■ BACKCASTING

for all healthcare organizations

Envisioning paths to nationwide VBC

Is nationwide VBC the future – and how could we get there?

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How could *nationwide* value-based payment become a reality in the next 5 to 10 years? Looking to today's market for clues, our team envisioned several scenarios of how influential stakeholders could make that happen.

In each scenario, we describe what the future would look like, how it would unfold, and what it would mean for major stakeholders in healthcare—and what to do if this future doesn't look rosy for your organization.





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How we tackled the question

With our Advisory Board brain trust, we approached this question in three phases.

Phase 1: Influence mapping – Assessing industry power dynamics in VBC

Before we could analyze scenarios to nationwide risk, we needed to map out how much influence various stakeholders have on the outcome of VBC. How does (or could) each sector wield that influence? Who is most motivated to act? Who is at risk of being left out entirely?

We answer those questions in our VBC stakeholder infographic. This thinking laid the groundwork for how stakeholder dynamics would play out in a wide range of paths to nationwide risk.

Phase 2: Divergence – Brainstorming paths to nationwide risk

Next, we wanted to envision as many paths as possible that could catalyze the industry toward broad adoption of risk. We convened a group of more than 25 researchers with a wide range of expertise and brainstormed the following question with them: What are paths to meaningful risk? Our open-ended discussion generated 24 discrete scenarios, some familiar and others more provocative. See the appendix for a list of the scenarios.

Phase 3: Convergence – Narrowing to paths worth exploring

With two dozen scenarios to play with, we began to filter down a few that we could explore in greater detail. We next asked the group of researchers two sets of questions based on the list above.

For the first set of questions, we told them to adopt a **specific stakeholder's lens**, such as a life sciences company or health plan—whoever they work with most. We asked:

- If you could wave a magic wand, what one or two scenarios would you want to make happen?
- Which one or two scenarios would you want to prevent from happening?

Responses were highly variable. Predictably, stakeholders opposed paths that hurt their business and supported paths that advantaged them.

For the second set of questions, we told the researchers to respond with **their own perspective**. We asked:

- Which scenario do you think would lead to the best quality and outcomes at the lowest cost?
- Which scenario do you think is the most likely?



Three scenarios to nationwide risk

In this series, we dive into three scenarios – some approachable, others harder to imagine. We'll start this series with the latter.

For each one, we answer:

- · How could the scenario unfold? How would it catalyze VBC?
- What would make it possible? What realities stand in the way?
- If this happens, what would the implications be for key industry stakeholders like physician groups, hospitals and health systems, and life sciences companies?

01

SCENARIO

Employers at the helm

Employers pursue steerage and direct contracting with value-based providers

02

SCENARIO

Tech disruption

Technology companies take their slice of healthcare, disrupting incumbents to reduce costs and make care delivery consumer-centric

SCENARIO

03

Dominant health plan

One national health plan take its vertical integration strategy to the extreme, controlling where care happens and how it's paid for



Employers at the helm

The scenario

In this scenario, persistently poor economic conditions would push cost-conscious employers to embrace self-insurance and reduce medical spending by steering employees to the most cost-effective care options. Instead of relying on payers to manage their spending and networks, employers would explore direct contracting with low-cost, high-quality provider organizations, especially in primary care. To incentivize employees to use these providers, employers would leverage value-based benefit design.

To gain market power, small and medium employers could band together into regional alliances. National players would look to partner in regions where their workforce is less concentrated.

As a result, employers would push risk adoption in the commercially insured population, outpacing Medicare risk adoption.



1. EMPLOYERS AT THE HELM (CONT.)

Impact on the industry:

1. Healthcare would become (even more) local, creating further fragmentation.

As employers form alliances with one another, they would seek to centralize their provider networks, thus creating a "walled garden" of care. Patient choice would be limited outside the region, but care within the market would be tailored to the employee population. The localization would create competition between national "health solutions companies" (i.e., OptumCare and CVS), which have expansive PPO networks, and employer alliances, which would use bespoke HMO networks. (Note: Advisory Board is a subsidiary of Optum. All Advisory Board research, expert perspectives, and recommendations remain independent.)

2. Employers' pursuit of ASO contracts would threaten traditional health plan and PBM businesses.

Employers would aggressively carve out benefits to third-party administrators and specialized service providers. Payers that haven't diversified their service offerings run the risk of being relegated to administrative services only (ASO) businesses. In contrast, diversified health solutions companies could still serve employers in administrative services, benefit navigation, performance improvement, etc.

Similarly, employers could seek alternatives to traditional pharmacy benefit manager (PBM) arrangements. <u>Steerage toward generics</u> and <u>cost-plus models</u> could serve as initial alternatives. The move away from status quo pharmacy benefits would drive further employer separation from contracts with national payers.



1. EMPLOYERS AT THE HELM (CONT.)

Why this scenario is possible

To employers, healthcare isn't a profit driver—it's a cost center. Health benefit costs are expected to <u>rise by 5.4% in 2023</u>, and employers are bracing for accelerated increases in the years to come. But instead of cost-cutting, employers are prioritizing employee retention due to a tight labor market. Assuming labor conditions cool, stark economic realities will force an aggressive pivot toward cost reduction. There's a discontinuity between what employers want and what insurers are offering, and to regain control over healthcare incumbents, the remaining fully insured employers may shift to self-insurance. The transition ultimately would give them better oversight of expenses and freedom to experiment with employer partnerships and value-based benefit design.

<u>The unpopularity of cost shifting strategies</u> like high-deductible health plans is leading employers to consider a new steerage strategy: value-based benefit design. Instead of simply gatekeeping specific services or medications, it offers <u>incentives</u> to employees to choose cost-effective care. It also requires less capital and scale than soft steerage, like <u>Walmart's approach</u>.

The Walmarts and Boeings of the world aren't the only ones who can effectively self-insure; regional employers can too. However, unlike national employers, who often have the capital and critical mass of employees to take on risk themselves, regional employers require partnership to effectively self-insure. Forming employer alliances solves one major problem—it allows employers with small workforces to combine their employees into one large risk pool, which avoids the risk of a few employees creating catastrophic costs. Moreover, alliances encourage employers to share claims data allowing them to effectively price healthcare services in their market. This, along with a conjoined workforce presence, allows alliances to form preferred provider networks and steer their employees toward high-value providers or negotiate for better rates. What's formed is essentially a regional HMO.

National employers could be part of this as well. They may not have a critical mass of employees in every market and gaining access to these regional HMOs, whether through partnership or purchasing, could be more cost-effective than going through national payer networks. The resulting framework allows employers across markets to align their resources and utilize value-based care.



1. EMPLOYERS AT THE HELM (CONT.)

The reality is...

- The economy could improve resulting in reduced pressures in healthcare costs.
- Worsening economic conditions may not motivate employers to take on the risk of healthcare costs.
- Employee satisfaction with narrow networks, no matter how tailored, will likely be low.
- Health solutions companies may have superior networks and offerings, making them the preferred partner for most employers.
- While some examples of self-insured alliances exist, nationally scaled ventures like Haven demonstrate that these partnerships are not so easily executed.

Implications

Not every stakeholder would be a winner in this future scenario. Here's how key stakeholders would be affected and how they should respond.



INDEPENDENT MEDICAL GROUPS

How they win

Independent medical groups (IMGs) have one key advantage in this scenario: they're far cheaper than hospital outpatient departments (HOPDs). IMGs, especially those with experience in commercial risk-based arrangements, are well-positioned for partnerships with cost-sensitive employers.

How they lose

Most employers would be new to this level of involvement in risk aggregation, healthcare benefits, and care delivery. That is a steep learning curve. Without a foundation of trust and understanding, employer-provider partnerships are at risk of fall out without immediate big wins.

How to run at the wins

Begin exploring direct-to-employer partnerships with small and medium employers or alliances in your region. Employers of all sizes are looking for ways to manage cost more effectively.

How to avoid the losses

Partners must be aligned on a shared definition of success to drive toward. Importantly, don't set yourselves up for failure on what is and isn't achievable in the first couple years of a contract. Define short- and long-term wins.



1. EMPLOYERS AT THE HELM (CONT.)



PHARMACEUTICAL INDUSTRY DISRUPTORS

How they win

Drugs are a top cost center in healthcare. Companies that find ways to disrupt the status quo and save purchasers money will win out in this scenario over incumbent PBMs and manufacturers.

How they lose

Scale and proof of concept are of primary concern. While traditional PBM offerings are costly, their processes are far more entrenched and recognizable. Disruptive players have a lot to prove, but the potential for disruption is big.

How to run at the wins

Articulate exactly how your offering alleviates employers' cost problem. There are various areas to target, including generic alternatives, transparent PBMs, and cost-plus models.

How to avoid the losses

Transparency with pricing is vital. Even if you came out as more expensive than a traditional PBM or drug manufacturer, transparency <u>may</u> be refreshing enough to win favor.



HEALTH SOLUTIONS COMPANIES

How they win

Widespread self-insurance is less of a threat to health solutions companies than traditional plans since health solutions companies have already broadened their capabilities beyond health insurance. In this scenario, employers want partners willing to help them navigate their challenges toward effective self-insurance. Health solutions companies are well positioned to do just that.

How they lose

This scenario would likely mean more competition for health solutions companies' traditional insurance offerings and provider networks.

How to run at the wins

Don't get stuck holding onto the past. If the industry moves in this direction, health solutions companies must evolve to serve employers in a new way. Understanding their biggest challenges, such as navigating various vendor relationships and benefit offerings, will be key.

How to avoid the losses

Continue to <u>evolve</u> your value proposition and core identity to realize growth and business stability through strategic diversification.



1. EMPLOYERS AT THE HELM (CONT.)



REGIONAL HOSPITALS AND HEALTH SYSTEMS

How they win

Acute care will always be necessary and growing local healthcare purchasing power would mean regional hospitals and health systems would continue to be necessary in this scenario. Granted, inpatient costs vary dramatically on the regional level.

How they lose

Regional hospital and health system HOPD costs are unsustainable. In this scenario, employers would seek high-value arrangements with independent practices or vertically integrated medical groups long before HOPDs, due to facility costs.

How to run at the wins

Assess how your prices stack up with other acute care facilities in your region. Make sure your prices meet employer standards to maintain a regional presence. Otherwise, employers have been known to cut high-cost hospitals from networks.

How to avoid the losses

Find ways to reduce cost, or purchase assets that produce better margins. For example, explore acquisition of urgent care facilities, primary care practices, or ambulatory surgery centers as competitive offerings in your market.



Traditional health plans would come up short in this scenario.

How they lose

Without diversified service offerings, traditional health plans could be relegated to administrative services only.

How to avoid the losses

Diversify offerings sooner rather than later.

Demonstrating the value your organization brings over other third-party administrators offering claims processing is essential to retaining business.



Tech disruption

The scenario

In this scenario, technology companies (such as Amazon, Apple, Google) would fully commit to disrupting the healthcare industry. They would see an opportunity to expand their profits without cannibalizing existing revenue streams—a challenge incumbent players struggle to overcome. Each company would deploy strategies that reduce costs, make care easier to access, and improve consumer experience.

Technology companies are *outsiders*. While they are reliant on incumbent expertise, they aren't beholden to incumbent priorities. Every dollar generated from their healthcare businesses is net new revenue, which means they can operate in lower-cost ways without eating into preexisting revenue streams leading to downstream cost reduction.

The result of this scenario would be a consumer-centric healthcare industry and a reduction in total cost of care.



Impact on the industry:

1. The push toward greater tech enablement would expose digital inequities.

Tech companies' digital-first approach would force stagnant players to invest heavily in digital infrastructure and offerings. However, digital access, literacy, and trust in technology companies are currently barriers to adoption. Appropriately, all stakeholders (tech, providers, payers, and government) would have to make improving digital equity a top priority.

2. Other providers would be forced into capitated arrangements to compete with consumer-centric tech companies.

Patients would grow accustomed to consumer-centric care delivery, which would force incumbent providers to make convenience and patient satisfaction more important. Reducing costs for incumbent providers often requires <u>demand</u> <u>destruction</u>—an unattractive position for businesses with already thin margins. For those providers looking to compete, adopting two-sided risk or capitated payments would be necessary to stay competitive.

3. Technology companies would rely on incumbents to fill necessary roles in the healthcare ecosystem, fostering an industry of giants.

In the heavily regulated healthcare industry, tech companies are reliant on partnerships with incumbent players. The only alternative would be to buy a hospital or health plan, and it's unclear whether tech companies want all the regulations and additional competition that comes with those purchases. Instead, under this scenario, tech companies would leverage their proficiencies as service offerings to major payers, health systems, and employers, further isolating local and regional players.



Why this scenario is possible

Tech companies have tried to disrupt healthcare before—with little to no success. They have a lot to prove when it comes to innovating the industry, but that hasn't stopped them from trying. Their <u>willingness to divest</u> and fully pivot business priorities is a unique strength in healthcare. The industry is long overdue for change, and a high tolerance for risk (with the funds to back it up) might be the necessary factor to push us into a new era of care.

Instead of starting from scratch, tech companies in this model would have chosen to center their healthcare strategy on already viable models. Amazon's <u>acquisition of One Medical</u> is a prime example. But the winning strategy won't look the same for every player. Each company's unique aims, approaches, and skill sets could allow them all to succeed independently while contributing to industry-wide change.

Tech companies' distinct strategies primarily tackle cost and convenience. Central to each of their strategies is a focus on consumer experience, something that sets them apart from incumbent stakeholders. Below are three examples of business opportunities tech might capitalize on:

- Develop intuitive patient navigation services to connect patients with low-cost, high-quality providers.
- Replace outdated low-acuity care delivery with convenient, high-quality, digitalfirst care.
- Simplify and centralize the patient data experience.

Providing care that is accessible, digitally enabled, low-cost, and high-quality is most advantageous in a value-based payment environment. And we know tech companies often use a subscription payment design (not dissimilar to capitation).

The reality is...

- The risk is immense. No entity has ever delivered on truly integrating data and care delivery at this scale.
- Consumer trust in technology companies and concerns over patient privacy may stunt opportunities early.
- This scenario assumes telehealth and other digital care continue to be reimbursed, and patients continue to utilize the offerings.
- The provider supply is limited, and this scenario would require a critical mass of clinicians who would willingly work for these tech companies.



2. TECH DISRUPTION (CONT.)

Implications

Not every stakeholder would be a winner in this future scenario. Here's how key stakeholders would be affected and how they should respond.



How they win

As the arbiter of employee benefits, employers would directly benefit from any advancement that makes care delivery less expensive and more consumer-centric.

How they lose

Forfeiting too much control over benefit design and claims data could diminish employers' ability to champion employee preferences.



How they win

Member data on a national scale makes national health plans powerful resources for tech companies. Many of the business opportunities proposed would overlap with health plans' digital front door strategy—meaning plans can benefit from service offerings as well.

How they lose

Tech companies' outsider status may threaten national health plans' dominance in the market. Since tech companies can work around inefficiencies that incumbents are tied to, health plans may be at risk of losing revenue to tech companies' solutions.

How to run at the wins

Seek partnership with tech companies early. Be a partner in developing the technologies—the expertise and data employers bring is invaluable.

How to avoid the losses

Don't forfeit your voice by assuming these tech companies can solve all your problems. Proactive partnerships with defined goals can ensure that employers stay in the driver seat. Continuing to push for price and data transparency will ensure tech doesn't cut employers out of the equation.

How to run at the wins

Identify inefficiencies in member experience and leverage tech and service offerings to improve member engagement and downstream cost projections.

How to avoid the losses

Data is gold. Set standards for when national plans share information or access to members with technology companies. There must be a mutual benefit to tech companies' offers that don't impede traditional business streams.



2. TECH DISRUPTION (CONT.)



LIFE SCIENCES COMPANIES

How they win

Insights from product ecosystem and centralized patient data would both support real-world evidence (RWE) and patient-reported outcome measure (PROM) initiatives. Connecting patients with prescriptions in a timely and easy way would help as well.

How they lose

There would be new competitors in the RWE and PROM space. Tech companies' outsider status strikes again. Competition for personalized data from tech companies' devices will be a new battle in a growing space for life sciences firms.

How to run at the wins

Find ways for pharmaceuticals and/or medical devices to be linked to these data streams to demonstrate efficacy. Creating an ecosystem of data is key.

How to avoid the losses

Solidify dominance in medical device spaces to ensure tech companies cannot move in on your territory. Lean into tech-enabled devices and use your in-depth expertise to your advantage.



INDEPENDENT MEDICAL GROUPS

How they win

Since movement to two-sided risk and capitated arrangements is key to competition, independent medical groups (IMGs) are largely in a good position to pivot or continue advancing their care models. Additionally, IMGs tend to be more agile in their approach to technology, giving them another edge in transitioning.

How they lose

Most IMGs lack the scale tech companies are looking for in a partner. This means IMGs benefit only after tech companies' offerings are sold as services rather than benefiting throughout the development stages

How to run at the wins

Find ways to market or improve your bespoke offerings to patients. Maintaining patient loyalty will be essential for incumbent providers. Additionally, consider accelerating investment in care transformation if you haven't already.

How to avoid the losses

Leaning into your ability to pivot quickly and scale new approaches will be to IMGs' benefit. Ensuring that NPS scores and engagement is high will be critical. While data can inform providers of gaps in care, acting on data is a different story. Smaller providers have the perk of being "boots on the ground" with their patients. Use this advantage to make tailored offerings even more meaningful.



2. TECH DISRUPTION (CONT.)



NATIONAL HOSPITAL OPERATORS

How they win

National hospital operators have the scale tech companies are looking for in a partner. Massive patient volume, data from acute care, and national infrastructure all play into tech companies' needs for expertise. Centralized patient data will be a massive improvement for acute care providers who don't interact with patients often. Additionally, acute care will be a necessary feature of this future state, as only so many solutions can be done virtually.

How they lose

Convenience is not an advantage for national hospital operators. Digital offerings and high-touch outpatient clinics will eat away at hospital outpatient department and ambulatory surgery center offerings, especially if they operate on a fee-for-service basis. Additionally, agile adaptation is sorely lacking in the hospital landscape.

REGIONAL HEALTH PLANS

How they win

Regional plans could benefit from improvements to the member experience and digital front door much the same as their national counterparts, but they won't be the first choice when tech companies are looking for a partner.

How they lose

Limited member scale or network footprint could leave partnership prospects lacking for regional health plans. And national plans will likely continue to eat up market share as the "industry of giants" grows.

How to run at the wins

Position yourself as an acute care partner to digital-first tech clinics. There will come a time when a patient needs to use acute services, and you need to ensure that you are a preferred partner. Also, consolidate acute care data to share with tech companies. Assisting in the development of tech opportunities could benefit hospitals greatly.

How to avoid the losses

Prop up more digital offerings where possible and make hospital services more consumer-friendly. You may not be able to control the services patients need at your facilities, but you can control the hospital experience and quality of care.

How to run at the wins

Make the case for the value of your member data. Once you've attracted a tech company to partner with, identify the inefficiencies in your member experience. Then, leverage tech and service offerings to improve member engagement and downstream cost projections.

How to avoid the losses

Ensure you have a solid foothold in your regional market. Tailor your services to retain business at home first, but then fight to reap benefits from tech improvements when and where possible.



2. TECH DISRUPTION (CONT.)



HOSPITALS AND HEALTH SYSTEMS

How they win

Hospitals and health systems have attempted to make care delivery tech-enabled for years, but without much luck. Tech companies could provide services to modernize hospitals and health systems, thereby minimizing the risk of up-front investment needed previously.

How they lose

Most hospitals and health systems won't have the scale tech companies are looking for in a partner. For this reason, competing with national hospital operators is not a viable strategy. The inability to quickly pivot service offerings and financing mechanisms makes outcompeting smaller providers a challenge, as well.

How to run at the wins

Tech companies aren't experts in acute care. While they can provide services to improve your technological infrastructure, it's up to you to assess where they're needed and where they're not. Carefully examine your digital maturity to narrow down where tech companies could provide value.

How to avoid the losses

Hospitals and health systems have two options: increase the breadth of services or improve the depth of care delivery. Increasing breadth through acquisition or partnership with other regional providers would allow you to capture more reliable volumes. Improving depth of care by engraining services in community need would cement your value in the market. The second strategy requires service rationalization, but it creates a more sustainable, lean business model. and where possible.



O3 Dominant health plan

The scenario

In this scenario, one dominant national health plan would acquire a vast footprint of ambulatory care providers and become vertically integrated. The plan would focus on growth through vertical assets nationwide for better population health management and industry control. With a broad, low-cost network, it could attract more Medicare Advantage and employer customers.

With the emergence of "health solutions companies," this scenario is imaginable. It's where industry momentum is already headed. What is different here is that one plan would separate itself from the pack. It would control the industry. It could decide to push providers toward capitated arrangements.

As a result, this plan's proficiency in capitated outpatient care delivery could lower costs for patients, employers, and Medicare while maintaining quality.



Impact on the industry:

1. Hospitals would consolidate and seek partnership for volume.

The vertically integrated entity would limit inpatient volume, squeezing already slim hospital margins. Hospitals would begin to close due to lack of demand. The remaining profitable hospital operators (namely forprofits such as Tenet Healthcare, HCA Healthcare, and Community Health Systems) would seek partnership with the dominant health plan.

2. Remaining competitor plans and ambulatory providers would lose considerable market share.

With lower costs and better access, the dominant organization would outcompete health plan competitors for employers' business. The national plan would also leave some ambulatory care providers out of its network, leaving specialists disproportionately impacted. Some specialists would agree to strict cost and quality requirements to join the network. Others would close entirely.



Why this scenario is possible

National health plans are already <u>diversifying</u> their business models through vertical integration. For example, UHG's Optum Care focuses on acquiring practices that are well positioned to take on Medicare and <u>commercial risk</u>. (Note: Advisory Board is a subsidiary of Optum. All Advisory Board research, expert perspectives, and recommendations remain independent.) CVS/Aetna continues to <u>acquire providers</u> to fuel its growth strategy. <u>Recent forecasts</u> show these plans and other nontraditional players will own 30% of ambulatory physicians by 2030.

On the other hand, hospitals across the nation continue to <u>operate in the red</u>. Their margins are squeezed by continued outpatient shift, legislation reducing their prescription drug profits, and deferred care from the pandemic. Continued struggles leave them open to acquisition by profitable hospital operators like HCA and Tenet.

National health plans are unlikely to buy hospitals, especially since one of their main priorities is to prevent unnecessary hospitalizations and ED visits. But there will always be a need for acute care. And hospital operators need some kind of patient flow. Thus, a dominant national health plan would need to partner with a hospital operator to send members to hospitals when needed and influence the future acute care footprint.

The reality is...

- Robust M&A activity invites regulatory scrutiny. The DOJ actively <u>blocks large</u> mergers. This scenario exists only with a laissez-faire FTC and DOJ.
- Acquisitions don't guarantee integration. This strategy would require considerable "systemness" efforts.
- A dominant national health plan may balance outright ownership with partnerships. Once it has acquired a critical mass in key markets, it can pursue partnerships instead of M&A. Over time the plan's strategy could slow or change altogether as it learns more.



3. DOMINANT HEALTH PLAN (CONT.)

Implications

Not every stakeholder would be a winner in this future scenario. Here's how key stakeholders would be affected and how they should respond.



INDEPENDENT MEDICAL GROUPS

How they win

Groups succeeding in risk would become highly sought after, garnering leverage in negotiations with potential suitors.

How they lose

Integrating medical groups at scale risks physician autonomy. Specialist practices would have to lower total cost of care or get squeezed out of the market entirely.

LIFE SCIENCES COMPANIES

How they win

It would become easier for life sciences companies to pursue long-term, outcomes-based payment methods. In this scenario, patients would no longer be switching from plan to plan. As a result, this dominant national health plan would be incentivized to manage patients across their lifespan, rather than for only one to three years.

How they lose

Life sciences companies would lose pricing power. This giant health plan would have concentrated buying power and thus be able to dictate costs.

How to run at the wins

Continue adoption of risk-based payment and investments in population health management. Consider prospective offers while the market is favorable.

How to avoid the losses

Proactively seek partnerships with cooperative entities to retain autonomy and capture market share.

How to run at the wins

Develop drug and medical devices that reduce costs over a long horizon, especially for pediatric patient populations. Consider alternative payment model options to support long-term partnerships.

How to avoid the losses

Partner with a variety of provider organizations and health plans to maintain competition in the industry.



3. DOMINANT HEALTH PLAN (CONT.)



How they win

Employers would become less dependent on health benefits as a differentiator for talent. The dominant health plan would manage health throughout employees' lives and thus find it beneficial to invest in upstream, preventive care.

How they lose

Employers would lose the ability to shop for health benefits. Without competitive offerings, they'd be at the mercy of the dominant health plan's premium rates, provider network, and other offerings.



REGIONAL HEALTH PLANS

Regional health plans would come up short in this scenario.

How they lose

Regional health plans would lose market share and be squeezed out of the market due to fierce competition.

How to avoid the losses

How to run at the wins

and quality improvements.

How to avoid the losses

as public options.

Employers would need to demonstrate to

employees that capitated health plans will

Advocate for state or federal safeguards to

protect against exorbitant premium rates, such

provide superior out-of-pocket cost reduction

Don't wait. Be the first to establish an advantageous relationship with regional providers. Also, consider diversification as a defensive strategy.



HOSPITALS AND HEALTH SYSTEMS

Hospitals and health systems would come up short in this scenario.

How they lose

Hospitals and health systems lack the infrastructure to scale value-based payment. As the dominant health plan would be centered on VBC, decreased patient volumes would push already slim margins over the edge.

How to avoid the losses

Don't get caught flat-footed. Diversify revenue streams away from fee-for-service models. Additionally, health systems could attempt a defensive partnership with regional health plans to capture some patient volume. Build a strong community tie by tackling social determinants of health in your area, thus making your facility an invaluable asset to the community. If all else fails, hospitals and health systems may have to cut their losses and partner with the dominant health plan. Forfeiting some control is better than being squeezed out of the market.



Parting thoughts

Value-based care is decidedly a move away from a broken system that is often profitable toward a system that will not reward everyone the same way. That future will be better for some than others. To solve the healthcare industry's cost problem, some players will lose out.

Today's leaders must ask themselves: What am I willing to sacrifice to secure a place in a VBC future? What combination of wins and losses are acceptable to me (and my partners)?

As this backcasting analysis demonstrates, the stakeholders who create the future of VBC future will not only ensure it works to their advantage, but they will also influence which stakeholders get left behind. Shaping that future starts now.



Appendix

24 paths to nationwide risk-based payment

- Incredibly slow march of cross-industry partnership
- Health plans purchase physician groups and clinics
- Health plans mandate risk and leave FFSminded provider organizations out of network
- 4. Provider-sponsored health plans partner with employers at scale
- States eliminate employer-based insurance and move to a public option
- 6. States move to personal health budgets
- One state becomes an HMO (and all other states follow: 50 HMOs)
- 8. The government creates Medicare Advantage for All
- 9. U.S. federalizes healthcare delivery entirely
- The government redesigns pay-forperformance incentives to promote greater competition
- Employers form a coalition to force plans and providers into risk to reduce costs
- Largest employers team up with major integrated delivery networks (IDNs) via direct contracting
- Consumers create healthcare unions (or build on existing unions) to put pressure on employers
- 14. One national health plan fully vertically integrates and partners with large hospital operators
- Provider organizations and plans consolidate to one or two brand-name IDNs with plans (like a Kaiser or Intermountain)

- 16. A large technology-driven company like Amazon buys CVS/Aetna and partners with major hospital operators for inpatient care delivery
- 17. National health plan sells their physician group entities to a large tech company, who scales them
- 18. Tech-enabled companies acquire primary care businesses with a focus on specific markets (such as Amazon buys Kaiser for commercial market and Apple buys ChenMed for Medicare and MA)
- 19. Investors pour more dollars into existing independent disruptors that each section off their primary care market (for example, ChenMed takes seniors; Amazon and OneMedical take commercial) and create narrow, low-cost networks for all specialty and acute careA major life sciences company (such as Pfizer) buys medical groups
- 20. A life sciences company and a large health system enter into risk together, circumventing PBMs and growing outcomesbased contracting
- 21. A third-party organization develops a standard risk-based payment model and sells it to provider organizations and plans, stamping out a unified VBC future
- 22. A digital company, life sciences company, and physician group partner up to unify the patient experience at a lower cost care
- 23. Private equity groups work together to come up with a single healthcare strategy and push the whole industry to VBC



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