2024 Annual Health Care Trends Report

Analysis on forces driving change, what to watch and how to move forward for C-suite health care leaders

Economics, regulatory pressure, workforce and consumer demands combined with breakthrough innovation continue to transform the health care industry. These changes come with both excitement and uncertainty.

It's predicted that escalating costs combined with workforce shortages will make it difficult to meet growing care delivery demands. However, just as COVID accelerated adoption of telehealth, it's also predicted that breakthroughs in generative AI could accelerate information flows, workflows, therapeutic innovation and decision-making. And experts believe innovations such as digital care delivery and new drug and gene therapies offer opportunities to cure diseases and enhance outcomes. These enhancements, aimed at creating a simple, seamless health care experience, are being embraced across the health system.

This year's activities mark a momentous shift in the health care industry.

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Financial headwinds and emerging competition mandate adoption of tools and strategies that can bring cost, demand and services into alignment. The business model that can best serve as a conduit for this alignment is value-based care.

Shifting from a transaction-based model to one that is outcomes-based enables providers to focus on the overall health and well-being of patients, rather than keeping a narrow focus on individual services. Value-based care is outcomes-based by nature. It connects with a person's full health journey and considers their mental, physical, emotional, social and financial well-being. This approach can leverage today's innovations to reduce costs, satisfy workers and consumers, and focus health care actions when and where they are needed most.

For some organizations, this is a major shift in mindset. And operationally, it does not happen overnight. To make the transition, leaders — even those who have already entered risk arrangements — need a true analysis of what drives optimal results and what resources and tools are required to scale success. But as we track industry trends, the direction is clear. Regulatory pressure for value continues to rise, especially in high-risk, high-cost populations. And we know commercial markets tend to follow Medicare's guidance.

As we consider trends driving change in 2024, we see opportunities for value-based care in each one. Managing emerging risk, addressing health equity and increasing membership — especially in commercial contracts — represent current growth opportunities. But these all require an outcomes-based approach to achieve that growth.

This report looks at how the following trends are driving health care to become more interconnected, more agile and more preventive.

> It's becoming urgent that today's leaders actively seek out opportunities to build or partner on value-based initiatives. Whether just getting started or maturing your capabilities, forward momentum could prove more important than having all the answers. Opportunities in value-based arrangements will vary based on organizational type, size, financial strength and the populations served, each being an important part of the equation. The more you move down the path to value, the more you'll learn about how to capitalize on these opportunities in the best way for your organization.
>
> **– Doug Dalton**
> SVP Provider Enablement
> Optum

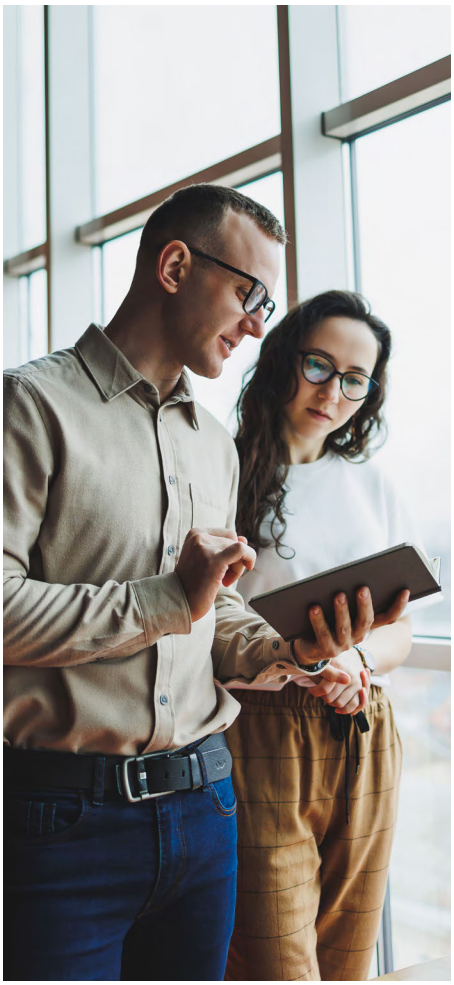
7 trends driving health care transformation in 2024

1. **Economic climate**
2. **Regulatory complexities**
3. **Workforce challenges**
4. **High-cost drugs**
5. **Health equity advancements**
6. **Consumerism**
7. **Generative AI**

Trend 1: Economic climate

Inflation drives up health care spending, adds pressure for cost containment and increased technology enablement

McKinsey estimates that annual U.S. health expenditures are likely to be $370 billion higher by 2027 due to the impact of inflation.[1] Medical inflation typically lags general inflation due to the multiyear contracts between insurers and hospitals for the prices of procedures. However, PricewaterhouseCooper (PwC) projects that health care costs will rise 7% this year and inflation will drive providers to seek rate increases from insurers to offset their rising costs.[2]



Forces driving economic decisions in 2024

Price inflation, a tight labor market, regulatory changes and increased utilization of specialty pharmacy drugs are affecting the financials of the health care sector.

Workforce shortages are pushing up labor costs and limiting access to consumers. The combination of provider burnout and rising consumer demand is having an impact on utilization, outcomes and quality ratings, adding more pressure to margins. Health leaders who can afford to are leveraging technology advancements to support upskilling, new care delivery models and removing friction from the experience.

The rising prices of existing drugs and the high cost of newly approved drugs and therapies are impacting stakeholders across the health ecosystem. For example, according to a 2023 analysis by AARP, list prices of drugs with the highest aggregate Medicare spending have more than tripled since they were introduced to the market.[3] The median cost of new cancer therapies has surpassed $260,000 and new-generation weight-loss drugs for obesity and type 2 diabetes can retail for over $1,000 a month.[4,5] These high costs are leading consumers to forgo needed care, employers to reconsider their employee benefits and hospitals to shift budgets away from critical infrastructure or staffing investment.

The combined influence of rising regulatory pressure and consumer behavior is accelerating the shift to value-based models. As health plan mergers continue in 2024, payers will look to optimize resources and align care management and reimbursement for high-risk populations. Providers should expect the shift to value-based care to expand.

Economic climate: Progress, challenges and what to watch

Change always comes with a cost. New care models, workflows, technologies or therapies need to be assessed for their ability to improve outcomes and impact financial performance in a responsible way.

Data and technology innovation can now predict utilization needs and opportunities by geography, at the segment or even member level. It can spot patterns and abnormalities. It can identify where new types of services or workflows could improve outcomes and reduce costs. This can help to guarantee that any new investments in clinical care delivery will result in cost savings. This growing connection between technology, workforce and value can make sure that an organization's limited resources are used most efficiently and effectively.

Promoting wellness, disease prevention and care coordination reduces long-term health care costs and generates revenue through value-added services and improved patient outcomes. However, a value-based approach will likely require investments in specialized staffing, technology and health equity as well as consideration of social drivers of health (SDOH). The next generation of value-based care doubles down on improved patient outcomes and optimal use of resources, enabled by technological advancement.

Leaders can continue to apply risk management and actuarial principles to manage the adverse risk of very high-dollar claims. Applying cost-prediction models can help anticipate what is likely to be needed by populations based on their current illness burden. As potent but expensive interventions continue to emerge, it is essential to evaluate their long-term cost effectiveness and their impact on patient outcomes. There is a pressing need for more comprehensive cost analysis as well as advocacy for coverage based on the positive impact new interventions can have on outcomes.

Workforce shortages are leading to severe service delays in some areas. This has shifted more care delivery to virtual, outpatient and in-home settings. It has also inspired a deeper look at automation and upskilling to alleviate access issues while also reducing costs.

Technology advancements in AI, machine learning (ML) and natural language processing (NLP) have the potential to reshape care delivery, reduce administrative inefficiencies, predict needs and align resources.

> It's important to track, and forecast, the impact emerging technologies and changes in health care practices have on specific populations and their potential for introducing new risk and new opportunities.

– Jim Dolstad
VP Actuarial Consulting
Optum

These innovations empower decision-making, increase speed to market, reduce cost and improve overall margins. But they have to be integrated thoughtfully, which can also require time, resources and financial investment. Organizations that adapt technology in a responsible way are going to be more equipped to optimize investment and navigate through this volatile economic environment.

Moving forward in this economic climate

Employ risk management and actuarial principles to manage high-dollar risk.

Apply cost prediction models to anticipate needs and demands.

Evaluate long-term cost effectiveness and impact on outcomes of new interventions.

Use data to identify consumers and populations with unmet needs and inefficient utilization patterns.

Sustain the shift to technology-enabled care delivery in virtual, outpatient and in-home settings.

Promote wellness, disease prevention and care coordination.

Apply emerging technology in a responsible way to connect workforce, outcomes, patient satisfaction and value.

Why the time to act is now

In 2024, change is happening across every area of health care and the financial consequences of not being agile enough to keep pace with change are significant. Health care leaders must be proactive in assessing market changes and swift in implementing strategies to reduce costs and maintain quality. It is equally important for leaders to have the foresight to identify growth opportunities and empower their organizations to respond promptly and effectively.

Economic climate sources

1. Fleron A, Krishna A, Singhal S. The gathering storm: The transformative impact of inflation on the health care sector. McKinsey & Co. Sept. 19, 2022.
2. PWC. Medical cost trend: Behind the numbers 2024.
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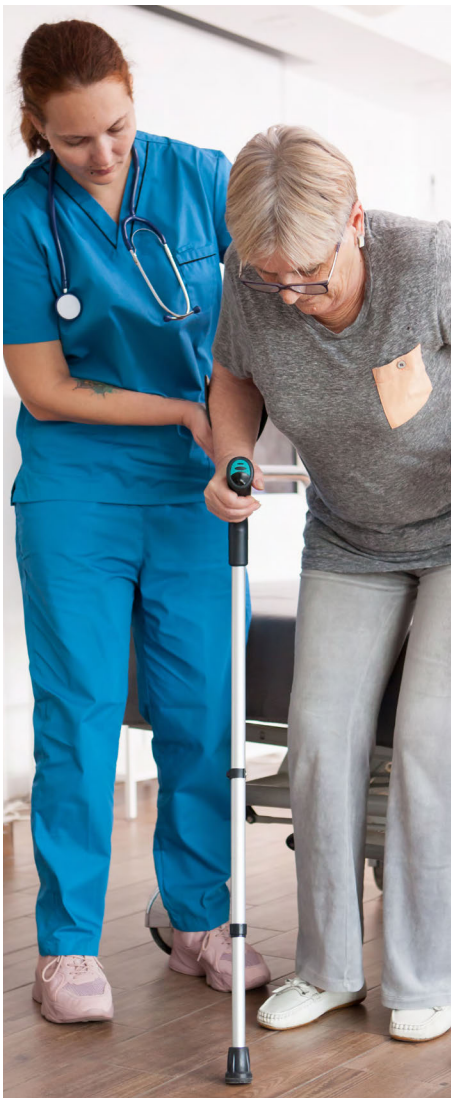
4. Barber MJ, Gotham D, Bygrave H et al. Estimated sustainable cost-based prices for diabetes medicines. JAMA Network. March 27, 2024.
5. Weintraub K. Weight-loss drugs cost $1,000 a month but less than $25 to make. Why do we pay so much? *USA Today*. April 1, 2024.

Trend 2: Regulatory complexities

Shifting membership, declining quality and rising risk increase momentum for value-based arrangements and consumer-centric care

Changes in how and where consumers access coverage have a significant impact on utilization, cost and market share. As of 2024, 14 million individuals have been disenrolled from Medicaid and will transition to state exchanges, employer coverage or abandon the health system.[1] Medicare currently covers nearly 70 million individuals and another 4 million will turn 65 this year.[2,3] Enrollment in state exchanges continues to grow significantly, with over 21 million individuals gaining coverage in 2024.[4]



In addition to these adjustments, as well as the impact of the Inflation Reduction Act, recent policy changes are putting pressure on health care systems to accelerate the shift to value-based care (VBC). Some estimates project that 90 million lives will be in VBC models by 2027.[5] The shift to VBC continues to gain momentum. However, this level of business realignment is not an overnight process and requires careful navigation to move from the traditional fee-for-service model to value-based care.

Forces driving regulatory decisions in 2024

CMS has posted final rules for Medicare, prescription drugs (Part D), Star Ratings and the integration of Medicare and Medicaid for the contract year 2025.[6] Medicare Advantage and Part D continue to promote competition, increase access to care, include behavioral health services, and protect individuals from inappropriate marketing and prior authorization.

In light of rising drug costs, the rule protects consumers from being guided based on broker or agent financial incentives. As the cost of new and existing drugs continues to rise, it is structured to make sure Medicare drug plans remain affordable to consumers.

Another mandate from CMS regarding Star Ratings and quality bonus payments is for health care organizations to recognize underlying conditions and limit disease progression. This expectation will bring data analytics, coding and risk adjustment into even sharper focus.

CMS is working to integrate Medicaid and Medicare policies, as they share common goals of controlling costs and eliminating fraud, waste and abuse. The innovation generated through the Center for Medicare and Medicaid Innovation (CMMI) can be used to inform Medicaid policy as well. This keeps health equity at the forefront.

In fact, CMS mandates that Medicare Advantage plans incorporate a health equity expert in their utilization management committees and conduct an annual analysis of prior-authorization policies to address potential disparities in access to care for enrollees with disabilities or limited income and resources.

The new rule mandates that Medicare Advantage plans provide personalized mid-year communications to enrollees regarding any unused supplemental benefits. This is to guarantee that the substantial federal investment of over $65 billion annually in these benefits aligns with the needs of beneficiaries.[7]

Regulatory environment: Progress, challenges and what to watch

Membership moves have put tens of millions of lives in flux, as well as disrupting the business strategies of the health organizations who serve them. To effectively manage rising costs associated with regulatory adjustments, health care organizations must reassess their revenue streams and prioritize cost containment. They can do this by expanding telehealth services, adopting automation, upskilling health care professionals, forming strategic partnerships, and transitioning toward VBC models and more sophisticated risk-adjustment models.

Reimbursement has been stagnant or down for Medicare Advantage plans and the number of Medicare Advantage Plans shrank for the first time in 10 years.[8] Despite this overall contraction, most major payers have expanded plan offerings, hinting at a concentrated market. But this changing landscape continues to challenge payers to shore up margins and meet market and regulatory scrutiny.

As redetermination moves consumers off Medicaid, employers will feel pressure to pick up the cost of these premiums for their employees. Already stretched with rising labor costs, they will be looking to their health partners for creative solutions. Furthermore, regulatory changes are prompting health care leaders to reevaluate and modify their business models and reimbursement structures. It is critical for leaders to proactively manage the fast-paced financial and operational disruption caused by shifts in membership and policy changes.

Recent CMS policies emphasize the importance of a patient-centered experience. One that addresses individual needs and preferences, while also tracking and analyzing consumer behaviors throughout their entire health care journey. Local culture, beliefs, ethnicity, economics and demographics guide an individual's approach toward their health.

> Medicare's predictability and the guidance from CMS drive not only Medicare but also Medicaid, making it crucial for health leaders to actively engage, provide input and participate in the cross-functional stakeholder discussions to address cost, access and quality in health care models.
>
> **– Tejaswita Karve**
> Senior Director, Star Ratings
> Optum

What works in Boston may not work in Atlanta, and what works in Atlanta may not work in Oregon. CMS recognizes this and has put rules and incentives in place. It expects health organizations to be flexible enough to respond to these dynamics at the individual and community level.

As the regulatory environment continues to progress, innovators can focus on specific use cases for AI, maximizing the investment in electronic medical records (EMRs), promoting environmental sustainability and finding new ways to make a positive impact on each community.

Moving forward in this regulatory environment

Expect membership disruption in every line of business.

Revisit revenue streams with a heightened focus on cost containment.

Identify the counsel that can shorten the timeline on the shift to risk and understand the levers that drive success.

Understand the risk in the populations you serve. Ready your organization with specialized services, technologies, care coordination and attention to SDOH.

Ensure data analytics, coding and risk adjustment models are able to embrace SDOH and drive action at the member level.

Use this insight to build a consumer-centric experience for every individual.

Develop processes for identifying fraud, waste and abuse that do not interfere with the patient/provider relationship.

Why the time to act is now

As the largest and most predictable payer, Medicare leads change in the industry. Its guidance is the beacon for transformation and health organizations will need to keep pace. Based on recent policy adjustments, speed and accuracy in the shift to value provides the best opportunity to mitigate costs and ensure long-term sustainability. Innovation and collaboration between payers and providers is necessary to better manage care transitions, address social drivers of health and identify predictive indicators of disease and costs.

Regulatory environment sources

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7. CMS. Biden-Harris Administration finalizes rule expanding access to care and increasing protections for people with Medicare Advantage and Medicare Part D. April 4, 2024.
8. Kaiser Family Foundation. AIS Directory of Health Plans. Baltimore Health Analytics.

Trend 3: Workforce challenges

Maximizing value-based care and digital advancements in a labor-strapped industry

Many health care organizations find themselves chronically under-resourced during a time when specialized staffing is crucial for the success of value-based care and new digital strategies. This year, high turnover rates continue. Some estimates project a gap as high as 200,000–450,000 registered nurses and 50,000–80,000 doctors by 2025.[1]

With health costs increasing, benefits packages — beyond health coverage — have become more important to attract new employees and retain existing ones. The projected growth in health care labor costs, combined with the clinical labor shortage, may result in an additional $170 billion in costs by 2027.[1]

On the positive side, it is estimated that implementing digital and AI-driven interventions in care delivery, administrative simplification, clinical productivity and technology enablement could generate over $1 trillion in savings.[1] But this too will require investments in technology, training and transition management.

Forces driving workforce decisions in 2024

Care utilization continues to rise, putting more pressure on existing staff. Growth in the aging population and an increasing demand for mental and behavioral health services is not matched by growth in the workforce.

To bring that ratio into balance, leaders are using upskilling, automation, remote work, telehealth and progressive hiring and retention strategies. They prioritize talent leadership, invest in leadership training and provide change management resources.

Health care employers are also uncovering generation-specific strategies, such as offering telecommuting opportunities to experienced RNs and wellness and lifestyle benefits to younger employees. With a broadening array of ancillary benefits becoming available, employers expect to increase employee satisfaction and well-being and achieve the anticipated ROI over the long term.

However, as restructuring of the workforce continues, providers may still be compelled to seek higher rates from payers as they cope with current wage hikes, workflow transitions and inflationary pressures. Even if employment levels do stabilize next year, health plans should anticipate challenges due to labor costs associated with increased utilization of care.

Workforce: Progress, challenges and what to watch

Workforce challenges have significant implications for patient care and access. Patients may experience delays or even forgo care altogether due to shortages and limited availability. Access delays can also have a negative impact on revenue and quality for both providers and health plans alike – including Star Ratings, CAHPS scores and performance-based incentive payments.[2] Delays can erode the consumer experience and amplify the costs associated with workforce challenges.

Automation continues to emerge as a promising strategy to manage workforce challenges. Intelligent automation can streamline processes, reduce administrative burdens, expand capacity and allow health care professionals to focus on high-value tasks. To maximize any technology investment and to ease transition in the workflow, it's important to reduce waste or eliminate redundancies or inefficiencies and identify increased productivity needs *before* automation. Developing a business case for automation investments and reaping the benefits from redesign can help health systems manage the near-term labor shortage and prepare for the future workforce and new workflows.

It is crucial to prioritize proactive workforce management. This involves planning for future care team models and implementing policies for labor management. These include strategies for recruitment, vacancy management and the timely replacement of positions. With proactive management strategies in hand, leaders are equipped to make decisions that serve not just the immediate need but accommodate the overall growth goals of the organization and long-term plans to cultivate talent.

Finally, culture and a safe and supportive work environment are essential. With mental health demands rising, longer hours, heavy workloads, and emotional and psychological stress, the health care workplace can be extremely challenging. Building resilience into the workforce will require proactive measures such as front-line de-escalation strategies, behavioral health emergency response teams, and resources for working caregivers and parents that create a safe culture and make team members feel valued.

> To effectively address the challenges in the care environment, such as rising violence and stress, it is essential to implement front-line de-escalation strategies that support the front-line staff and foster a culture of safety and value for all team members.
>
> **– Rob Linnander**
> VP Optum Advisory Services

Moving forward on workforce challenges

Be proactive in developing a workforce management strategy.

Encourage talent leadership by providing opportunities for growth, promoting a culture of autonomy and recognizing leadership qualities.

Understand the related risks workforce shortages pose for your quality scores.

Identify ways to cut waste and redundancy, as well as increase productivity, as you build a business case for workforce automation.

Employ safety protocols, foster open communication and invest in training and development to keep the culture safe, supportive and resilient.

Why the time to act is now

The need to find clinical employees is intense and growing more so every day. In today's competitive talent landscape, health systems need a strong workforce strategy to avoid negative consequences like delayed services, lower quality ratings, high turnover and reduced reimbursements.

The role of generative AI is expected to grow in 2024. To match resources to consumer demand, health organizations should strive to keep pace with the adoption of new technologies, apply it to serve the growing populations in their markets and to help support the diverse needs and productivity of their workforce.

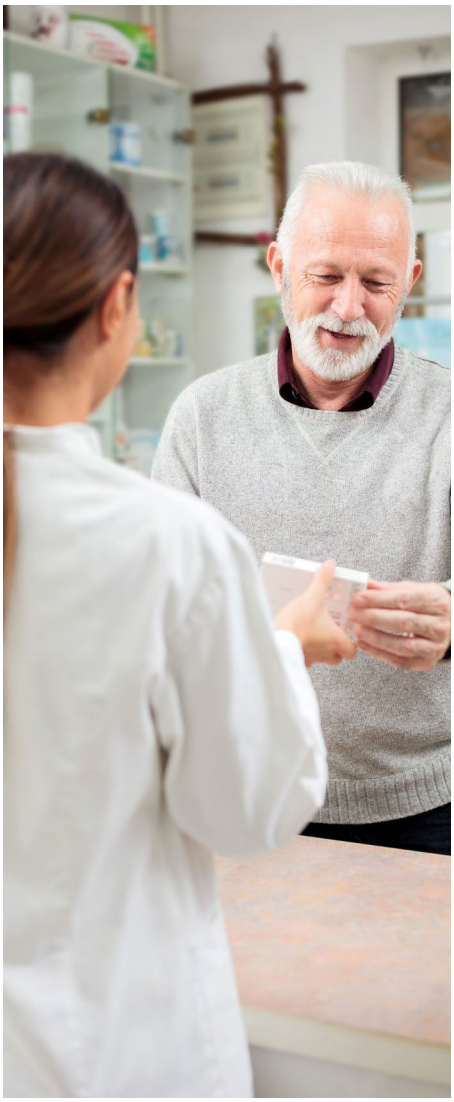
Workforce challenges sources

1. Fleron A, Krishna A, Singhal S. The gathering storm: The transformative impact of inflation on the health care sector. McKinsey & Co. Sept. 19, 2022.
2. Linnander R. Optum C-Suite Trend Report Interview – Workforce Challenges. March 2024.

Trend 4: High-cost drugs

Soaring prices for innovative therapies create health inequities and prompt questions about who will bear the costs

For over a decade, the United States has consistently had the highest per capita spending on prescription drugs compared to other countries.[1] In the past few years, specialty medications and targeted gene therapies have demonstrated remarkable clinical advancements. But their high costs are simply unaffordable for some and create new health disparities for many more.



Today, we are in an era of life-science innovation with new therapies continually emerging. But a recent report noted the median annual list price for these new specialty drugs in 2023 was a stunning $300,000.[2] While the eligible patient population for each high-cost drug is typically small, the increasing number of high-cost drugs means every year a payer has an even greater likelihood of experiencing unpredictable high-cost claims. The emerging dilemma is who will pay for it and how?

In the past 12 months, there has also been an acceleration in overall drug spend that is primarily coming from new treatments for diabetes and obesity. In many cases, the rising demand for expensive GLP-1 agonist drugs is so great it is causing measurable upward changes to trend projections. Whether or not GLP-1's will reduce total cost of care in the long term will be determined over the next few years.[3]

Increasing drug costs and utilization are driving many employers and insurers to shift costs to consumers through higher copays, deductibles and premium costs. Many consumers cannot afford this added spend, with some likely avoiding or delaying treatments altogether.

Forces driving drug coverage decisions in 2024

Actuaries are still studying the costs and health benefits of GLP-1 agonist drugs to treat diseases. While effective at weight loss, the current price point does not offset the direct cost of downstream events such as cardiovascular disease or strokes. Though these medications are effective at weight loss, there's no evidence that patients can get off these drugs in the long term and maintain a long-term benefit.

At this price point, the medical cost offset is not enough to financially justify the cost of the drugs. But that does not mean consumers shouldn't have them. It means ongoing analysis and achieving affordability is key.

According to contributing experts, as manufacturing ramps up and shortages ease, competitive offerings will create more leverage for health plans to encourage manufacturers to negotiate their prices for formulary position and/or coverage criteria that allows plans to appropriately manage coverage. New products are expected to gain FDA approval over the next several years and bring needed competition to current GLP-1 agonist drugs.[4]

High-cost drugs: Progress, challenges and what to watch

The GLP-1 class of drugs continues to gain traction because they are effective for most people. New therapies and new clinical evidence continue to emerge, and providers will have to stay current with those evolving guidelines. It is likely data relative to the dosage and length of treatment will adjust. Chronic weight management best practices will continue to emerge over time. We may find that what is clinically effective the first year may not be appropriate or necessary for the second year. As these drugs are now used on an increasingly broad scale, we will learn more about who they help, what doses are best over the long term and which patients may be able to manage long-term weight loss without needing a drug.

But truly delivering a long-term health benefit requires more than the medicine. Providers will need to use this drug benefit to help patients make additional behavioral modifications that improve their health. Providers and health plans need to be ready with wraparound programs that address the whole health needs of these consumers. They need to make sure every consumer has access to the right clinician, health coach and information that will help them make the most of this investment and lead to the health outcomes they seek.

To get there, the industry as a whole needs to advocate for more affordability and allow for more flexibility in the coverage criteria for different patient populations.

Managing costs of high-cost drugs over the long term presents unique challenges, as the dollar swings are much more dramatic, sometimes even from a single claim. For example, you might be a health plan with 1,000 lives covered, allowing for $1 to $2 million per year in drug spend. Suddenly, you have one claim that presents for $3 million dollars. It's unaffordable. The infrastructure does not yet exist for how to pay for these high-cost specialty events and how to amortize the costs over time.

Many smaller health plans, state exchanges and small to mid-sized employers are simply unable to take on the risk and fund the high cost of these drugs. Employers are forced to make hard choices between retirement funding and salary increases or drug coverage. These are tough choices forced upon them by current price points.

> Affordability is key to improving access to innovative therapies, and as more competitive products enter the market, our ability to negotiate with drug manufacturers improves.
>
> **– Michael Einodshofer**
> Chief Pharmacy Officer
> Optum Rx

To achieve real progress, there needs to be more competition, more advocacy for affordability and more alignment of financial incentives across the health care ecosystem. Consider a provider group or a prescriber group taking risk on pharmacy. They would find ways to remove waste within current prescribing habits. They'd be financially motivated to keep patients adherent to therapies that have a meaningful medical impact. And they would be working with the most current clinical guidelines to identify the low-cost medication that can achieve the quality outcome everyone seeks.

Moving forward on high-cost drugs

Consider a stop loss policy, specialty risk protection or a gene therapy risk protection program to protect against sudden financial exposure to high-cost drug claims.

Financially prepare for covering obesity drugs in the future, especially as clinical indications expand and affordability improves.

Advocate for more affordability, price transparency and more clinical studies of new therapies.

Employ data analytics to understand the prevalence of need within the consumers you serve.

Make sure those who do need a high-cost drug have the affordability and the access they require.

Develop the wraparound services that will generate the most benefit out of the drug coverage.

Why the time to act is now

Specialty drugs, gene therapies and many other drugs can be lifesaving. GLP-1 agonists can be lifechanging. The industry must work quickly to provide equitable access to breakthrough medications for patients who need them.

Health plans and employers need to protect against unseen risk, as one claim can leverage a tsunami of financial risk. Providers must stay alert to new studies and guidance that impact the efficacy of these new drugs.

Everyone needs to examine the value driven between stakeholder relationships in the prescription drug system, build resilience in the supply chain and engage in transparency. These actions with policy reform will support improved access and affordability.

High-cost drug sources

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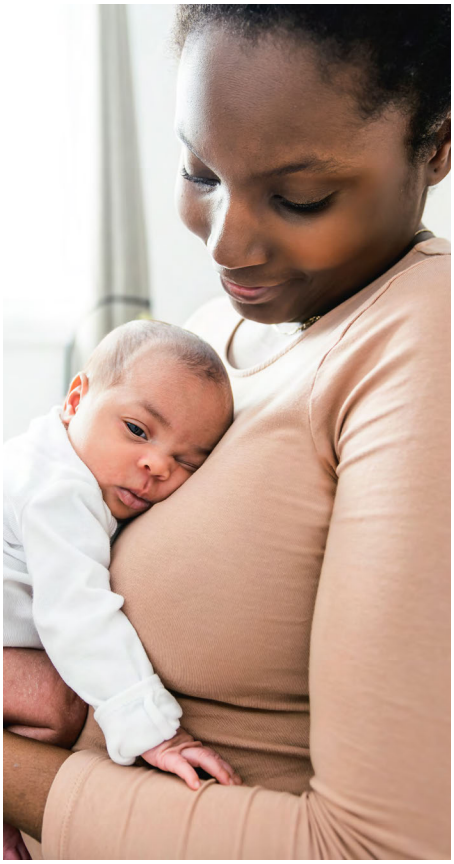
Trend 5: Health equity

Poor outcomes, economic impact and regulatory pressure drive advancement

The presence of disparities within the U.S. health care system prevents individuals from accessing affordable, high-quality care. These inequities result in avoidable costs and financial waste. They also impede the ability of individuals to attain optimal health and well-being. Inequities in the U.S. health system could exceed $1 trillion in annual spending by 2040 if left unaddressed.[1] This would have consequences for everyone.



The Centers for Medicare and Medicaid Services (CMS) sees the risk and recently released an updated framework to further advance health equity for the more than 170 million individuals supported by its programs. This framework will inform action across health care for the next 10 years.[2]

More than 80% of health care C-suite executives see improved health equity as a top 10 goal for 2024. Nearly 50% expect to increase their health equity investment.[3] They see it as a workforce recruitment and retention tool and a strategy for growth.

Forces driving health equity in 2024

Health equity continues to be a key goal for federal[4] and state governments.[5] States have ramped up their funding and messaging toward health equity initiatives, with an increased focus on behavioral health services.[6] Additionally, financial implications remain a part of the equation. More and more states are moving toward risk-adjusting Medicaid for SDOH. In addition, CMS has revised Stars to put more emphasis on health equity and SDOH. If a Medicare Advantage plan falls from 4 Stars or higher to 3.5 stars, the consequence for most plans will be a significant loss in revenue.[7]

CMS is committed to modernizing systems and services to enhance public health. In response to the increasing need for health equity, the U.S. Department of Health and Human Services (HHS) intends to invest in improved data management practices.[8] This investment will facilitate access to and standardization of demographic data, enabling the identification of disparities and informing targeted health interventions.

Digital health technology is being used to promote health equity and improve access to health care services. Regulatory pressure is also driving efforts to increase access to clinical trials and treatments to ensure they are tailored to the unique needs of various populations.

Health equity: Progress, challenges and what to watch

Health disparities come with economic costs, but addressing these disparities can lead to shared economic benefits. And for organizations with value-based competencies, addressing health equity is a lever for growth.

Disparities in the health system, particularly in chronic conditions and maternal outcomes, contribute to a dangerous rise in costs. Populations with higher rates of these disparities face escalating expenses over time.

A shared economic benefit is achieved by identifying populations that experience poor outcomes or have a higher likelihood of a diagnosis. This enables effective cost reduction through early prevention, identification and management of chronic conditions.

Yet, data availability, credibility and trust are some of the biggest challenges in addressing health disparities. Credible and validated self-reported data is limited and difficult to obtain. This hinders understanding of where disparities specifically exist. Additionally, systemic mistrust of the health delivery system affects the willingness for individuals to share their information. This remains a major barrier to data collection.

As these barriers are broken down, AI can be instrumental in generating personalized care plans based on individual health history and lifestyle factors. This should lead to more effective treatments, improved health outcomes and reduced costs.

Health organizations are making progress. Life sciences companies are reaching more diverse patient populations for clinical trials.[9] And in state government, whole-person care is driving priorities for Medicaid coverage expansion.

> Organizations that can successfully convene and share best practices will be the leaders in the health equity space. This sharing should include specific details on what interventions worked, why they worked and how they can be replicated in other communities or populations.
>
> **– Catherine Anderson**
> Senior VP Health Equity Strategy
> UnitedHealth Group

Moving forward on health equity

Gain commitment from your board of directors and leadership teams to make health equity a fundamental aspect of daily work, embedding it across all operations.

Build reliable data, insights and infrastructure to understand disparities in your populations and communities, as well as the interventions that drive impact.

Make community engagement a core competency. Build authentic relationships with community-based organizations — which often have the best understanding of what's needed — to improve outcomes.

Combine health care and community insight to address the root cause of community health challenges.

Design health equity initiatives to be sustainable over the long term. Make sure communities have sufficient infrastructure and resources to be effective.

Why the time to act is now

Prioritizing health equity — as 80% of health care executives do — aligns with the business imperatives of improving health outcomes, reducing costs, meeting regulatory requirements, attracting talent and building relationships across the community. It is essential for promoting a healthier, more equitable and resilient society.

One of health care's biggest opportunities is to provide better care for underserved populations by reducing long-standing health disparities. Health equity is a catalyst for growth and crucial in the context of value-based care. But regardless of whether health care providers operate under a fee-for-service or value-based care model, addressing health equity and social drivers of health is vital for improving health outcomes and ensuring quality care for all.

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Trend 6: Consumerism

New priorities and expectations are reshaping the health care mindset

New attitudes toward health are influencing consumer expectations, impacting engagement with the health care system and redefining business priorities. Consumers are facing economic headwinds, rising health concerns and looking for affordable pathways to better health. Tech-savvy generations such as Gen Z and millennials prioritize holistic health, embrace digital solutions, and seek discussions on affordability, climate change and mental health. And 61% of baby boomers say they would use telehealth for their chronic disease management.[1]

Gen Z and millennials willingly share their data for personalized insights and view wellness as a form of self-care. This is evident in the growth of the global wellness market, which is projected to reach $1.8 trillion by 2024.[2]

A recent KFF Health Tracking Poll asked voters what they want to hear the candidates talk about regarding health care during the 2024 election cycle.[3] Consumers said they prioritize discussions on the affordability of health care, inflation, the future of Medicare and Medicaid, access to mental health care, and prescription drug costs. These topics are considered “very important” by a wide majority, highlighting their significance to consumers.

These attitudes are increasing demand for personalized and digital-first health care experiences and greater transparency and accessibility in health care services. These preferences are driving significant shifts in the way health care is delivered and experienced.

All consumers want choice, convenience and affordability. But it is not enough to simply increase access and deliver appropriate, timely services. Health organizations must meet growing expectations around transparency, sustainability and mental health if they want to earn younger generations of consumers.

Forces driving consumerism in 2024

Experts believe simplicity, access and improved outcomes remain top priorities for consumers across all demographics. Consumers expect the same level of digital access that they get from other industries. They want tools that empower them to make the most informed decisions.

They are currently feeling an inflationary pinch as the cost of coverage, care and prescriptions becomes a greater percentage of their household expenses. Despite not knowing the term "value-based care," they are increasingly invested in their health care and are actively adopting preventive digital solutions. Experts agree that consumers won't buy what they don't trust or can't afford. Systems without reliable, affordable options could find consumers going elsewhere or see their outcomes decline.

Now that virtual care has taken hold, consumers continue to utilize it as an option because it can be quick, convenient and cost-effective. However, data also tells us that patients still prefer in-person visits when given the choice. This could be due to behavioral inertia. Patients and providers alike are accustomed to health care being delivered in person. To avoid falling back into the status quo, health care will need to solve the problems that make some perceive telehealth as less desirable. Issues reported include lack of access and technological difficulties, privacy, spending enough time with their physicians and receiving proper examinations. Interestingly though, high satisfaction coexists between both virtual care and in-person settings, hinting at the value of both given the right applications. Health care leaders will be challenged to find the balance between these services to continue to improve access, maximize outcomes and meet changing consumer expectations.[4]

Consumers are expecting personalized, friction-free experiences that can meet them where they are. Recent advancements in generative AI hold significant potential. AI-driven, personalized care plans based on individual health history and lifestyle factors can lead to improved treatments, higher engagement and better outcomes. AI is also now able to streamline administrative tasks, resulting in quicker and more efficient service for consumers.

Consumerism: Progress, challenges and what to watch

People want to make educated decisions when choosing care and expect a consumer-focused, seamless digital experience that includes their medical records, care plans, billing and scheduling in one place. Offering such a seamless experience can drive engagement, loyalty and market share.

Consumers want to understand the cost of care and how to pay for services. They also seek information that guides them to appropriate sites of care, as well as the care modality that offers the best experience at the right price.

The industry is still learning about segmentation but can start with broad strokes. For example, women are often the health decision-makers, managing family care and requiring solutions that might not exist. We could consider the difference for consumers in managing acute care versus chronic conditions. Consider generational preferences as well.

> It's best to begin with the basics and get them right, consistently. All consumers are concerned with finding appropriate care, understanding the cost of care, knowing how to access care, scheduling appointments and understanding payment options.
>
> **– Rita Khan**
> Chief Consumer Officer
> Optum

As an industry, we have an obligation to respect how these situations and outlooks can shift consumer needs, expectations and behaviors.

Consumers also expect individualized care plans. This requires harnessing medical data, including social drivers of health and self-reported data. The industry is making some progress here, but there is room for growth. By collecting and sharing data more completely, payers and providers can better predict utilization trends and implement more proactive strategies. As we make more progress here, everyone will benefit.

It's crucial to engage with consumers and understand their changing needs and behaviors. This extends beyond simply offering services and surveys. It includes richer levels of interaction to understand the consumer's journey from seeking health care to managing their care holistically.

Moving forward with consumerism

Be certain health leaders see the business mandate for prioritizing a personalized, seamless, easy experience for consumers.

Start by delivering the basics consistently. Focus on increasing access to care and information to empower consumers to make wise choices.

Include the voice of consumers early and often as you evolve your services. Understand how they interact with health services and what affects their decisions.

Use data to understand consumer behaviors and equip providers to match care plans with their preferences.

Gather ideas from across the workforce and your ecosystem on how your experience can reduce friction for everyone.

Why the time to act is now

A good consumer experience is a crucial component of an organization's financial strategy. The financial levers of value-based care, the new capabilities of generative AI and workforce challenges should inspire leaders to take immediate steps to simplify the health care experience. Delayed action compromises satisfaction, lowers quality ratings and raises the level of investment required to catch up later.

Consumers have demonstrated they will abandon organizations that cannot offer digital access, empower their decision-making and provide the quality care they need. A simplified experience can build patient loyalty, improve outcomes and help strengthen an organization's financial position.

Consumerism sources

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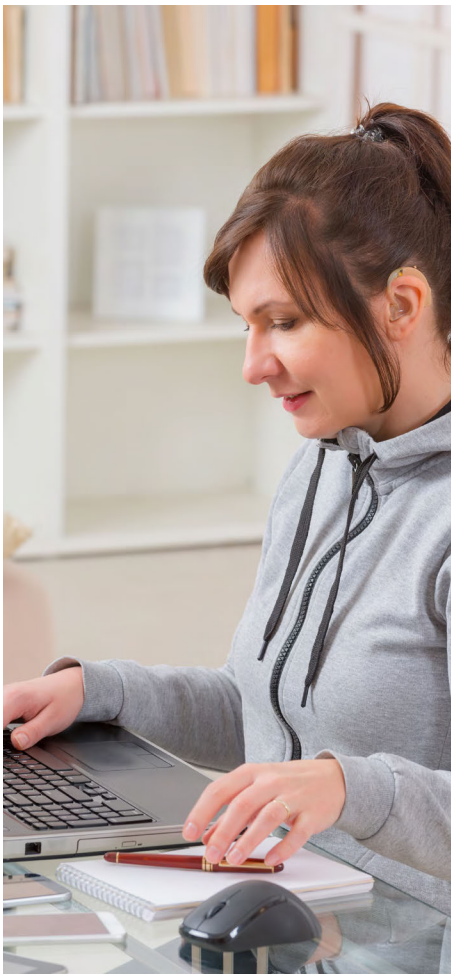
Trend 7: Generative AI

New models are poised to deliver significant advancements in every area of health

Generative AI is about to become increasingly ubiquitous in health care. It has powerful new abilities, when combined with other forms of AI and ML and other technologies, to streamline tasks through real-time consolidation of a complete array of clinical and financial information sources. It is projected that through these new capabilities, AI could generate $1 trillion in improvements across the health industry.[1]



Generative AI is a powerful tool gone mainstream. Used in connection with other advanced technologies, it increases our ability to efficiently analyze large quantities of complex information. This information is unstructured data, including clinical notes, diagnostic imagery, medical charts and recordings. This data can be used independently or in conjunction with structured data, such as claims, to extract valuable insights, speed decision-making and streamline workflows. It can be leveraged with cloud-based services and made interoperable for maximum efficiency and scalability.

As inspiring as these breakthroughs are, there are inherent risks associated with the use of generative AI in health care. It is imperative to continually involve health care practitioners to verify the accuracy and usefulness of any technology as its applied.

Health care executives will need to weigh the benefits and risks of incorporating generative AI tools. Health care organizations will be responsible for ensuring the safe and responsible use of these innovative technologies. Even as regulations surrounding generative AI continue to evolve, advocating for responsible use, regardless of legislative action, will be the focus for many organizations.

Forces driving generative AI decisions in 2024

Generative AI hit the mainstream in 2023 and has only gained steam in health care through evolving multimodal and small language models.[1] This adoption also continues driving down costs of using these advanced tools, increasing access to them over time.

By analyzing and combining both structured and unstructured data, multimodal AI models can now generate insight as a tool for informing human decision-making. These models can understand multiple types of data, such as images, text and videos. They leverage capabilities such as machine learning, natural language processing and computer vision to integrate content across various modalities. With human oversight and governance, they can make predictions, help humans take action, automate tasks, and continuously learn and adapt. With each passing day, these tools are becoming increasingly intuitive and more dynamic.

Small language models are constructed using high-quality sources, yet they have lower storage and memory requirements. These models can be customized to suit specific tasks and meet regulatory standards, thereby facilitating faster adoption.

The administration's recent budget and executive order on the use of AI outlines priorities for AI-enabled capabilities within the Health and Human Services sector. Focus areas include the development of AI tools that can aid in diagnosis and treatment, monitor and address public health risks, accelerate the approval process for medical products and therapies, and support AI regulation and safety efforts.[2,3]

Generative AI: Progress, challenges and what to watch

Health care has been using AI in administrative and risk management areas for some time. But generative AI's capability to include unstructured data and speed insight across the entire health ecosystem is a significant change. Its multimodal capabilities allows it to cut through in health care in new ways. Combining generative AI with clinical judgment and clinical insights can help many get to sustainable and equitable use cases.

For instance, consider a scenario where a nurse practitioner has access to a comprehensive overview of a patient's health history. By employing predictive analytics, generative AI can assist the nurse practitioner in identifying the most pertinent questions to ask. This enables clinicians to quickly address immediate needs and uncover previously unnoticed concerns or underlying causes. These types of insights can now be scaled and applied to various objectives. They are anticipated to tackle goals such as minimizing complications during care transitions, expediting diagnostic reviews, supporting virtual care and reducing unnecessary or avoidable utilization.[4]

Now consider a scenario where a call center employee has access to comprehensive member information and immediate resources and guidance. This real-time information enables the call center to provide consumers with a comprehensive list of available services or covered benefits. It can prompt care authorizations and deliver upfront information regarding scheduling, cost obligations and payment options.

Imagine a scenario where a consumer has ongoing access to an integrated physical and mental health care plan. They can communicate directly with their care team, employ digital monitoring tools, and receive ongoing coaching and decision support — anywhere, anytime.

> AI can now be used to solve consumers' most frustrating pain points, support the front-line workforce and enable clinicians to practice at their highest level. The emerging opportunities are in aiding disease prediction and prevention.
>
> **– Dame Vivian Hunt**
> Chief Innovation Officer
> UnitedHealth Group

Consumers will thrive from a unified approach that keeps them informed and engaged in their health and financial well-being.

Using population-level data and broad data sets, generative AI can help us tackle systemic issues such as accessibility, affordability and equitable outcomes. This presents an opportunity and responsibility to make meaningful improvements.

Moving forward with AI

Bring cross-functional leadership together to identify relevant new use cases.

Appraise the quality of existing data sets and, if necessary, strategies to improve them.

Assess existing operations, human resources, existing AI tech stack, cloud and interoperability needs to determine requirements needed to accommodate large models.

Determine what is required to integrate generative AI models into existing data and analytics models and AI roadmaps.

Consider the value of building custom models that work in a health care-accredited environment and to your organization's ethical and operating standards.

Gauge the various levels of risks related to privacy, security and error associated with each use case. Then create the testing, governance, policies and legal frameworks that are critical to overseeing the use and fairness of generative AI.

Make sure adoption of new AI-driven processes is well supported with training, resources and support.

Always prioritize safe and responsible use to ensure patient safety and security and maintain trust in the health system.

Why the time to act is now

Generative AI has the power to cut through the enigmas facing health care — simplification, satisfying experiences, expedited decision-making, lower costs and improved outcomes. Generative AI can learn and adapt by analyzing data and patterns and then make adjustments based on what it discovers and what human guidance is received. This adaptive learning has already begun, and health organizations need to engage now or risk being left behind. By effectively integrating generative AI, organizations can reshape the health care experience and demonstrate the performance and simplicity that consumers and the workforce have long awaited.

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Where do we go from here?

While there is uncertainty and a variety of challenges ahead, the mandate by health care consumers is still clear. Create a simple, seamless health care experience. One that is also responsive and connected with more choice and real transparency. For industry stakeholders, value-based care is a common thread at the heart of this mandate and continues to move beyond concept and into an enduring practice that will transform the way health care operates.

Beyond ever-evolving trends, health care leaders all continue to look for opportunities to remove waste, refresh systems and reinvest in the next-generation health care experience.

However, these 2024 trends give us a glimpse into the future. Financial sustainability and growth in 2024 and beyond will depend on our collective response and collaboration around today's challenges. Exceptional leadership, deep insights and strategic partnerships that can guide the complex decision-making required can help the most forward-looking organizations achieve their missions.

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