendous growth in drug spending in recent years, employers have devoted more time to understanding the inner-workings of this sector. Strategies such as prior authorization requirements and limitations on drug dispensing supply are becoming increasingly common. Even more targeted strategies, such as the use of outcome-based pricing for certain drugs or the use of pharmacogenomic testing are at the frontier of employer cost control efforts.

We believe the urgency for employers to adopt these strategies will only grow in the coming years, as employers' medical costs return to and potentially even exceed recent norms.

Fig. 27: Employer cost control efforts becoming ever-more sophisticated



Insight #4

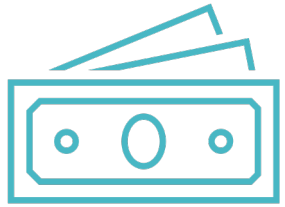
Workers require commitments to work-life balance, workplace safety, and DEI to remain engaged in what they rightly see as a more dangerous and less stable profession.

Healthcare employers have had a particularly challenging time retaining workers across the past year. While the typical retention levers and talent attractors of benefit enhancements and wage increases have been and will be a critical part of the industry's response, they will be far from sufficient. This is especially true for provider organizations that have the unique challenge of retaining a clinical workforce facing burnout.

Traditional employee value propositions focus heavily on "total rewards": benefits and compensation. Career advancement opportunities and company culture are viewed as differentiators on top of the rewards package. We believe the current environment requires healthcare employers to consider a few additional factors as well. There are three in particular we would highlight (fig. 29).

1. **Acknowledging the job has gotten more difficult.**

   To begin, employers need to acknowledge that the nature of working in healthcare—especially for those on the frontlines—has gotten fundamentally more difficult. The ongoing nature of Covid-19 has led to permanent disruptions in utilization and workflow, above and beyond the typical ebbs and flows experienced in the past. This has led to an upward rebasing of wages which will not revert to pre-pandemic norms. The record-setting wage increases secured by nurses during the latest round of nursing strikes is a notable reflection of this trend.



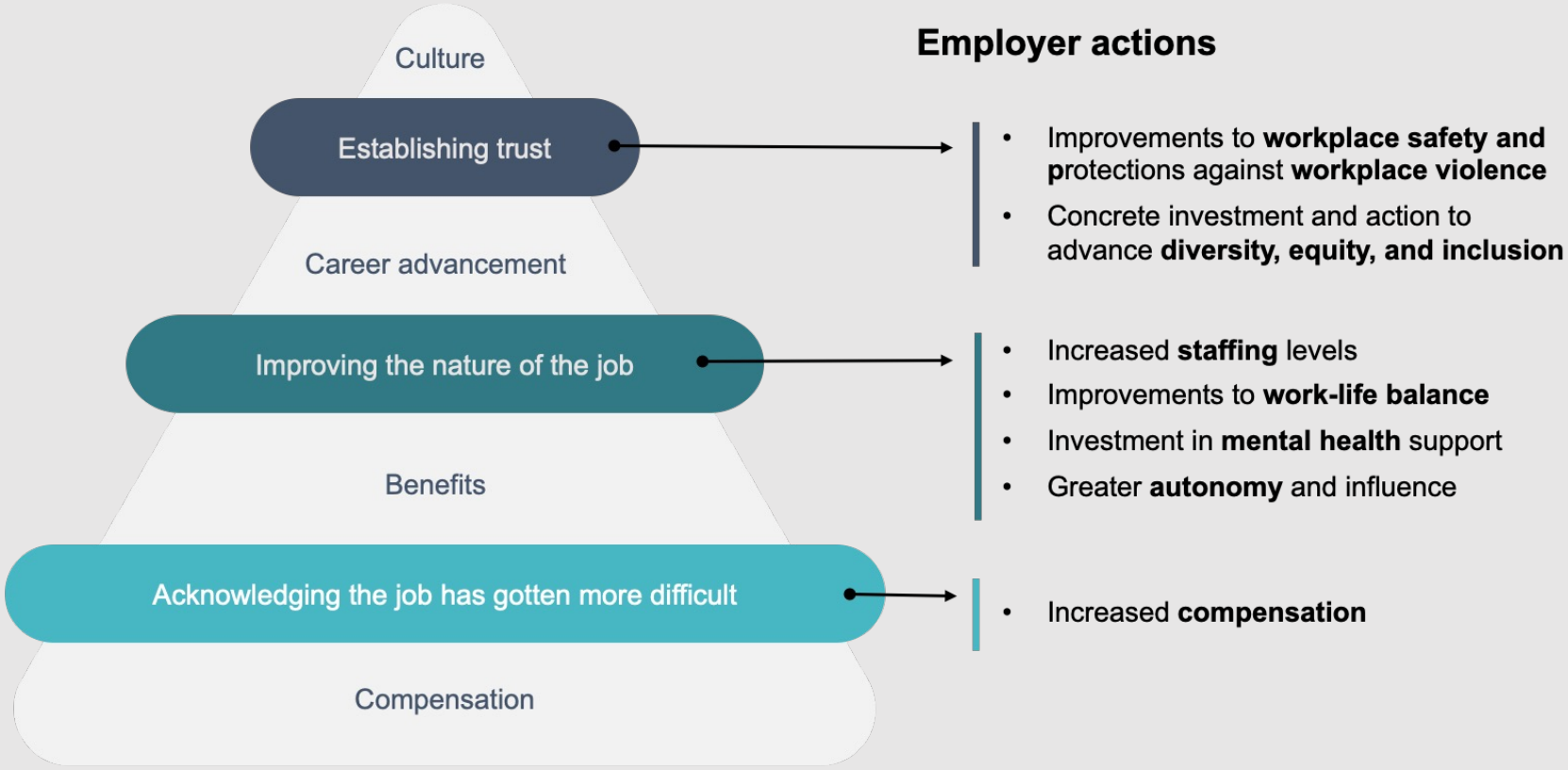
2. **Improving the nature of the job.**

   That said, compensation increases alone are insufficient—a fact, again, well-demonstrated by recent strikes, which have seen nurses place heavy emphasize on non-monetary factors. Employers must take concrete action to improve the nature of the job itself. In many cases, this will include commitments to increase staffing levels as a burnout reduction measure. Investments in behavioral health are also growing in importance as rates of depression have spiked across the past few years. Staff are also looking for a sense of autonomy and influence wherever possible.

3. Establishing trust.

Finally, healthcare employers will need to take additional steps to restore trust among their workforces. There are two critical aspects to this. First, demonstrating a commitment to workplace safety and providing protections against workplace violence, which is on the rise in recent years. And second, investing in strategies and actions designed to advance diversity, equity, and inclusion.

Fig. 28: New employee compact emerges



Insight #5

The principal cause of health system margin challenges is the enormous upward pressure on labor costs—and when margin problems come from internal pressures, the solutions require long-term structural solutions.

Workforce challenges have been particularly acute for hospitals and health systems—and are the principal cause of the ongoing margin pressures facing this segment of the industry (fig. 29, page 38). Historically, unchecked labor cost growth has been harsher on hospital finances than robust pricing growth has been beneficial. And while there is reason to believe that price hikes are on their way, the sheer magnitude of the cost increases that many markets have seen means that even large price hikes are likely to fall short relative to the cost burden. It could take years of sustained price hikes to fully account for the labor cost inflation of the past couple of years.

These pressures will have consequences not only for health systems, but for the industry as a whole (fig. 31, page 37). Namely:

Capital investment in infrastructure will likely falter. As credit spreads widen between the relative haves and have-nots, debt will become even more expensive for not-for-profit systems in need of new or replacement construction.

Outsourcing will start to look a lot more appealing. Revenue cycle will be a prime target, and models from large health plans and their affiliates will garner more attention.

Procedural care and MA will be front and center. Surgeries have been health systems' profit centers for 40 years. But Medicare Advantage has also emerged as a major profit center: for health systems, the sheer amount of utilization driven by MA means it is often the most profitable patient segment on an annualized basis.

Hospitals will try to deploy more top-of-license care, but should expect significant pushback. When done correctly, these can improve efficiency, staff engagement, and patient satisfaction, but done poorly, it up can damage the credibility of the

whole concept, with staff often accurately lamenting that their days are filled with only the most challenging parts of the job.

Employers will bear the brunt of price hikes, prompting more steerage-first strategies. As noted previously, most employers are unlikely rely on cost-shifting to manage rising healthcare expenses. More are likely to turn to steerage-first strategies, and the systems that win preference are likely to be the dominant players for the next decade in their markets.

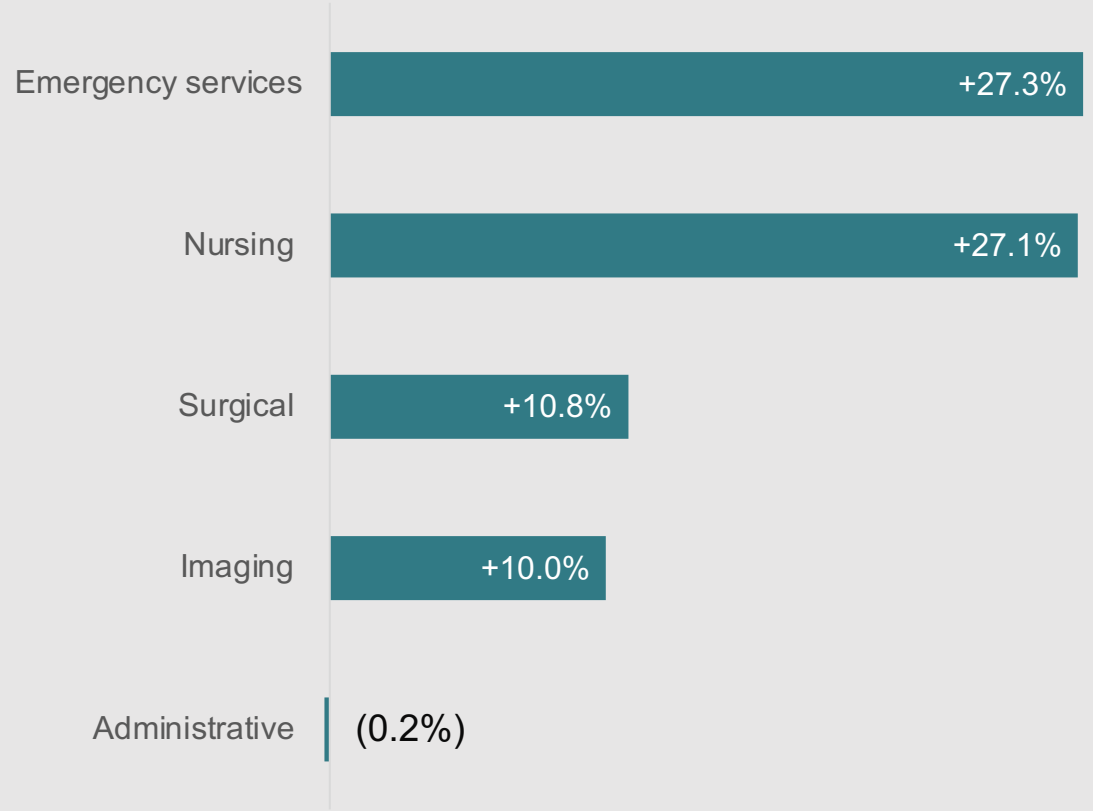
The battle for market share will only heat up. The pandemic helped shift market share in some regions as health system responses to Covid-19 varied widely. The battle to engage profitable specialists is likely to heat up as many orgs seek to return to the status quo ante.

The weakest system performers will either close or receive bailouts. A key metric to watch will be regional occupancy rates: those above 70% mean that hospitals are close to being overwhelmed. On the other hand, rates in the low-60s means suggest excess capacity in the market, dimming the chances of a bailout.

Providers will attempt to consolidate. Financial pressure tends to be the most persuasive argument for regulators, but with little evidence that consolidation reduces costs, systems face an increased hurdle in getting M&A approved.

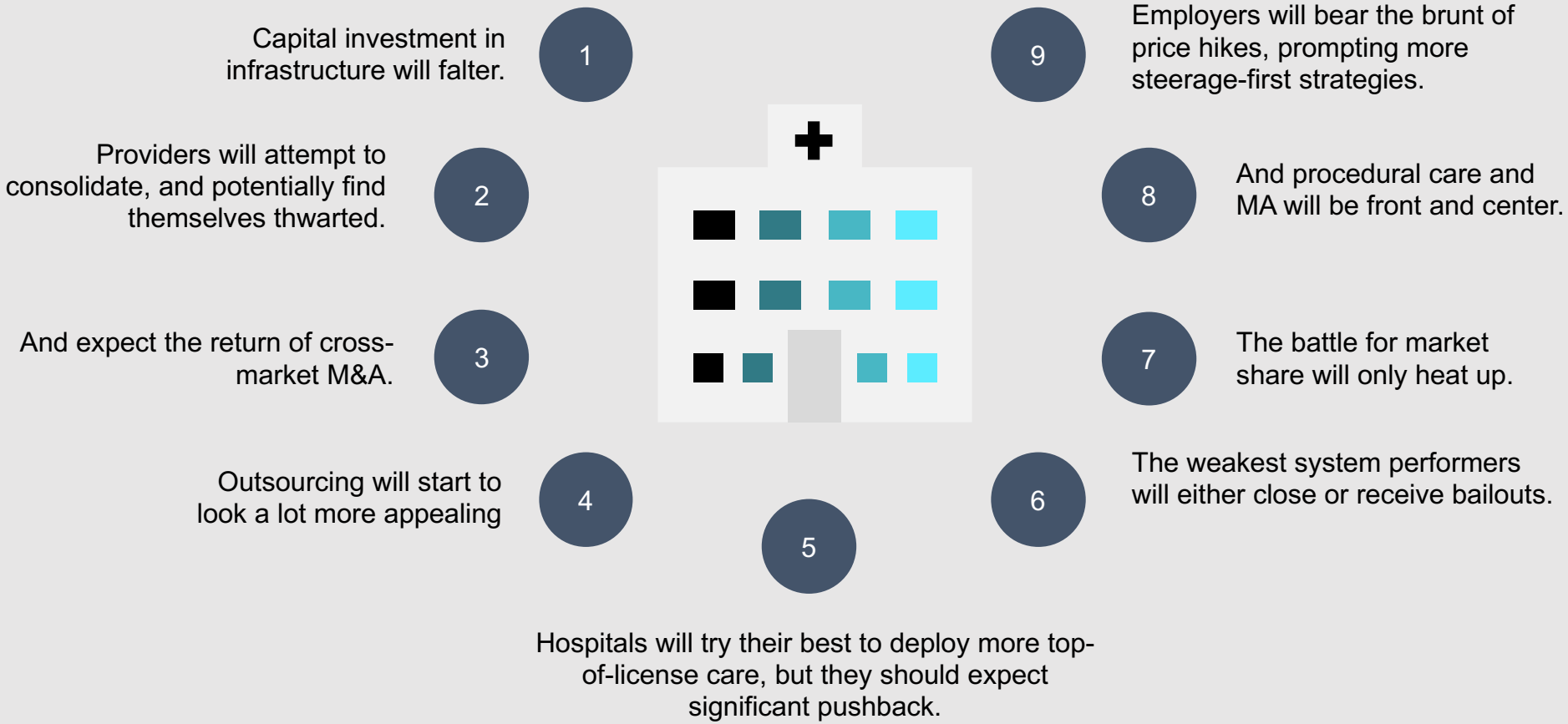
Cross-market M&A will likely return. Major cross-market M&A is challenging when credit spreads are narrow. But as they widen with interest rate hikes, it becomes far more doable for a large out-of-town system to acquire a smaller one in another region.

Fig. 29: % change in expenses per FTE, 2019-2022



Source: Syntellis and the American Hospital Association, "Hospital Vitals: Financial and Operational Trends," February 2023.

Fig. 30: Nine potential consequences of ongoing provider margin pressure



Insight #6

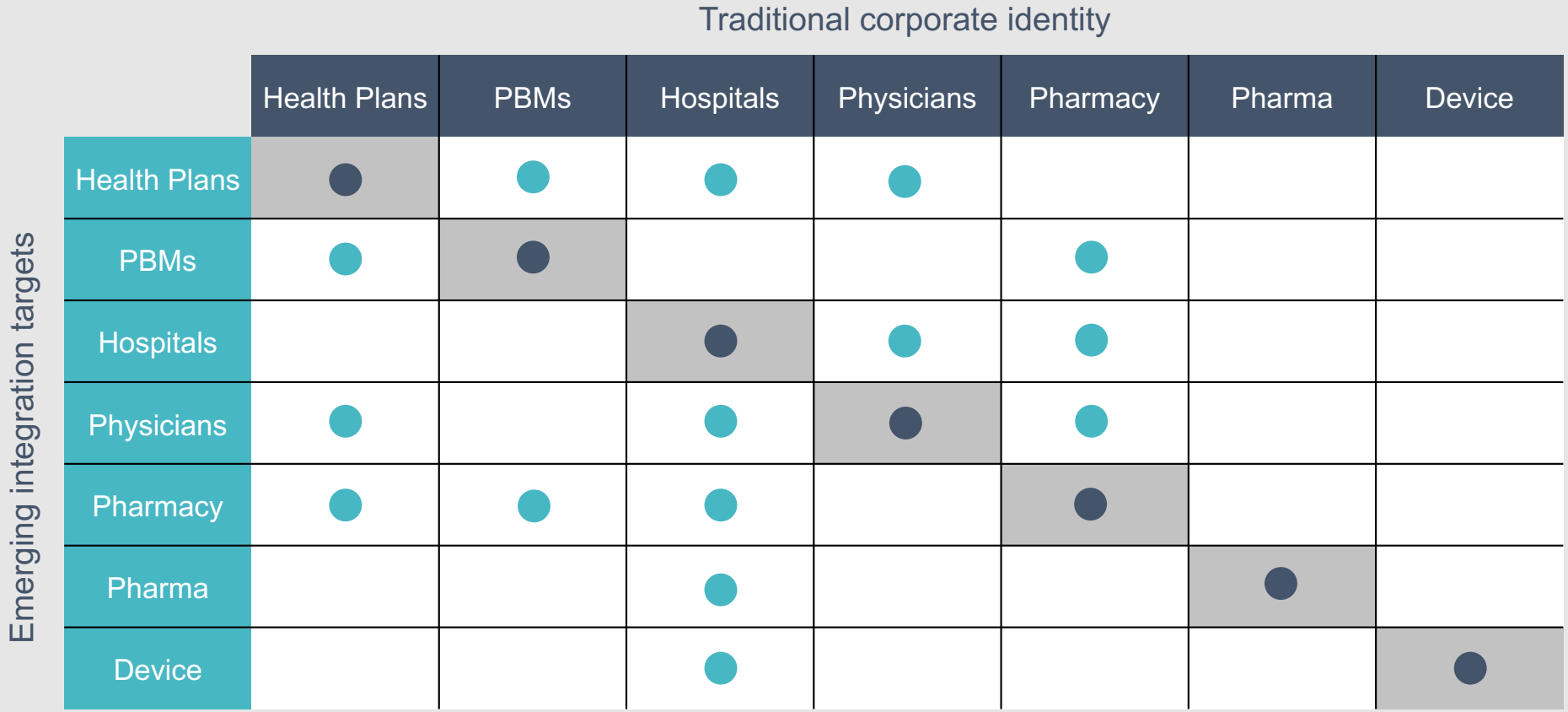
The end of the independent anything: most types of healthcare entities (but especially physicians) will seek shelter in scale. But although vertical consolidation *can* generate better patient outcomes with greater efficiency—and also entrench terrifying market power—it very rarely produces either result.

A renewed push toward consolidation would not be unique to the hospital space. In particular, vertical consolidation is increasing in many different parts of the healthcare ecosystem—and with so many healthcare companies feeling ongoing margin pressure, this trend is only likely to continue in the near future (fig. 31): Tech companies are buying virtual care or medical groups. Health systems are buying nearly any kind of provider (especially medical groups), plus small insurance plans. Medical groups are buying other medical groups in different specialties. A unifying theme among all of these deal types is physicians. And they're are also the reason why this kind of M&A sparks such heated debate—with passionate arguments both for and against.

The general argument for vertical integration, in any industry, is always the same: joining forces between disparate parts of the value chain will generate efficiency, increase scale, improve outcomes and convenience, and lower costs for purchasers. The argument against is similarly industry-agnostic: Consolidation will entrench market power. It rarely has any impact on quality, can produce negligible improvements in convenience, generates limited no scale, and almost certainly raises prices for purchasers (in the case of healthcare: the government, employers, and consumers).

In healthcare (at least to-date), there are certainly elements of truth in both the aspirations and the fears. Most of the positive outcomes that proponents are hoping for—and most of the negative outcomes that detractors fear—require integration (not just consolidation) to pull off; and that rarely occurs. Managing diverse assets as a portfolio is much easier and potentially more lucrative than creating an integrated business with all the parts dependent on one another.

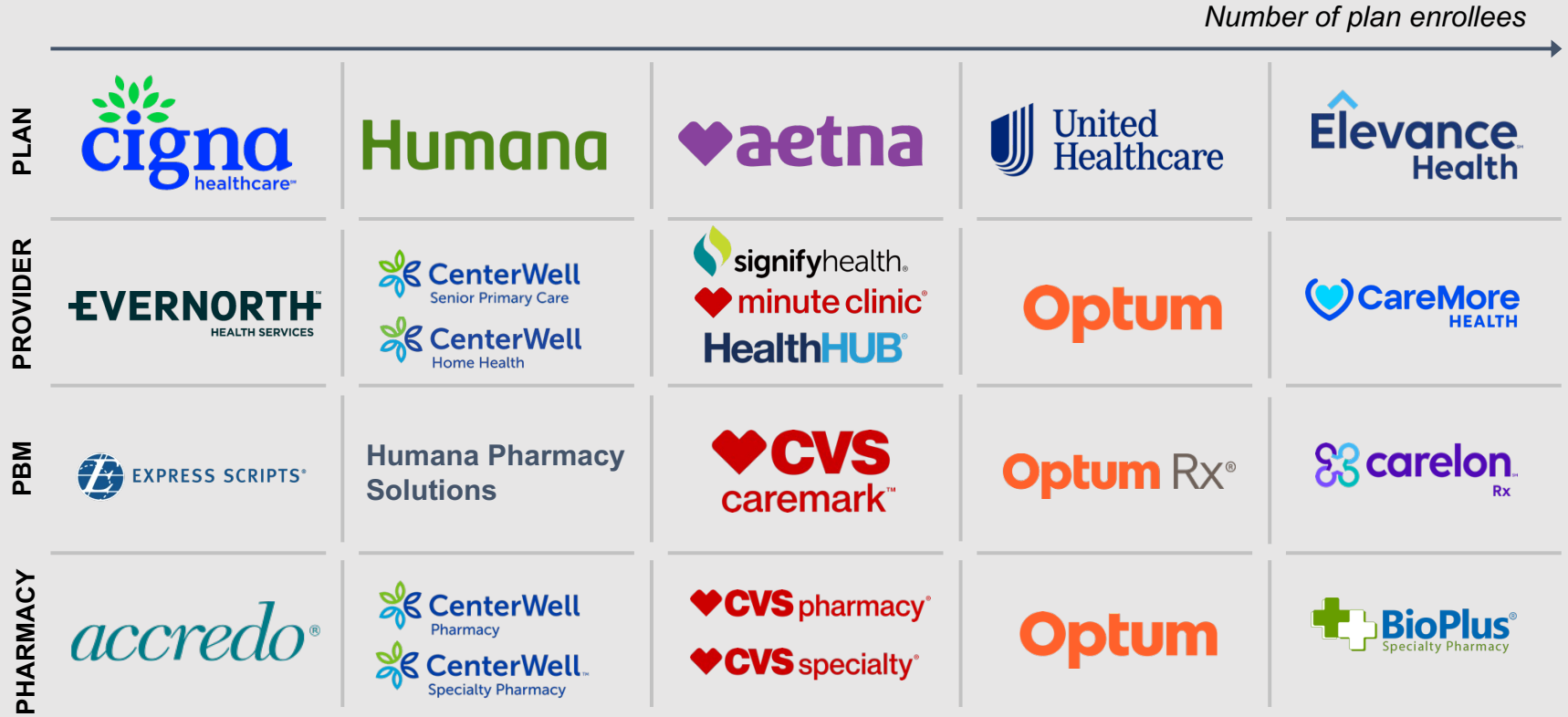
Fig. 31: Vertical integration a growing trend across industry sub-sectors



This is likely true even of the biggest companies with the greatest levels of vertical consolidation, typically with four components: a health plan, pharmacy benefit manager (PBM), pharmacy services, and a provider arm (fig 32). While these organizations *could* achieve the aspirations (or manifest the fears) of vertical integration, today they largely operate as diverse portfolios of businesses which comprise a series of flywheels and hedges, enabling their parent companies to survive in nearly any economic environment.

Still, these deals are attracting an increasing amount of regulatory scrutiny, particularly as concerns over their potential influence over physician behavior continue to mount. Some of the attempts to promote competition in healthcare (such as the potential ban on non-competes) could enable faster growth of these conglomerates, while others (such as stricter M&A oversight) could slow them down.

Fig. 32: Biggest plans are now all vertically-integrated



Insight #7

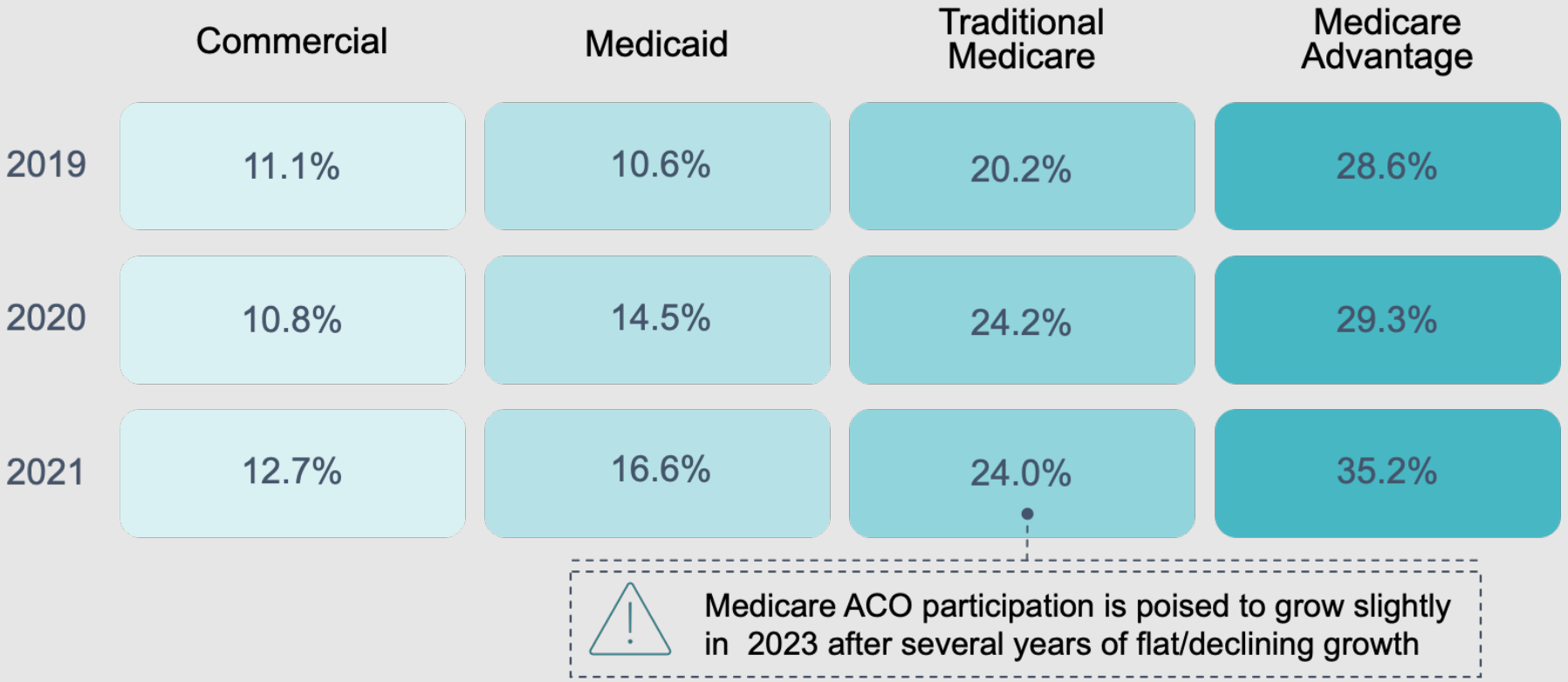
The focus of **value-based care** will shift away from traditional Medicare toward other aims, including helping preserve the profitability of MA, improving outcomes in behavioral and women's health, and delivering cost savings to employers.

The enablement of value-based care has often been touted as a major goal of the recent push toward vertical consolidation. And with much of that effort focused in the Medicare Advantage space, it is unsurprising that MA leads the pack when it comes to adoption of risk-based payment models (fig. 33, page 44).

This has been true for so long now that it's easy to gloss over. But it's worth considering why this is the case, especially given that the preeminent driving force behind the value movement has been the federal government, which has used the traditional Medicare program as its primary channel for pushing value-based payment and care delivery models. MA has raced to the front of the pack because risk in MA presents several different compelling business opportunities. For example, MA's senior population is older and sicker than the general population (such as the employer-sponsored population), meaning that there's plenty of opportunity to improve health outcomes in ways that also reduce cost. And compared to traditional Medicare, the MA contract negotiation process gives plans and providers flexibility to customize care and payment models in a way that a large-scale national program like the Medicare Shared Savings Program simply does not.

The overall high level of funding, combined with the severity adjustment aspect of MA reimbursement, has also created aligned incentives between plans and providers. The two can not only partner to boost care coordination and reduce avoidable hospitalizations/emergency department use, but also to ensure thorough documentation of patient conditions—the key to increasing MA payments. In sum, neither providers' or plans' business models have been upended by VBC. In fact, both have been *sustained* by such models.

Fig. 33: Percentage of payments in two-sided risk models



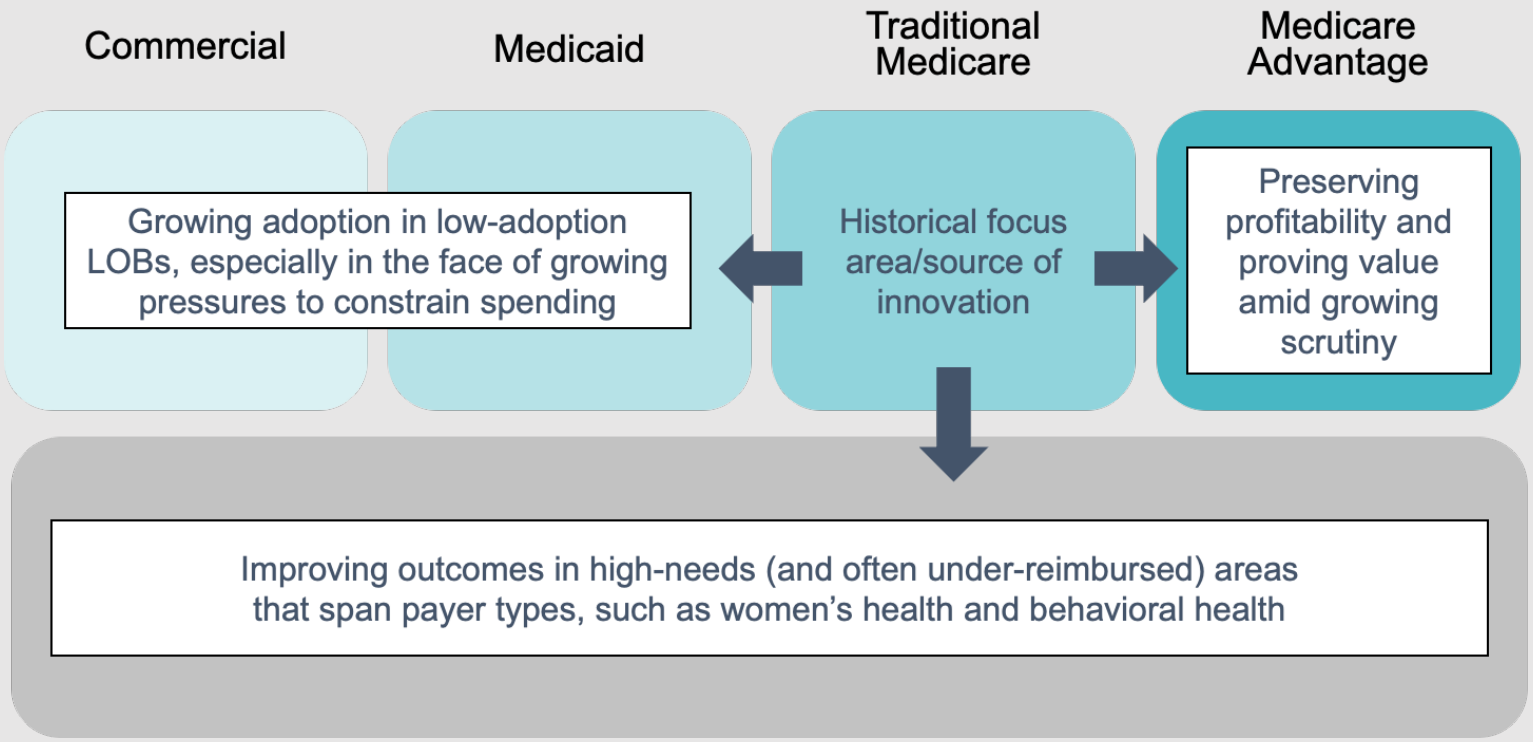
Source: Health Care Payment Learning & Action Network, "Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Traditional Medicare Programs," November 9, 2022.

It is unsurprising, then, that the center of gravity within the VBC movement has slowly and steadily shifted away from the traditional Medicare space (fig. 34). MA has been the clear leader for some time now, but a few other areas of focus have emerged as well.

The lack of significant uptake within the commercial and Medicaid lines of business is increasingly being underscored as an opportunity by the investor community. Of course, the types of payment and care models deployed for each of these segments are likely to be very different.

Value-based payment is also being deployed with a lens toward improving profitability and outcomes in areas that have historically had unfavorable economics and/or particularly acute shortfalls in quality. Two rising focus areas today are behavioral and women's health.

Fig. 34: VBC's focus is shifting away from (traditional) Medicare



Insight #8

Health equity efforts are converging on maternal health as leaders see a tangible ROI in a long-standing problem area. But all disparities are becoming core to clinical quality—we cannot lose sight of the broader drivers outcome inequality.

The focus on women's health broadly, and on inequities in women's health specifically, has emerged repeatedly in this year's research. "Femtech" is one of the few areas that defied 2022's headwinds in healthcare investment. Nearly all employers are expanding coverage for women's health benefits. Value-based women's health models are on the rise.

What the industry appears to be responding to is a compelling mix of business opportunities and worthy problems: employers' need to retain women amid declines in workforce participation; the lack of health tools designed for and by women; and a long list of gender, geographic, and racial inequities in the women's health space.

Daunting as these challenges may be, they also likely feel more inflectable to organizations than issues tied to racism and intergenerational poverty.

That said, understanding the larger drivers of health inequity will be critical in making progress in areas outside of women's health. By understanding the broader drivers of unequal outcomes, leaders can expand their efforts to other areas that serve business needs and present opportunities for improved equity.

Developing a meaningful health equity strategy is ultimately an exercise in calibration: Go too narrow and risk under-addressing a critical structural issue; go too broad and risk over-promising or talking in platitudes without making meaningful progress.

Fig. 36: Equity efforts converging on women's health

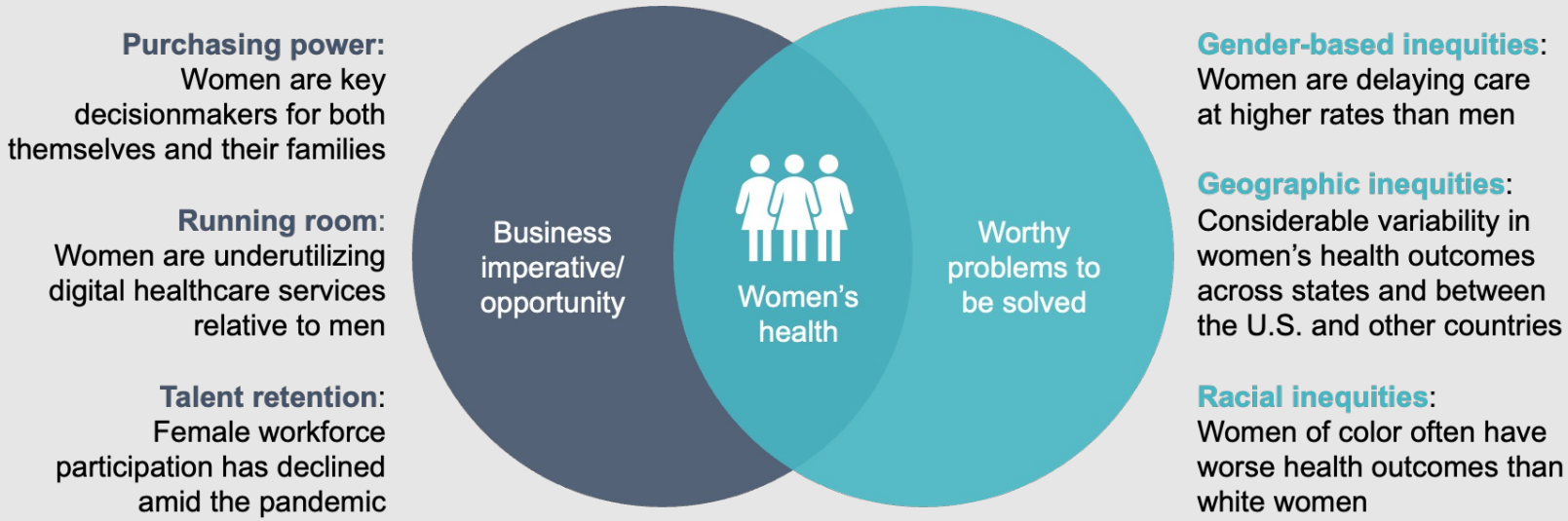


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Fig. 37: Spectrum of approaches to Environmental, Social, and Corporate Governance

Section 4

4 imperatives for healthcare leaders

Prioritize enablement over novelty. Favor tech that can enable value-based care, accelerate clinical trials, expand the reach of clinicians, and automate simple-but-time-consuming tasks.

Consolidate to right-size, not just grow. Consolidation will be about acquiring new capabilities enabling more comprehensive solutions with greater leverage and necessarily lower costs.

Define a clear corporate identity. As the lines between industry sectors blur, a new generation of corporate identities is emerging. As these new identities come into focus, scrutiny and skepticism will follow.

Forge a new compact. Patients are unwilling to cede some pandemic-era conveniences. Workers need support beyond compensation. Communities are demanding a more equitable system.

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