



Connecting Advisory Board's 2026 Industry Trends to Data & AI-Driven Outcomes

Our Speakers



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Agenda

- Advisory Board – 2026 State of the Industry
- Stabilizing Access and Financial Health
- Controlling Costs and Improving Performance
- Elevating Care Quality and Strengthening Trust
- Q&A

2026 State of the Industry

Unraveling assumptions about the control of care delivery

PRESENTATION AT A GLANCE

I Safety net access hurtles toward a tipping point, where community care is a patchwork hinging on private support

- Coverage reductions and scrutiny
- Rural provider vulnerability
- Local pharmacy instability
- AMC business model shift

II Purchaser spend management strategies reach the limits of generic scale, and delegation to niche experts prevails

- Utilization and spending trends
- GLP-1 navigation programs
- Behavioral health platforms
- Variable copay plans

III Care decision makers span new power brokers who exert influence over treatment choices, overlapping with clinicians

- Patient trust and experience
- Direct-to-consumer sources
- Medical group ownership
- AI and automation vendors

**Advisory Board's annual
State of the Industry research**

WHAT IT IS

Not just a landscape scan — our stance on the trajectory of healthcare.

Advisory Board's "State of the Industry" presentation equips all healthcare executives with the knowledge and insights to capitalize on today's business opportunities and mitigate tomorrow's market risks.

We cut through the noise to highlight the pivotal shifts happening in healthcare, how stakeholders are responding, and what leaders must consider to stay ahead.

These materials capture and distill the key insights from across all Advisory Board research projects to articulate **our stance on the trajectory of healthcare**.

The diffusing control of care delivery heading into 2026



SAFETY NET ACCESS

The care ecosystem tipping point

Utilitarian
patchwork

Diffusing responsibility



Reduced incumbent control
over preferred revenue
segments and service capacity



PURCHASER SPEND MANAGEMENT

The limits of generic scale

Niche
delegation

Diffusing ownership



Reduced incumbent control
over disease management
programs and referral patterns



CARE DECISION MAKERS

The new power brokers

Sprawling
advisors

Diffusing influence



Reduced incumbent control
over selected treatment
options and care adherence

01

Safety net access

FOUNDATIONAL ASSUMPTION

Baseline subsidy

Public funding enables a viable community access baseline

The government subsidizes enough healthcare funding to make it **financially viable for private players to support a collective safety net**, preserving a minimum baseline level of access to care for the population.



EMERGING DYNAMIC

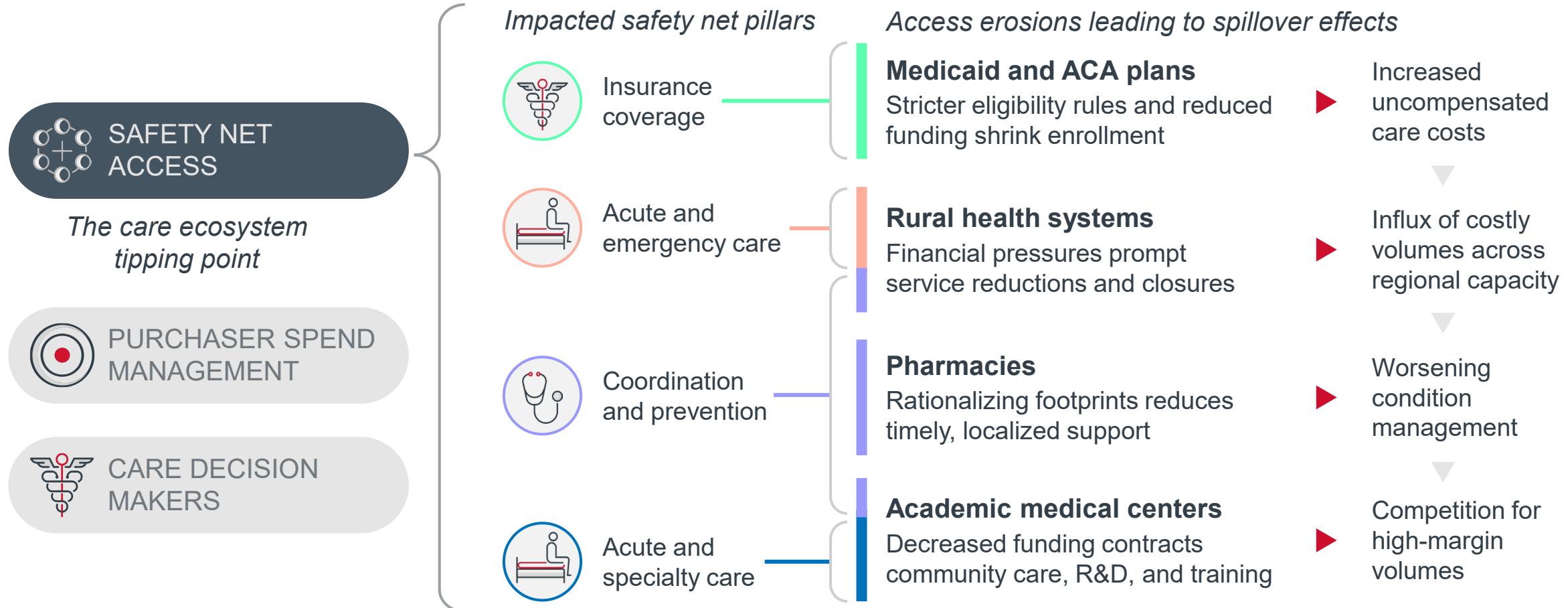
Utilitarian patchwork

Funding reverts to pre-pandemic level, with commercial opportunities.

Funding change re-emphasizes original aims of Medicaid, and reverses ACA exchange access to pre-expansion state. Long term viability will depend on **selective guardrails on access**, and creating space for more flexible offerings, such as population risk management or referral steerage.

A diffusion of responsibility for safety net access

Shrinking safety net makes the consequences of access reductions into a problem for everyone



OBBA Impact on Medicaid and ACA Marketplaces

Major Medicaid provisions in OBBBA¹

ELIGIBILITY



Work requirements

- States **must require** Medicaid enrollees ages 19–64 to work 80+ hours monthly
Effective December 31, 2026



Eligibility Determinations

- States must conduct redeterminations at least **every 6 months** for expansion adults
Effective January 1, 2027



Retroactive coverage

- **Limits retroactive Medicaid coverage** to 1 month for expansion enrollees, 2 months for traditional enrollees
Effective January 1, 2027

FINANCING



Provider taxes

- **Prohibits establishment** of new provider taxes or increasing rates of existing taxes
- **Reduces safe harbor limit** for expansion states by 0.5% yearly until reaching 3.5%
Effective October 1, 2028



State-directed payments

- **Caps state-directed** provider payments
- Grandfathered payments drop 10% yearly until reaching 100% of Medicare rates²
Effective January 1, 2028

1. One Big Beautiful Bill Act.

2. 110% for non-expansion states.

Federal policies target ACA enrollment



End of enhanced subsidies

- Enhanced subsidies to expire end of 2025
- Marketplace enrollment doubled from **11.4M** to **24.3M** with enhanced subsidies



OBBA¹ and Marketplace integrity final rule²

- Pauses SEP³ for low-income individuals
- DACA recipients lose eligibility
- Stricter income verification
- Pre-enrollment SEP verification



Navigator cuts

- Navigator funding reduced by 90%
- Impact will most affect rural, Latino, and non-English speaking populations

1. One Big Beautiful Bill Act.

2. Legal action pending.

3. Special enrollment period.

4. Excludes final rule changes under litigation.

Stabilizing Safety Net Access Through Data-Driven Insight

As safety net role diffuses, leading health systems use data and AI to protect access, capacity, and margin

See the True Cost of Access

Financial clarity to prioritize what sustains community care

- Activity-based costing exposes true service-line costs
- Enables smarter decisions to sustain community care

Outcome: Preserved margin while maintaining access

Impact: Allina Health identified ~\$33M in annual savings

Absorb Demand Without Breaking Capacity

Operational insight to manage rising acuity and volume

- Analytics optimize patient flow from ED to discharge
- Maximizes use of beds, clinics, and care teams

Outcome: More patients served with existing resources

Impact: Thibodaux Regional generated \$1.2M while expanding primary care access

Protect Earned Revenue to Fund Care

Revenue integrity under volatile reimbursement

- Real-time underpayment detection and recovery
- Analytics-driven denials prevention and documentation insights

Outcome: Captured revenue reinvested into access and community care

02

Purchaser spend management

FOUNDATIONAL ASSUMPTION

Generalist gatekeeping

Uniform cost and quality standards drive network performance

Managing health spend is fundamentally about **wielding sufficiently broad scale**. Large enough risk pools to distribute costs, market power to negotiate comprehensive network contracts, and general utilization management tactics help payers contain enough costs to provide access to a wide network and array of treatment options.



EMERGING DYNAMIC

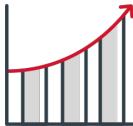
Niche delegation

Specific treatments and conditions require unique expert overseers

Payers are layering on **targeted solutions for specific treatments and conditions** on top of traditional outcomes management tactics as emerging treatments often require specialized expertise, further fragmenting coverage and adding complexity to payer-provider relationships.

Perfect storm of headwinds continue spike in cost trend

Health plan leaders' assessment of key drivers for increased medical spending in 2025 Q1 and Q2



Specialty service utilization



Specialty drugs (especially infusions and GLP-1s)



Downstream specialty care and outpatient procedures in MA (especially orthopedics)



Behavioral health services (especially ABA¹ for autism)



Elevated unit costs



Procedure coding and **billing intensity**, aided by AI and automation



Rate negotiation pressure from input cost growth (especially labor)



Out-of-network payment increases through No Surprises Act settlements



Insurance constraints



Demographic shifts challenging actuarial pricing



High-cost claimants outpacing **stop loss** pricing



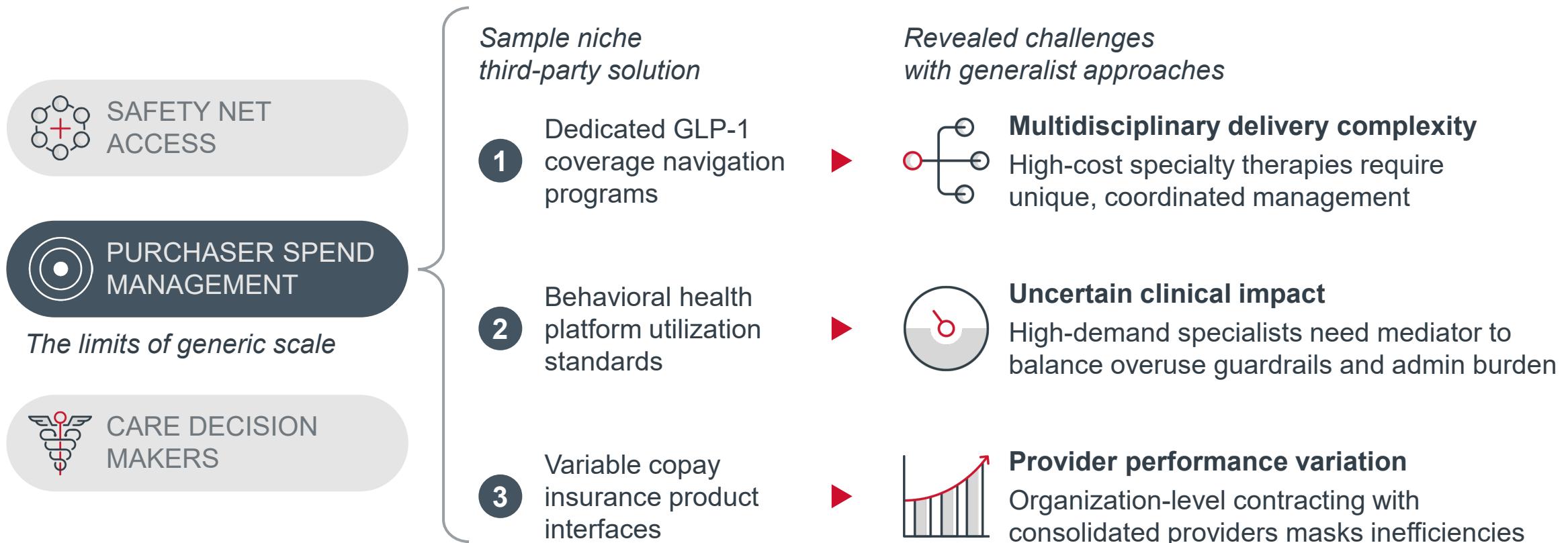
Public scrutiny on utilization management tactics

1. Applied behavior analysis.

Source: Advisory Board health plan executive interviews, 2025; Investor relations Q1 2025 and Q2 2025 earnings call transcripts for \$CI, \$CNC, \$CVS, \$ELV, \$HUM, and \$UNH; accessed through www.investing.com.

A diffusion of ownership over spend management

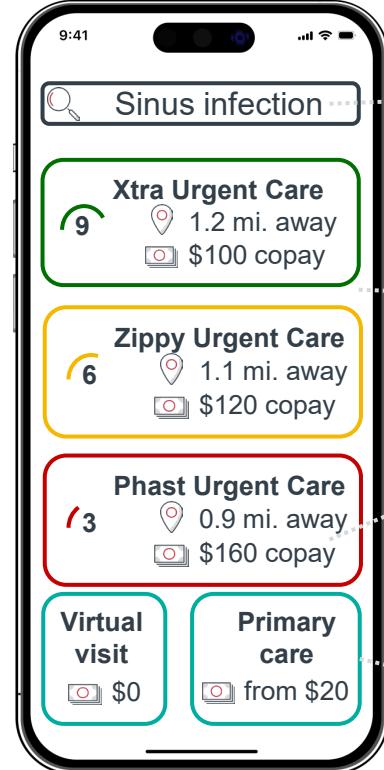
Cost drivers create an opportunity for new players to carve out a member management niche



Variable copay plans gaining traction to steer members

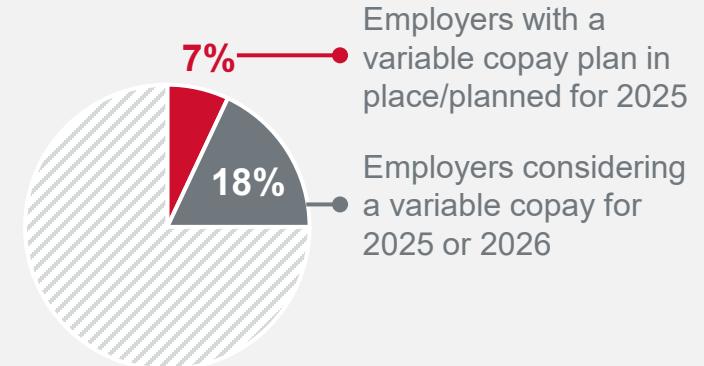
Variable copay plans incentivize members to choose high-quality, low-cost providers

KEY FEATURES	SAMPLE INTERFACE
 No or low deductibles	Members search for a specific service or condition
 Provider scores based on quality and cost at the location and/or service level	Members see a ranked list of providers with up-front costs
NOTABLE PLAYERS	Members pay more for lower ranked providers
<ul style="list-style-type: none">Surest (UHC): “Smart copays” vary by provider, site, service, and conditionSimplePay (Aetna) / Coupe Health (BCBS): Color tiering by facility; single monthly bill of copays	Member costs vary by type of care and/or site of care



Sources: [Employers: A health benefit that actually feels like a benefit](#), Surest. Accessed July 31, 2025; [Minemyer P. UnitedHealthcare rebrands Bind plans as Surest as it eyes further growth](#). Fierce Healthcare. August 11, 2022; [Harshey T, Umland B. New survey: Needles starting to move on alternative medical plans](#). Mercer. June 20, 2024; [How It Works](#), Surest. Accessed July 31, 2025; [Surest Enrollees Have 54% Lower Out-of-Pocket Costs and 11% Lower Total Medical Costs than Other Commercially Insured Individuals](#). UnitedHealth Group. December 2023; [Coupe Health for Group Health Plan Brokers](#). Coupe Health. Accessed July 31, 2025; [Coupe Health provides simple, cost-saving alternative to standard health plans](#). Blue Cross MN. Accessed July 31, 2025.

Products catch employers' eyes...



...but skepticism remains

- Up-front costs not always accurate
- Require competitive provider market
- Require member engagement

Controlling Costs as Spend Management Fragments

As purchaser strategies shift from generic scale to niche delegation, leading organizations use data and AI to regain visibility, control cost drivers, and improve performance.

Make Cost Drivers Visible—Not Abstract

Clarity into what's driving spend inflation

- Analytics surface the true drivers of rising cost: specialty utilization, unwarranted clinical variation, and high-cost service lines
- Enables leaders to quantify impact by condition, provider, and episode

Outcome: Focused action on the costs that matter most

Impact: WakeMed achieved \$10M in savings

Manage Complexity Created by Niche Delegation

Insight across fragmented vendor and program ecosystems

- Measure utilization, outcomes, and cost across fragmented specialty groups
- Cut through complexity as payer and employer strategies diversify

Outcome: Confident decisions in a fragmented spend landscape

Impact: Carle Health generated \$1.6M in savings

Turn Utilization Management into Performance Improvement

From blunt controls to data-driven optimization

- Standardize care where variation drives cost without outcomes
- Support value-based care readiness through population health, quality, and risk insight

Outcome: Lower total cost of care without sacrificing access or quality

Impact: UPMC guided smarter investment decisions, improving financial and clinical outcomes

03

Care decision makers

FOUNDATIONAL ASSUMPTION

Clinician centrality

Treatment decisions orient on the patient-clinician interaction

Healthcare treatment decisions are **centered around the patient-clinician interaction**, with a reliance on clinicians as trusted authorities with the sole influence over creating an appropriate treatment plan.



EMERGING DYNAMIC

Sprawling advisors

External voices reshape options for patients and clinicians

Treatment decisions are increasingly **influenced by voices and dynamics beyond traditional relationships**. Widespread patient dissatisfaction coupled with activities by technology vendors, social media, and other third parties add greater complexity to the patient-clinician relationship, diffusing influence over care decisions.

A diffusion of influence over care decision makers



New clinical influencers go direct to consumers

Gathering health information



52% of Americans have tried a health tactic¹ they found on **social media** in the last year, while 34% tried a tactic from their healthcare provider



Women turn to TikTok for health information and **OBGYNs are there to meet them**

ABC News



25% of adults under 30 say they use **AI chatbots** at least once a month to find health information and advice



Chatbots routinely answer health queries with **false information that appears authoritative**

CBC News

Seeking care and treatment



11% of adults who have taken a GLP-1 obtained them from an **online provider or website**



Direct-to-consumer models run the risk of **pushing drugs on patients** who might not need them

Fierce Pharma



Longevity startup **Function Health**, which offers members lab tests and clinician summaries, was valued at **\$2.5B**



Function Health collaborates with GRAIL to offer **multi-cancer early detection test** nationwide

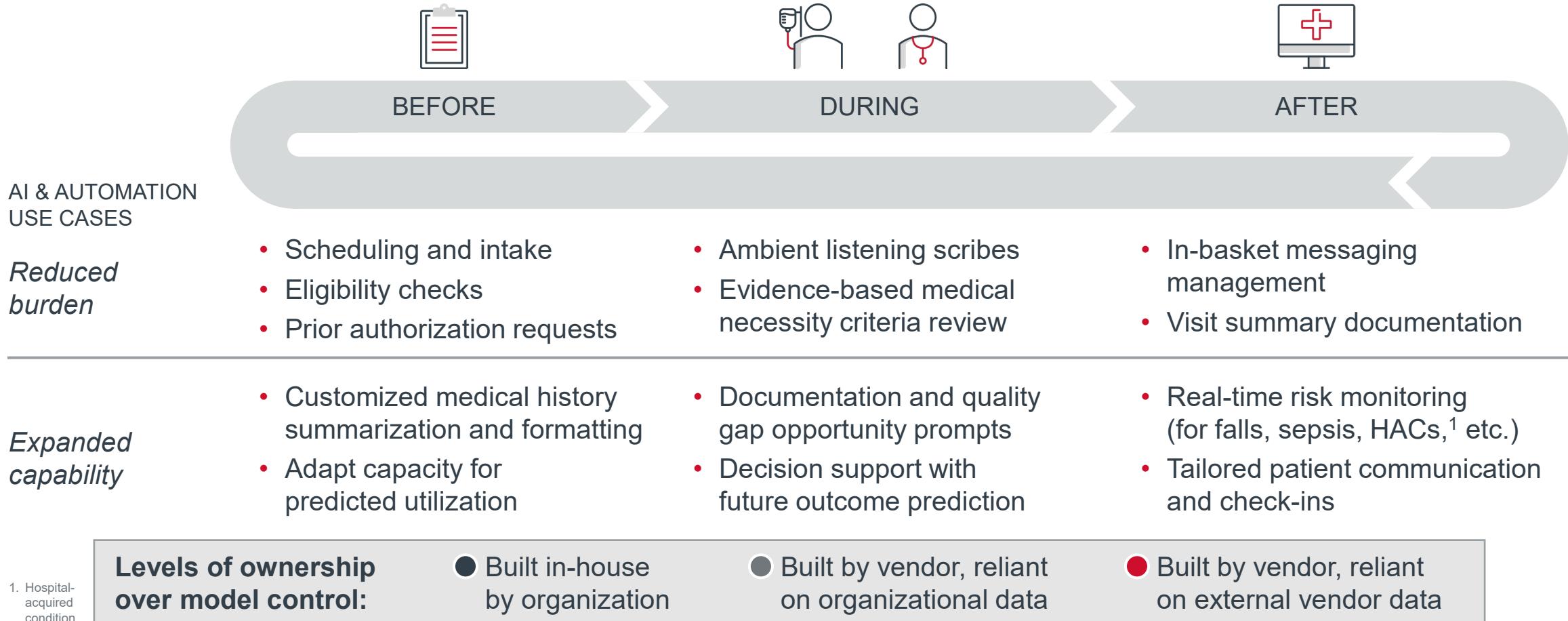
PR Newswire

1. Health and wellness tool, resource, trend, or product.

Sources: [State of consumer health](#). Healthline. October 8, 2024; Kindelan K. [Women turn to TikTok for health information and OBGYNs are there to meet them](#). ABC News. February 13, 2020; Presiado M, et al. [KFF health misinformation tracking poll: Artificial intelligence and health information](#). KFF. August 15, 2024; Zafar A. [Talk to medical professionals, not just ChatGPT, urge Ontario doctors](#). CBC News. July 12, 2025; Montero A, et al. [KFF Health Tracking Poll May 2024: The Public's Use and Views of GLP-1 Drugs](#). KFF. May 10, 2024; Goldman M. [More pharma giants embrace direct-to-consumer sales](#). Axios. August 4, 2025; Bradbury R. [Redpoint-led round values longevity startup Function health at \\$2.5B](#). PitchBook. February 19, 2025; Function Health collaborates with GRAIL to offer multi-cancer early detection test nationwide. PR Newswire. December 4, 2024.

The technological transformation of the clinical journey

AI and automation implementation across the journey of patient-clinician interactions



Elevating Care Decisions in a Fragmented Influence Landscape

As decision-making diffuses beyond the clinician–patient relationship, leading organizations use data, analytics, and AI to restore trust, consistency, and performance.

Support Clinicians as AI Reshapes the Care Journey

Enablement—not replacement—of clinical judgment

- Analytics and AI reduce documentation burden and surface quality gaps in real time
- Support clinicians with decision support amid growing complexity

Outcome: More time for care, less time on administrative work

Rebuild Trust Through Transparency & Measurement

Clarity for clinicians, leaders, and patients

- Visible and actionable quality, safety, and experience metrics
- Supports confidence in care decisions amid misinformation and external influence

Outcome: Stronger clinician engagement and patient trust

Impact: CHNW used prescribing analytics to **align surgeons** on safer, evidence-based opioid use

Reduce Unwarranted Clinical Variation

Trusted insight to guide consistent, evidence-based care

- Analytics reveals unwarranted variation in outcomes and practice patterns
- Drive clinician alignment on evidence-based standards

Outcome: Improved quality and reduced avoidable harm

Impact: Piedmont **reduced harm events and improved clinical outcomes** through analytics-led quality redesign

“

Cost, Clinical Quality and how these two interact to drive the Consumer experience have to be front and center of everything we do in 2026

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Questions?

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