EXECUTIVE BRIEFING PREVIEW

16 Things CEOs Need to Know in 2022

Advisory Board

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

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

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

This preview contains the first nine of our 16 top insights about the state of the health care industry in the wake of the Covid-19 pandemic. Members of select Research programs[1] have access to the full briefing.

For more information, please contact us at **programinquiries@advisory.com** or visit **advisory.com/memberships**.

1) Health Care Advisory Board (Strategy for hospitals and health systems), Health Care Industry Committee (for health care professional service companies), Clinical Innovators Council (for life sciences firms), Health Care IT Forum (for digital health companies), and Health Plan Advisory Council (for health plans).

16 things CEOs need to know in 2022

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

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

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

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

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

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

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

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

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

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

PART II. AN INDUSTRY AT THE CROSSROADS: HOW TODAY'S DECISIONS WILL SHAPE THE FUTURE OF HEALTH CARE

01

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

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

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

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

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

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

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

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

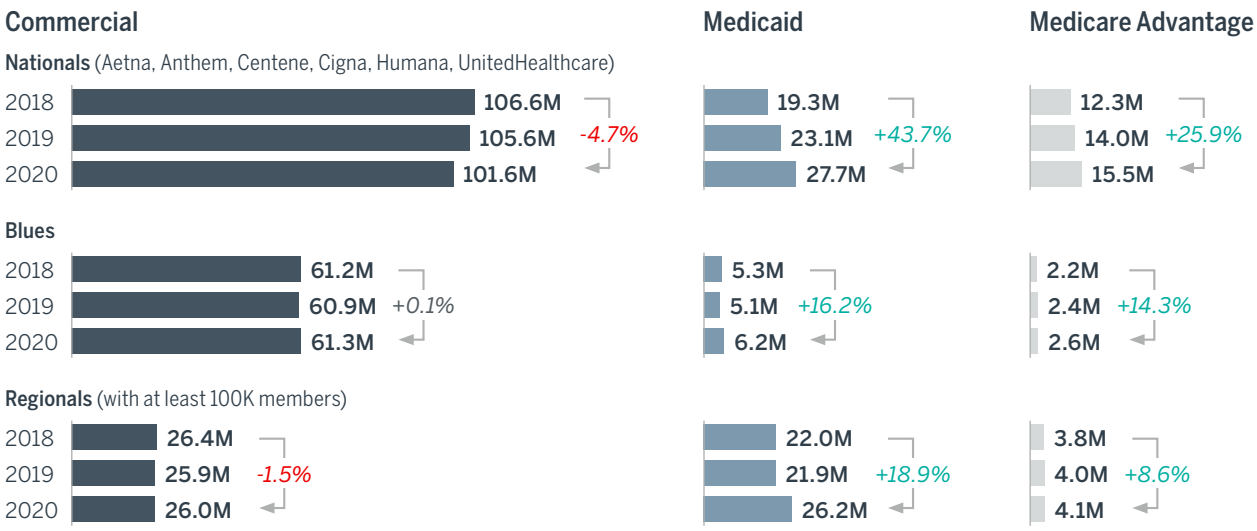
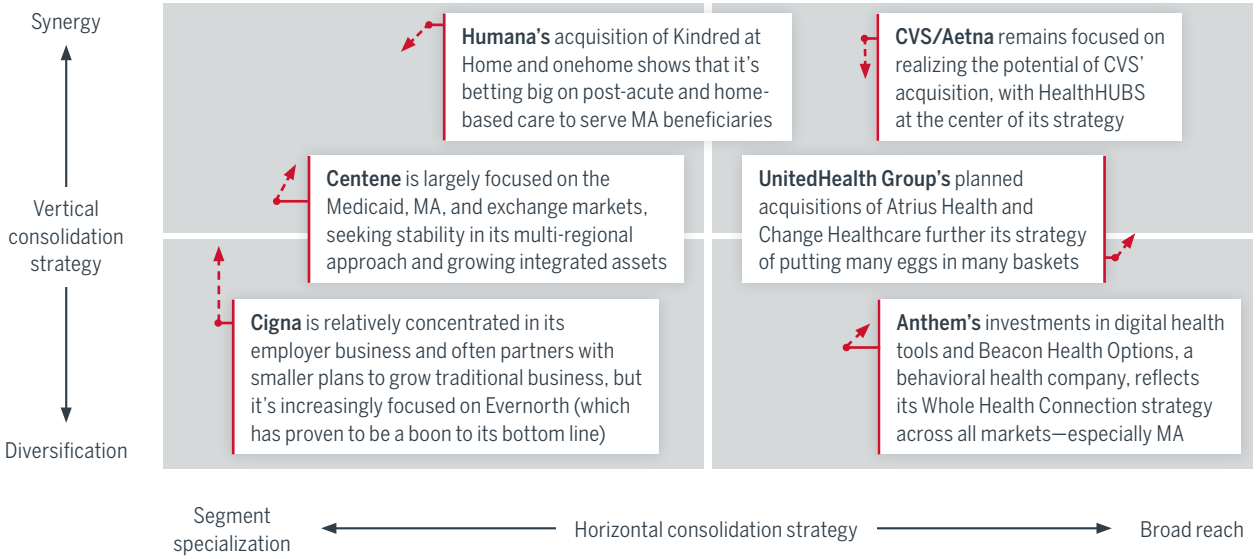


FIGURE 1.2: **RELATIVE CURRENT CONSOLIDATION STRATEGIES OF THE NATIONAL HEALTH PLANS—AND WHERE THEY'RE TRENDING**



02

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

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

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

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

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

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

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

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

Modern Healthcare health system financials database

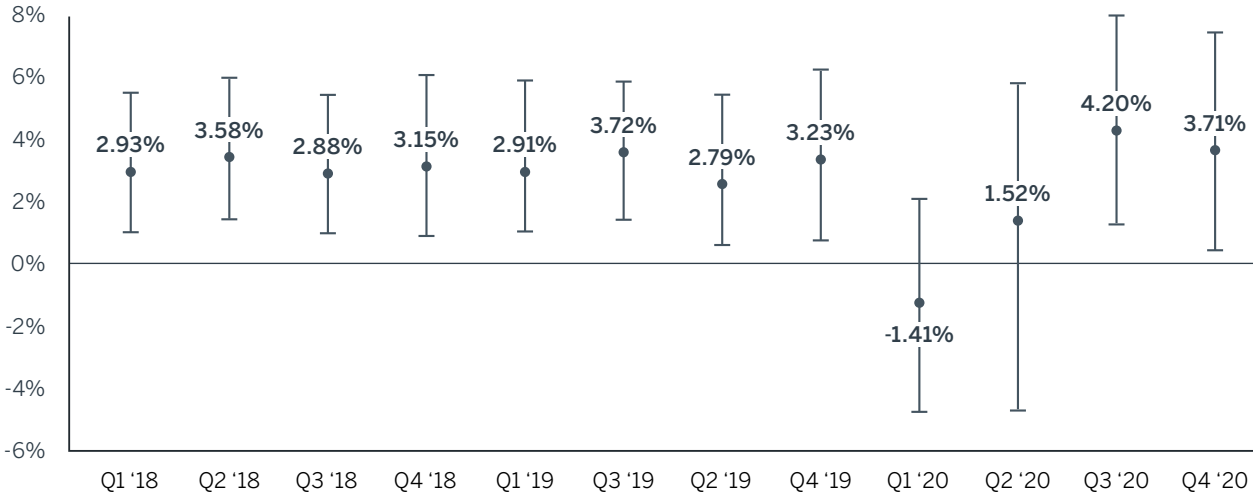


FIGURE 2.2: **AS M&A PICKS UP, DEALS CENTER ON REGIONAL STRENGTH**

Acquisitions of community hospitals

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

Mergers between regional systems

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

Divestitures by national systems

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

Deal ambition

Regional players expanding and solidifying regional strength

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

FOR MORE INFORMATION

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

03

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

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

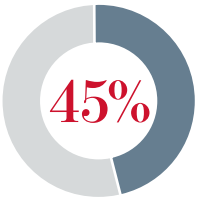
Once again, the local severity of Covid-19 affected how any individual practice fared. Large and multispecialty groups weathered volume fluctuations more easily, as did groups with capitated arrangements. Agile governance structures also proved critical, especially as practices had to move quickly to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

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

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

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

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

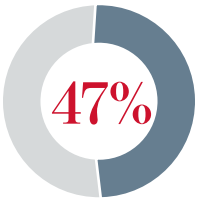


Percentage of physicians who experienced **no financial or practice-related ill effects** due to Covid-19

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

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

Clinicians in desperate need of a break



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

Physicians leaving due to Covid-19

Survey conducted February 2021

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

11% Considering **early retirement**

8% Considering **leaving medicine** entirely

FOR MORE INFORMATION

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

04

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

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

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

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

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

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

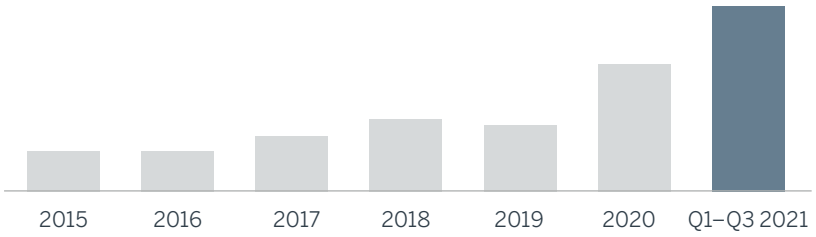
8) Galvin G, "Half of Voters Support Plan to Let Medicare Negotiate Drug Prices," Morning Consult, September 2021.
9) Hawks C, et al., "Q3 2021 digital health funding: To $20B and beyond!" Rock Health, October 2021.

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

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

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

Full year 2015-2020 and Q1–Q3 2021



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

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

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

05

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

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

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

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

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

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

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

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

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

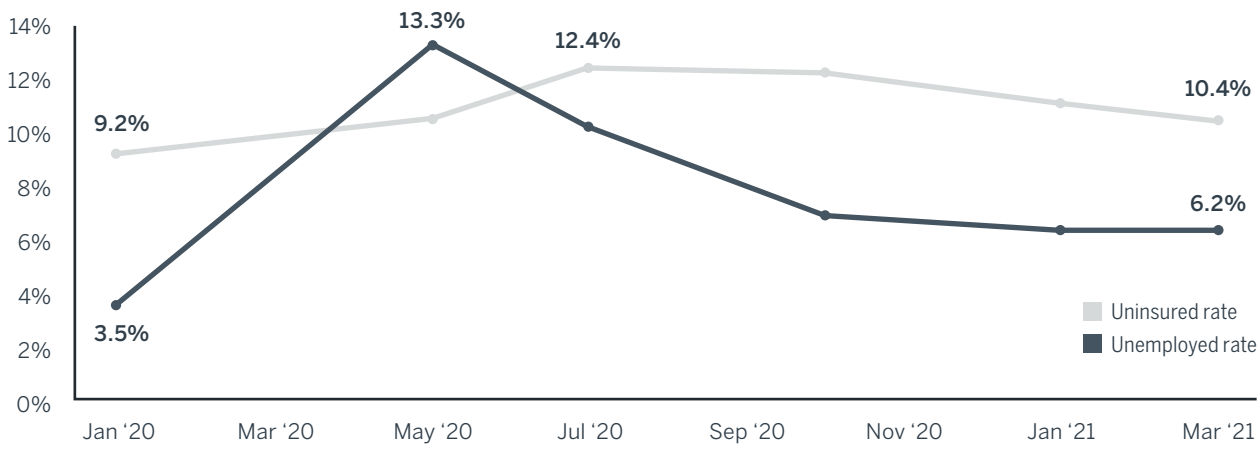
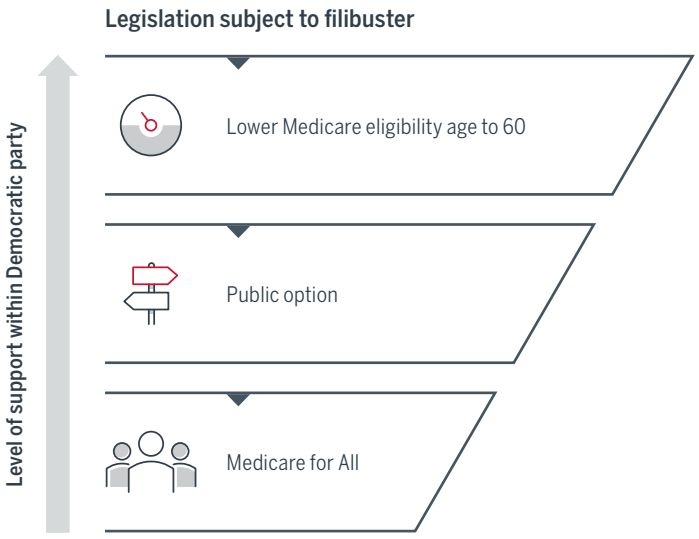


FIGURE 5.2: **FEDERAL COVERAGE REFORMS FACE A DAUNTING BARRIER**



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

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

06

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

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

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

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

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

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

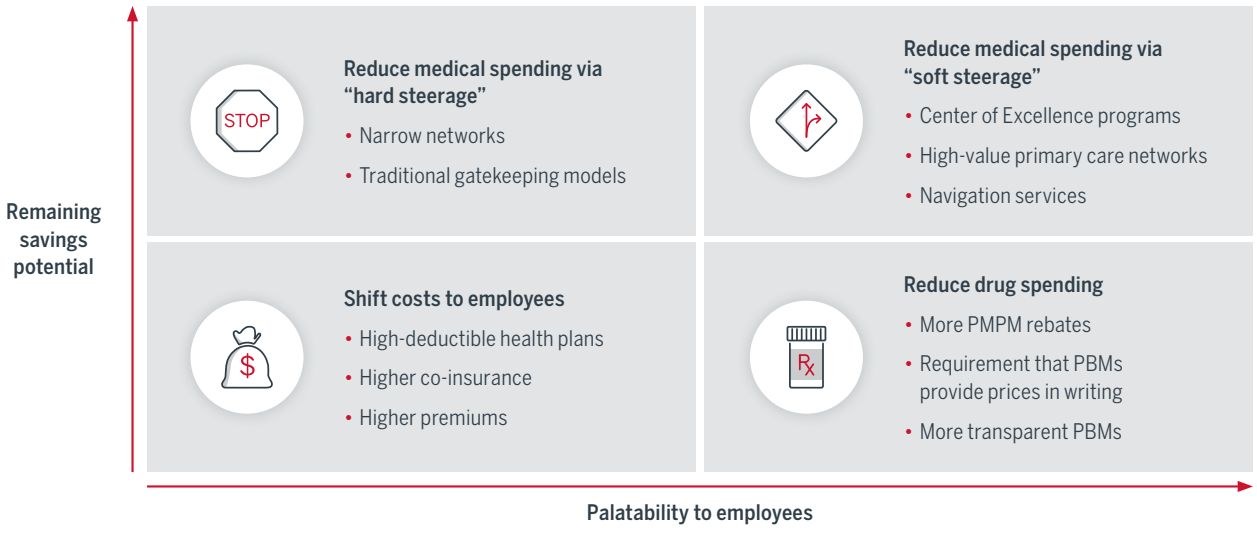
2020 Over one-third (**37%**) of employers reported health care costs that were **8% or more** below budget

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

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

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

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



07

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

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

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

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

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

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

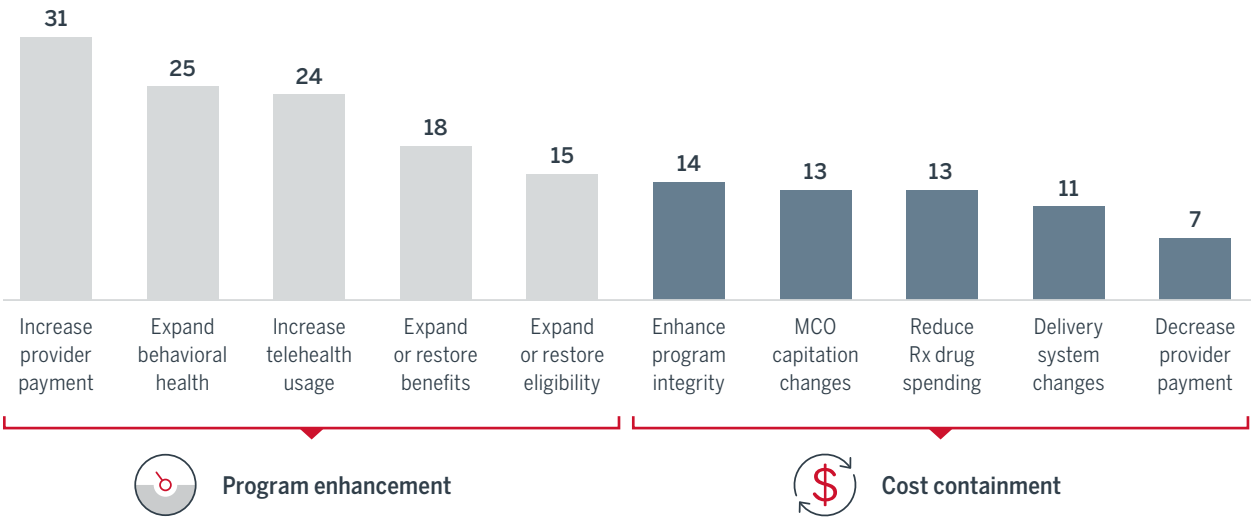


FIGURE 7.2: **STATE MEDICAID PROGRAMS TACKLING HEALTH DISPARITIES**

Expanding postpartum coverage

26

States extending Medicaid coverage to 12 months postpartum in 2022

Building SDOH requirements into MCO contracts

140%

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

Adopting health equity standards

5

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

FOR MORE INFORMATION

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

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

08

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

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

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

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

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

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

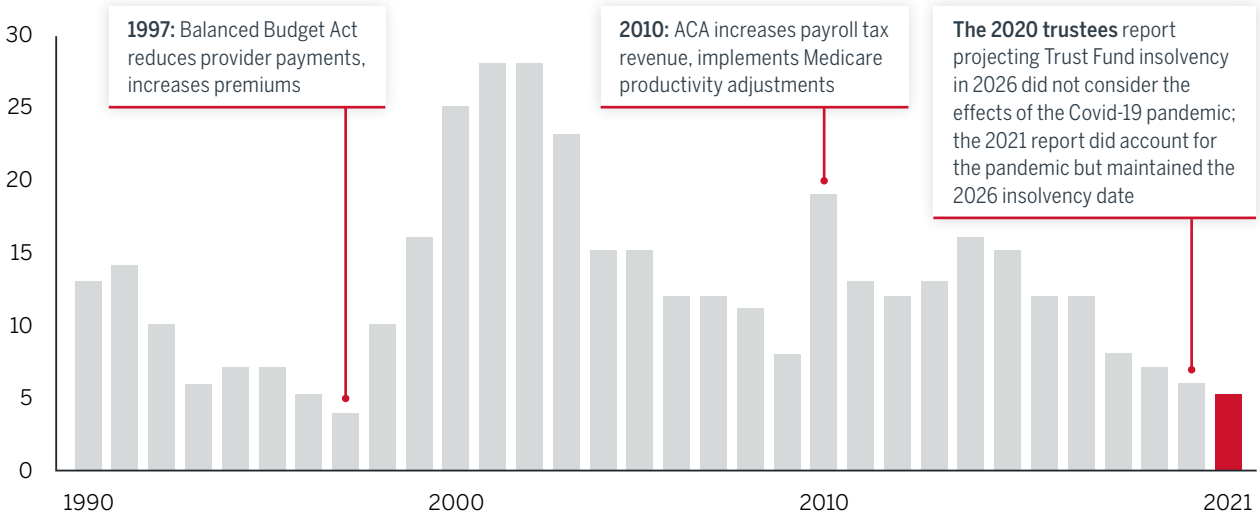
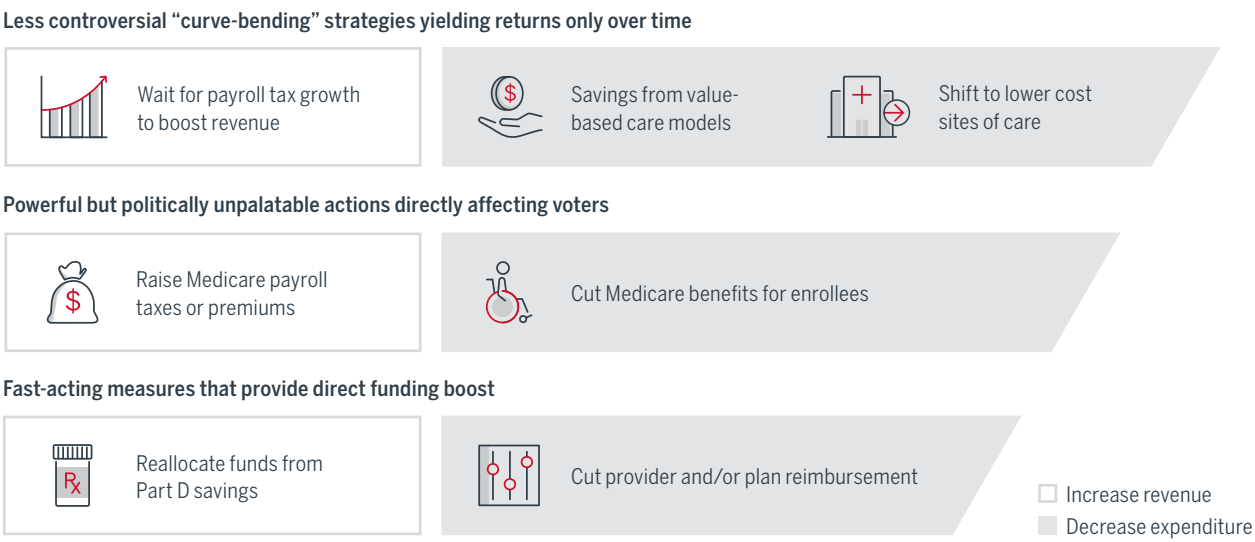


FIGURE 8.2: **OPTIONS FOR TRUST FUND SOLVENCY BALANCE POLITICS AND TIME**



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

09

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

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

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

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

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

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

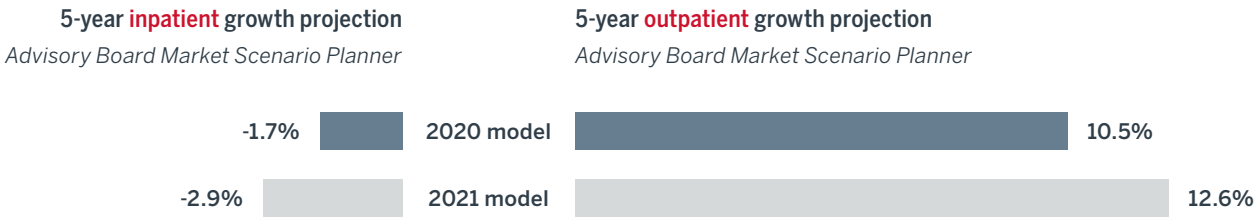
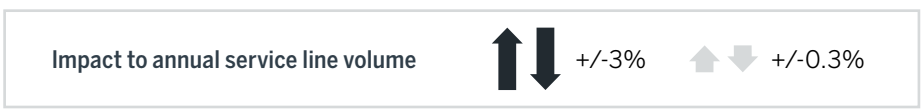


FIGURE 9.2: **COVID-19-RELATED IMPACTS ON SERVICE LINE DEMAND**

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



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