

Transforming Healthcare

Physician enablement: Value-based care

11 April 2023

Key takeaways

- US healthcare spending has grown at a staggering pace over the past few decades, tripling from approximately 6% of GDP in 1970 to nearly 20% in 2020, while comparable developed countries have "only" doubled to 11%.
- One potential solution to curb rising costs is physician enablement. According to BofA Global Research, not only could this help to better manage healthcare costs, but as primary care physicians play a role in influencing nearly 100% of downstream healthcare spending despite representing just 6% of actual spend (source: Humana), it could also result in better patient outcomes.
- In a capitation approach to value-based care, providers receive a fixed, per-person (or "capitated") payment that covers all health care services over a defined period, adjusted for each patient's expected needs, and are also held more accountable for high-quality outcomes.

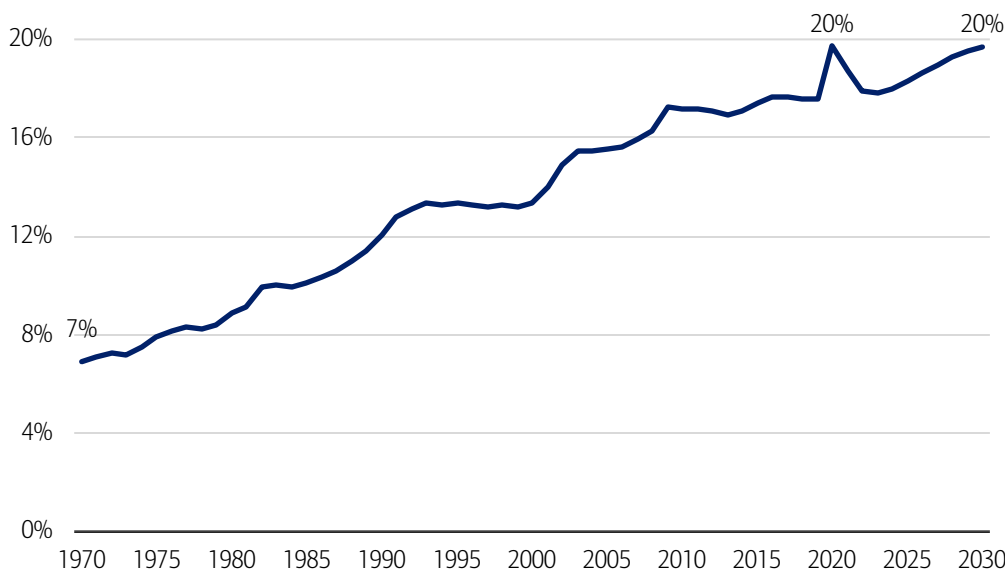
Biggest healthcare shift in generations

The problem: Healthcare costs are growing too quickly

The portion of US GDP dedicated to health spending has increased dramatically over the past few decades at a pace well above comparable developed countries (Exhibit 1). In 1970, approximately 6% of the GDP (versus 5% for comparable countries) was dedicated to total health spending through public and private funds. This figure has nearly tripled to 20% in the US for 2020, while comparable countries 'only' doubled to 11% (Exhibit 2).

Exhibit 1: Total national health expenditures as a percentage of GDP, 1970-2030E

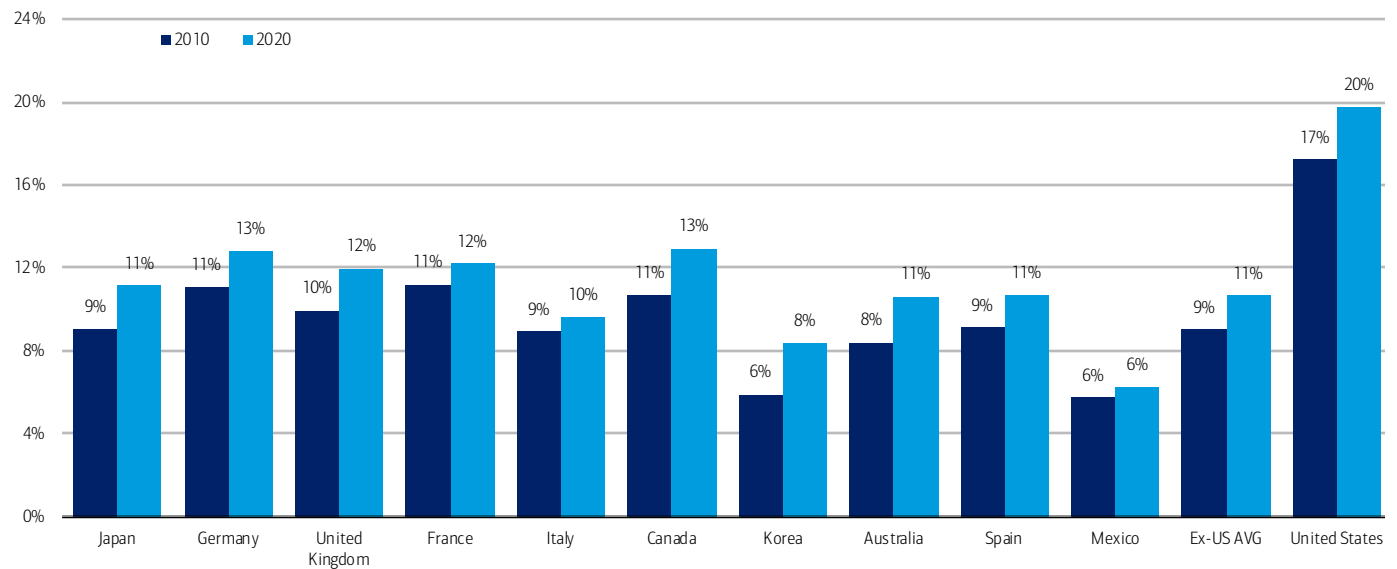
Healthcare costs in the US have been (and are projected to continue) rising



Source: Centers for Medicare and Medicaid Services (CMS), Congressional Budget Office (CBO), National Health Expenditure (NHE)

Exhibit 2: Healthcare expenditures as a % of GDP by country

As a % of GDP, the US spends almost double the amount spent by the next 10 largest Organization for Economic Co-operation and Development (OECD) economies on average



Source: CMS, CBO, OECD

The solution: Enabling physicians to drive better outcomes

According to BofA Global Research, it is clear that the current approach to healthcare in the US is unsustainable. At the heart of the recent trend in the physician enablement sector is the idea that healthcare costs can be better managed by providing actionable health information at the point of care through technology, and financially incentivizing providers to take better care of patients. This effectively allows them to be more invested in patient outcomes. In particular, recognizing that the primary care physician is the ‘front door’ and as ‘quarterback’ can play a huge role in influencing nearly 100% of downstream healthcare spending of a patient, despite representing just 6% of actual spend (source: Humana).

In healthcare, capitation has received increasing consideration in recent years and under this approach, providers receive a fixed per person (or “capitated”) payment that covers all health care services over a defined period, adjusted for each patient’s expected needs, and are also held accountable for high-quality outcomes. At its core, capitation models are about changing provider incentives to focus on cost and quality over quantity of services

Where we are: Fee-for-service

The most common healthcare payment method in the US today is fee-for-service (FFS). In an FFS healthcare model, providers earn a fee for every service they perform, creating an incentive to perform more services to maximize revenue. FFS neither effectively promotes the elimination of waste, nor does it incentivize cost control or quality outcomes. However, despite its widely acknowledged deficiencies, it remains the most traditional payment model of US healthcare.

Fee-for-service model created unintended consequences

By way of background, in 1965 the US first established the Medicare and Medicaid programs to care for elderly and lower-income populations. Interestingly, the primary method for reimbursing providers followed the philosophy of paying the ‘cost’ of delivering each unit of care plus some markup, known as cost-plus. This method was inherently flawed and created the incentive for providers to spend as much as possible, knowing they would get a return on any spending, regardless of the outcome.

While costs under the cost-plus system were audited by the government to ensure they were medically appropriate, the incentive problem it created was too difficult to overcome and costs began to both increase and vary widely across different provider groups for the same services. As a response, in the 1980s the Medicare program began to create standardized fee categories of billing codes and reimbursement rates. Instead of billing for the cost of care provided, providers could now only get reimbursed for “the average cost of an efficient provider” to provide the service. This was an improvement in that it created an incentive for providers to become more efficient in order to capture a spread between the payment and their costs. However, it did nothing to eliminate the incentive to provide more services.

The main obstacles in a fee-for-service model include:

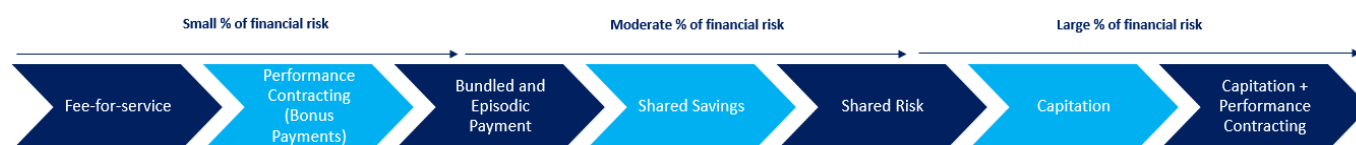
- **Emphasis on volumes to maximize billable events:** Under FFS, physicians and other providers are paid more money if they provide more services, so they often look to provide the highest number of healthcare services. There is an incentive to run more tests and perform more expensive procedures than may be necessary.
- **Over-service makes it hard to gauge 'true' costs:** Since providers are generally in the habit of over-prescribing services, the types and volumes of care being used to treat a given disease vary widely and make it difficult to gauge an appropriate cost for a patient or disease state.
- **Overabundance of caution from legal threat:** This issue of focusing on volumes can be compounded by the current legal system, which leaves physicians liable for misdiagnosis and drives the practice of defensive medicine. If a provider gets more money to run a test to go from 98% confident in a diagnosis to 100% confident and reduce the likelihood of getting sued, why not order that test, regardless of the cost?
- **A lack of focus on quality:** Notwithstanding the fact that healthcare providers want to do a good job, their main focus is on what happens at their site of care, with little attention paid to the longer-term clinical outcomes for the patient. In fact, most providers have little data on what happens to patients after they leave their doors. Without the time, resources, or financial incentives to follow patients, there is little reason for physicians to even try to do so. These gaps in care dramatically reduce the overall quality of care and can lead to significant increases in costs.
- **A barrier to shifting care to the low-cost setting:** With the focus on quantity, not quality of care, many physician practices bought MRIs and other imaging equipment in an effort to capture more of the economics of the patients that they see. As a result, there is an incentive to use that machine, even if a freestanding imaging center might be a lower cost option. In the end, the patient can receive suboptimal care, pay a higher price, or both.
- **Little focus on preventative care:** The current model is based on treating people after they get sick, and there are few incentives to keep people healthy.

What is value-based care?

In response to the rapid growth in healthcare spending and the acknowledgement that it is unsustainable, there has been a move to shift away from fee-for-service toward fee-for-value service, which is sometimes called value-based care or value-based purchasing. There are many different value-based reimbursement models that can be implemented to link financial rewards with clinical performance and cost control. These models range from an FFS base with extra payments for providers who meet quality goals, to a shared-risk framework, all the way to full capitation (passing 100% of underwriting risk from the insurer to the doctor) (Exhibit 3). The main thing they have in common is that they incentivize providers to deliver not only top-quality care, but also lower costs.

Exhibit 3: Spectrum of advanced payment models by order of risk taking

Value-based care is a spectrum of paying for performance and taking downside risk



Source: BofA Global Research

Value-based care models

Quality-linked and bonus payments

Under quality-linked arrangements, providers continue to be paid through the FFS model. However, in addition to the base rate, providers would be paid an additional amount for hitting certain quality benchmarks, such as completing annual wellness visits to document health status, and would potentially be penalized if they do not. In cases where the providers assume some downside, the arrangements typically involve a 'quality withhold' payment where the original FFS rate is reduced by some amount (typically ~5%) and only repaid once quality measures are reached in addition to a potential quality bonus. The upside of this arrangement is that it starts motivating providers to think about something beyond simply doing more.

Additionally, providers have generally been receptive to quality-linked bonus payments as they are generally seen as an upside to the existing contracting rates. While this method of reimbursement helps align incentives to some degree, the reality is that it

focuses physicians on a very narrow set of measures which do not necessarily improve health outcomes or lower overall costs as much as more integrated models do.

Bundled payments

Following the lead of some insurers in the private market, in 2016 the government introduced ‘bundled’ payments which extends payments to cover care episodes, defined to include all necessary inpatient and outpatient services required to treat a specific injury or illness from the time of diagnosis through recovery. The single fixed fee covers the costs of the physicians and other clinicians, drugs, devices, facilities, and any other resources dedicated to the episode of care.

This approach incentivizes providers to collaborate across the continuum of care to deliver high-quality, low-cost healthcare. Unfortunately, there is no incentive to focus on preventative care, since the payment begins at the time that the episode starts (after there is already a healthcare issue). However, there is a real incentive to ensure that there are no gaps in care when a patient moves from one care setting to the next during recovery. The bundled payment rate is based on the average cost of an episode, so providers can make money by continuing to spend below the bundled rate, but would be at risk if costs go above the rate.

While the bundled payment approach does encourage more value-oriented care within a case bundle, it creates no durable incentive for the provider group to lower overall medical costs. Instead, it still encourages groups to push a greater number of bundles or procedures to maximize revenue.

Shared savings/shared risk

Shared savings and risk arrangements tend to be in-line with how people generally think about value-based care in that providers are assigned a number of enrollees and there is a benchmark spending target for that pool of members for which the provider must manage down costs. Unlike full risk arrangements where providers are paid the full rate each month (see below), shared risk providers are usually paid on a fee for service basis during the period. However, at the end of the period, actual spending is compared against the benchmark level of spending and if there are savings, the providers share a percentage of the upside (net of any fee for service spending).

Shared savings can be structured as “one-way risk” models (where there is upside if costs are below the benchmark, but no penalties if costs are above the benchmark) or “two-way risk” models (where providers share in the upside if costs come in below the benchmark and the downside if costs come in above the benchmark). Two-way risk models usually share a greater percentage of the upside in return for taking risk to the downside.

One potential downside of shared savings / risk is that the portion of the upside may not justify additional investment into the infrastructure needed to make it work for the provider. Said another way, if a provider is willing to invest into the care management infrastructure needed (which can involve shifting the entire way of operating the practice) to feel confident that it can control medical costs, then having to share the upside it expects with another party reduces the return on investment and makes it harder to justify even if there is minimal downside.

Full risk or “capitation”

The most advanced form of value-based care a provider can enter into is a full risk, or capitation arrangement. Under capitation, providers are paid a fixed payment for each enrollee per month, regardless of the services that the enrollee receives. If the provider can keep the costs below the capitated rate, then it makes money, while if costs go above the capitated rate, it loses money. Essentially, the managed care payer is fully offloading risk onto the provider. Types of capitation arrangements include:

- **Global or full capitation:** A provider operates under a global capitation model if it is reimbursed on a per-member per-month basis (PMPM) to cover the entire range of healthcare services. In this model, historic data is used to project future costs and rates for services – e.g., paying the provider more for a patient with multiple chronic conditions than for a patient who is relatively healthy.
- **Partial capitation:** A provider operates under a partial or blended capitation model if it receives capitated reimbursements only for certain types of services – e.g., physician specialists.
- **Sub capitation:** This is the process where one provider takes risk on a broad set of services and then pays a PMPM to another provider to provide a subset of services – e.g., a provider taking global cap might sub capitate to an orthopedic physician group through a partial capitation contract to cover orthopedic costs.

Capitation: What are the differentiators?

A focus on the number of enrollees, not number of services

Capitation incentivizes providers to implement preventative measures to control healthcare utilization. Under this model, reducing costs for care and limiting unnecessary services is in the strategic interest of providers. By delivering care in the most efficient and cost-effective way, providers are able to attract enrollees and generate a consistent stream of revenue.

Places the provider in the driver seat of care

Under capitation, utilization risk shifts from payers to providers, because providers are paid a fixed reimbursement based on the number of enrollees, regardless of the cost of care. This framework encourages physicians and other healthcare professionals to carefully consider each dollar spent on patients, but it also encourages them to spend money on prevention, rather than simply treating patients after they get sick.

Incentivizes cost controls, long-term investment into preventative care

Under integrated care models, the incentives are to control costs, so an incremental test is more likely to be run by the doctor if there are true diagnostic benefits from doing so. While this model could incentivize a short-term reduction in services in order to hit a target, if physicians are routinely denying care, eventually, the patient will have a healthcare issue that needs to be treated in a high-cost setting. As a result, there is a long-term incentive to focus on preventative medicine and to spend a modest amount of money today to avoid a costly health issue tomorrow.

Lower institutional care the main driver of savings, therefore not a conflict

Integrated care arrangements with doctors allow managed care organizations (MCOs) to incentivize keeping patients out of higher cost institutional care settings such as hospitals, nursing homes, etc. In this arrangement medical costs are lower for MCOs, and physicians earn more money without cannibalizing their own businesses.

Adjusting payments based on demographic factors

In most cases, the capitated amount will be risk adjusted to ensure that providers are not disincentivized from taking the high-risk patients. These payments are usually adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members based on the chronic conditions that these patients have. In order to match payments with expected average costs, a capitated provider will be paid more to care for a patient that is sicker than average and would be paid less than average to care for a patient who is healthier than average. The key here is that the rate is based on *expected average cost* for a patient with those characteristics, creating a financial incentive for the provider to lower costs to below average.

Critics say providers are incentivized to reduce care

Some healthcare leaders make the argument that physicians and other clinicians should be focused only on clinical outcomes. They raise concerns that pressure on the healthcare providers to make the right financial decisions could come at the expense of the health of their patients. For example, capitation could hurt the physician-patient relationship as they have competing interests in mind.

Difficulty in penetrating new markets, shift behavior

There is a wide variation in acceptance (and success) of capitation by geography. In general, California, Florida and Texas have seen the most acceptance of capitation payments by providers, while other regions such as the Northeast and Midwest are far less penetrated. As a market begins to embrace a capitated model, it increasingly becomes solidified as a core payment mechanism, however, first getting to that point can be a challenge.

Past capitation effort had mixed results

In the 1990s, a capitated payment model was implemented under the 'HMO' (Health Maintenance Organization) model, which failed to sustainably improve care delivery and payment. Under that system, some of the risk management responsibilities shifted from payers to providers. Meanwhile, insurers began to implement a 'gatekeeper' approach, which required patients to see a primary care doctor first, to obtain a referral to see specialists, diagnostics, surgeries or even hospitalizations. Additionally, insurance companies implemented stringent prior authorization requirements, leading to delayed and denied care.

Providers, especially small healthcare organizations, were ill-prepared and unable to take on the newfound financial risk but signed the contracts in order to gain share and drive patients to their hospitals. Even larger systems often failed to develop sustainable risk management practices. Meanwhile, other providers failed to change practice patterns, and running capitation with a fee for service mindset (i.e., the more you do, the better) quickly led to losses. As a result of the inability to predict risk and control costs, providers largely rejected the capitated model and returned to fee for service. The percentage of physician visits under capitation declined from the mid-1990s to the mid-2000s.

Value-based care: Why is this time different?

Despite past failures, capitation payment models as a way to pay for physicians have again accelerated in recent years. In BofA Global Research's view, there are several key differences today that make the approach more sustainable:

1. A focus on the sickest patients, better microeconomics

Unlike the broad-based approach of the 1990's HMO model, much of the new adoption of capitation arrangements today is on a more targeted basis towards the sickest patients with the greatest opportunity to drive savings. Since the savings are on a higher dollar amount of spending, the greater focus also drives better microeconomics by providing a meaningful gross dollar margin opportunity at the patient level, which is generally enough to shift behavior away from fee for service.

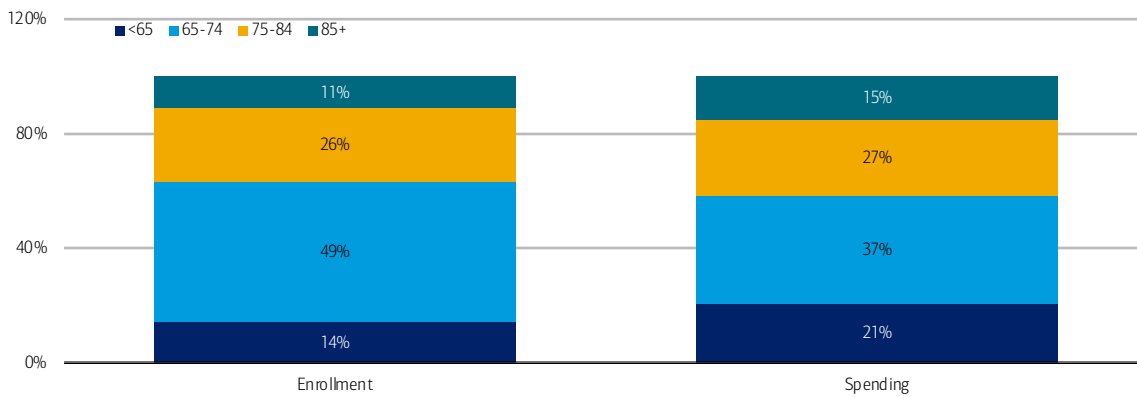
The older, the costlier. Sickest patients represent most of the spending

The Medicare Payment Advisory Commission's (MedPAC) statistics show that older enrollees represent a disproportionate amount of spending. For example, beneficiaries >85 represent 15% of spend but just 11% of enrollment, while patients ages 65-74 represent 37% of spend but 49% of enrollment (Exhibit 4). Older patients are more prone to injuries and illnesses and are more likely than others to require care for multiple chronic conditions and functional limitations.

Meanwhile, setting aside age, the top 10% of costly beneficiaries represent 60% of Medicare program spending (Exhibit 5). Essentially this implies that in order to address healthcare spending, efforts should be focused on addressing the needs of the sickest members rather than an approach catered to the average.

Exhibit 4: Breakdown of Medicare enrollment and spending by age cohort

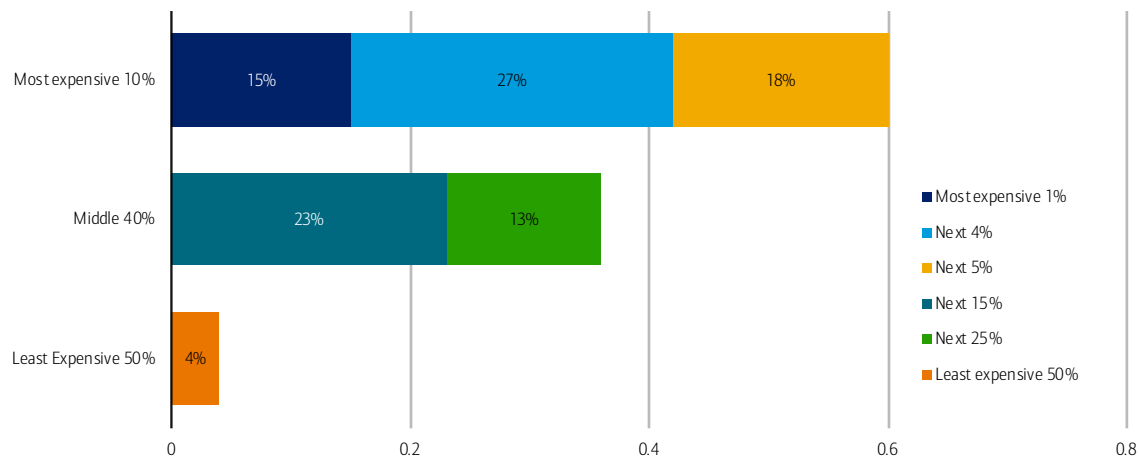
Older enrollees represent disproportionate spending..



Source: MedPAC

Exhibit 5: Breakdown of spending by percentage of enrollment (% of enrollment is the left Y axis and % of spending is the bottom X axis)

...meanwhile top 10% costliest enrollees represent 60% of program spending



Source: MedPAC

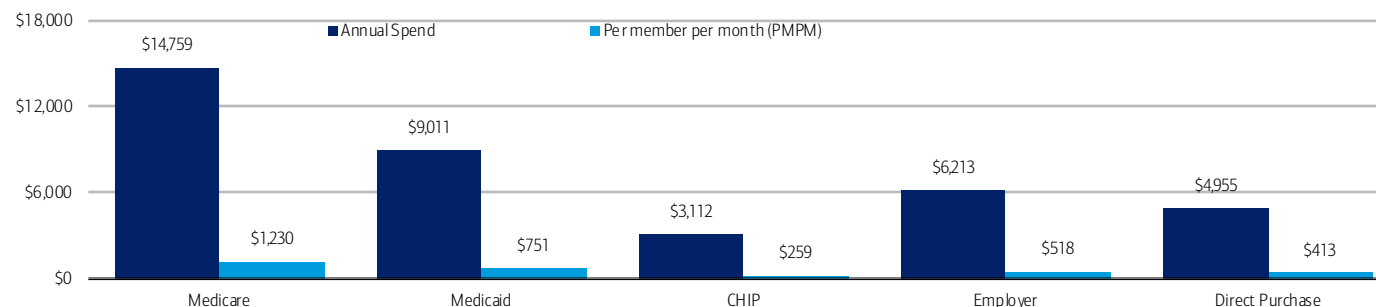
Government programs have highest spending per member

Unsurprisingly, members in government programs (focused on seniors/low-income populations) have significantly higher spending per member. This is because qualifying for Medicare and Medicaid is based on age (older seniors are typically sicker) as well as acuity (persons with disabilities). Therefore, spending on a Medicaid/Medicare member can be 50%-100% higher than

the average person on employer coverage (Exhibit 6). This is especially meaningful given that the unit cost rates in commercial are about 250% of Medicare, implying that utilization in Medicare is 4x higher than commercial.

Exhibit 6: Spending per enrollee by plan sponsor type

Spending per enrollee is materially higher for government



Source: CBO,

2. Growth in government programs brings standardization

Meanwhile, another key industry development over the last 30 years is the growth of government programs such as Medicare and Medicaid due to the Affordable Care Act and aging population, which together now cover about 1/2 of the US population. Alongside the rise of government programs, there has been a simultaneous growth in the rate at which those programs are outsourced to private industry. Today, nearly half of Medicare beneficiaries (Medicare Advantage or “MA”) and more than three quarters of Medicaid beneficiaries (Managed Medicaid) are served by private insurers (but ultimately paid for by the taxpayer).

Smoother premiums, smoother costs

Today, however, most full-risk value-based care contracts are made within government program constructs. The premiums an insurer receives (and therefore the rate a provider would receive to manage risk) are determined by a transparent government calculation referred to as a benchmark. By having a benchmarking approach to reimbursement, there is much less variability year to year and between beneficiaries.

Of greater importance, these benchmarks are generally calculated by looking at average beneficiary costs within the unmanaged government fee for service program. This creates a relatively low bar against which to generate savings. At the same time, plans can drive the same relative level of savings every year to maintain profitability. In the case of privately negotiated commercial plans, if an insurer drives down costs, the employer group would likely expect to pay the insurance company a lower amount of premiums in the following year to reflect that, meaning that the provider would have to find incremental savings every year just to maintain margins.

In contrast to the commercial market, these programs have more government mandated guidelines with more standardized benefits, networks, and rates paid to providers, meaning there is also less variability in the costs associated with treating patients with the same demographics.

Better mechanisms for risk adjustment further matches revenue to costs

When insurance companies take risk, the aggregate spending averages to be a predictable amount due to the law of large numbers, as the sickest members are offset by relatively healthy members who each pay the same premiums. The larger the membership base, the more likely this is to be true. However, provider panels are significantly smaller than insurance company enrollment and are much more at risk of higher-than-expected costs due to adverse selection (the potential that you will have a disproportionately higher percentage of high-cost patients).

To prevent providers from avoiding sick patients, government programs like Medicare Advantage (MA) have a mechanism called ‘risk adjustment’ to pay insurers and risk-taking providers more to treat sicker patients (since they have higher expected medical claims). These risk adjustment models are increasingly common in Medicaid programs but are much less prevalent in commercial.

Quality measures act as guardrails for bad outcomes

Aside from the direct financial incentive of generating savings, one additional mechanism that most value-based care programs have in place to ensure that providers don’t withhold necessary care is quality metrics. Essentially, programs such as MA codify specific quality metrics such as a percentage of annual wellness visits, medication adherence, cancer screenings, vaccinations, and other leading indicators that providers need to manage towards in order to qualify for bonuses or receive full payment.

3. Greater appreciation for social determinations of health

In the past 30 years, BofA Global Research notes a greater appreciation for how the ‘social determinants of health’ influence healthcare spending. Essentially, the healthcare community is increasingly recognizing that healthcare outcomes are dynamic and not based solely on what is decided in a clinical setting (such as medications or medical history). For example, access to housing, nutritious meals, transportation to the doctor, financial assistance programs such as food stamps, a gym, or to mental health resources are all becoming recognized as important inputs to keeping a patient healthy.

Government and private sector have begun to pay for more social services

Additionally, government programs such as Medicare and Medicaid and private sector employers are supporting the role of social determinants of health by paying or contributing to some of them. In turn, this allows risk-taking providers to route patients to these necessary and outcome-changing services and gives the providers more tools at their disposal.

By coordinating benefits, provider can increase adherence, patient satisfaction

Finally, it’s worth noting that these perks and resources are generally available to many of the beneficiaries that capitated providers treat, but the patients are often unaware that they exist. With value-based care, providers now have an incentive to ensure patients are receiving all of these available resources which increases medical adherence in general (as a patient cannot seek care without transportation or stable mental condition) as well as increases the perceived value of the service from a patient’s perspective (as the patient receives all of these additional benefits after visiting the provider even though the provider isn’t paying for the services).

4. Advancement in healthcare technology

Another issue with capitation in the 1990s, was that providers did not have the technology to fully understand their own costs and were unable to predict whether the capitated rate that they received would be enough. Meanwhile, a fee-for-service world did not lend itself to building out the capabilities or technology to identify patients at high risk of a health issue in advance, because it was not necessary under that model. A lack of sophistication in understanding how to price risk and how to first identify and then engage with high-risk populations is one of the biggest gating factors to widespread capitation. However, in recent years, there has been a proliferation of health information technology (healthIT) and greater interoperability initiatives, which give the provider greater access to the relevant data needed to manage risk.

5. Dedicated models, physicians more focused

A more straightforward reason practices may be more successful in value-based care this time around is the proliferation of groups focused exclusively on this opportunity. By remaining focused on a specific model of care and reimbursement, the physician is going to be more effective at driving outcomes. Intuitively this makes sense, as it would be difficult for a physician to treat a subset of patients under fee-for-service (where the incentive would be to bill for as many services as possible) and simultaneously treat other patients under value-based care (where the incentive is to bill for fewer services and prevent costly hospitalizations). Taking this even one step further, many companies are focusing exclusively on seniors, which makes it even easier for physicians to execute on a standardized treatment model than if the doctor were to pivot from an 18-year-old male to a 30-year-old pregnant woman to an 85-year-old male.

6. “Field of dreams” model aligns financial incentives

Finally, if we return to the concept of “incentives drive outcomes,” potentially the single biggest driver that supports this shift is the introduction of the minimum medical loss ratio (MLR) requirement as part of the Affordable Care Act (ACA). The ACA implemented a minimum MLR of 80-85% for health plans depending on the product (individual and small group commercial at 80% and MA and large group commercial at 85%), essentially capping health insurance gross profits at 15-20%. Essentially, insurers are now required to spend 80-85% of all premium dollars on healthcare costs. If the MLR falls below this level, the managed care organization (MCO) rebates the difference back to the customer.

Minimum MLR aligns incentives of the MCO

This minimum MLR creates a number of dynamics that encourage capitation. First, it creates an easy payment reference point for providers to assume risk. Second, it creates an incentive for the MCO to capitate at the minimum MLR as it maximizes their own gross profit while offloading all of its risk. Third, since payments are risk adjusted based on the health status of the patient, it ensures that the doctor will work to fully document the patient’s health, resulting in higher revenue to the MCO (and the doctor who gets 85% of that MA premium). Fourth, since MCOs receive bonus payments for high quality (and doctors get 85% of that amount), it incentivizes physicians to focus on hitting quality targets. From an MCO’s point of view, this maximizes revenue (through higher risk scoring and quality bonuses), while locking in maximum margins on that higher revenue and eliminates direct exposure to fluctuations in cost trend. As a result, if an insurer can build a physician network that can control both costs and risk score while delivering quality, membership will follow.

If the provider can manage costs, they can more than double profitability

Normally a primary care provider would only get paid when they see the patient (1-2x per year), without any regard for what happens outside the walls of the clinic. However, under value-based care the provider gets paid as a percentage of premiums and can increase their earnings by focusing on controlling patient costs. According to BofA Global Research, if the provider is

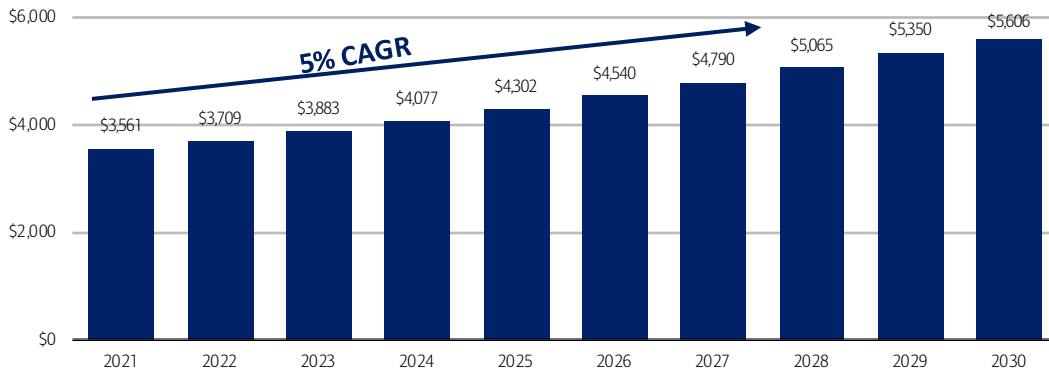
successful, shifting to value-based care can increase revenue by more than 11x, and profitability by 2-4x or more. Therefore, under value-based care when MCOs win, the physician's business wins too.

Seizing the opportunity, beyond Medicare

As of 2022, the US has spent about \$3.7 trillion on delivering healthcare, and this is expected to continue growing 5-6% per year (Exhibit 7). Therefore, the theoretical opportunity for value-based care and physician enablement is to manage all of that spending and earn a margin on the savings. Given that fee-for-service is still the predominant form of payment for healthcare spending today, there is a large penetration opportunity in converting more physicians towards value-based care.

Exhibit 7: National US spending on health insurance estimates from National Health Expenditures forecasts over time

Physicians have the opportunity to manage >\$3.7 trillion of health insurance spending, which is expected to compound at 5% going forward

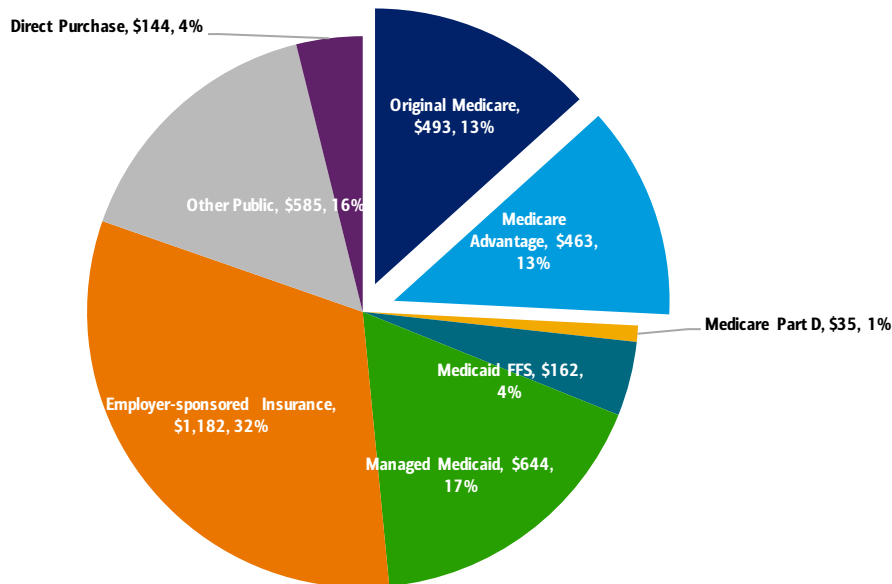


Source: CMS

While the Medicare market is already a large, fast-growing industry, it is still only about 26% of overall healthcare spending (Exhibit 8). In many ways, the Medicare market is the most attractive for a wider range of physicians due to its demographic tailwinds, greater opportunity to medically manage patients, and positive reimbursement dynamics. However, once physicians are able to accept and manage capitated risk and see the value in the model it would follow that the eventual opportunity is to cover 100% of total healthcare spending, starting with Medicaid (another 21% of spend) and Commercial insurance (another 32%+).

Exhibit 8: Cost of coverage by plan sponsor tile, 2021 (\$ billions)

Medicare just 26% of healthcare spending, opportunity to eventually cover 100%

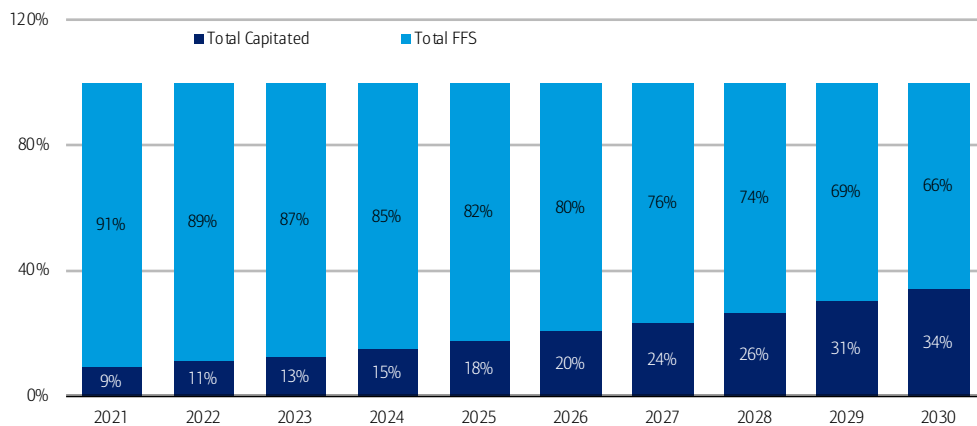


Source: CBO, BofA Global Research

With the Federal government pushing for 100% value-based care penetration in Medicare by 2030, BofA Global Research estimates that the \$420 billion of spending in capitation-like models in 2021, could grow to \$1.9 trillion by 2030 (of which \$1.2 trillion would be in Medicare alone), representing growth of 21% per year (Exhibit 9 and Exhibit 10).

Exhibit 9: Estimated capitation penetration rate in overall healthcare spending

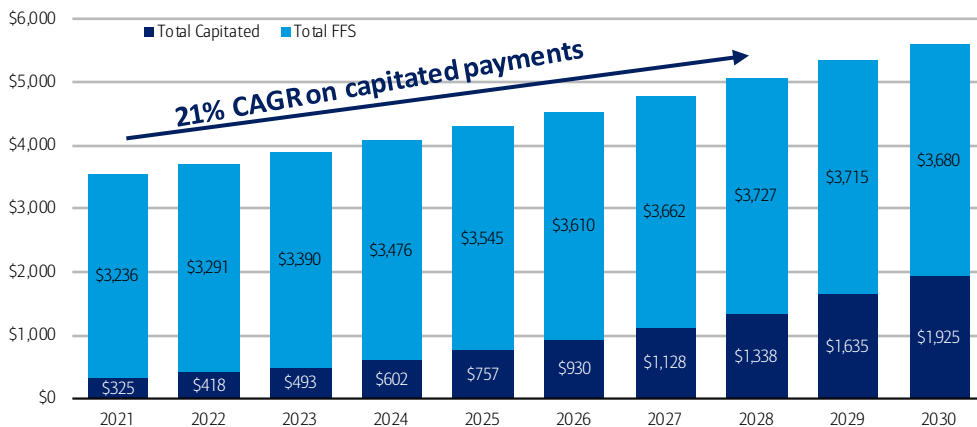
Actual penetration rate likely in the 11% range...



Source: S&P Global, Statutory Filings, CMS, BofA Global Research estimates

Exhibit 10: Estimated capitation spending versus FFS spending in overall healthcare spend

...could power 21% CAGR through 2030



Source: S&P Global, Statutory Filings, CMS, BofA Global Research estimates

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