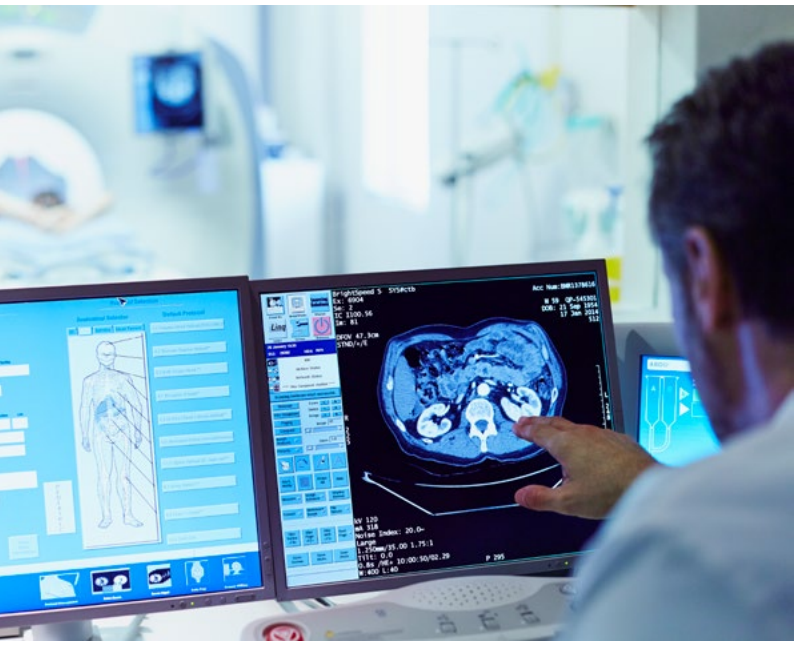
HEALTHCARE INDUSTRY GROUP

The State of Transformation for U.S. Healthcare Providers

Market dynamics for health systems are shifting. The most significant driver is the federal Medicaid mandate, which expired at the end of December 2025 and is now pending legislation. This uncertainty is prompting health system leaders to rethink strategy and operations. In this context, we'll share how other health systems are responding and what these changes mean for organizations like yours.

THE PICTURE IS CLEAR: THE NEED FOR CHANGE IS NO LONGER DEBATABLE

Across the provider landscape, leaders agree: the status quo is no longer viable. Every health system recognizes the need for change—what's different now is the intensity and urgency of the pressures.



In recent years, many organizations treated transformation as a gradual, programmatic effort focused on optimization and incremental gains. The environment has changed. We're moving from a "transformation" pace to a "restructuring" pace.

The core drivers are:

- Persistent revenue shortfalls, even after pursuing revenue diversification strategies such as 340(B)
- Tightening reimbursement and increasing payer mix volatility
- Cost inflation outpacing revenue growth
- Workforce and labor instability
- Structural declines in commercially insured patients

> The question is no longer whether to transform—it's how quickly you can move and how bold you're willing to be.

PROVIDER RESPONSES: MORE PROACTIVE, MORE INTEGRATED, MORE URGENT

We're seeing a markedly different response nationwide than we were just three months ago.

Tightening Shared Services and Integrating Operations

Organizations - especially those that have completed acquisitions over the past five years - are accelerating efforts to truly integrate IT, HR, finance, revenue cycle, and clinical service lines.

The mandate is clear: If you bought scale, now you must leverage it.

Leaders are eliminating redundancies, aligning governance, standardizing platforms and centralizing functions that have long remained fragmented.

Labor Strategy Reassessment

With federal funding waning and insurance eligibility growing more uncertain—especially for Medicaid and Medicare Advantage—many systems are reassessing their entire labor model:

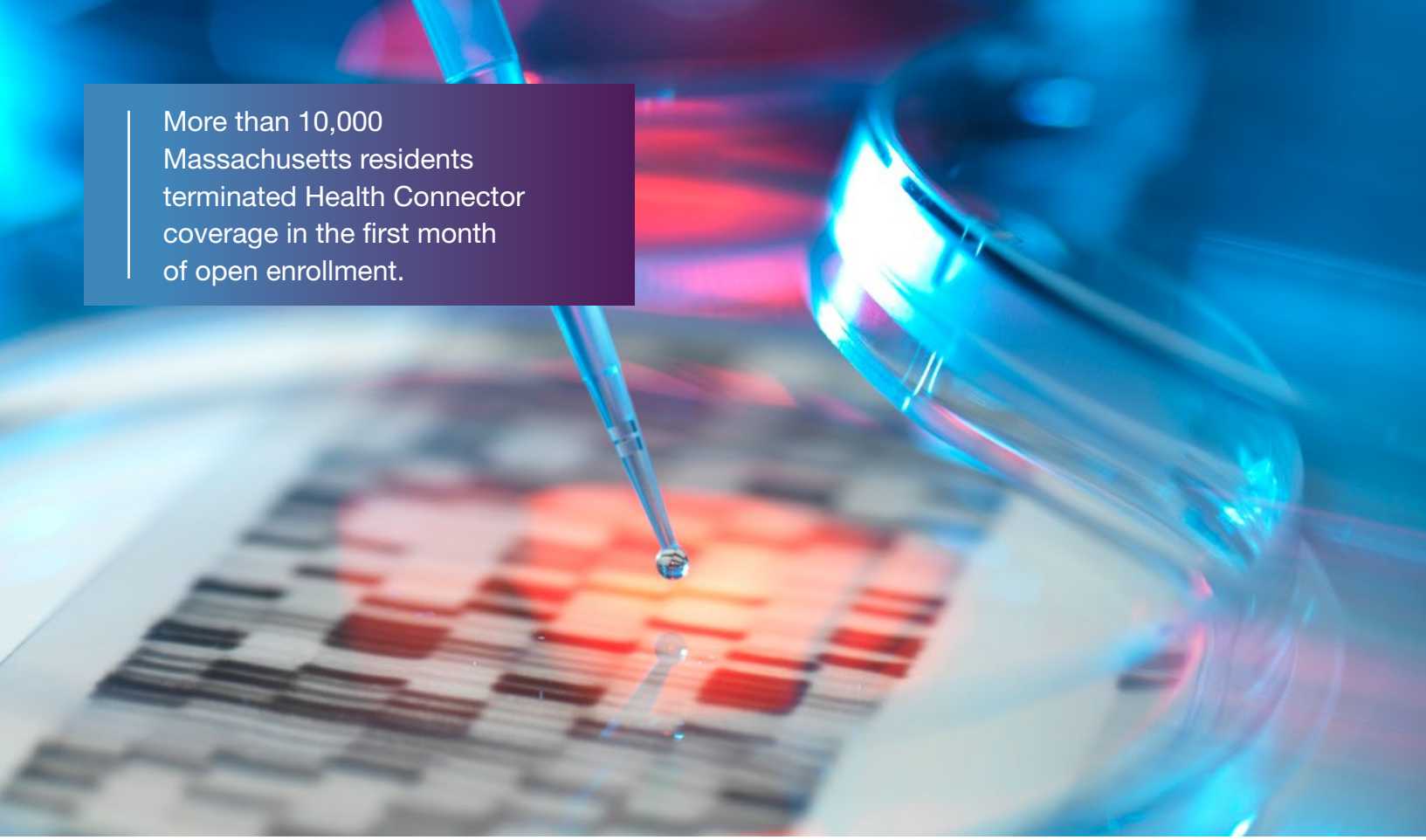
- **How many FTEs can the system sustainably afford?**
- **Which roles must remain in-house, and which can be outsourced or automated?**
- **How do we maintain operations if the payer mix deteriorates?**

This isn't about short-term flexing—it's about long-term, structural labor redesign.

Balance Sheets Are Driving Strategy - More Than Ever

Balance sheets are increasingly separating the "haves" from the "have-nots." Boards nationwide are asking the same question: How do we secure solvency and relevance over the next five years?

- **Stronger systems are pursuing growth**—through acquisitions, partnerships, and new service lines such as ASCs, home-based care, and ambulatory expansion.
- **Weaker systems are taking a different path**—shoring up liquidity, driving deeper cost reductions, and rationalizing services, including selective service line closures, to prepare for what's ahead.



> More than 10,000 Massachusetts residents terminated Health Connector coverage in the first month of open enrollment.

MARKET CONDITIONS HAVE SHIFTED: INSURANCE COVERAGE IS NO LONGER STABLE

One of the most consequential trends is the rapid deterioration in coverage affordability—especially visible in Massachusetts.

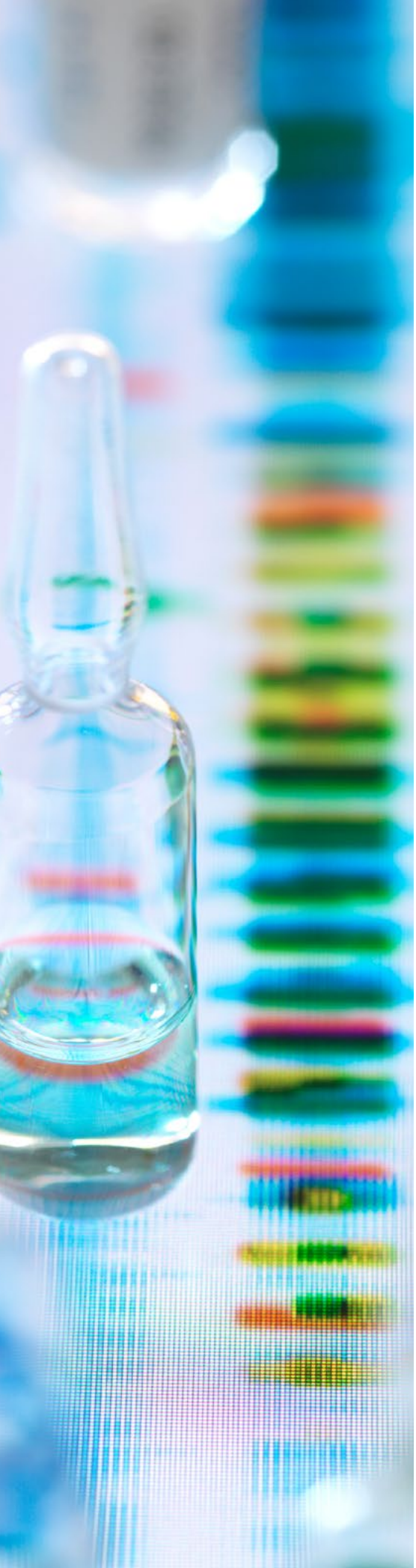
Consider this example with national implications:

- In the first month of open enrollment, more than 10,000 Massachusetts residents terminated Health Connector coverage for 2026—double last year's pace—amid projected premium spikes tied to the potential expiration of enhanced ACA subsidies on Dec. 31, 2025.
- Those enhanced subsidies—created by the American Rescue Plan and extended by the Inflation Reduction Act—are set to sunset at year-end, which would revert. eligibility and generosity to pre-2021 rules, including the return of the 400% FPL cap.
- National reporting shows consumers facing steep increases and marketplace churn as policymakers struggle to agree on an extension or alternative, with multiple proposals failing to advance in Congress.

What this means

- Households are already dropping coverage in anticipation of unaffordable premiums next year.
- Exchange affordability and accessibility are poised to erode without action, especially for middle-income consumers who would again face the subsidy cliff above 400% FPL.
- Safety-net and community providers will shoulder more uninsured and underinsured volume.
- Payer mix will deteriorate, pressuring revenues even as cost structures remain elevated.

This isn't just a policy debate. It's immediate financial exposure—and it's unfolding in real time.



WHAT THIS MEANS FOR HEALTH SYSTEMS

Given these pressures, three implications are clear for boards and executives.

Increase Speed

Organizations that act before revenue gaps fully emerge are preserving stability. Those that wait risk deeper, more disruptive restructuring later.

Make Scale and Integration Nonnegotiable

Systems that grew through acquisition must finish the integration journey—operational, clinical, and financial—to realize true economies of scale.

Demand Strategic Clarity

Boards must guide decisive choices:

- Where will we grow?
- What will we stop doing?
- How will we navigate payer-mix deterioration?
- What capabilities must we build—or shed—to remain viable in 2026 and beyond?

Without a clear north star, cost cutting alone won't be enough.

The provider landscape is shifting fast.

Transformation has moved from a multi-year ambition to a near-term imperative. Market forces—from labor and payer mix to subsidy changes—now reward speed, integration and strategic discipline.

Health systems that act with urgency, boldness and clarity won't just stabilize—they'll position themselves for growth on the other side of this transition.

CONTACT

Chris George
Managing Director
A&M Healthcare Industry Group

chris.george@alvarezandmarsal.com

Follow A&M on:

ABOUT ALVAREZ & MARSAL

Founded in 1983, Alvarez & Marsal is a leading global professional services firm. Renowned for its leadership, action and results, Alvarez & Marsal provides advisory, business performance improvement and turnaround management services, delivering practical solutions to address clients' unique challenges. With a world-wide network of experienced operators, world-class consultants, former regulators and industry authorities, Alvarez & Marsal helps corporates, boards, private equity firms, law firms and government agencies drive transformation, mitigate risk and unlock value at every stage of growth.

To learn more, visit: AlvarezandMarsal.com/healthcare